NHS Digital

Agenda: Part 1 (Public Session)

07 September 2016 – 10:00 to 12:30

Venue: Macdonald Hotel Manchester, London Road, Manchester, Greater Manchester, M1 2PG

Ref No	Agenda Item	Time	Presented By
NHSD 16 03 01	***Chair's Introduction and Apologies* (oral)**	10:00	Chair
NHSD 16 03 02	***Declaration of Interests and Minutes***	10:05	Chair
	(a) Register of Interests (paper) – **for information**		
	(b) Minutes of Board Meeting on 08 June 2016 (paper) – **to ratify**		
	(c) Matters Arising (oral) – **for comment**		
	(d) Progress on Action Points (paper) – **for information**		
NHSD 16 03 03	***Strategic Delivery and Operational Performance***	10:15	
	(a) Board Performance Pack (paper) – **for information**		CEO
	(b) Paperless 2020 Update Report (paper) – **for comment**		Chief Operating Officer
	(c) Corporate Business Plan 2016-17 (paper) – **for ratification**		Director of Finance and Corporate Services
NHSD 16 03 04	***Strategy and Capability***	10:45	
	(a) Clinical Governance and Safety (paper) – **for information**		Medical Director and Caldicott Guardian
NHSD 16 03 05	***Governance and Assurance***		
	(a) Data Release Audit Status Report (paper) **– for information.**	11:00	Medical Director and Caldicott Guardian
	(b) **Directions for Acceptance:**	11:15	
	i. Directions: Diabetes Prevention Programme (paper)		Director of Information and Analytics [1] (i to iii)
	ii. Department of Health Directions: GP Metrics (paper)		
	iii. Department of Health Directions: Interim Out of Area Treatment (OATs) Collection Direction (paper)		
	iv. National Pandemic Flu Directions (paper)		Chief Operating Officer
	v. NHS Improvement Mandatory Request for Patient Level Costing (paper) – **for ratification**		Director of Information and Analytics [2]
	(c) **Committee Reports:**	11:40	
	i. Annual Assurance and Risk Committee (ARC) Report: 31 August 2016 (oral)		Committee Chair
	ii. Information Assurance and Cyber Security Committee (IACSC): 04 August 2016 (oral)		Committee Chair
	iii. Remuneration Committee: 12 August 2016 (oral)		Chair
	(d) Terms of Reference for the Board and the Board sub-committees (papers) – **for approval**	12:10	Chair
	(e) Board Appointments (paper) – **for approval**		Chair
	(f) Board Forward Business Schedule 2016-17 (paper) – **for information**		Chair
NHSD 16 03 06	***Any other Business*** (subject to prior agreement with Chair)	12:25	Chair

[1] To be presented by the Medical Director and Caldicott Guardian
[2] To be presented by the Medical Director and Caldicott Guardian

NHSD 16 03 07 ***Background Paper(s)*** (for information only)

(a) Type 2 Objections Including Information Commissioners Office Undertaking Update (paper) – **for information**
(b) Forthcoming Statistical Publications (paper) – **for information**
(c) Programme Definitions (paper) – **for reference**

Date of next meeting 30 November 2016 at NHS Digital, Trevelyan Square, Boar Lane, Leeds, LS1 6AE

Board meeting – Public Session

Title of paper:	**NHS Digital Board Members Register of Interests**
Board meeting date:	07 September 2016
Agenda item no:	NHS 16 03 02 (P1) a
Paper presented by:	Chair
Paper prepared by:	Annabelle McGuire, Secretary to the Board
Paper approved by: (Sponsor Director)	N/A
Purpose of the paper:	NHS Digital is required by its Standing Orders to maintain a publically available Register of Members' Interests. The Register contains, as they become available, the Declarations of Interest made by Board members.
Key risks and issues:	N/A
Patient/public interest:	Corporate Governance Transparency and Openness
Actions required by the board:	For information

NHS Digital Board Register of Interests 2016-17

Name	Declared Interest
Non-Executive Directors	
Noel Gordon: Chair	• NHS England Non-Executive Director • Pay Services Regulator (PSR) Non-Executive Director **Other Offices:** • Allen International – Non Executive Director • Uservoice.org - Chair of Trustees • AgeUK Development Board – Board Member • University of Warwick – Member of the Audit Committee • Advisory Committee, Accelerated Access Review - Member • Aleron – Senior Advisor **Shareholdings:** • Accenture
Sir Ian Andrews: Non-Executive Director Senior Independent Director	• Director of IMA Partners Ltd (formerly known as Abis Partnership Ltd) provision of legal and management consultancy services to government, academia (KCL[1]) and Transparency International UK • Consultancy advice to DH on aspects of governance of NHS Transformation, renegotiation of Connecting for Health contracts with CSC[2], and oversight of Fujitsu Arbitration process **Other Offices:** • Conservator of Wimbledon and Putney Commons • Trustee Chatham Historic Dockyard • Member of UK Defence Academy Academic Advisory Board
Dr Sarah Blackburn: Non-Executive Director	• Director - The Wayside Network Limited • Independent member of the Management Board, RICS[3] **Employment (other than with the NHS Digital):** • The Wayside Network Limited **Other Offices:** • Audit Committee member, RAC Pension Fund Trustee **Contracts held in last 2 years:** The Wayside Network Limited has: • a contract to supply GP and primary care nursing services to Avon and Wiltshire NHS Partnership • a zero hours contract with the Chartered Institute of Internal Auditors to provide an External Quality Assessment Reviewer and a viva voce

[1] King's College London
[2] Computer Sciences Corporation
[3] Royal Institution of Chartered Surveyors

Name	Declared Interest
	examiner **Shareholdings:** • 50% of The Wayside Network Limited
Sir John Chisholm: Non-Executive Director	• Executive Chair – Genomics England Ltd. • Director – Historic Grand Prix Cars Association Ltd.
Professor Maria Goddard: Non-Executive Director	• Member of Board of Directors for the York Health Economics Consortium at the University of York. • Professor of Health Economics at the University of York and head of department/director of the Centre for Health Economics at the University of York
Sir Nick Partridge: Non-Executive Director Vice-Chair	**Other Offices:** • Chair, Clinical Priorities Advisory Group, NHS England • Deputy Chair, UK Clinical Research Collaboration
Executive Members of the Board	
Andy Williams: Chief Executive Officer (CEO)	• None
Rachael Allsop: Director of Workforce	• None
Beverley Bryant: Director of Digital Transformation	**Contracts held in last two years:** • Director of Digital Technology, NHS England (until 31 May 2015) **Other relevant interests:** • Silent Partner – Wildtrack Telemetry Systems Limited
Rob Shaw: Chief Operating Officer	• None
Carl Vincent: Executive Director of Finance and Corporate Services	• None

Name	Declared Interest
Ex Officio Board Members	
Professor Martin Severs: Interim Director of Information and Analytics, Medical Director and Caldicott Guardian	• Trustee of Dunhill Medical Trust, a research charity • Professor of Health Care for Older People with University of Portsmouth (Honorary) **Other Offices:** • Member of National Data Panel **Other relevant interests:** • Member of Royal College of Physicians, British Geriatrics Society, the Faculty of Public Health Medicine and British Medical Associates.
Tamara Finkelstein: Director General for Community Care, Department of Health	• To be confirmed
Keith McNeill: Chief Clinical Information Officer, NHS England	• To be confirmed
Executive Management Team Directors	
Tom Denwood: Director for Provider Support and Integration	• British Computer Society (BCS) Health, Vice Chair Policy and Strategy (a voluntary role at this registered charity) • Senior Responsible Owner (SRO) for Local Service Provider (LSP) Programmes on behalf of Department of Health • Senior Responsible Owner (SRO) for the Health and Social Care Network (HSCN) Programme on behalf of Department of Health (DH).
James Hawkins: Director of Programmes	• Parent Governor at St Peters Church of England Primary School, Harrogate
David Hughes: Director of Information and Analytics	• To be confirmed

Health and Social Care Information Centre

Minutes of Board Meeting – Wednesday 08 June 2016

Part 1 - Public Session

Present:

Non-Executive Director (Chair)	Noel Gordon
Non-Executive Director (Vice-Chair)	Sir Nick Partridge
Non-Executive Director (Senior Independent Director)	Sir Ian Andrews
Non-Executive Director	Dr Sarah Blackburn
Non-Executive Director	Sir John Chisholm
Non-Executive Director	Prof. Maria Goddard
Chief Executive Officer	Andy Williams
Director of Workforce	Rachael Allsop
Chief Operating Officer	Rob Shaw
Director of Finance and Corporate Services	Carl Vincent

In attendance:

Director of Digital Transformation	Beverley Bryant
National Provider Support and Integration Director	Tom Denwood
Director Of Programmes	James Hawkins
Interim Director of Information and Analytics, Medical Director and Caldicott Guardian	Prof. Martin Severs
Secretary to the Board and Head of Corporate Governance	Annabelle McGuire

1. **Chair's Introduction and Apologies** HSCIC 16 02 01 (P1)

1.1 The Chair convened a meeting of the HSCIC Board; he noted it was his first meeting as Chair.

The Chair welcomed Beverley Bryant, Director of Digital Transformation to her first Board meeting.

The Chair paid tribute to and thanked on behalf of the Board the previous Chair, Kingsley Manning for his extraordinary contribution and efforts in establishing and leading the HSCIC, he hoped to build upon these foundations.

1.2 The Chair confirmed that no apologies had been registered for the meeting.

2. **Declaration of Interests and Minutes** HSCIC 16 02 02 (P1)

2.1 (a) Register of Interest (paper): HSCIC 16 02 02 (a) (P1)

The Board agreed the register of interests was correct.

Sir Ian Andrews (non-executive director) notified a minor change in his overall Board declaration of interests, for reflection in the Register of Interests at the next meeting.

Sir Nick Partridge (non-executive director) notified a minor change in his overall Board declaration of interests, for reflection in the Register of Interests at the next meeting.

2.2 (b) Minutes of Board Meeting on 04 May 2016 (paper): HSCIC 16 02 02 (b) (P1)

As the Chair had not been present at the previous meeting Sir Nick Partridge (Non-Executive Director and Vice Chair) confirmed the minutes of the previous meeting were correct. The Board ratified the minutes of the meeting on 04 May 2016.

2.3 (c) Matters Arising (oral): HSCIC 16 02 02 (c) (P1)

There were no matters arising discussed.

2.4 (d) Progress on Action Points (paper): HSCIC 16 02 02 (d) (P1)

The Board noted the progress on action points resulting from the previous meetings. The Chair confirmed the monitoring of actions to completion.

3. **Business and Performance Reporting** HSCIC 16 02 03 (P1)

3.1 (a) Board Performance Pack (paper): HSCIC 16 02 03 (a) (P1)

The Chief Executive Officer presented this item. The purpose was to provide the Board with a summary of performance in April 2016. He highlighted by exception items for the Board's awareness.

He drew the Board's attention to the Programme Achievement key performance indicator, and to benefits reporting which was in development. He said that Service Performance had a red status, noting that this was a sensitive indicator and that this was due to GP Extraction Service performance issues. The Chief Operating Officer provided a response saying he felt this was an exceptional event, and explained the mitigating actions taken.

The CEO was pleased to report the good use of the training budget. He observed that recruitment had slowed, which he believed was temporary and due to transformational activities. The Director of Workforce and Transformation noted that it was a mixed picture in respect to staff engagement and morale, which was expected. She spoke about a number of workforce initiatives for increasing capacity and capability.

The CEO spoke about the development of the Data Quality indicator highlighting the progress made to demonstrating a more accurate representation. He noted the publication of the Data Quality Maturity Index, scheduled for quarterly updates. Work would continue on the development of the Data Quality indicator. The Board requested a re-examination of the measures used in the indicator

Action: Interim Director of Information and Analytics

The Board received the Board Performance Pack and noted the update.

3.2 (b) Annual Report and Statutory Accounts 2015-16 (paper): HSCIC 16 02 03 (b) (P1)

The Director of Finance and Corporate Services introduced this item. The purpose was to approve the Annual Report and Statutory Accounts 2015-16. He observed that the National Audit Office (NAO) audit had gone well this year, noting as expected there were some areas for improvement. The NAO report had not quite completed their work on their audit, but they were confident that no material issues would arise.

Non-Executive Director and ARC Committee Chair Dr Sarah Blackburn reported that the ARC had met in the morning and were recommending the Board approve the Annual Report and Statutory Accounts 2015-16.

The Board approved the Annual Reports and Statutory Accounts 2015-16 as a true, fair and accurate report, noting the dynamic environment in which the organisation was operating. The Board authorised the approval of minor non-material changes to the report prior to setting before Parliament to the CEO Andy Williams.

The signing and laying before Parliament of the Annual Report and Statutory Accounts 2015-16 was expected in early July 2016.

The Board thanked the Director of Finance and Corporate Services and the finance and audit teams for their considerable efforts.

4 **Transparency and Governance** HSCIC 16 02 04 (P1)

4.1 **Committee reports:**

(i) (a) Assurance and Risk Committee (ARC): 08 June 2016 (paper): HSCIC 16 02 04 (a) (P1)

The Committee Chair presented this item. The purpose was to provide the Board with a summary of organisational risk management, control, and assurance. She said that the Committee considers the HSCIC overall has a reasonably sound system to ensure the organisation remains within the risk appetite approved by the Board, she observed there remains scope for some improvements.

Non-Executive Director Sir Ian Andrews said that the cyber threat status would consistently be amber/red due to the unknown nature of threats that may arise.

Non-Executive Director Sir Nick Partridge observed that there had been a noticeable increase in focus in respect to risk management activity, which provided a higher level of assurance than in previous years.

The Chair thanked the Committee Chair for her ongoing exemplary work and for the extraordinary amount of effort undertaken by the Committee in 2015-16. The Board received and noted the update.

(ii) (a) Information Assurance and Cyber Security Committee (IACSC): 03 May (oral): HSCIC 16 02 04 (a) (P1)

The Committee Chair presented this item. The purpose was to provide the Board with an update from the Committee, which had met on 03 May 2016. He noted that it was rare for an organisation to have an Information Assurance and Cyber Security Committee. However, the vulnerability of organisations, the system, and a growing recognition that these were national security issues had led to the constitution of the Committee. He observed that there had been excellent representation from across government departments.

The Committee had considered the recommendations from the Information Security Standards Review, an update from the Information Security Risk Board chaired by the Department of Health, the development of the national cyber security programme CARECert, and progress on the internal cyber security programme, which included funding issues.

The Committee had also considered the proposals for a National Cyber Security Centre, observing that there was a good level of confidence across Whitehall in respect to progress.

He emphasised that raising the level of awareness of cyber security issues was of paramount importance. The Committee Chair observed that there was much work to do, and perhaps there would never be enough done. The focus was minimising risk and most importantly recovering from an incident. The Board noted the update.

4.2 (b) Board Forward Business Schedule 2016-17 (paper): HSCIC 16 02 04 (b) (P1)

The Committee Chair presented this item. The Chair said he would review future Board meeting schedules, format and structure of agendas, including the topics the Board should consider. The Chair invited Board members to notify the Board secretariat of items they wanted to add to future agendas. The Chair agreed to table his proposal for future Board arrangements in July so that any changes could be implemented from September onwards.

5 **Any Other Business (subject to prior agreement with chair):** HSCIC 16 02 05

There were no items of any other business discussed.

6 **Background Papers (for information)** HSCIC 16 02 06 (P1)

6.1 (a) Information Governance Strategy(Paper): HSCIC 16 02 06 (a) (P1)

The Board noted this paper for information.

6.2 (b) NHS England Diagnostic Imaging Dataset Directions (paper): HSCIC 16 02 06 (b) (P1)

The Board being satisfied with the assurances provided accepted the Direction.

6.3 (c) Data Access Sharing Requests Update (paper): HSCIC 16 02 07 (c) (P1)

The Board noted this paper for information.

6.4 (d) Forthcoming Statistical Publications (paper): HSCIC 16 02 07 (d) (P1)

The Board noted this paper for information.

6.5 (e) Programme Definitions (paper): HSCIC 16 02 07 (e) (P1)

The Board noted this paper for information.

7 **Date of Next Meeting**

7.1 The next statutory Board meeting will take place on Wednesday 07 September 2016.

The Board resolved that pursuant to the Public Bodies (Admission to Meetings) Act 1960 that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest' (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

Table of Actions:

Action	Action Owner
Work would continue on the development of the Data Quality indicator. The Board requested a re-examination of the measures used in the indicator.	**Interim Director of Information and Analytics**

Agreed as an accurate record of the meeting	
Date:	
Signature:	
Name:	
Title:	HSCIC Chair

Board meeting – Public Session

Title of paper:	**Update on action points from the previous meeting**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 02 d (P1)
Paper presented by:	Chair
Paper prepared by:	Annabelle McGuire, Secretary to the Board
Paper approved by: (Sponsor Director)	Action Updates as submitted by the relevant Executive Management Team director.
Purpose of the paper:	To share an update on action points from the previous meeting for information.
Key risks and issues:	As stated in the action and commentary
Patient/public interest:	Corporate Governance
Actions required by the board:	To note for information

Summary of progress against Board meeting actions

✓ = completed
c/f = on-going

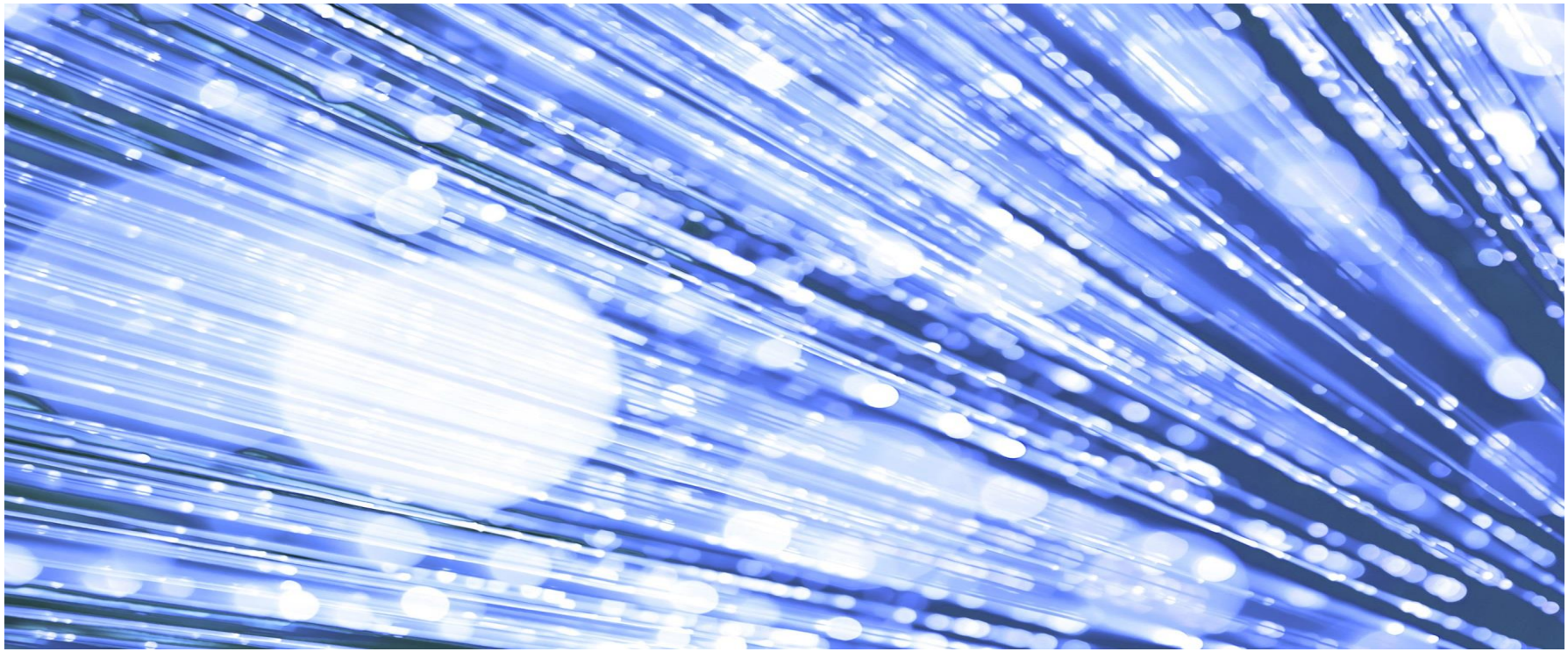
Status	Summary of Action	Commentary	Responsible Director	For Information Only
✓	Data Release Audits: The Board requested sight of the mechanism for undertaking the audits and consequential funding options in an appropriate timescale.	Stakeholder engagement with NED Maria Goddard, NED Sarah Blackburn and Andrew Street (York University) NED has commenced to discuss current thinking and receive input. A meeting with the ICO is arranged for mid-July to benchmark their auditing function and a meeting with Government Internal Audit is to be arranged. The submission of an options paper to the Board is scheduled for September.	**Interim Director of Information and Analytics, Medical Director and Caldicott Guardian**	Yes
c/f	The CEO spoke about the development of the Data Quality indicator highlighting the progress made to demonstrating a more accurate representation. He noted the publication of the Data Quality Maturity Index, scheduled for quarterly updates. Work would continue on the development of the Data Quality indicator. The Board requested a re-examination of the measures used in the indicator	Work to revise the Data Quality KPI to be based on the Data Quality Maturity Index (DQMI) has commenced. A proposal will return to EMT for discussion in August prior to the September Board meeting. The DQMI was discussed with DH Sponsors mid-June and was well received.	**Interim Director of Information and Analytics, Medical Director and Caldicott Guardian**	Yes

Board Meeting – Public Session

Title of paper:	NHS Digital Board Performance Pack
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 03 a (P1)
Paper presented by:	Carl Vincent, Director of Finance and Corporate Services
Paper prepared by:	David O'Brien, Head of Business Intelligence
Paper approved by: (Sponsor Director)	The Performance Pack is approved collectively by EMT in its corporate business management meeting held in advance of the Board papers being issued.
Purpose of the paper:	To provide the Board with a summary of NHS Digital's performance for July 2016.
Justification for inclusion in public board:	
Additional Documents and or Supporting Information:	No additional documents
Please specify the key risks and issues:	The corporate performance framework monitors NHS Digital performance including information governance and security.
Patient/public interest:	The public interest is in ensuring the NHS Digital manages its business in an effective way.
Supplementary papers:	For information only, a document entitled 'KPIs in Development has been placed in the Virtual Boardroom application. This shows work in progress mock-ups of new KPIs for Data Quality, Reputation, and Workforce.
Actions required by the Board:	**To note for information**

Board Performance Pack

July 2016 Data



www.digital.nhs.uk **enquiries@nhsdigital.nhs.uk** **@nhsdigital**

Contents

NHS Digital Performance Summary

Programme Achievement is reported as Amber-Green. Across all reported programmes overall delivery confidence for July was 65.1%, a decrease from 67.3% in June. One programme was rated as Red: Child Protection - Information Sharing, now Red for four consecutive months.

This KPI and supporting appendices now include information about Paperless 2020 programmes. Ten of these programmes are reporting progress via highlights reports, the appendices to this pack include a P2020 delivery dashboard derived from the highlights reports data. The appendices to the private pack include a tracker showing the progress made in initiating all P2020 programmes. In the coming months the main KPI page will be revised to strengthen reporting of P2020 work while retaining appropriate attention on legacy programmes.

Benefits data is reported for a limited selection of programmes: this data indicates that, compared to the baselined business case figures, 91% of planned investment is forecast to take place and 88.2% of expected benefits are forecast to be realised as a result.

IT Service Performance is reported as Red. 96.7% of services (56 out of 58) achieved their availability target. 92.9% of High Severity Service Incidents (26 out of 28) were resolved within their target fix time. 86.7% of services (13 out of 15) achieved their response time target. This KPI is Red this month, the key factor being a SUS performance issue at a critical level.

Organisational Health: The overall position remains amber, and is forecast to remain so next month. The overall compliance rate for mandatory training for all staff dipped but remains above target. The overall sickness absence level has decreased by 0.2%, with a small increase in long-term absence and a small decrease in short-term absence. Both short and long-term absence remain below levels for the same period last year. The business continues to attract and grow new talent: 11 interns started their 8 week placements in July. An apprenticeship event is being organised to target students who are exploring how to move from their course of study into the workplace. There has been a positive net movement in staff with 35 new hires joining this month. As predicted the seasonal slowdown in recruitment is reflected in the level of active recruitment taking place during the month. The rolling turnover rate has remains in the target bracket for the fourth month in a row. The overall PDR completion rate remains below target: completion figures and lists of outstanding PDRs will be sent to Heads of Workforce to help drive up the numbers.

Data Quality is reported as Green - all scheduled data quality reports were produced as planned. A new Data Quality KPI is in development and will be discussed in detail at the Board's development day in October. The proposed new KPI will include (a) information from the Data Quality Maturity Index concerning data quality across the system, and (b) information about the performance of NHS Digital's data quality processes.

Financial Management (NHS Digital) is reported as Green: This KPI is now based on the forecast surplus for the year, and is subject to an 'optimism adjustment' to factor in external developments and the resultant volatility in the organisation's bottom line for 2016/17. At Month 4 this KPI is reported as Green, with a forecast surplus for the year of £6.0m.

KPI Developments

A number of the corporate KPIs are undergoing development to ensure they remain fit for purpose. Drafts / mock-ups of three of these have been circulated to the Board as a separate item for information. These three are:

- Workforce (currently known as Organisational Health)
- Data Quality
- Reputation

Proposals for these, plus the Programmes Achievement KPI, will be discussed at the Board's development day in October.

Performance This Period

Performance Tracker: Rolling 12 months

Performance Indicator	Owner	Current Period	Current Forecast	Previous Forecast	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Programme Achievement	James Hawkins	A/G	A/G	A/G	A/G	A/G	A/G	A/G	A/G	A/G	A/G	A/G	A/G	A/G	A/G	A/G
IT Service Performance	Rob Shaw	R	G	G	A	G	G	G	G	G	G	G	R	R	R	R
Organisational Health	Rachael Allsop	A	A	A	A	A	G	G	A	A	A	A	A	A	A	A
Data Quality	Martin Severs	G	G	G	G	G	G	G	G	G	G	G	G	A/G	G	G
Financial Management: NHS Digital	Carl Vincent	G	G	G	G	G	A	A	A	R	R	R	N/A	G	G	G

KPI	Programme Achievement
KPI Owner	James Hawkins

Previous RAG	67.3%	A/G
Current RAG	65.1%	A/G
1 Month Future Forecast RAG	66.0%	A/G
2 Month Future Forecast RAG	69.5%	A/G
3 Month Future Forecast RAG	72.2%	A/G

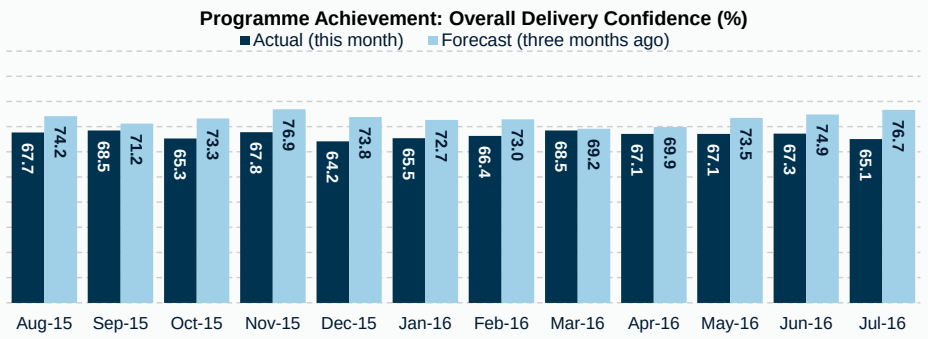
Overall delivery confidence across the portfolio for July is 65.1% (Amber Green). The delivery confidence figures derive from a combination of legacy programmes and the ten Paperless 2020 (P2020) programmes that are now formally reporting progress via highlights reports. The number of P2020 programmes reporting in this way will increase as mobilisation advances, and data from these programmes will be incrementally built-in to the figures for this KPI.

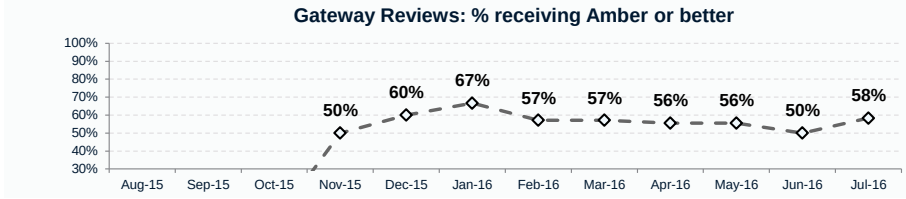
RAG Distribution

- One programme is reported as Red: CP-IS. This is the fourth consecutive month that CP-IS has reported Red for overall delivery confidence.

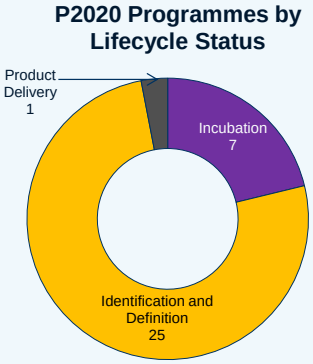
- Three programmes reported a delivery confidence of green: NHS Choices, Spine2 and SUS Transition.

KPI and Portfolio Composition
The appendices distinguish between P2020 programmes and non-P2020 programmes ('Legacy'). The KPI for Programmes Achievement will develop over the next few months to strengthen the reporting of P2020 whilst retaining appropriate attention to legacy programmes.





Gateway Reviews: 3 gateway reviews were carried out in July, GPSoC, CSC and eRS. We have not yet received a score for eRS . The rescore for HSCN has also now been included.



Lifecycle status Definitions:

- **Incubation** - Programme is undergoing a review process before initiation: (Health apps, Out of Hospital Care, Personal health record, Digital Child Health, Digital Diagnostics, Data Content, Innovative uses of Data)
- **Identification and Definition** - The initial concept for the programme is being expanded into a tangible business proposition including the basis for deciding whether to proceed with the programme or not.
- **Product Delivery** - The programme is co-ordinating and managing activity according to the Programme Plan. Currently only NHSMail2 is currently in Product Delivery

10 P2020 Programmes are currently able to report Delivery Confidence via highlight reports.

Benefits Reporting

In July:

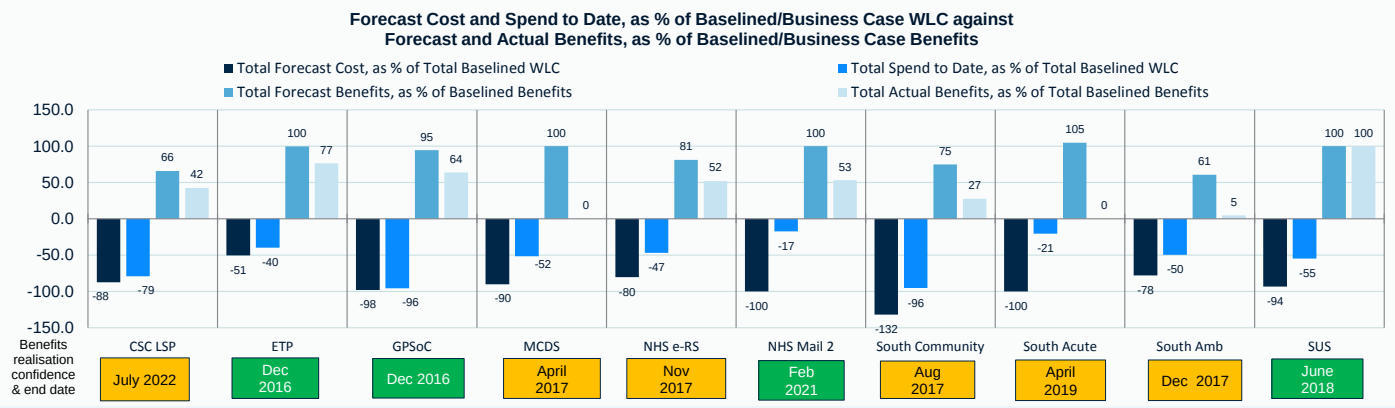
Average forecast cost as % of baselined / Business Case Whole Life Cost = 91%

Average spend to date as % of baselined / Business Case Whole Life Cost = 55%

Average forecast benefits as % of baselined / Business Case benefits = 88.2%

Average actual benefits reported to date as % of baselined / Business Case benefits = 42%

Current Criteria for inclusion:
Portfolio Office is in receipt of a Highlight Report and benefits data is reported.



KPI	**IT Service Performance**
KPI Owner	**Rob Shaw**

Previous RAG	R
Current RAG	R
Forecast RAG	G

Availability: 56 of 58 services (96.6%) achieved their availability target in July. The two exceptions were:

1. SUS: failed its availability target at a critical level. This resulted in a Red status for the overall KPI RAG. This breach was due to the SUS database becoming unresponsive on 01 July.

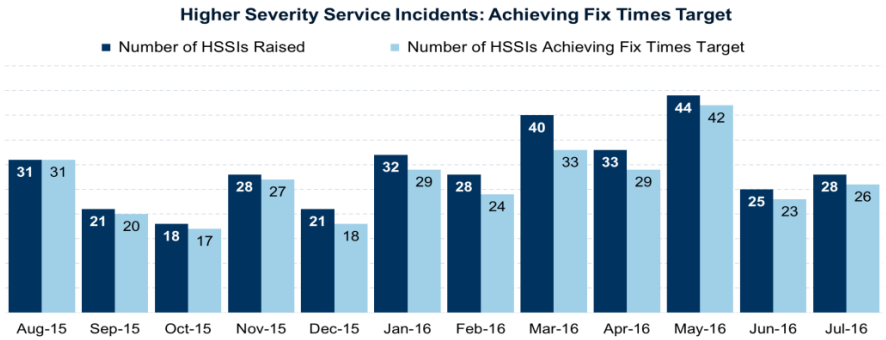
2. NHS Digital e-Referral Service: failed its availability target at a non-critical level. This breach was due to a number of servers losing their DNS configuration after a restart following the scheduled deployment of an e-RS operating system patch on 23 July. Root cause analysis for this breach is ongoing at the time of report production.

Fix Times: There were 28 High Severity Service Incidents (HSSIs) in July, compared to 25 in June. The rolling 12 month average is 29 per month. One HSSI was logged as a security incident, and one HSSI was logged as having both security and clinical safety implications.

26 of the 28 HSSIs (92.9%) achieved their fix time target. Two HSSIs failed their fix time target:

1. NHS Digital e-Referral Service: one Severity 1 HSSI failed its fix time target. This related to the e-RS outage referenced above. This HSSI took 5 hours and 17 minutes to fix against a target of 2 hours.

2 SUS: one Severity 1 HSSI failed its fix time target. This related to the SUS database issue referenced above. This HSSI took 5 hours and 22 minutes to fix against a target of 2 hours.



Response Times: Performance for the majority of services was good, with 13 out of 15 (86.7%) achieving or exceeding their response times target. Two services failed to meet their response time target:

1. Calculating Quality Reporting Service (CQRS): experienced a repeat failure at a non-critical level on Message Type 2a and a further repeat failure at a non-critical level against Message Type 4.

- Message Type 2a failed at a non-critical level this month as 18 out of 206 measurements failed to meet one or more of the service level thresholds. These were marginal failures with low impact on users: performance is significantly improved compared to the months prior to the introduction of the new Message Type Service Levels in May.

- The Message Type 4 breach was again caused by several instances of a long running Detailed Provider Achievement report. GDIT have deployed changes in early July which has improved performance for this Message Type and continue to investigate possible patterns of user behaviour which appears to impact the SLAs negatively.

2. CSC NME's Lorenzo: response times failed at a critical level against Transaction Types 7 and 8 on the LOR5101 (North West) Instance. Root Cause Analysis for this failure is ongoing at the time of report production.

Incidents of note outside the reporting period: Since the reporting period of July 2016 the following HSSIs have been reported which are worthy of note:

03/08 - e-RS: Users were experiencing latency or receiving messages on transactions, delaying the processing of referrals by up to 15 minutes, due to an issue with hardware servers. Impacted servers were restarted in order to resolve this issue.

04/08 - NHSmail2: Delays when sending/receiving emails to external domains outside NHSmail, due to a Load Balancer issue. The impacted Load Balancer was removed from live service and traffic failed over to the alternative Load Balancer to resolve this issue.

05/08 - NHSmail2: High volume of mail stuck in the processing queue on the relay server, due to issues with the IMSVA (InterScan Messaging Security Virtual Appliance) at both Accenture's Data Centres. Root Cause to be confirmed.

07/08 - iPatient: PAERS (Patient Access to Electronic Records) was unavailable to all users. Root cause is to be confirmed.

Forecast: It is forecast that a GREEN RAG status will be achieved in August 2016.

Performance Indicators	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
No. of Services achieving Availability target	64	65	63	59	57	56	56	56	57	55	60	56
No. of Services breaching Availability target, but not to a critical level	1	0	0	0	1	0	1	1	1	0	0	1
No. of Services breaching Availability target at a critical level	0	0	0	0	1	0	0	0	1	2	1	1
Total No. of Services measured for Availability Performance >>>>	65	65	63	59	59	56	57	57	59	57	61	58
No. of Services achieving Response Times target	22	22	19	16	16	15	14	14	13	15	15	13
No. of Services breaching Response Times target, but not to a critical level	0	0	0	1	1	2	0	0	0	0	1	1
No. of Services breaching Response Times target at a critical level	2	2	4	1	1	1	4	4	4	2	1	1
Total No. of Services measured for Response Times Performance >>>>	24	24	23	18	18	18	18	18	17	17	17	15
Total number of Higher Severity Service Incidents (HSSIs)	31	21	18	28	21	32	28	40	33	44	25	28
Total number of HSSIs achieving Fix Times target	31	20	17	27	18	29	24	33	29	42	23	26
% HSSIs achieving Fix Times target	100%	95%	94%	96%	86%	91%	86%	83%	88%	95%	92%	93%

Caveats:

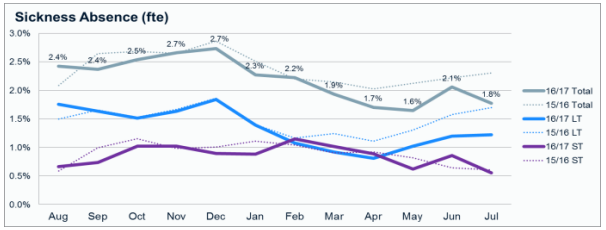
1. Current month's Availability data for the Atos (GPET-Q) service is yet to be received at the time of report production. Data to be included in next month's KPI.
2. Current month's HSSI Fix Time data for the Atos (GPET-Q) and Atos (GPET-E) services is yet to be received at the time of report production. Data to be included in next month's KPI.
3. All data in this report is unverified and subject to change, as none of it has yet been through Service Reviews with Supplier s.
4. If any changes are needed following the completion of all Supplier Service Reviews, these will be reflected in next month's K PI.

Organisational Health
Rachael Allsop

Overall Position: The overall position remains amber, and is forecast to remain so next month in spite of an increase in both new starters completing mandatory training and PDR submissions. The overall compliance rate for mandatory training for all staff has dipped again this month but still remains above target. The overall sickness absence level has decreased by 0.2% this month, with a small increase in the longterm absence and a small decrease in the short-term absence levels. Both short and long-term absence levels remain below those for the same period last year. The business is continuing to attract and grow new talent, 11 Interns started their 8 week placements in July. An apprenticeship event is being organised in August to target students who are exploring how to move from their course of study into the workplace.There has again been a positive net movement in staff with 35 new hires joining this month. As predicted the seasonal slowdown in recruitment is reflected in the level of active recruitment taking place during the month. The rolling turnover rate has continued to remain in the target bracket for the fourth month in a row. The overall PDR completion rate remains below target following the submission deadline at the end of June; further submissions have been received in July. Completion figures and lists of outstanding PDRs will be sent to Heads of Workforce to help drive up the numbers.

Previous	A
Current	A
Forecast	A

Summary Table	Target	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Engagement Score	>=70		73						75				
Engagement Actions Completed	>=90%	99%	96%	96%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PDR Completion	>=90%	89%	91%	12%	87%	90%	90%	90%	90%	80%	48%	74%	80%
Annual Training Spend / Head	£275/Year	£161	£192	£206	£228	£325	£352	£395	£518	-	-	£89	TBC
12 Month Average Sickness Absence%	<=3%	2.0%	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%	2.2%	2.2%	2.2%
Mandatory Training - All Staff (composite)	>=90%	#	#	#	#	45%	76%	89%	93%	93%	94%	93%	92%
Mandatory Training - New Starters (composite)	>=90%	#	#	#	#	#	#	52%	50%	61%	66%	59%	65%
Time to Hire - In post	>=70	54	64	62	62	69	69	72	78	56	51	53	60
Turnover	9% - 11%	8%	8%	8%	8%	8%	8%	8%	8%	11%	11%	11%	11%
Net Monthly Movement	TBC	12	3	11	43	12	28	-2	-13	-55	1	14	16



Engagement

- The **action plan** to track progress on the Corporate Response has been considered by the Workforce SMT and will be rolled out in September following some final amendments and clarification of responsibilities.
- Potential options for future staff surveys, developed by the staff survey steering group, have been presented to the Workforce SMT and the feedback is being incorporated into a final set of proposals for the **2016 survey**, which is likely to be launched in November.
- The staff survey group is also considering an option to develop the **'pulse' survey** as a tool to measure progress against survey actions rather than the current use as part of the 'reputation' KPI.

Training and Development

Training Days *(Civil Service Learning)*

- 364 training days and 228 hours of e-learning have been booked through CSL for FY16/17 as 1st May 2016. This equates to an average of 0.43 training days per person based on headcount.

Mandatory Training - Induction of New Starters

- Corporate Induction event 52% / Online Induction access 78% - those who have joined in the last 3 months

Mandatory Training - All Staff

- Fire Safety compliance score: 88%
- Information Security compliance score: 96%
- Information Governance compliance score: 95%

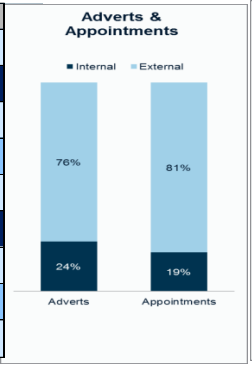
PDR Monitoring is now reported on a rolling 6 month basis

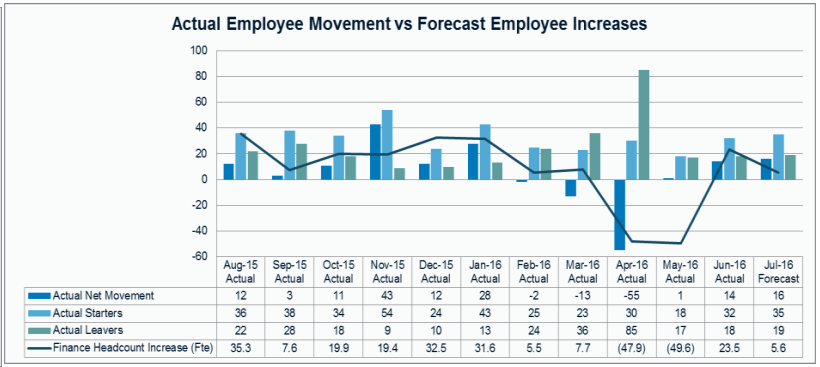
Sickness Absence

- The graph above shows the actual absence in month. The long-term absense level has **increased marginally**, but the short-term absence has **decreased** this month.
- Both short and long-term absence remains **below the level** for the same period last year.
- The 12-month rolling average absence rate has **remained stable** .

Growing Talent Summary	Final position, cumulative 15/16	Projected placements for 16/17	Appointments 16/17 to date
Work Experience Unpaid work shadowing up to 2 weeks	6	8	7
Apprenticeship Paid training role against framework/standard	7	63	2
Internship Paid 8 week placement	18	10	11
Graduate Training Scheme Paid high potential training scheme	9	30	14

Recruitment Summary		
Live Campaigns	% Total Time	Working Days
Advertising	**approval to advert**	
12	2.3%	1.43
Selection	**advert to outcome**	
26	61.9%	39.23
Appointment	**outcome to checks**	
50	21.5%	13.59
	checks to agreed start date	
	14.3%	9.03





	Aug-15 Actual	Sep-15 Actual	Oct-15 Actual	Nov-15 Actual	Dec-15 Actual	Jan-16 Actual	Feb-16 Actual	Mar-16 Actual	Apr-16 Actual	May-16 Actual	Jun-16 Actual	Jul-16 Forecast
Actual Net Movement	12	3	11	43	12	28	-2	-13	-55	1	14	16
Actual Starters	36	38	34	54	24	43	25	23	30	18	32	35
Actual Leavers	22	28	18	9	10	13	24	36	85	17	18	19
Finance Headcount Increase (Fte)	35.3	7.6	19.9	19.4	32.5	31.6	5.5	7.7	(47.9)	(49.6)	23.5	5.6

Attracting and Growing Talent

- 11 **interns** joined us in July - working on a variety of assignments for an 8 week period over the summer.
- An **apprenticeship** event will be held in August - one of the strongest periods for this type of recruitment as students look for their next step.
- A **recruitment campaign** is being planned for September following the Star Chamber on 24 August, however, adverts are currently being placed for ad hoc high priority vacancies.

Recruitment

- Now in the middle of the summer period, **active recruitment** reflects the expected seasonal low.
- Requirements are being finalised for a new **recruitment system** to replace NHS Jobs. Reporting within the system will provide us with a number of more sophisticated metrics such as cost per hire and quality of hire.
- Time to hire in July averaged 60 days to start date which **remains within our target**.

Net Movement

- **Headcount** at the end of July was 2749.
- 11 of the 19 **leavers** in July had less than 2 years' service. Over the past 12 months, 57% of leavers had only been employed for 2 years or less.
- A number of leavers in July were employed in the **Commercia**l profession. Face to face exit interviews were held and feedback provided to the profession.
- A full review of the exit process is being carried out, with the aim of increasing exit questionnaire responses.

KPI	**Data Quality**
KPI Owner	**Martin Severs**

New KPI pages for Data Quality are in development. These will show (a) data quality across the health and care system and (b) performance of NHS Digital's data quality processes.

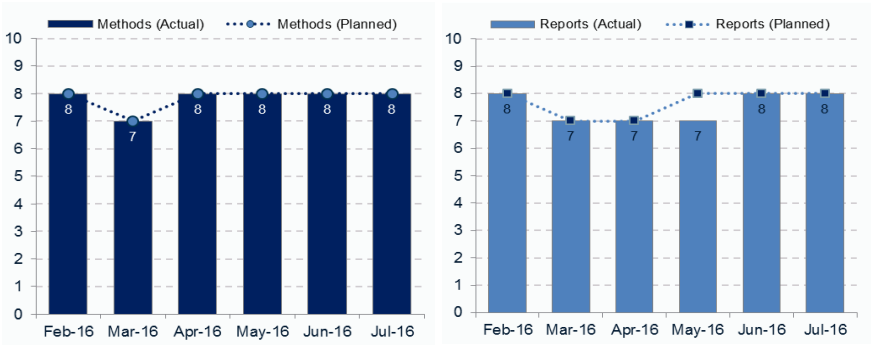
Previous RAG	G
Current RAG	G
Forecast RAG	G

Overall Position
The overall RAG rating this month is GREEN

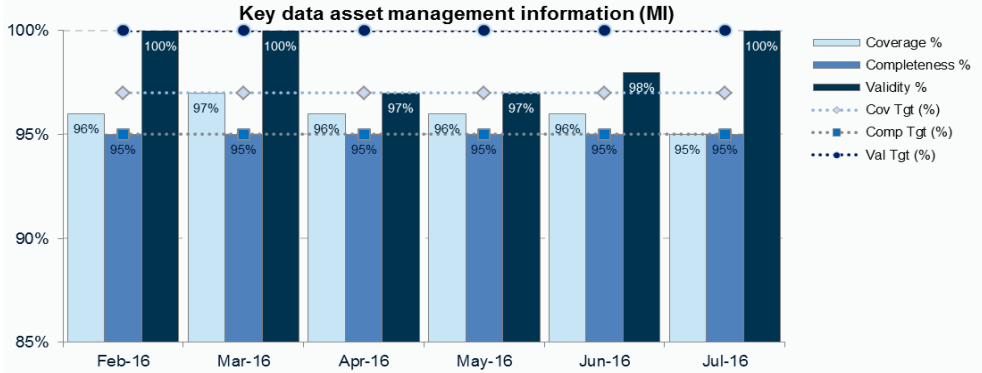
Forecast
The forecast RAG is GREEN

Notes:
- The data for this report is sourced from the HSCIC teams responsible for landing, assessing and reporting on the quality of the individual datasets in line with the current version of the applicable Standardisation Committee for Care Information (SCCI) approved information standard
- There is up to a seven month lag due to the current data submission and reconciliation processes

Key data asset key performance indicator (KPI)



Key data asset management information (MI)



Key Performance Indicator (KPI) Commentary
- The KPI measures HSCIC performance in terms of access to data quality assessment methods and the reports based on the results of their application
- The current scope is eight key datasets: Admitted Patient Care; Outpatients; Accident & Emergency; Improving Access to Psychological Therapies; Mental Health Services; Diagnostic Imaging; Sexual and Reproductive Health Activity; and the National Child Measurement Programme.
- The May 2016 actual for Reports is 7 due to production difficulties experienced by the Diagnostic Imaging Dataset team post data processing move from the SAS development environment to the SAS live environment

Management Information (MI) Commentary
- The validity figures are displayed as 100% due to rounding
- MI measures the quality of data submitted by those data providers expected to submit data to the HSCIC in accordance with the current version of the applicable Standardisation Committee for Care Information (SCCI) approved information standard
- Data providers are responsible for the quality of data submitted. The HSCIC reports results of data quality assessments back to data providers to influence improvements
- The six key datasets currently in scope for these indicators are: Admitted Patient Care, Outpatients, Accident & Emergency, Improving Access to Psychological Therapies, Mental Health Services and Diagnostic Imaging
- The data items reported in this MI are not currently aligned to those reported in the DQMI. A single source of data for use by all corporate data quality reports is planned

NHS Number completeness and validity by dataset - cumulative available data (November 2014 - July 2016)

Dataset	Completeness of NHS Number (%)	Validity of completed NHS Number (%)
Admitted Patient Care (APC)	99%	100%
Outpatients (OP)	99%	100%
Accident & Emergency (A&E)	95%	100%
Improving Access to Psychological Therapies (IAPT)	95%	100%
Mental Health & Learning Disabilities Dataset (MHLDDS)[1]	100%	100%
Mental Health Services Dataset (MHSDS)[2]	99%	100%
Diagnostic Imaging Dataset (DID)	97%	100%

NOTE: Completeness shows the percentage of records that contained a value in the NHS Number field. Validity shows the percentage of those values that were valid. N.B. Figures are rounded.

[1]MHLDDS figures based on data up to and including February 2016.
[2]MHSDS figures based on data from and including April 2016.

Dataset level information by data quality measure - cumulative available data (November 2014 - July 2016)

Dataset coverage (%)	Completeness of reported data items (%)	Validity of completed data items (%)
98%	100%	100%
96%	100%	100%
91%	98%	100%
98%	87%	98%
98%	95%	98%
92%	85%	99%
100%	92%	99%

NOTE: Each dataset reports on different data items with different rules for completion and validation. Consequently, the results for completeness and validity should not be compared on a like-for-like basis. N.B. Figures are rounded.

[1]MHLDDS figures based on data up to and including February 2016.
[2]MHSDS figures based on data from and including April 2016.

KPI	**Financial Management (NHS Digital) - for public session of the Board**
KPI Owner	**Carl Vincent**

Previous RAG	G
Current RAG	G
Forecast RAG	G

	Budget (£m)	Forecast (£m)	Var (£m)
Income (GiA, ring-fenced & other)	(222.6)	(222.3)	(0.3)
Costs (incl. contingency)	222.6	226.5	(3.9)
(Surplus)/Deficit	**0.0**	**4.2**	(4.2)
Optimism adjustment:	(5.0)		(5.0)
P2020 income to cover staff		(15.0)	15.0
Staff costs/ recruitment of 250 FTEs		7.3	(7.3)
Release contingency		(2.5)	2.5
(Surplus)/Deficit - adjusted	**(5.0)**	**(6.0)**	1.0

REVISED KPI
The financial target for this year is a surplus of £5m from the original GiA budget.
KPI RAG status for the remainder of the year will be measured as follows:

Green	Surplus between £3.5m and £6.5m
Amber	Surplus from £2.0m-£3.5m or £6.5m-£8.0m
Red	Surplus under £2.0m or over £8.0m

The financial target for the 2016/17 financial year is to end the year with a £5m surplus against the maximum GIA budget set by the DH. This reflected an assessment of the likely pace of recruitment compared to the forecast in the teams across the organisation, and a prediction of the likely additional income for the Paperless 2020 programmes (P2020).

At M4 the detailed forecast based on current headcount plus optimistic recruitment assumptions results in a forecast overspend for the year if we were to receive no additional Income. Therefore the M4 forecast has been adjusted by a high-level optimism adjustment of £10.2m which takes into account expected P2020 funding to fund staff costs, an estimated realistic recruitment profile for the remainder of the year (250 FTE) and a release of contingency that was set aside at the spending review stage to fund workforce reductions - this results in a revised expected surplus of £6.0m against the restated surplus of £5.0m.

Budgets and forecasts are expected to change over the course of this financial year as the impact of P2020 and any funding realignment is factored into the organisational financial position. Given the expected volatility of the bottom line over the coming months, it is proposed to use a simplified financial KPI for the remainder of this financial year so that the key financial measure - our expected surplus for the year - can be clearly monitored.

Financial details are included in the Management Accounts in the Performance Pack.

2015-16 Financial Year Tracker	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	
RAG Rating	G	G	G									

Appendix 1 - Management Accounts

2016/17 NHS Digital Management Accounts as at 31st July 2016

Summary Position

£'m	Year-to-Date			Full Year		
	Budget	Actual	Var	Budget	F'cast	Var
Grant-in-Aid	(42.0)	(42.0)	(0.0)	(137.6)	(137.6)	(0.0)
External Income	(23.3)	(20.6)	(2.7)	(69.3)	(69.7)	0.4
Total Income	**(65.3)**	**(62.6)**	**(2.7)**	**(207.0)**	**(207.3)**	**0.4**
Staff Costs	46.0	48.9	(2.9)	139.2	140.9	(1.6)
Non-Staff Costs	19.5	16.7	2.9	60.6	63.5	(2.9)
Unallocated Costs	(0.3)	0.0	(0.3)	7.2	7.2	0.0
Total Costs	**65.3**	**65.6**	**(0.3)**	**207.0**	**211.5**	**(4.6)**
Optimism adjustment	(1.5)	0.0	(1.5)	(5.0)	(10.2)	5.2
(Surplus)/ Deficit	**(1.5)**	**3.0**	**(4.5)**	**(5.0)**	**(6.0)**	**1.0**
Ring-Fenced Programme GiA						
RF GiA Income	(4.8)	(4.5)	(0.3)	(15.6)	(14.9)	(0.7)
Staff Costs	3.0	2.7	0.3	9.4	8.7	0.7
Non-Staff Costs	1.8	1.8	0.1	6.2	6.2	(0.0)
(Surplus)/ Deficit	**(0.0)**	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**0.0**
Capital Expenditure	3.9	2.7	1.2	15.0	15.0	0.0
Depreciation	5.1	5.3	(0.2)	15.4	15.6	(0.2)

NOTE: figures throughout may not sum due to roundings to £0.1m. Exact figures are available if required

The core GiA budget for the financial year has been restated to be an estimated £132.6m, £5.0m under the maximum GIA budget set by the DH. This reflects an adjustment to include a realistic assessment of the likely pace of recruitment compared to the forecast in the teams across the organisation, and a prediction of the likely additional income for the Paperless 2020 programmes (P2020). Overall, on current headcount, plus additional planned recruitment we would be heading to an overspend for the year without any additional Income. Hence the M4 forecast has been adjusted by a high-level optimism adjustment of £10.2m which takes into account expected P2020 funding to fund staff costs, an estimated realistic recruitment profile for the remainder of the year (250 FTE) and a release of contingency that was set-aside at the spending review stage to fund workforce reductions - this results in a revised expected surplus of £6.0m against the restated surplus of £5.0m.

Core GiA - the year-to-date outturn for the first four months of the year is £4.5m/ 11% above budget. The £4.5m overspend is due to lower than budgeted income and higher than budgeted staff costs, partially offset by lower than budgeted non-staff costs. The forecast outturn for the full year is £1.9m/ 1.4% over the restated budget, due to higher than budgeted staff and non-staff costs, partially offset by a central adjustment for achievable recruitment and P2020 income.

External income is £2.7m below budget for the year-to-date and £0.4m above budget for the full year. The variances are largely offsetting reduced expenditure on externally funded work but are also impacted by a conservative approach to income recognition in the early months of the year while ABR reporting becomes established compared to a largely flat-phased budget.

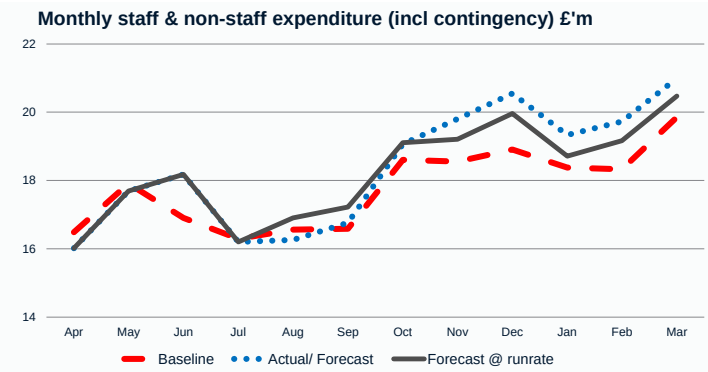
Staff Costs are £2.9m above budget for the year-to-date and forecast to be £1.6m over budget for the full year. This is partly due to the budget for Staff Costs including savings targets from resource matching which have not yet been fully realised. Additionally, the Professional Pools budgets have not yet been increased for expected additional P2020 funding, even though some staff costs are now being incurred in the Pools for these programmes.

Non-Staff Costs are £2.9m under budget for the year-to-date but are forecast to be £2.9m over budget for the full year, primarily driven from External Services. A breakdown is shown on Page 2.

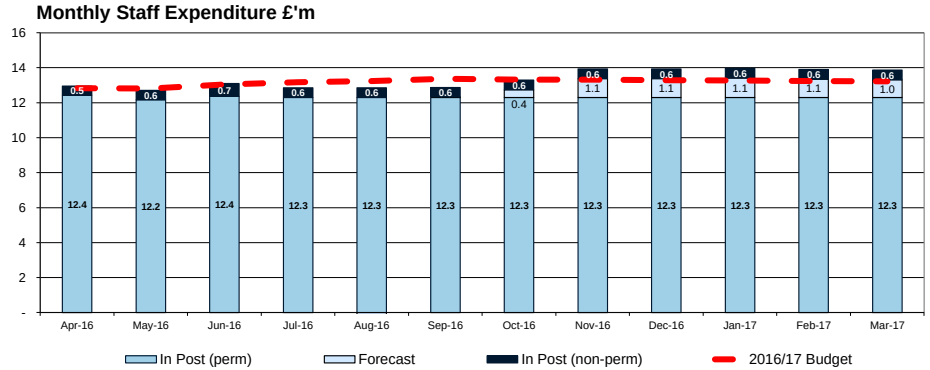
Ring-fenced GiA - the year-to-date outturn is £0.3m under budget and forecast to be £0.7m under budget for the full year, driven by lower staff costs due to recruitment delays. To Note: RF budget and costs have increased by £4.0m in the M3 reports to include additional ring-fenced funding for HSCN transition costs.

Capital - £1.2m under budget for the year-to-date but expected full year spend remains at budget.

It should be noted that budgets and forecasts are expected to change over the course of this financial year as the impact of P2020 and any funding realignment is factored into the organisational financial position.



Monthly trend of gross actual/ forecast expenditure for the organisation against the budget and against an extrapolation if staff costs remain at July levels for the year



Actual staff costs, showing permanent staff by current establishment and future recruitment, plus forecast non-permanent staff. The red line shows the budget.

Appendix 1 - Management Accounts

2016/17 NHS Digital Management Accounts as at 31st July 2016

Detail by Income/ Expenditure Type

£'m	Year-to-Date			Full Year			
	Budget	Actual	Var	Budget	F'cast	Var	
Income							
Grant in Aid	(42.0)	(42.0)	(0.0)	(137.6)	(137.6)	(0.0)	
Grant in Aid (ring-fenced)	(4.8)	(4.5)	(0.3)	(15.6)	(14.9)	(0.7)	
Income	(23.3)	(20.6)	(2.7)	(69.3)	(69.7)	0.4	Financial recognition of external income is dependent on data to come from ABR reporting therefore there may be some adjustments required in the coming months as that reporting becomes operational. Forecast at M4 includes additional £2.3m for NSCP from Cabinet Office.
Total Income	**(70.1)**	**(67.1)**	**(3.0)**	**(222.6)**	**(222.3)**	**(0.3)**	
Staff Costs							
Permanent Staff	52.9	49.6	3.3	161.2	156.1	5.1	
Non Permanent Staff	3.2	2.7	0.4	8.5	8.3	0.2	Variance is across most professional pools; breakdown shown on following page
Staff Payroll costs	**56.1**	**52.4**	**3.7**	**169.8**	**164.4**	**5.3**	
Savings to be found	**(5.3)**	**0.0**	**(5.3)**	**(15.8)**	**(10.5)**	**(5.3)**	
Permanent Staff	(1.0)	(0.4)	(0.7)	(3.1)	(2.5)	(0.7)	Capitalisation of staff costs is heavily reliant on the data quality from ABR; more review is to be done of the data coming through the time-recording system against assets.
Non Permanent Staff	(0.8)	(0.4)	(0.4)	(2.2)	(1.8)	(0.4)	
Capitalised Staff Costs	**(1.8)**	**(0.8)**	**(1.0)**	**(5.4)**	**(4.3)**	**(1.0)**	
Net Staff Costs	**49.0**	**51.6**	**(2.6)**	**148.6**	**149.6**	**(1.0)**	
Other Costs							
External Services	7.9	6.7	1.2	25.4	29.2	(3.7)	
ICT	6.7	5.7	1.0	20.9	19.9	1.0	
Travel and Subsistence	1.6	1.6	0.0	4.7	4.7	(0.1)	Full year variance on External Services is primarily from increased spend on Workpackages, in particular £2.3m for NCSP programme funded by additional income forecast from Cabinet Office
Estates and Facilities	4.1	3.7	0.5	12.9	12.8	0.0	
Staff-related Costs	0.7	0.4	0.3	2.1	2.1	0.0	
Communications	0.3	0.3	(0.1)	0.8	1.0	(0.2)	
Total Other Costs	**21.4**	**18.4**	**2.9**	**66.8**	**69.7**	**(3.0)**	
Unallocated Costs							
Central Contingency	(0.3)	0.0	(0.3)	7.2	7.2	0.0	
Savings							
Savings	(1.5)	0.0	(1.5)	(5.0)	(10.2)	5.2	
Depreciation							
Depreciation Grant-in-Aid	(5.1)	(5.1)	(0.0)	(15.4)	(15.4)	(0.0)	
Depreciation expenditure	5.1	5.3	(0.2)	15.4	15.6	(0.2)	
	0.0	**0.2**	**(0.2)**	**0.0**	**0.2**	**(0.2)**	

Appendix 1 - Management Accounts

2016/17 NHS Digital Management Accounts as at 31st July 2016 — **Detail by Professional Pool**

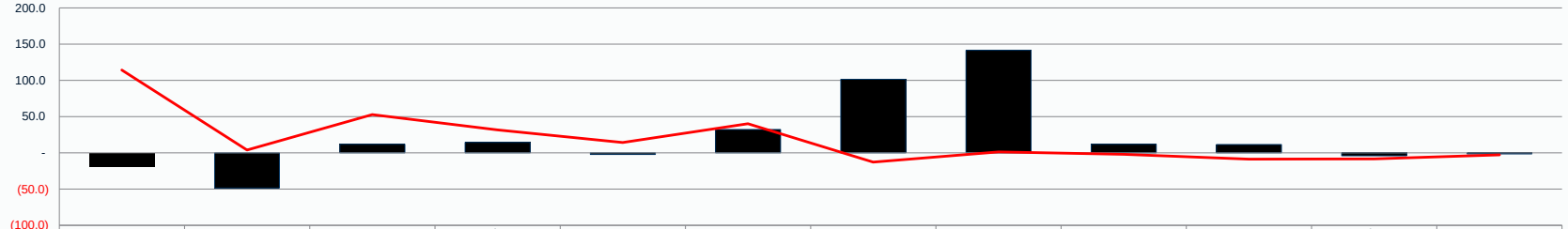
Staff Costs/ FTE	Year-to-Date £'m			Full Year £'m			Year-to-Date FTE			Full Year FTE		
	Budget	Actual	Var	Budget	F'cast	Var	Budget	Actual	Var	Budget	F'cast	Var
Project & Programme Delivery 1 (9 & 8d)	1.7	2.0	(0.3)	5.0	5.6	(0.6)	59.8	58.3	1.5	58.3	63.6	(5.3)
Project & Programme Delivery 2 (8c)	2.8	3.3	(0.5)	8.3	8.8	(0.5)	131.2	120.6	10.5	132.2	135.8	(3.6)
Project & Programme Delivery 3 (8b)	2.9	3.2	(0.4)	8.7	8.8	(0.1)	157.8	143.5	14.3	156.9	155.3	1.5
Project & Programme Delivery 4 (8a)	2.4	2.6	(0.2)	7.2	7.2	(0.1)	158.3	138.8	19.5	161.3	162.2	(0.9)
Project & Programme Delivery 5 (7&6)	1.8	2.0	(0.2)	5.5	5.4	0.1	175.5	150.3	25.2	168.5	169.2	(0.8)
Project & Programme Delivery 6 (5 & below)	0.5	0.5	(0.0)	1.5	1.4	0.0	59.0	52.4	6.7	56.0	55.9	0.2
Benefits Management	0.5	0.6	(0.1)	1.5	1.6	(0.1)	29.4	27.2	2.2	29.4	29.4	-
Business Analysis	2.1	2.0	0.1	5.9	5.6	0.3	117.1	101.3	15.8	111.6	113.7	(2.1)
Project & Programme Delivery Group	**14.6**	**16.3**	**(1.7)**	**43.6**	**44.5**	**(0.9)**	**888.0**	**792.4**	**95.7**	**874.0**	**885.0**	**(11.0)**
Data Management	1.0	0.9	0.1	2.9	2.8	0.1	63.3	55.9	7.4	63.3	69.6	(6.3)
Information Analysis & Statistics 1 (9, 8 & 7)	2.3	2.3	(0.0)	7.0	7.0	0.0	128.0	121.6	6.4	129.0	127.5	1.5
Information Analysis & Statistics 2 (6 & below)	1.4	1.4	0.0	4.2	4.3	(0.1)	126.9	122.1	4.8	124.9	131.5	(6.6)
Information Governance	1.2	1.0	0.1	4.3	3.9	0.4	69.5	49.3	20.2	77.5	76.5	1.0
Information Standards	0.9	1.0	(0.1)	2.8	2.8	(0.0)	53.8	44.8	9.0	53.8	53.5	0.3
Knowledge and Information Management	0.2	0.2	0.0	0.5	0.5	0.0	9.7	9.5	0.2	9.7	8.7	1.0
Information Management Group	**6.9**	**6.7**	**0.2**	**21.6**	**21.2**	**0.4**	**451.1**	**403.2**	**47.9**	**458.1**	**467.2**	**(9.1)**
Infrastructure & Technology Specialist	2.2	2.3	(0.1)	6.4	6.8	(0.4)	110.6	108.2	2.4	108.6	113.6	(5.0)
IT Service Operations	0.5	0.5	(0.0)	1.5	1.6	(0.0)	39.4	39.3	0.2	39.4	40.4	(1.0)
Service Management 1 (9 & 8)	2.6	2.6	0.0	7.7	7.7	(0.0)	118.6	113.2	5.4	117.8	119.8	(2.0)
Service Management 2 (7 & below)	1.4	1.3	0.0	4.2	4.1	0.1	98.9	95.0	3.9	99.4	100.0	(0.5)
Software Development	3.4	3.2	0.2	10.3	10.2	0.1	173.5	158.6	15.0	181.1	196.0	(14.9)
Solution Assurance	3.3	3.1	0.2	10.2	9.7	0.5	169.9	154.0	15.9	170.5	175.0	(4.4)
System Engineering	0.5	0.5	(0.1)	1.6	1.7	(0.1)	23.0	21.8	1.2	27.0	25.8	1.2
Technical Architecture	2.1	2.3	(0.2)	6.3	6.5	(0.2)	90.2	74.6	15.6	89.7	90.4	(0.7)
Clinical Informatics	1.7	1.9	(0.1)	5.1	5.1	(0.0)	58.0	55.7	2.3	56.0	56.1	(0.0)
Information Technology Group	**17.7**	**17.7**	**0.0**	**53.3**	**53.5**	**(0.1)**	**882.1**	**820.2**	**61.9**	**889.6**	**917.0**	**(27.4)**
Communications and Marketing	1.2	1.2	(0.1)	3.4	3.5	(0.1)	74.6	70.5	4.1	69.8	68.5	1.3
Contact Centre	0.7	0.7	0.0	2.2	2.2	0.0	76.7	77.9	(1.2)	77.7	77.9	(0.2)
Relationship Management	0.2	0.3	(0.1)	0.7	0.9	(0.2)	11.4	13.0	(1.6)	11.4	12.4	(1.0)
Communication & Stakeholder Relations Group	**2.1**	**2.3**	**(0.1)**	**6.3**	**6.6**	**(0.3)**	**162.7**	**161.4**	**1.4**	**158.9**	**158.8**	**0.1**
Business and Operational Delivery 1 (9 & 8)	3.0	3.0	(0.0)	8.9	8.9	0.0	114.5	107.9	6.7	114.5	114.1	0.5
Business and Operational Delivery 2 (7, 6 & 5)	1.8	1.7	0.1	5.3	5.0	0.2	161.2	146.7	14.6	158.2	156.7	1.5
Business and Operational Delivery 3 (4 and below)	1.0	0.9	0.1	2.9	2.8	0.1	116.4	104.2	12.2	116.4	118.3	(1.8)
Finance	0.9	1.0	(0.1)	2.8	2.8	(0.1)	58.7	58.6	0.0	55.6	57.0	(1.4)
Human Resources	0.8	0.8	(0.1)	2.3	2.3	(0.0)	49.0	47.7	1.4	46.1	45.0	1.2
Procurement & Contract Management	1.7	1.6	0.1	5.4	5.0	0.4	67.5	60.7	6.8	68.5	68.5	-
Business Administration Group	**9.1**	**9.0**	**0.1**	**27.5**	**26.8**	**0.7**	**567.4**	**525.8**	**41.6**	**559.3**	**559.5**	**(0.1)**
Non-Pooled Headcount	**0.2**	**0.1**	**0.0**	**0.4**	**0.4**	**0.0**	**9.1**	**6.6**	**2.5**	**8.1**	**7.7**	**0.4**
Academy	**0.2**	**0.2**	**0.0**	**0.8**	**0.5**	**0.3**	**23.0**	**26.0**	**(3.0)**	**33.0**	**17.0**	**16.0**
Corporate	**0.1**	**0.2**	**(0.1)**	**0.3**	**0.4**	**(0.1)**						
Total	**50.8**	**52.4**	**(1.6)**	**154.0**	**153.9**	**0.1**	**2,983.5**	**2,735.5**	**247.9**	**2,981.1**	**3,012.2**	**(31.1)**
Capitalised	**(1.8)**	**(0.8)**	**(1.0)**	**(5.4)**	**(4.3)**	**(1.0)**						
Net Staff Costs	**49.0**	**51.6**	**(2.6)**	**148.6**	**149.6**	**(1.0)**						

Appendix 1 - Management Accounts

2016/17 NHS Digital Management Accounts as at 31st July 2016

Headcount

Permanent Staff - Forecast Increase vs Budgeted Increase [FTE]



	Apr-16 Act	May-16 Act	June-16 Act	Jul-16 Act	Aug-16 Fct	Sept-16 Fct	Oct-16 Fct	Nov-16 Fct	Dec-16 Fct	Jan-17 Fct	Feb-17 Fct	Mar-17 Fct
Forecast Increase (FTE)	(18.9)	(48.6)	12.0	14.7	(2.0)	32.5	101.5	141.5	11.9	11.7	(4.0)	(1.3)
Budgeted Increase (FTE)	114.5	3.9	53.1	31.9	14.3	40.2	(12.7)	1.2	(1.9)	(8.8)	(8.2)	(2.6)

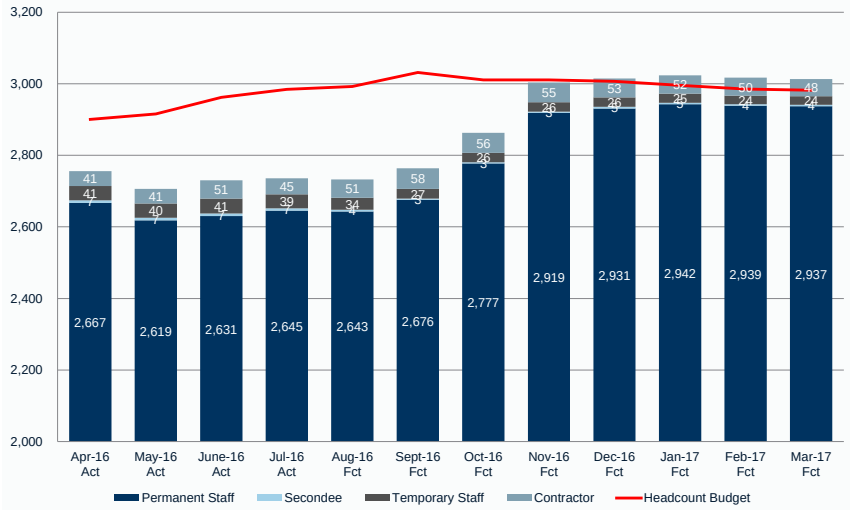
Forecast Increase (FTE) — Budgeted Increase (FTE)

The budget included a net increase of 203 permanent FTE over M1-4; however, due to staff leaving in April and May under the MAR scheme, net permanent headcount reduced by 41 FTE over the four months.

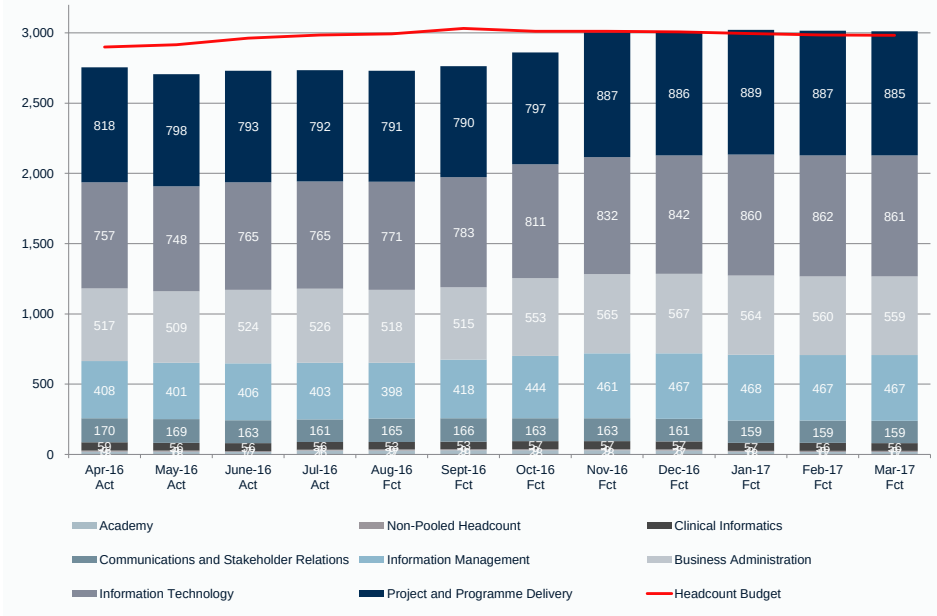
Note: FTE increase figure is as at payroll date therefore may differ from HR figures for the whole of the month.

Workforce: Budget vs Forecast [FTE]

(note: axis starts from 2,000)



Workforce: Budget vs Forecast by Profession [FTE]



Appendix 1 - Management Accounts

2016/17 NHS Digital Management Accounts as at 31st July 201 — Activity-Based Reporting

CORPORATE DELIVERY FUNCTIONS (Programmes, Projects & Services)

£'000 Directorate	Income	Staff Costs	Desk charge	IT charge	Other Costs	Delivery Support Functions *	Overhead charge	Net Total
PSI	(2,539)	9,308	566	289	1,237		2,443	**11,304**
HDS	(5,790)	8,159	564	288	2,702		2,229	**8,152**
O&AS	(12,532)	11,685	788	403	4,137		3,131	**7,611**
I&A	(3,387)	6,724	592	303	2,490		1,775	**8,497**
CPL	(95)	1,825	131	67	615		504	**3,046**
DT	(9)	578	59	30	20		166	**846**
F&CS		4	0	0			1	**6**
Workforce								**0**
ASI - to be remapped	(29)	129	8	4	(6)		33	**138**
To be mapped	(59)				0			**(59)**
Grand Total	**(24,441)**	**38,412**	**2,707**	**1,384**	**11,195**	**0**	**10,283**	**39,541**

CORPORATE OVERHEAD FUNCTIONS

£'000 Directorate	Income	Staff Costs	Other Costs	Net Total
PSI		196		**196**
HDS		273	6	**279**
O&AS	(322)	2,138	6,190	**8,006**
I&A		219	2	**221**
CPL		236	12	**247**
DT		891	162	**1,052**
F&CS	(78)	3,092	4,198	**7,212**
Workforce		643	18	**661**
ASI - to be remapped		70	0	**70**
To be mapped	(253)	100	393	**240**
Grand Total	**(653)**	**7,858**	**10,980**	**18,186**

NOTE: Above figures are year-to-date to July 2016. Full Year forecast reporting is in development. Figures, mappings and general data quality are still subject to detailed review by Portfolio Owners and Finance. Detailed breakdown to Portfolio Item available in Tagetik Analytics. "Other Costs" include depreciation (primarily GPES and Corporate ICT)
* Allocations are to be finalised for Delivery Support Functions

KPI	Programme Achievement
KPI Owner	James Hawkins

Appendix 2 - **P2020** Programme Delivery Dashboard

Paperless 2020 Dashboard - July 2016

Domain	P2020 No	Reporting Month:		Exec Portfolio	Overall Delivery Confidence RAG						Key Delivery Milestones			Current year financial forecast against budget			Investment justification (BC, MoU etc) forecast spend status			Benefits realisation confidence			
					May	Jun	Jul	Aug	Sep	Oct	May	Jun	Jul	Apr	May	Jun	May	Jun	Jul	May	Jun	Jul	
A	1	P0394	NHS Citizen Identity	HDS	G	G	A/R	A/R	A/R	A/R	G	G	G	R-O	R-O	R-O	R	R	R	N/A	N/A	N/A	-
A	2	P0425	NHS.UK	HDS	-	A	A	A	A/G	A/G	-	A	A	-	G	G	-	G	G	-	N/A	N/A	-
C	9	P0208	GP Systems of Choice Replacement	HDS	A	A	A	A	A	A	A	A	A	R-U	R-U	R-U	G	G	G	G	G	G	
C	12	P0413	GPES Continuity	HDS	A	A	A	A	A	A	A	A	A	A	A	A	N/A	N/A	N/A	-	N/A	N/A	N/A	-
D	15	P0341	SCIP	PSI	A	A	A	A/G	A/G	A/G	A	A	A	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
F	20	P0238	NHS e-Referrals	HDS	A	A	A	A	A	A	G	G	G	A	A	A	G	G	G	A	A	A	
H	25	P0453	National Data Services Development	I&A	A	A	A	A	A	A	A	A	A	G	G	G	N/A	N/A	N/A	-	A	A	A	
I	29	P0196	NHSmail 2	HDS	A/R	A	A	A	A/G	A/G	A	A	A	R-U	R-U	R-U	G	G	G	G	G	G	
I	30	P0190	Health and Social Care Network	PSI	A/R	A/R	A/R	A/R	A/R	A/R	R	R	R	R-U	R-U	R-U	A	A	A	A	A	A	
J	32	P0325	Cyber Security Programme	OAS	A/G	A/G	A/G	A/G	G	G	G	G	G	G	G	G	G	G	G	N/A	N/A	N/A	-

1st letter = RAG,
2nd letter = Under / overspend

Delivery Confidence - Paperless 2020:	
July-2016	A 58.00%
June-2016	A/G 66.00%

The current Delivery Confidence for the current Paperless 2020 Portfolio is Amber and is forecast to improve to Amber/Green by October 2016.

Sourced from Highlight Reports (Key RAGs) July-16
Sourced from Highlight Reports Jul-2016

KEY

Trend

⇧	RAG improvement from previous month
⇨	RAG same as previous month
⇩	RAG decrease from previous month

Non Completion

NR	No report provided or report provided but missing RAG in a section for which a RAG should have been provided
N/A	Data item is not applicable to programme or project (for example, MOUs may not be responsible for Benefits Realisation or be accountable for GDS Spend Approval)
TBC	Data item was not available at the time of report production (for example, discrepancies with budget figures or a lack or information around the progression of an approval)

KPI	Programme Achievement
KPI Owner	James Hawkins

Appendix 2 - **P2020** Programme Delivery Dashboard

Paperless 2020 Dashboard - July 2016

Domain	P2020 No		Reporting Month:	Quality Management against plan				Programme / Project end date				Current Investment Justification approval status				Digital & Technology Spend Controls Status				Resourcing Against Plan				Progress against planned mitigation for risk			
				May	Jun	Jul		May	Jun	Jul		May	Jun	Jul		May	Jun	Jul		May	Jun	Jul		May	Jun	Jul	
A	1	P0394	NHS Citizen Identity	N/A	N/A	N/A	-	G	G	G	⇨	G	G	G	⇨	N/A	N/A	N/A	-	A	A	A	⇨	G	G	G	⇨
A	2	P0425	NHS.UK	-	R	R	⇨	-	R	R	⇨	-	G	G	⇨	-	G	G	⇨	-	A	A	⇨	-	A	A	⇨
C	9	P0208	GP Systems of Choice Replacement	G	G	G	⇨	G	G	G	⇨	G	G	G	⇨	G	G	G	⇨	G	G	G	⇨	A	A	A	⇨
C	12	P0413	GPES Continuity	N/A	N/A	N/A	-	N/A	N/A	N/A	-	A	A	A	⇨	N/A	N/A	N/A	-	A	A	R	⇩	A	A	A	⇨
D	15	P0341	SCIP	G	G	G	⇨	G	G	G	⇨	G	G	G	⇨	G	G	G	⇨	A	A	A	⇨	G	G	G	⇨
F	20	P0238	NHS e-Referrals	G	G	G	⇨	G	G	G	⇨	G	G	G	⇨	G	G	G	⇨	A	A	A	⇨	G	G	G	⇨
H	25	P0453	National Data Services Development	G	G	G	⇨	G	G	G	⇨	A	A	A	⇨	A	A	A	⇨	A	A	A	⇨	G	G	G	⇨
I	29	P0196	NHSmail 2	G	G	G	⇨	A	G	G	⇨	G	G	G	⇨	G	G	G	⇨	G	G	G	⇨	A	A	A	⇨
I	30	P0190	Health and Social Care Network	G	G	G	⇨	A	G	G	⇨	G	G	G	⇨	A	A	A	⇨	G	G	G	⇨	R	R	R	⇨
J	32	P0325	Cyber Security Programme	G	G	G	⇨	G	G	G	⇨	G	G	G	⇨	N/A	N/A	N/A	-	G	G	G	⇨	G	G	G	⇨

Overall Delivery Confidence for Paperless 2020 (Calculated):	
July-2016	A 58.00%
June-2016	A/G 66.00%

The current Delivery Confidence for the current Paperless 2020 Portfolio is Amber and is forecast to improve to Amber/Green by October 2016.

Sourced from Highlight Reports (Key RAGs) Jul-2016

Trend

⇧	RAG improvement from previous month
⇨	RAG same as previous month
⇩	RAG decrease from previous month

NR	No report provided or report provided but missing RAG in a section for which a RAG should have been provided
N/A	Data item is not applicable to programme or project (for example, MOUs may not be responsible for Benefits Realisation or be accountable for GDS Spend Approval)
TBC	Data item was not available at the time of report production (for example, discrepancies with budget figures or a lack or information around the progression of an approval)

KPI	Programme Achievement (other Directorates)
KPI Owner	James Hawkins
Data Owner	Tom Denwood (Prov Sup), Martin Severs (I&A), Rob Shaw (O+AS)

Appendix 3 - Programme Delivery Dashboard

Existing Portfolio Delivery - July 2016

Reporting Month		Exec Portfolio	Overall Delivery Confidence RAG							Risk	Key Delivery Milestones			Current year financial forecast against budget			Investment justification (BC, MoU etc) forecast spend status			Benefits realisation confidence		
			May	Jun	Jul		Aug	Sep	Oct	RPA	May	Jun	Jul	Apr	May	Jun	May	Jun	Jul	May	Jun	Jul
P0012	Electronic Transfer of Prescriptions	HDS	A	A	A	⇨	A	A	A	N/A	G	G	G	R-U	R-U	R-U	G	G	G	G	G	G
P0026	NHS Choices	HDS	G	G	G	⇨	G	G	G	High	G	G	G	R-U	A	A	G	G	G	N/A	N/A	N/A
P0183	South Community Programme	PSI	A/G	A/G	A/G	⇨	A/G	A/G	A/G	Med	A	A	A	G	G	G	A	A	A	A	A	A
P0182	South Ambulance Programme	PSI	A	A	A	⇨	A	A	A	Med	A	A	A	G	G	G	G	G	G	A	A	A
P0181	South Acute Programme	PSI	A	A	A	⇨	A	A	A	High	A	A	A	R-U	R-U	R-U	G	G	G	A	A	A
P0031	CSC LSP	PSI	A	A	A/G	⇧	A/G	A/G	A/G	High	G	G	G	R-U	R-U	R-U	G	G	G	A	A	A
P0004	Child Protection – Information Sharing	PSI	R	R	R	⇨	R	A/R	A	Med	R	R	R	R-U	R-U	R-U	A	A	A	A	A	A
P0037	HJIS Current Service	PSI	A/G	A/G	A/G	⇨	A/G	A/G	G	N/A	G	G	G	R-O	R-O	R-O	G	G	G	N/A	N/A	N/A
P0207	Health & Justice Information Services	PSI	A	A/R	A/R	⇨	A/R	A/R	A/R	Med	A	A	R	R-U	R-U	R-U	G	G	G	G	G	G
P0301	FGMP	PSI	A	A	A	⇨	A	A	G	N/A	A	A	A	G	G	G	G	G	G	N/A	N/A	N/A
P0055	Maternity and Childrens Dataset	I&A	A/G	A/G	A/G	⇨	A/G	A/G	A/G	High	A	A	A	G	G	G	G	G	G	A	A	A
P0050	Spine 2	OAS	G	G	G	⇨	G	G	G	High	G	G	G	R-U	R-U	R-U	G	G	G	G	G	G
P0335	SUS Transition	OAS	G	G	G	⇨	G	G	G	High	G	G	G	A	G	G	G	G	G	G	G	G

Delivery Confidence - Existing Portfolio:	
July-2016	A/G 70.77%
October-2016	A/G 78.46%

The current Delivery Confidence of the existing Portfolio is Amber/Green in June 2016 and is forecast to improve but remain Amber/Green in October 2016

KEY

Trend

⇧	RAG improvement from previous month
⇨	RAG same as previous month
⇩	RAG decrease from previous month

NR	No report provided or report provided but missing RAG in a section for which a RAG should have been provided
N/A	Data item is not applicable to programme or project (for example, MOUs may not be responsible for Benefits Realisation or be accountable for Digital and Tech Spend Approval)
TBC	Data item was not available at the time of report production (for example, discrepancies with budget figures or a lack or information around the progression of an approval)

KPI	Programme Achievement (other Directorates)
KPI Owner	James Hawkins
Data Owner	Tom Denwood (Prov Sup), Martin Severs (I&A), Rob Shaw (O+AS)

Appendix 3 - Programme Delivery Dashboard

Existing Portfolio Delivery - July 2016

		Quality Management against plan			Programme / Project end date			Current Investment Justification approval status			Digital & Technology Spend Controls Status			Resourcing Against Plan			Progress against planned mitigation for risk		
		May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul
P0012	Electronic Transfer of Prescriptions	G	G	G	G	G	G	A	A	A	G	G	G	A	A	A	A	A	A
P0026	NHS Choices	A	G	G	G	G	G	G	G	G	G	G	G	G	A	A	G	G	G
P0183	South Community Programme	G	G	G	G	G	G	G	G	G	G	G	G	A	A	A	A	A	A
P0182	South Ambulance Programme	G	G	G	G	G	G	G	G	G	G	G	G	A	A	A	G	G	G
P0181	South Acute Programme	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G
P0031	CSC LSP	G	G	G	A	A	A	G	G	G	G	G	G	G	G	G	G	G	G
P0004	Child Protection – Information Sharing	G	G	G	R	R	R	G	G	G	G	G	G	A	A	A	R	A	A
P0037	HJIS Current Service	G	G	G	G	G	G	G	G	G	N/A	N/A	N/A	G	G	G	G	G	G
P0207	Health & Justice Information Services	G	G	G	A	A	A	G	G	G	G	G	G	A	A	A	A	A	A
P0301	FGMP	G	G	G	G	G	G	G	G	G	G	G	G	A	A	A	G	G	G
P0055	Maternity and Childrens Dataset	A	A	A	A	A	A	A	A	A	G	G	G	A	A	A	A	A	A
P0050	Spine 2	A	A	A	G	G	G	G	G	G	G	G	G	A	A	A	A	A	A
P0335	SUS Transition	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G

Delivery Confidence - Paperless 2020:	
July-2016	A/G 70.77%
October-2016	A/G 78.46%

The current Delivery Confidence of the existing Portfolio is Amber/Green in June 2016 and is forecast to improve but remain Amber/Green in October 2016

KEY

Trend

⇧	RAG improvement from previous month
⇨	RAG same as previous month
⇩	RAG decrease from previous month

NR	No report provided or report provided but missing RAG in a section for which a RAG should have been provided
N/A	Data item is not applicable to programme or project (for example, MOUs may not be responsible for Benefits Realisation or be accountable for Digital and Tech Spend Approval)
TBC	Data item was not available at the time of report production (for example, discrepancies with budget figures or a lack or information around the progression of an approval)

Board Meeting – Public Session

Title of paper:	**"Paperless 2020" Update**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 03 b (P1)
Paper presented by:	Rob Shaw, Chief Operating Officer
Paper prepared by:	Richard Clay, Programme Head
Paper approved by: (Sponsor Director)	Rob Shaw, Chief Operating Officer
Purpose of the paper:	To update the Board on the delivery progress of Paperless 2020 and the outcomes of the recent "Deep Dives" held in July 2016
Additional Documents and or Supporting Information:	National Information Board Leadership Summit on 8th September on Paperless 2020 Delivery Progress (paper includes 2 embedded documents; Annex A is pending confirmation at the time of submission)
Please specify the key risks and issues:	Reputation impact to NHS Digital if delivery is not successfully achieved to Ministerial expectations
Patient/public interest:	Direct – patients and public will directly benefit from the transformation of health of health of care resulting from the successful delivery of the collection of programmes called "Paperless 2020"
Supplementary papers:	• Annex A: Mapping of Current Portfolio to P2020 and Key Outcomes • Annex B: Paperless 2020 Domains – Programme Delivery Confidence Overview
Actions required by the Board:	The Board are asked to note the update on the delivery of Paperless 2020 and the outcomes of the recent "Deep Dives" held in July 2016.

NHS Digital

“Paperless 2020”

Delivery Update

7 September 2016

Information and technology
for better health and care

Contents

Purpose

This paper provides the National Information Board (NIB) with an update on the Paperless 2020 portfolio of programmes, which were announced at the NIB Leadership Summit in April 2016.

This paper outlines the progress made since then and provides further details on the programmes comprising the portfolio, an overview on how they will be delivered and measures being taken to assure delivery.

This paper is intended to help fulfil NIB's oversight role.

Background

Personalised Health and Care: A Framework for Action was published in November 2014 and was elaborated into a set of requirements by the eight NIB workstreams, which culminated in the publication of the workstream roadmaps (in June and September 2015). This set of requirements was translated into a proposed delivery portfolio during the Summer of 2015 and that was used to inform the health and care submission to the Spending Review that Autumn.

The subsequent financial settlement from the Spending Review required a review of our plans and priorities for transforming health and care through technology and a further period of intensive planning took place during February and March 2016. This involved representatives from NHS Digital, NHS England, the Department of Health and other Arms Length Bodies including CQC and Monitor.

In April 2016 we announced the 33 programmes, organised into 10 business domains, which we have collectively termed "Paperless 2020". This portfolio translates our ambition and objectives into a set of business led delivery programmes.

The overall composition of "Paperless 2020" was presented to the Secretary of State on the 4th April 2016 and announced at the NIB Leadership Summit on 20th April 2016.

Portfolio Structure

We have organised the programmes into a series of ten domains, related to the Five Year Forward View, in order to link technology and information to the transformation of the way care is delivered. We have appointed a Domain Business Sponsor to ensure the planned outcomes remain relevant to the needs of the health and care system, especially during periods of change.

The Domain Business Sponsor is a key leadership role and will work with the Senior Responsible Owners (SRO) and delivery teams to represent the needs of the health and care system and ensure that the programme outcomes remain relevant.

Governance

We have appointed Senior Responsible Owners at the domain level for each of the Domains, to lead and drive the work in the domains. The SROs will be accountable for delivery progress across the domain and will play a lead role in shaping and leading the necessary business change. This allows the SRO to consider the transformation of health and care for the domain resulting from the collective delivery of the multiple programmes within that domain.

NHS Digital has assigned delivery ownership of each Domain to a member of the NHS Digital Executive Management Team and appointed Programme Directors/Programme Heads to lead the programmes. The NHS Digital Executives will work closely with the Domain Business Sponsors and Senior Responsible Owners to define our delivery approach and ensure delivery is on track.

NHS Digital is mobilising resources to deliver the new programmes. We have examined our existing initiatives and delivery plans and are in the process of assigning appropriately skilled resources to the new programme teams, as our delivery plans are being developed and transitioning from the old to the new portfolio.

We understand the critical importance of clinical input throughout the lifecycle of a change and transformation programme but this is vital during the design and initiation stages. NHS Digital is aligning clinical resources to the Domains and Programmes within Paperless 2020 at this early stage of delivery to make sure clinicians are not just represented but have an active voice to shape both the outcomes which will support the transformation of care and the way the programme will be delivered.

We are working closely with the Strategic Clinical Reference Group as they develop the clinical priorities and requirements which will allow us to achieve the maximum clinical benefit from Paperless 2020. As the clinical requirements evolve we will map the delivery of these to the relevant Domains and Programmes. We will continue to work with the Strategic Clinical Reference Group to track delivery progress.

Tracking Delivery Progress: "Deep Dive" Checkpoint Reviews

Having identified and announced the key leadership roles responsible for delivery (including the Domain Business Sponsors, Senior Responsible Owners and Programme Directors/Programme Heads), we held a series of "Deep Dive" reviews; one per domain in July 2016.

The purpose of the sessions was to ensure complete alignment between the Domain Business Owners, Senior Responsible Owners and Programme Directors/Heads during the crucial "start-up" period. Each Domain was asked to present their long term vision, outline the scope of the programmes within their domain and provide an update on delivery.

The reviews were conducted by a "core" team" which included representatives from across the system including Andy Williams, Beverley Bryant and Rob Shaw (from NHS Digital), Tim Donohoe (from the Department of Health), Keith McNeil, Juliet Bauer and Ronan O'Connor (from NHS England) along with representatives from the Infrastructure and Projects Authority.

These sessions acted as a checkpoint on progress and enabled us to understand the cross-cutting issues facing the programmes. It also consolidated an understanding and agreement of scope between the Domain Business Sponsor, Senior Responsible Owner and the Programme Directors/ Programme Heads.

Progress Since April 2016

Portfolio Scope and Composition

During the Deep Dives sessions a number of proposals were made to amend the composition of the domains and the component programmes which they comprise. For example we believe the Personal Health Record programme better aligns to Domain A (Self Care and Prevention) than where it currently resides (within Domain D- Integrated Care).

We are currently assessing the impacts of all these changes and we will progress this through a change control mechanism which we will agree between NHS Digital, NHS England and the DH to ensure any changes from the baseline are appropriately tracked with appropriate governance. We expect to be able to communicate these agreed changes in late September 2016.

Financial Re-baselining

The individual programmes are separate entities which will need separate financial justification and approvals before any major investment decisions are made. The overall portfolio finances are therefore inherently integrated and tightly coupled. In our planning work earlier this year we had to balance the priorities for delivery with the need to ensure overall affordability based on the Spending Review settlement. Affordability considerations required the portfolio finances to balance within each financial year and separately by both revenue and capital spend, over the next five years.

Since April 2016 further work has been undertaken on the cost profile of delivering the portfolio. This has identified some changes to the original position. Some programmes are seeking additional funding (for example to allow earlier delivery of benefits, such as in the case of electronic referrals) whereas others have reflected on the profile of spend over the five years and the revenue-capital split.

We have considered the changes identified by the programme teams and have investigated areas of forecast change in a series of financial "Star Chamber" reviews. These reviews tested the validity of the proposals and any resulting anomalies. We also had some areas of underspend from existing activity to balance against these proposed changes. As a result we have achieved a balanced portfolio. We will track delivery progress against this revised position and if we need to revisit this due to future changes this may require some decisions about sequencing and priority to be taken.

Interdependencies/Scope

We have already identified the key technical interdependencies across the portfolio and we are ensuring our plans align to the timely delivery of these. The critical, cross portfolio areas of dependency across the Paperless 2020 portfolio include:

- Developing and applying a mature and standards-based interoperability architecture, allowing information to flow in a meaningful way between across the system;
- The delivery of the National Data Services Development Programme including the Data Services Platform as this is a crucial element of the supporting infrastructure to enhance our future capability for the efficient processing and storage of datasets from across health and care;
- Building enhancements to the National Spine, which is the key national infrastructure upon which we will develop components to enable the safe and secure transfer of information between organisations (for example through the Message Exchange Service for Health) and develop the National Record Locator Service;
- Providing a solution for Citizen Identity, enabling citizens to asset their identity and benefit from the provision of digital health and care services. This will enable patients and citizens to transact online, for example in managing their own referrals, prescriptions and appointments;
- Acting on the outcomes of the Review of Data Security, Consent and Opt-Outs undertaken by the National Data Guardian for Health and Care to ensure that we safeguard information about patient's health and care and enable the public to make informed choices about how their data is used; and,
- Ensuring we have an ability to uniquely identify patients to ensure that the right information about a person is always presented to clinicians and care staff.

Delivery Plans

Annex A shows the Domains and the Programmes which comprise them. Annex B shows a mapping to the Domains of our existing initiatives. Annex B also shows the existing delivery commitments over the coming years to give an outline of when delivery will take place.

More detail on the individual programme plans has been developed and this will be combined into a single, overarching plan to be presented to the Secretary of State in September 2016.

A small number of programmes in the portfolio remain with an "Incubation" stage where the scope of our ambition has not yet fully crystallised into a clear set of deliverables or clarified this scope with their business stakeholders and sponsors. In order to ensure that during this critical initiation phase we are providing extensive support to these programmes and the delivery teams are working closely with key stakeholders to define a clearly agreed scope which balances the priorities for transforming health and care whilst ensuring the scope of our ambition remains affordable.

The programmes which are currently in this "incubation" state are:

- Health Apps Assessment and Uptake (including Wearables);
- Personal Health Record;
- Digital Diagnostics; and,
- Out of Hospital Care.

We have reviewed our existing initiatives to ensure clear strategic alignment between any existing activities and our new programmes. All our existing initiatives have been mapped to the domains to ensure optimum use of the NHS Digital delivery resources and provide delivery clarity. This has identified some initiatives which are closing, having successfully delivered the outcomes required and also a series of existing initiatives which are no longer change programmes but a critical live service (such as the Electronic Prescription Service) which we will continue to deliver but as a live service.

Controls and Reporting

Portfolio delivery performance is governed and held to account through the Informatics Portfolio Management Board. The Board meets monthly and receives reports on delivery performance and financial performance and future forecasts. This Board is comprised of representatives from across the health and care system.

In future portfolio delivery progress reporting will be the responsibility of the Digital Delivery Board which is currently being established and will be chaired by Keith McNeil as Chief Clinical Information Officer for NHS England. NHS Digital will provide the Digital Delivery Board with reports on delivery, financial forecasts and benefit achievement.

Annexes

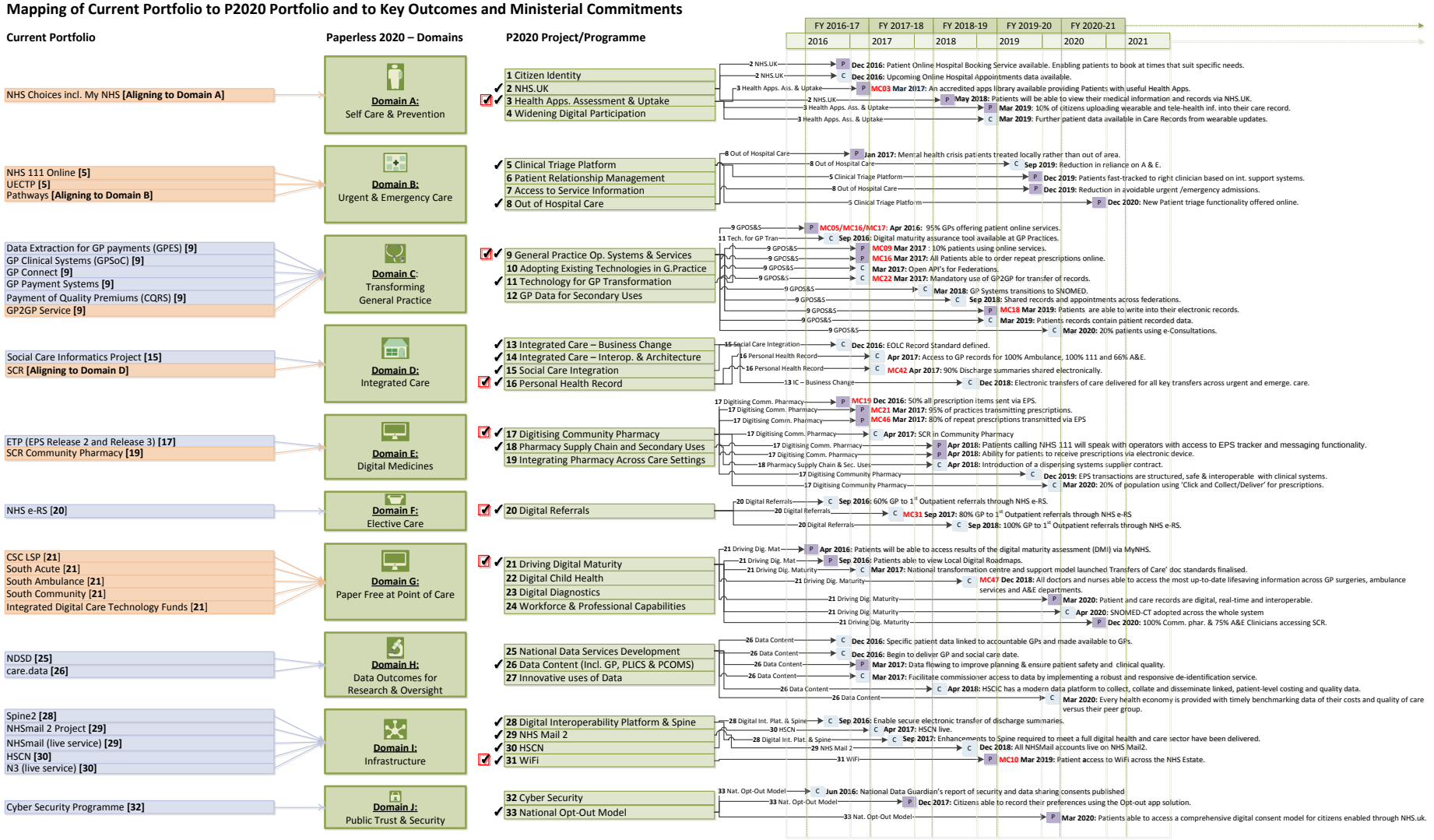
Annex A: Mapping of Current Portfolio to P2020 and Key Outcomes (File attached)

Annex B - Mapping of Current Portfolio tc

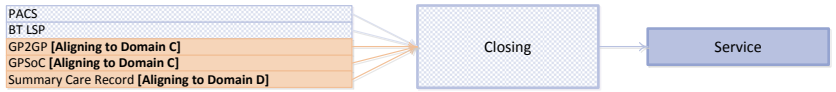
Annex B: Paperless 2020 Domains – Programme Delivery Confidence Overview (File attached)

Annex C - Domains and P2020 Delivery C

Mapping of Current Portfolio to P2020 Portfolio and to Key Outcomes and Ministerial Commitments



Projects and/or Programmes Closed, currently Closing and Transitioning to Service



KEY: Project/Programme in Current Portfolio mapped to a Domain in P2020 Portfolio; Project/Programme in Current Portfolio Closed or currently Closing; Project/Programme in Current Portfolio Transitioning to Service; [XX] = Project/Programme number in P2020; P Outcomes for Patients; C Outcomes for Clinicians; MCXX Unique Ministerial Commitment Reference; ✓ P2020 Programme with a Key Outcome; ☑ P2020 Programme with a Key Ministerial Commitment

P2020 Domains – Programme Delivery Confidence Overview

Version 3.0

RAGs taken from latest Highlight Reports, covering July activity

Domain A	Domain B	Domain C	Domain D	Domain E	Domain F	Domain G	Domain H	Domain I	Domain J
We will deliver the online services that patients need to take control of their own care, which will reduce the pressure on front line services.	We will help to deliver the national urgent and emergency care strategy by providing the digital infrastructure, algorithms and pathways we require.	We will use technology to free GPs from time consuming administrative tasks and provide patients with online services.	We will better inform clinical decision making across all health and care settings by enabling and enhancing the flow of patient information.	We will enable and improve pharmacy decision making and outcomes by providing patients and prescribers with streamlined digital services.	We will improve referral management and provide an improved treatment choice for patients by automating referrals across the NHS.	We will create an NHS "paper free at the point of care" by driving up levels of digital maturity and by enabling the NHS workforce to better utilise the benefits of digital technology.	We will deliver the health and care information and insight which is fundamental to informed policy making, commissioning and regulation by improving information collections, analysis and reporting.	We will enable information to move safely and securely across all health and care settings by providing robust and future-proofed national systems and networks.	We will provide the means for citizens to set their consent preferences. We will provide confidence that clinical and citizen information is held safely and securely and protect health and care systems from external threats.
1 Citizen Identity: Jul Sep **Oct**	5 Clinical Triage Platform: Jul Sep Oct	9* GP Opps Systems and Services: Jul Sep **Oct**		17 Digitising Community Pharmacy: Jul Sep Oct	20 Digital Referrals: Jul Sep **Oct**			29 NHSmail2: Jul **Sep** **Oct**	
2 NHS.UK: Jul **Sep** **Oct**	6 Patient Relationship MGMT: Jul Sep Oct	10 Adopting existing Tech in GPs: Jul Sep Oct		18 Pharmacy Secondary Uses: Jul Sep Oct					
3 Health Apps: Jul Sep Oct	7 Access to Service Info: Jul Sep Oct	11 Tech for GP Transformation: Jul Sep Oct		19 Integrating Pharmacy: Jul Sep Oct					
4 Digital Participation: Jul Sep Oct	8 Out of Hospital care: Jul Sep Oct	12 GP Data for Secondary Uses: Jul **Sep** **Oct**							
HDS									
			13 Integrated Care - Business Change: Jul Sep Oct			21 Driving Digital Maturity: Jul Sep Oct		30 HSCN: **Jul** **Sep** **Oct**	33 National Opt-Out Model: Jul Sep Oct
			14** Integrated Care - Interoperability and Architecture: Jul Sep Oct			22 Digital Child Health: Jul Sep Oct		31 Wi-Fi: Jul Sep Oct	
			15 Social Care Integration: **Jul** **Sep** **Oct**			23 Digital Diagnostics: Jul Sep Oct			
			16 Personal Health Record: Jul Sep Oct			24 Workforce and Professional Capabilities: Jul Sep Oct			
PSI									
							25 National Data Services Development: **Jul** **Sep** **Oct**		
							26 Data Content: Jul Sep Oct		
							27 Innovative uses of Data: Jul Sep Oct		
I&A									
								28** Digital Interoperability Platform + Spine: Jul Sep Oct	32 Cyber Security Programme: **Jul** **Sep** **Oct**
OAS									

***Note**: Delivery confidence for Programme 9 is that of GPSoC Replacment only, based on its most recent Highlight Report

****Note**: It is proposed that Programmes 14 and 28 are merged into a single Programme

KEY

Num.	Programme name	Jul	Current reporting month
		Sep	2 month forecast (from current reporting month)
		Oct	3 month forecast (from current reporting month)

R	Successful programme / project delivery appears unachievable. There are major issues which are not manageable. The project/programme may need re-baselining.
A/R	Successful programme / project delivery is in doubt. Urgent action needed to ensure significant risks and issues are managed.
A	Successful programme / project delivery appears feasible. Significant issues exist but appear resolvable.
A/G	Successful programme / project delivery appears probable, although constant attention needed to ensure risks do not materialise into major issues threatening delivery.
G	Successful programme / project delivery to time, cost and quality appears highly likely and there are no major outstanding issues that threaten delivery success.

Board Meeting – Public Session

Title of paper:	**Corporate Business Plan 2016/17: Formal Ratification**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 03 c (P1)
Paper presented by:	Carl Vincent, Director of Finance and Corporate Services
Paper prepared by:	David O'Brien, Head of Business Intelligence
Paper approved by: (Sponsor Director)	Carl Vincent, Director of Finance and Corporate Services
Purpose of the paper:	To formally ratify the approval of the refreshed NHS Digital Corporate Business Plan 2016/17. The business plan was approved by the Board on 27 July via a 'Chair's Action' procedure, and this decision now requires formal ratification
Justification for inclusion in public board:	The Corporate Business Plan is a public document, its ratification should take place in public session.
Additional Documents and or Supporting Information:	The Corporate Business Plan document was previously circulated to the Board ahead of the 27 July session. This document has not been re-issued for the 07 September meeting, but is available to Board Members through the Virtual Boardroom application.
Please specify the key risks and issues:	Uncertainties relating to funding and governance arrangements across the system made it difficult to plan activity and budgets for 2016/17. The requirement for HSCIC to manage with a reduced GiA budget in 2016/17 and in subsequent years. The organisation's ability to mobilise at pace to deliver its Paperless 2020 commitments.
Patient/public interest:	It is in the patient/public interest that this organisation plans it business well, with clear and achievable delivery commitments supported by sustainable financial plans.
Supplementary papers:	No supplementary papers, other than the Corporate Business Plan document available through the Virtual Boardroom application
Actions required by the Board:	**To ratify the previous decision to approve the refreshed 2016/17 Corporate Business Plan**

NHS Digital

Corporate Business Plan

Formal Ratification

7 September 2016

Information and technology
for better health and care

Contents

Executive Summary

This paper presents a refreshed version of the 2016/17 NHS Digital Corporate Business Plan for formal ratification by the Board. The business plan has been updated to capture more detail about the Paperless 2020 work. During the original business planning process there was insufficient clarity or certainty about Paperless 2020 to enable this to be included in the business plan approved in March.

Since the original planning process, Executive Portfolios have refreshed their 2016/17 plans and deliverables in light of the emerging detail about Paperless 2020 work. The Head of Business Intelligence has liaised with business leads across the organisation, and with the Paperless 2020 planning group, to ensure that the refreshed business plan captures the Paperless 2020 work sufficiently. This refreshed plan was approved by the Board on 27 July via the 'Chair's Action' procedure, and this approval now requires formal ratification.

Background

- Department of Health (DH) Arms-Length Bodies are required to prepare and publish an annual business plan. Given the financial, governance and other uncertainties affecting the 2016/17 planning process, DH agreed that this organisation could issue an 'interim' business plan at the end of March, followed later by a refreshed version. DH stipulated that the refreshed version should say more about Paperless 2020, about which there was incomplete information during the original planning process.
- The interim 2016/17 Corporate Business Plan was approved by the Board at its meeting on 30 March. This refreshed version was approved the Board on 27 July via a 'Chair's action', and now requires formal ratification by the Board.

Recommendation

1. The Board is asked to ratify the previous decision to approve the refreshed 2016/17 Corporate Business Plan.

The refreshed business plan follows the same format as the original document approved in March. However, there have been revisions throughout the document, mostly to insert references to Paperless 2020 or to reflect the organisation's transformation, new branding and other internal matters. The main changes to the document are as follows:

- an additional Section 1.3 to introduce the Paperless 2020 context
- additions to Sections 2.1 to 2.5 referencing specific elements of Paperless 2020 work
- a new Appendix 1 setting out the Paperless 2020 portfolio
- a new Appendix 2 showing how existing work maps across to Paperless 2020
- updated 2016/17 commitments /deliverables
- the organisation is positioned as NHS Digital rather than HSCIC

The refreshed business plan document, as approved in July, is available to Board members via the Virtual Boardroom application.

Implications

Strategy Implications

The Corporate Business Plan directly supports implementation of the NHS Digital's strategy 2015-2020, Information and Technology for Better Care. The business plan sets out the key delivery commitments that take forward this strategy during 2016/17. The business plan commitments for 2016/17 are organised around the NHS Digital's five strategic priorities, plus the sixth priority of transforming how we engage and work.

In addition, the business plan represents NHS Digital's contribution to other strategies within the health and care system, including:

- NHS England: Five Year Forward View
- Department of Health: Shared Delivery Plan: Our Health 2020
- The National Information Board: Paperless 2020

The document does not describe new governance and funding arrangements to be put in place across the system. These arrangements are yet to be agreed by all relevant bodies so it would be premature to put this information in the public domain in our business plan.

Financial Implications

The activities described in the business plan will be delivered during a period of financial restraint across the public sector. NHS Digital's Grant-in-Aid budget is expected to be reduced by 30% in real terms over the next four years, in line with government policy set out in the 2015 Comprehensive Spending Review.

The business plan sets out an overall operating budget of £227 million for 2016/17. Of this, £149 million is Grant-in-Aid received from the government, and the remainder is made up of income from other sources. This budget includes an estimate of the revenue funding we expect to receive for Paperless 2020 programmes.

Given the likely scale of the reduction in our funding over the coming years, the business plan outlines how we intend to manage on a lower budget. This includes reducing costs relating to staffing and buildings, achieving technical efficiencies, and improving the internal efficiency of the organisation.

Stakeholder Implications

DH and NHS England were involved throughout the original budget-setting and business-planning process. This included regular meetings and conference calls with key players, feedback on earlier drafts of the business plan, discussion at formal Accountability Meetings and other meetings.

There has been business-to-business engagement between NHS Digtial and other commissioning bodies, and wide-scale engagement across NIB partners regarding planning, budgeting and delivery arrangements to support the Paperless 2020 portfolio. The business plan aligns with documents prepared by DH and NHSE to support governance changes across the system.

Handling

The document positions the organisation as NHS Digital rather than HSCIC. Following its ratification by the NHS Digital Board, the business plan will be published on the organisation's website and publicised to staff as part of the launch of the NHS Digital brand. The published document will reflect the new branding and visual identity associated the new NHS Digital trading name.

Risks and Issues

Three significant areas of risk associated with the business plan are as follows:

1. Uncertainties relating to funding and governance arrangements across the system. These uncertainties made it very difficult to plan activity and budgets for 2016/17, and these are not fully resolved.
2. The requirement for NHS Digital to manage with a reduced budget for 2016/17 and in subsequent years. The business plan sets out the organisation's general approach to mitigating the risks associated with this scenario.
3. The organisation's ability to mobilise at pace to deliver its Paperless 2020 commitments. This is now a corporate risk to be managed by the organisation, and the planned capability review will feed into this.

Corporate Governance and Compliance

NHS Digital, like all DH ALBs, is required to publish an annual business plan. This requirement is set out in the Framework Agreement between NHS Digital and DH.

Management Responsibility

The manager responsible for this work is David O'Brien, Head of Business and Operational Delivery (Business Intelligence). The responsible corporate director is Carl Vincent, Director of Finance and Corporate Services.

Actions Required of the Board.

1. The Board is asked to ratify the previous decision to approve the refreshed 2016/17 Corporate Business Plan.

NHS Digital
Business Plan 2016/17

Version 6.10 150716

Q1 refresh.

Final version to be approved by HSCIC Board on 27 July

Contents

1. Introduction to our Business Plan for 2016/17

1.1 Who we are and what we do

NHS Digital is the new trading name for the Health and Social Care Information Centre.[1] We are the provider of national information, data and IT systems that support health and social care services. Our key role is to improve health and care in England by putting technology, data and information to work in the interests of patients, clinicians, commissioners, analysts and researchers in health and social care.

We provide a range of technology and information services that are used by patients and service users, the public at large, and health and care professionals, as well as by research, industry and commercial organisations. These services support the commissioning, design and delivery of health and social care provision England, and provide information and statistics that are used to inform decision-making and choice.

We have statutory duties which we discharge on behalf of the health and care system. We:

- Manage the collection, storage, processing and publication of national health and care information, as directed by the Secretary of State and NHS England.
- Deliver the national technology and infrastructure services that underpin the provision of health and care services.
- Manage the development and delivery of information standards products and services needed to support health and care provision, and the commitments of the National Information Board.
- Fulfil our data quality assurance responsibilities by expanding the services we provide to support improvements in data quality, and publishing our annual data quality report.
- Act as the national source of indicators by, for example:
  - Producing and publishing the NHS Outcomes Framework, the Clinical Commissioning Groups Outcomes Framework, and the Adult Social Care Outcomes Framework;
  - Managing the national library of assured indicators and their methodology;
  - Co-ordinating the assurance processes necessary to support the design and use of robust and meaningful indicators.
- Provide advice and support to health and care organisations on information and cyber security, standards and information governance.
- Develop the Information Governance Toolkit to support greater self-assessment for integrated services.
- Support system-wide management of administrative burden, providing the Secretary of State with our assessment of opportunities for reducing its impact on the front line.

[1] Established in 2013, we are an independent public service which operates as an executive non-departmental arm's length public body of the Department of Health.

2016/17 is an exciting year for NHS Digital. As well as launching our new identity, we welcome Noel Gordon as our new Chair and we are entering a new phase of major investment in technology to support health and care services. Following the 2015 Spending Review, the Secretary of State for Health announced a £4.3bn investment over five years to support more effective and efficient health services. 2016/17 sees the commencement of this work, and although much of the funding will target local delivery there will be significant investment in the national infrastructure and systems delivered by NHS Digital.

Our values form the foundation for everything that we do. They shape how we work as individuals and teams across the organisation to deliver our strategy and plans. Our values are:

People Focused	Trustworthy	Professional	Innovative
We value and promote positive relationships with colleagues, customers and the public and are responsive to their needs	We act with integrity, impartiality and openness and in the best interests of the public	We deliver on our commitments by applying the highest levels of expertise, conduct and personal responsibility	We actively embrace change and bring new ideas to deliver excellent services for our customers and better outcomes for the public

Detailed information about our services can be found on our website.[2]

1.2 The context for our business plan

2016/17 is a critical year for the health and care system as we strive collectively to redesign care models that can respond to increases and changes in demand for services, and at the same time manage with significant reductions in budgets across the system. The new investment in technology and infrastructure delivered by NHS Digital will help the health and care system to manage with reduced levels of general funding.

This is a transitional year for NHS Digital as we gear up to implement the National Information Board (NIB)'s vision of personalised health and care services supported by technology, data and information. This vision will be realised through a portfolio of work now known as Paperless 2020. This portfolio has been organised into 33 programmes arranged across 10 domains, as shown at Appendix 1. Our refreshed business plan reflects the key role NHS Digital has to play in delivering Paperless 2020.

Paperless 2020 is a fast-paced, evolving context, and the detailed planning that will underpin successful delivery remains ongoing at the time of this business plan refresh. Note, however, that delivery of Paperless 2020 does not start from a blank piece of paper. Some of the work involves accelerating or repositioning existing areas of activity. Appendix 2 illustrates how existing informatics work across the health and care system is already taking forward elements of Paperless 2020. In contrast, some of the Paperless 2020 programmes are at very early stages of scoping and planning, and so the delivery of these will not commence during 2016/17.

[2] See http://www.hscic.gov.uk/article/6776/One-pager-summaries-of-our-work

As well as taking forward our Paperless 2020 commitments, this business plan supports the wider health and care priorities set out in the Department of Health's *Shared Delivery Plan* and NHS England's *Five Year Forward View.* These reflect a consensus view across the national organisations involved in the health and care system regarding the need to:

- Reconcile the growing demand for health and care services with reducing resources.
- Focus on prevention, self-management and well-being in addition to treating ill-health.
- Increase the personalisation of care and support services to empower the citizen.
- Accelerate and extend the integration and devolution of services.
- Restore and maintain financial balance.
- Deliver care access and quality standards for patients.

These objectives are long term: they cannot be resolved in a one-year timeframe or by just one or two organisations. They require consolidated planning and delivery across all health and care organisations – national and local, commissioners and providers, policy and regulatory – all pulling in the same direction.

In all aspects of our work we are committed to supporting the wider health and care system, delivering added value and benefits for our customers and stakeholders, health and care organisations, patients and the public at large. We have a key role in the delivery of NHS England's *Five Year Forward View*, and Appendix 3 shows how our work contributes to the implementation of the Department of Health's *Shared Delivery Plan*.

2. Our Strategy for 2015-2020, Our Priorities for 2016/17

This business plan sets out our ambitions and commitments for 2016/17. These are shaped around the key themes set out in our five-year strategy for 2015-2020*, Information and Technology for Better Care*[3], which are to:

- Ensure that every citizen's data is protected.
- Establish shared architecture and standards so everyone benefits.
- Implement national services that meet national and local needs.
- Support health and social care organisations to get the best from technology, data and information.
- Make better use of health and care information.

We published our strategy in 2015, and we continue to focus our work around its five themes as these remain relevant for 2016/17 and beyond. They reflect our own areas of ambition for NHS Digital as well as the needs of the wider health and care system. To illustrate this, Appendix 4 shows how our strategic objectives align with the Paperless 2020 domains.

The specific 2016/17 commitments set out in this business plan take forward the implementation of our strategy, fulfil our statutory duties, and mobilise delivery of the Paperless 2020 portfolio. Appendix 5 lists our commitments and deliverables for 2016/17. The following sections outline the context of these commitments.

[3] http://www.hscic.gov.uk/media/16232/HSCIC-Draft-Strategy-2015-2020-Information-and-technology-for-better-care/pdf/80435_HSCIC_Strategy_2015-2020-v1g_%281%29.pdf

2.1 Ensuring that every citizen's data is protected

The importance of public trust and data security is at the heart of our strategy and is also captured in the Paperless 2020 work on Public Trust and Security. We have a vital role to build and retain public trust in the way data is used by health and care organisations. This is a critical dependency for improving the personalisation of health and care services. We:

- Publish and maintain the Code of Practice for sharing personal confidential data;
- Design and implement the national service for managing people's preferences and objections regarding the way their health and care data is used.

Our priorities for 2016/17 are shaped by the National Data Guardian's review of the way citizen data is shared across the system, and by the need for a clearer model for managing their preferences for sharing their data. The National Data Guardian report was published in July, and, reflecting the importance of this work, NHS Digital has provided extensive support to this work. Key priorities this year include the Paperless 2020 work to develop a new national patient consent and opt-out model and improvements to the Information Governance toolkit used by organisations across the healthcare system.

Our focus on cyber security is a high priority for the health and care system. On behalf of the Department of Health we lead the system-wide response to the growing cyber security risks faced by health and care organisations. For example, our CareCERT programme strengthens cyber-security capability across a health and care sector which uses disparate local systems, many of which are running on suboptimal software and often without the use of the latest protection packages. We:

- Provide an incident response capability for the management of system wide security incidents and issues.
- Are enhancing the capability of the N3 network to monitor for malicious activity and automatically block access to malicious sites.
- Provide a threat analysis and reporting capability which will work with other key government agencies to publish relevant information to the health and care system as a trusted provider.
- Provide good practice guidance and tools to give all staff within health and care a base capability in security and their personal responsibilities.

National data and national systems are secure and have never lost any data to a cyber-attack. Through our delivery of the Paperless 2020 cyber security work we will continue to improve our ability to protect health and care systems, networks and information.

2.2 Establishing shared architecture and standards so everyone benefits

NHS Digital has an important role in the development and use of standards. Our strategy commits us to doing more to support their adoption, and Paperless 2020 includes a number of commitments regarding this work.

We have made progress in the main areas, notably the adoption of the Academy of Medical and Royal Colleges' guidance on the transfer of care, and the adoption of SNOMED. We:

- Publish technical and information standards and guidelines, which facilitate the adoption of SNOMED CT across health care services. These will be even more important in terms of interoperability across the new services and care models being developed under the auspices of the *Five Year Forward View*.
- Provide support and tools for use by local organisations, including integrated care pioneers and vanguard sites, to support effective information governance, through the Information Governance Alliance.

2.3 Implementing national services to meet national and local needs

Our strategy commits us to making better use of national services to support social care and local government, and to open up access and connectivity to a wider range of providers, developers and service users.

We deliver a suite of technology and infrastructure services which are critical to the routine operation of the NHS. Paperless 2020 commits us to go beyond this existing provision by delivering the next generation of digital services to meet national and local needs. Examples include:

- Urgent and Emergency Care: we will provide digital infrastructure and pathways to support urgent and emergency care.
- Transforming General Practice: we will deploy technology to free GPs from time-consuming processes and provide patients with online services
- Digital Medicines: we will provide patients and prescribers with streamlined digital pharmacy services
- Elective Care: we will use automation to improve referral management and patient choice
- Infrastructure: we will provide robust and future-proofed national systems and networks to enable information to move safely and securely across health and care settings

The Paperless 2020 developments will build on the existing national infrastructure and services already provided by NHS Digital. These include:

- The Spine, which connects over 28,000 healthcare IT systems in 21,000 different organisations. Around 70% of the total NHS workforce are registered users of the Spine, and it carries around 6 billion messages every year. Key national programmes and services also use the Spine, including the Summary Care Record (55 million records), the Electronic Prescribing Service (1.7million prescriptions every day), and the Personal Demographics Service (800 million records)
- NHSmail, which provides a secure email and messaging service for the NHS and non-NHS organisations involved in care services. In one month alone - March 2015 - it delivered 169 million messages.
- NHS Pathways, which is used so much by NHS 111 that its loss would have serious implications for demand on accident and emergency services and on general practice.

- The N3 network, which is the core communications infrastructure carrying most of the data traffic used by NHS bodies and their partners. It has 46,000 connections over 15,000 sites and carries 600 terabytes of data every month.
- The Summary Care Record, which covers over 54 million people. Clinicians access a record every 15 seconds - over 2 million views every year. On average, each view saves 29 minutes compared to a manual search of paper records.
- The GP Registration Service, which manages over 62 million patient records a year.
- The Cancer Screening Service, which sends out over 7 million invitations for people to receive breast or cervical cancer screening.
- The Electronic Referrals Service, through which over 40,000 patients a day are referred for treatment.
- NHS Choices, which is the UK's most popular health website with 48 million visits every month. It provides important information about health services, health news, and lifestyle. As part of the Paperless 2020 agenda it is now being updated to provide the digital platform for transactional services for patients and citizens.

2.4 Supporting organisations to get the best out of technology, data and information

To be more effective, we must get close to local health and care strategies and partnerships, alongside our plan to work with "digital champions" and to support the development of a vibrant supplier market.

We have made progress in building links and relationships with local projects to help enable interoperability. We have opened up good relations with local Clinical Information Officers, with clinicians, and with industry, notably through the Digital Leaders' Programme. In February 2016 we held a successful event attended by nearly 200 CIOs and CCIOs.

Our team of Strategic Account Managers has strengthened our work with the other national health agencies, the social care sector, research organisations, and with industry and the supplier market. We will continue to support local transformation programmes, especially as Vanguard sites gather momentum and devolution partnerships create new models for integrating health and care services.

Paperless 2020 sets out more commitments to help organisations get the best out of technology and data. These include:

- Integrated Care: developing integrated data flows between health and adult social care settings.
- Infrastructure: supporting care providers to make WiFi available to staff and service users, and, continued delivery of the Health and Social Care Network.
- Paper Free at the Point of Care: strengthening digital capabilities across the health and care workforce.

Our other priorities in 2016/17 include working with local authorities to improve uptake of the Child Protection Information Sharing system, and launching the new health information service for prisons and other secure institutions.

2.5 Making better use of health and care information:

We collect, analyse and publish national health and care data for widespread use, the importance of which is recognised in the *Five Year Forward View.* Our services include:

- National datasets for hospital, mental health, community and maternity activity.
- Clinical audit programmes commissioned by the Health and Quality Improvement Partnership. One of these, the National Diabetes Audit, is the largest clinical audit in the world, combining data from primary and secondary care sources.
- Health and public health surveys, which we run on behalf of DH and NHS England.
- Indicators routinely used across England, including the Summary-Level Hospital Mortality Index, the Outcomes Frameworks for health, public health and social care, Patient-Recorded Outcome Measures, and the NHS Safety Thermometer.
- Services which support payments across the NHS – the National Tariff System, Casemix and Healthcare Resources Groups, the Quality Outcomes Framework for GP services.
- Statistical publications which cover the full range of NHS and social care activities.
- Data supporting improved performance management and transparency published through different channels including data.gov.uk and My NHS.

Our immediate priority has been to implement and embed the recommendations from the review of data access carried out for us in 2013/14 by Sir Nick Partridge.[4] For example, we have worked hard to improve our Data Access Release Service. We are engaging more directly with our customers, and turnaround times for handling requests have improved. As a result, we are getting more favourable comments from our customers, particularly in research and academic organisations. We have introduced a new online request and triage service which will deliver even more efficiencies.

Our direction of travel in this area remains valid, but we recognise that this is the strategic objective on which we have made least progress to date. We can do more by measuring what really matters, requiring comprehensive transparency of performance data, and ensuring this data increasingly informs payment mechanisms and commissioning decisions. This imperative is captured in the Paperless 2020 work on Data Outcomes for Research and Oversight which commits us to improve information collections, analysis and reporting in order to deliver the information and insight fundamental to informed policymaking, commissioning and regulation.

We will deliver this work in the context of wider emergent issues regarding data, including:

- Gaps in information available to us, and interest in new data and new datasets.
- Managing new sources of data and new data flows (from different care settings, or from citizens themselves – insight and experience or health data from apps).
- Helping people and organisations use information to understand variations in health and care and inspire learning from the best.
- The growing importance of Big Data.
- The opportunity to strengthen relationships to support research.

[4] http://www.hscic.gov.uk/media/14244/Sir-Nick-Partridges-summary-of-the-review/pdf/Sir_Nick_Partridge's_summary_of_the_review.pdf

3 Transforming NHS Digital

3.1 Our transformation programme

Last year we set an ambition to transform our organisation in order to become, and be recognised as, 'a high performing organisation with a reputation as an outstanding place to work.' Stakeholders tell us that we have made progress, but we still have some way to go.

We have made major changes to the way we are organised and the way we work, in order to ensure that we:

- Develop an enriched workforce of the right size and with the right capabilities to deliver against our customers' requirements and ensure longevity for the organisation.
- Become a more agile and flexible organisation which delivers against our customers' future requirements.
- Become a more efficient organisation with a better grip on costs and staff utilisation.

Through our transformation process our customers will be able to:

- Receive more robust management information about the cost and effort required to deliver their requirements.
- Track the work they commission through a clearer process from investigation and scoping to delivery and right through to the closure of portfolio items.
- Engage in more effective relationships that reflect a clearer separation of 'client' and 'delivery' roles.

3.2 How we are organised

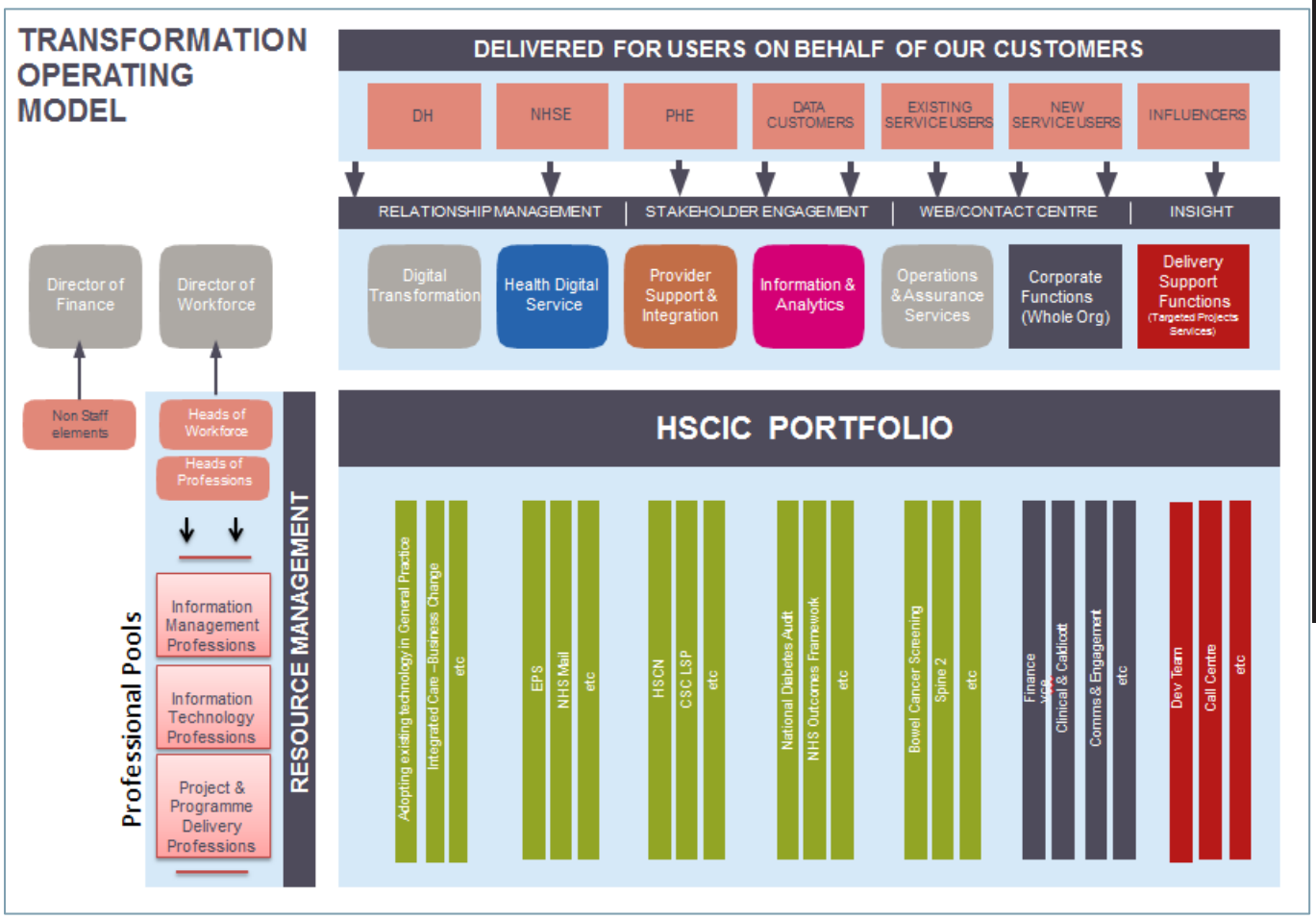
We have redesigned our organisational structure so that it is more appropriate for a customer-facing, demand-and-supply operating model. The diagram overleaf illustrates our new structure and operating model.

From 1st April 2016 our members of staff are aligned to resource pools, based on professional groups we established last year.

Our programmes and services are grouped together into executive portfolios delivering:

- **Health Digital Services**: patient-facing and citizen-facing services.
- **Provider Support and Integration**: services supporting health and care organisations and their staff.
- **Information and Analytics**: the collection, quality assurance, storage, analysis and dissemination of health and care data.
- **Operations and Assurance**: the live operations of all national services.
- **Digital Transformation**: strategy, customer relations, innovation, benefits realisation and implementation.

Each executive portfolio is managed by an executive director, responsible to the Chief Executive and the Board. They will manage the opportunities, programmes, projects and services in their portfolio areas to fulfil customer requirements and to ensure user needs are met. They will ensure that they operate safely, securely and to agreed budgets and service levels.



Two new executive director posts are critical to the effectiveness of this new operating model. Our Executive Director of Operations and Assurance Services has also become our Chief Operating Officer, with strategic and operational oversight of the full portfolio. Our Director of HR and Transformation has become our Director of Workforce, responsible for professional pools and resource management.

Our corporate functions support the operation of the whole organisation. These include:

- Portfolio Office
- Corporate Performance Management
- Business Planning
- Corporate Risk and Assurance
- Finance, Commercial and Procurement
- Human Resources
- Information Governance
- Internal IT and Corporate Systems
- Communications and engagement
- Strategy and Policy
- Clinical and Caldicott Guardian
- Resource Management
- Knowledge Management

3.3 Implementing the transformation

Change on this scale will inevitably involve separate phases of implementation, starting on 1st April 2016. The high-level timeline for these phases is shown below. Crucially, throughout the transformation process we must ensure that delivery of our core programmes and services is not compromised in any way.

April 2016	• All staff will be working to a generic job description within an agreed professional pool • All staff will be completing timesheets in our activity-based recording system • Resource managers will be in post, and will have adopted a single method for resource management to manage demand against supply • Heads of the professional pools will also be in post • Staff will continue to have a line manager, who directs and performance manages assigned staff resources • All opportunities, projects, programmes and services will be visible on the organisation's portfolio
April - June 2016	• All staff will have a career manager • Promotion standards will be introduced • Further rollout of talent management within the organisation • All the activities developed and implemented in Phase 1 will be refined and improved as required
June - September 2016	• A learning and development strategy will be in place • The activity-based recording system will be generating management information to support our resource management and reporting to our customers

4. Financial Information

4.1 The financial context and how we are funded

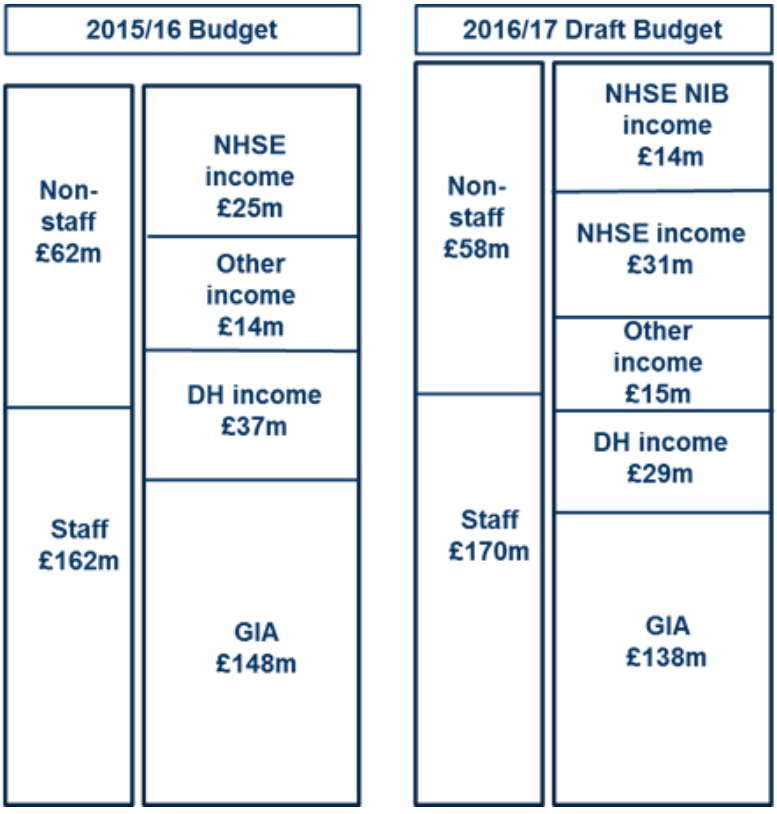
The activities described in this business plan will be delivered during a period of financial restraint across the public sector. We expect that our Grant-in-Aid budget will be reduced by 30% in real terms over the next four years, in line with government policy as set out in the 2015 Comprehensive Spending Review. We will work closely with our partners to agree sustainable plans for managing reductions in funding for programmes and services.

NHS Digital receives funding through a number of different routes. Our primary source of funding is Grant-in-Aid, which is an annually agreed budget received from the government. We are accountable to the Department of Health for the use of this funding.

The Department of Health and NHS England, our largest commissioner, agree with us that the way NHS Digital is funded is unnecessarily complex and undermines efficiency and productivity. We are therefore reviewing these arrangements and expect to introduce a more streamlined model during 2016/17.

4.2 Our budget for 2016/17

For 2016/17 we have set an overall operating budget of £227 million. Of this, £149 million is Grant-in-Aid and the remainder is made up of income from other sources. This figure includes an estimate of the revenue funding we expect to receive for Paperless 2020 programmes. We expect to have a capital investment budget of £15 million for 2016/17. This figure does not include any additional capital funding for Paperless 2020 programmes, but we expect that additional capital will be allocated for these as plans develop. We will also set a budget for non-cash Grant-in-Aid (depreciation). The diagram below shows a breakdown of our revenue budget for 2016/17 compared to 2015/16:



Further detail on the 2016/17 expenditure is as follows:

Expenditure	2016/17 £'m
Staff Costs	
Permanent Staff	164.3
Temporary Staff	5.5
Non-Staff costs	
Professional Fees/ Legal/ Survey Costs	17.5
IT maintenance and support	19.1
Premises & Establishment	10.5
Travel	5.1
General office supplies & services	5.4
TOTAL EXPENDITURE	**227.4**

4.3 Managing with a reduced budget

Given the likely scale of the reduction in our funding over the coming years, we have plans to manage our operations on a lower budget. These plans are effective on a number of fronts as set out below:

- **Staff costs**: our workforce strategy aims to create a more flexible and dynamic organisation that is more effective and more efficient. At the end of 2015/16 we ran a Mutually Agreed Resignation Scheme (MARS) through which we reached agreement with 100 staff that they could leave the organisation. This has created opportunities to reduce costs, either by reducing headcount or by reconfiguring work requirements and reprofiling the workforce skills mix.

  We have also reduced our expenditure on contingent workers during 2015/16, and will continue this trend during 2016/17, particularly in regard to Spine and the Digital Delivery Centres which will create opportunities for realigning key service functions.

- **Buildings costs**: we have numerous locations across the country with a variety of leases and variable quality of office space. We operate from four separate sites in Leeds alone. We will undertake some short-term rationalisation (for example, our office in Tavistock House, London, closed in March 2016). We are developing a locations strategy to ensure that our estate represents good value and is used in the most efficient way. We hope to develop an approach that fits better with our strategic requirements and uses new freedoms to source estates that provide the quality, flexibility and co-location that will improve our overall performance. In short, better office accommodation would lend itself to more agile delivery approaches. The flooding in Leeds during the 2016 New Year period reinforced our need to have complete confidence in our estate, particularly where this concerns our delivery of critical services and infrastructure on which the NHS depends.

- **Technical and allocative efficiency**: our new operating model, combined with a new funding model, will help us to deploy resources more flexibly across our programmes and services. This will improve our efficiency for our customers. We are also looking at further opportunities for insourcing some services. This will build on the substantial savings released through the insourcing of the Spine.

- **Improving productivity and efficiency across the organisation:** there are opportunities for rationalisation, cost reduction or improved productivity across our operations. During 2016/17 we will take forward a cost improvement progamme to identify and deliver such efficiencies. Where possible we have factored potential cost reductions into our plans, but in a number of areas it is not yet possible to estimate the potential savings. Potential efficiency improvements include the following:
  - The Data Services Platform will create opportunities for rationalising current collection, processing and dissemination activities. The full impact of this programme will not be known until 2017/18.
  - We are looking to rationalise first and second line support for technical and development operations.
  - Opportunities for channel shift, such as use of web and self service options compared to contact centre and other telephone contact lines. We do not expect these will release significant savings in the short term.
  - Our continued work to improve the Data Access Request Service processes will help improve productivity. This may be offset by increases in requests for data.
  - We are looking to rationalise external engagement activities by streamlining fuctions currently deployed across a number of services and making better internal use of shared intelligence and insight.
  - We are reviewing the cost and distribution of portfolio management functions across the organisation.
  - Opportunities for reducing travel and subsistence costs. These are unlikely to have a significant impact given the geographic dispersal of our staff, and the nature of our work requiring extensive external engagement and liaison.

5. How NHS Digital Operates

5.1 Our governance

NHS Digital is an executive non-departmental public body. Our most senior decision-making body is our Board. It meets in public at least six times per year, and is accountable to the public, Parliament and the Secretary of State for Health.

The Board is led by the Chair and comprises five Non-Executive Directors as well as our Chief Executive and some of our Executive Directors. This year Noel Gordon has joined the organisation as our new Chair, succeeding Kingsley Manning.

Three main committees support the Board, each chaired by a Non-Executive Director:

- The **Assurance and Risk Committee** ensures appropriate arrangements are in place to identify, evaluate and report on the effectiveness of risk management, other internal audit and assurance controls, and the efficient use of resources.
- The **Information Assurance and Cyber Security Committee** ensures that arrangements are in place to manage information assurance and cyber security risks and threats across the organisation. This committee also works in support of the wider health and social care sector.
- The **Remuneration Committee** reviews, approves and advises on matters relating to pay, including remuneration packages, performance related pay awards and redundancy.

Our main Board meetings take place in public. During 2015/16 we held some of these meetings in different locations around the country in order to provide opportunities to engage with other stakeholders in the health and care system. We are considering options for continuing this approach to Board meetings during 2016/17, but are mindful of the need to balance the benefits of doing so against the costs.

We publish details of our Board meetings, as well as additional information to meet the general standards of openness and transparency, such as directors' expenses. More details of our governance arrangements, including our Board and its members, can be found on our website.[5]

5.2 How we are held to account

Our Chief Executive is accountable to the Secretary of State for Health for discharging our functions, duties and powers effectively, efficiently and economically. The Department of Health is our sponsoring body and oversees the governance processes which hold this organisation to account.

We are also held to account through the Informatics Programme Management Board (IPMB) chaired by the Department of Health. The IPMB has system-wide oversight across the main health and care informatics programmes and services. During 2016/17 we expect a new system-wide body – the Digital Delivery Board – to replace the IPMB.

[5] https://www.gov.uk/government/ organisations/health-and-social-care-information-centre/about/our-governance

Each of our programmes has its own Senior Responsible Owner and associated governance boards. In addition, we have agreed with our main commissioners how we manage our business with them, principally through Provision of Services Agreements.

We publish key documents such as our strategy, business plan, annual report and accounts, a register of data releases supplied to customers under data sharing agreements, details of the directions we receive from DH and NHS England that set out their requirements for data or technology services, and other documents such as key policies or procedures that may be of interest to the public.

Occasionally we may get asked to attend government committees, such as the Health Select Committee or the Public Accounts Committee, to report on particular areas of our business. These are important parts of parliamentary scrutiny, key to ensuring that NHS Digital is held to account like other public bodies.

5.3 Fit for purpose 2020

NHS Digital operates in a complex and changing environment. Across the health and care system we are seeing widespread reinvention of roles, services and organisations. In terms of our own organisation, while mobilising to deliver Paperless 2020 we must also adapt to new governance arrangements across the system and embed our own internal transformation.

We must ensure that NHS Digital is well placed to operate successfully in this changing environment. During 2016/17 we will undertake a review of the capability and capacity of our organisation, and we will implement any recommendations that result from this.

5.4 Performance management and reporting

Our corporate performance management framework is used to manage and report on our performance. This supports transparent governance and constitutes an important channel of accountability to the public. It contains a mix of financial and non-financial performance information which is reviewed regularly by our Executive Team and our Board.

Appendix 6 lists our corporate key performance indicators. These are reviewed routinely and some changes will come on stream during 2016/17. For example:

- We will re-position the Programmes Achievement performance data to focus on Paperless 2020 programmes.
- We will enhance the Data Quality performance indicator to include information captured through our new Data Quality Maturity Index.

5.5 Risk management

Risk management practice within NHS Digital is supported by a comprehensive governance framework, including policy, strategy and guidance. Our risk management model is organised around a set of strategic risk areas, each owned by an Executive Director and supported by a more granular set of risks managed at the level of portfolios, programmes, services and corporate functions.

Appendix 7 lists our strategic risk areas. These are under review and some changes will come on stream during 2016/17.

5.6 Inclusion and diversity

The Equality Act 2010 brought the Public Sector Equality Duty into force on 5 April 2011. Its purpose is to ensure that all public bodies play their part in making society fairer by tackling discrimination and providing equality of opportunity for all. Moreover, research shows that high performing organisations are underpinned by a diverse and inclusive workforce.

NHS Digital is committed to a culture where all individuals receive fair and equal treatment in all aspects of employment. As the organisation progresses through its transformation process, we have an opportunity to make an explicit commitment to equality and inclusion, and to demonstrate a respect for diversity, by ensuring that this is a considered part of everything that we do. We have adopted the following objectives through which we will deliver our commitment to inclusion and diversity.

Workforce objectives

- We will deliver appropriate learning and development to ensure that all NHS Digital staff develop a good level of equality and diversity awareness.
- We will work towards having no difference in the employment outcomes for NHS Digital staff or potential recruits because of protected characteristics.
- We will develop best practice in workforce equality and diversity by creating internal and external networks and supporting positive action initiatives.

Service objectives

- Guided by industry best practice, when we communicate with the public and service users, we will seek to deliver clearer, more representative, and more accessible information and guidance.
- We will establish a network of staff who will investigate the ways in which we can ensure that our products, policies and behaviours reflect the communities we serve and do not disadvantage or otherwise negatively impact the public and users of our services.
- As the trusted national provider of high-quality information and data about health and social care, we will improve our focus on protected characteristics in the information that we collect and share. By doing so, we will improve knowledge about the health of, and care experienced by, those with protected characteristics.

6. Appendices

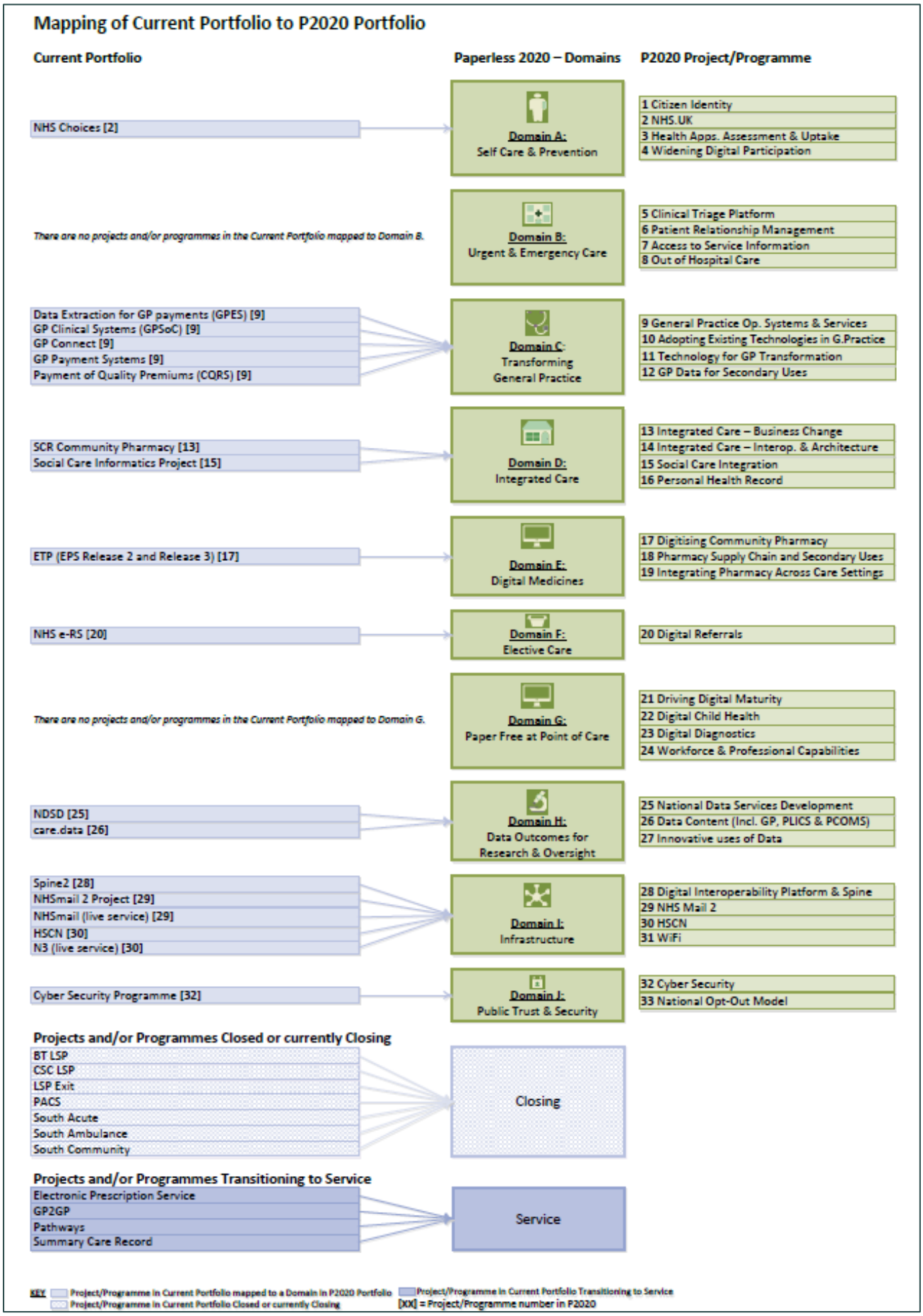
Appendix 1: The Paperless 2020 portfolio

Paperless 2020 Domain and Description				Paperless 2020 Programme	
A		**Self-Care and Prevention**	This domain will deliver the online services that patients need to take control of their own care, which will reduce the pressure on front line services	1	Citizen Identity
				2	NHS.uk
				3	Health Apps Assessment and Uptake
				4	Widening Digital Participation
B		**Urgent and Emergency Care**	This domain will help to deliver the national urgent and emergency care strategy by providing the digital infrastructure, algorithms and pathways we require	5	Clinical Triage Platform
				6	Patient Relationship Management
				7	Access to Service Information
				8	Out of Hospital Care
C		**Transforming General Practice**	This domain will use technology to free GPs from time consuming administrative tasks and provide patients with online services.	9	General Practice Operational Systems and Services
				10	Adopting Existing Technologies in General Practice
				11	Technology for General Practice Transformation
				12	GP Data for Secondary Uses
D		**Integrated Care**	This domain will better inform clinical decision making across all health and care settings by enabling and enhancing the flow of patient information.	13	Integrated Care: Business Change
				14	Integrated Care: Interoperability and Architecture
				15	Social Care Integration
				16	Personal Health Record
E		**Digital Medicines**	This domain will enable and improve pharmacy decision making and outcomes by providing patients and prescribers with streamlined digital services.	17	Digitising Community Pharmacy
				18	Pharmacy Supply Chain and Secondary Uses
				19	Integrating Pharmacy Across Care Settings

The Paperless 2020 portfolio (continued)

Paperless 2020 Domain and Description				Paperless 2020 Programme	
F		Elective Care	This domain will improve referral management and provide an improved treatment choice for patients by automating referrals across the NHS	20	Digital Referrals
G		Paper Free at the Point of Care	This domain will create an NHS “paper free at the point of care” by driving up levels of digital maturity and by enabling the NHS workforce to better utilise the benefits of digital technology.	21	Driving Digital Maturity
				22	Digital Child Health
				23	Digital Diagnostics
				24	Workforce and Professional Capabilities
H		Data Outcomes for Research and Oversight	This domain will deliver the health and care information and insight which are fundamental to informed policy making, commissioning and regulation by improving information collections, analysis and reporting.	25	National Data Services Development
				26	Data Content (including GP data, PLICS, and PCOMS)
				27	Innovative Uses of Data
I		Infrastructure	This domain will enable information to move safely and securely across all health and care settings by providing robust and future-proofed national systems and networks.	28	Digital Interoperability Platform and Spine
				29	NHSMail2
				30	Health and Social Care Network
				31	WiFi
J		Public Trust and Security	This domain will provide the means for citizens to set their consent preferences. We will provide confidence that clinical and citizen information is held safely and securely, and will protect health and care systems from external threats.	32	Cyber-Security
				33	National Opt-Out Model

Appendix 2: Existing informatics work mapped to Paperless 2020



Appendix 3: Our contribution to the Department of Health's Shared Delivery Plan

Theme	DH commitment	NHS Digital contributions referenced in the Shared Delivery Plan
1. Improving out of hospital care	1.1 Ensuring GPs are resourced and contracted to take personal responsibility for the health of their named patients in a meaningful way	• GP-level metrics to support accountability
	1.2 Transforming general practice by 2020 – 24/7 access, evening and weekend access and prevention	• GP-level metrics to support accountability • Practice-level metrics • Roll out new digital technologies • Data to support the risk-based approach to CQC inspections • Appointments and repeat prescriptions available online • Link 111 and out of hours services • Reduce bureaucracy and increase time for direct care
	1.3 Joining up home services, care services, surgeries and hospitals through integration of services including New Care Models of care on the basis that prevention is better than cure.	• Contribute to numerous metrics and scorecards (integration scorecard, Electronic Health Record scorecard, New Care Models metrics and evaluations) • Maximise the potential of the devolution deals • Community Pharmacy Integration Fund to be launched October 2016
	1.4 Building a sustainable social care system that supports people to maintain their wellbeing and remain out of hospital	No specific reference, but we have a significant contribution to support this: • Support local authorities make efficiencies and spread best practice • Support the transformation driven by the Care Act • Support the care market (sustainability) • Support to social care workforce
	1.5 Reducing the health gap between people with mental health problems, learning disabilities and autism and the population as a whole	• Data and metrics relating to access to services, CCG level metrics • Link to transformation plans that will be developed, e.g. children and young people, whole system approach to mental health (with Ministry of Justice and the Home Office)

Theme	DH commitment	NHS Digital contributions referenced in the Shared Delivery Plan
2. Creating the safest, highest quality health and care service	2.1 Making our hospitals the safest in the world (NHS as a learning organisation)	None listed
	2.2 Seven day services in hospitals	None listed (though we are producing the metrics)
	2.3 Improving cancer outcomes	None listed
	2.4 Improving the quality of care in providers	None listed
	2.5 Improving the patient's experience of all NHS services, in all settings, for all ages, focussing on maternity and end of life care	• Data supply for indicators and metrics • Maximise opportunity for real time free text feedback • Develop and implement new technologies and practices that reduce errors in clinical practice (proposals being developed)
3. Maintaining and improving performance against core standards while achieving financial balance	3.1 Minimum standards for A&E waiting times, ambulance response times, cancer and diagnostic services, referral to treatment waiting times	Not listed, but we provide data for indicators and metrics
	3.2 Operating within the budget the DH is given	None listed – though we do have a role on efficiency and productivity across the health and care system – including duty on burden management (and this is a general duty as an arm's length body)
	3.3 Being ready to play our part in any local or national emergency, should it arise	None listed (though services such as National Pandemic Flu Service are relevant)
	3.4 Transforming the way patients access services, including the introduction of mental health access standards and improvements to the urgent and emergency care system	• Data supply for indicators and metrics
4. Improvement in efficiency and productivity	4.1 Reducing demand for NHS care by improving public health, reducing unjustified variation in care, and developing out of hospital care	None listed (but our services have a significant contribution)
	4.2 Better use of provider resource	• Data supply for indicators and metrics (workforce, estates, reference costs, SUS) • Contribution to strategic developments re changes to tariff and payment

Theme	DH commitment	NHS Digital contributions referenced in the Shared Delivery Plan
	4.3 Reducing NHS costs	None listed
	4.4 Increase income through cost recovery and commercial opportunities	None listed (though we are involved, e.g. the Visitor and Migrant Cost recovery)
	4.5 Reduce system overheads	None listed
5. Preventing ill health and supporting people and communities to lead healthier lives	5.1 Significant reduction in rates of childhood obesity	• To be outlined following production of Childhood Obesity Strategy • Data supply for indicators and metrics • The National Child Measurement Programme (not referenced but relevant)
	5.2 Improve the treatment of diabetes	• Data supply for indicators and metrics • National Diabetes Audit
	5.3 Reduce NHS service demand through public health interventions to prevent ill health	None listed
	5.4 Improve global health security – leading the response to outbreaks before they become emergencies, developing smarter, swifter systems to prevent, detect and respond to international threats	None listed
	5.5 PM Challenge on dementia 2020	None listed (though we do provide data and metrics)
	5.6 UK as key influencer of global health and research priorities	None listed
6. Supporting research, innovation and growth	6.1 Wider growth agenda	None listed
	6.2 Increase uptake of effective innovations	Support the Accelerated Access Review
	6.3 Optimise the business environment for life science and health, and promote sector strengths	• Support new initiatives (Health North etc.) • Support research to improve effectiveness - link to “single front door” for research

Theme	DH commitment	NHS Digital contributions referenced in the Shared Delivery Plan
	6.4 Win the global race on health and life sciences trade and investment	None listed
	6.5 Create world-leading digital health industry	Still being scoped
	6.6 World leading genomics industry	None listed
	6.7 Increase health and wealth of the nation through health research	• Contribute where appropriate to research evidence • Collaborate and support, where appropriate, to research infrastructure
	6.8 Contribute to reducing the disability employment gap and increase the number of disabled people in work	None listed
7. Enabling people and communities to make decisions about their health and care	7.1 Empower patients with better and more equitable choice, access, information, digital support and overall experience of the NHS	• Data and metrics, including feedback • Information for choice • Intelligent transparency • Digital support • Patient experience and voice
	7.2 Empowering citizens with prevention programmes, greater support for carers and overall reduced health inequalities	None listed
	7.3 Empowering communities with greater devolution, local leadership and closer working relationships with local communities, voluntary sector, focussing on reducing health inequalities and improving health	None listed
8. Building and developing the workforce	8.1 Ensuring we have the right number of staff – primary care	None listed
	8.2 Ensuring we have the right number of staff – secondary care	None listed
	8.3 Changing the ways we work to be more productive by changing our skill mix and capability	None listed
	8.4 Ensuring we have an affordable workforce enabling us to live within our means	None listed

Theme	DH commitment	NHS Digital contributions referenced in the Shared Delivery Plan
9. Improving services through the use of digital technology, information and transparency (NHS Digital is joint lead with DH, NHS England and NIB.)	9.1 Enable me to make the right health and care choices – supporting digital channel shift for patients and citizens	• Digital primary care • Digital skills • Digitisation of GP registration • Remote digital monitoring and consultation • Health apps and assessments – increase usage, framework to support GPs in recommending apps • Trusted route into personalised digital care – nhs.uk • Digital training and education for citizens
	9.2 Transforming general practice	• GP2GP • Electronic receipt of discharge summaries • CQC to incorporate digital maturity in assessments
	9.3 Out of hospital care and integration with social care	• Transfer of care documentation • Carers to have shared access to digital tools (this under social care digitisation) • Digital 111 pathway through nhs.uk • Mental health crisis records (in NIB out of hospital care programme)
	9.4 Acute and hospital services	• Uptake EHR functionality as defined by digital maturity index • Design and deploy other technologies to bring additional non-clinical efficiencies (in NIB EHR programme) • Standardised data from diagnostic tests (In NIB Digital Diagnostics Programme) • Falsified medicines directive (in eMedicines supply chain programme) • 100% uptake of eReferrals • Improvements to elective care management • Increase uptake of workflow and resource management tools
	9.5 Paper free healthcare systems ad transactions	• Extend definition and roll out of SCR (integration and interoperability across care settings) • Patients understand and manage their medications (online medicines management – click and collect) • E-Prescribing system from GP to pharmacy to BSA • Embed data standards for interoperability • Enhancements to Spine to support interoperability

Theme	DH commitment	NHS Digital contributions referenced in the Shared Delivery Plan
	9.6 Data and outcomes for research	• Data Services Platform • Transparency to support population and health management, payment innovation and new models of care (innovative uses of data) • Genomics
	9.7 Leadership and capability	This has not yet been scoped. The work we are doing for the NIB is relevant here.
	9.8 Infrastructure	All of our infrastructure services are relevant. The following are referenced specifically: • NHSMail2/3 • Spine • HSCN
	9.9 Public trust and security	• Citizen identity • Digital consent model / National Opt-Out Model • CareCERT and cyber

Appendix 4: How our strategy aligns with the NIB's Paperless 2020 objectives

Paperless 2020 Domains		NHS Digital Strategic Objectives					
		Ensure that every citizen's data is protected	Establish shared architecture and standards so everyone benefits	Implement national services that meet national and local needs	Support organisations to get the best from technology data and information	Make better use of health and care information	Transforming the way we engage and work
A	Self-Care and Prevention	X		X	X	X	
B	Urgent and Emergency Care	X	X	X	X	X	X
C	Transforming General Practice	X	X	X	X	X	X
D	Integrated Care	X	X	X	X	X	X
E	Digital Medicines		X	X	X		
F	Elective Care	X	X	X	X	X	X
G	Paper Free at the Point of Care		X	X	X		
H	Data Outcomes for Research and Oversight	X	X			X	
I	Infrastructure	X	X	X		X	X
J	Public Trust and Security	X	X	X	X	X	X

Appendix 5: Our deliverables and commitments for 2016/17

The commitments set out in this section are described at a high-level. Each commitment has a more granular set of milestones, delivery against which is tracked and monitored. Progress in delivering the commitments in this business plan is reported quarterly to the Board.

STRATEGIC OBJECTIVE 1: ENSURE THAT EVERY CITIZEN'S DATA IS PROTECTED

We will assure the quality, safety and security of data and information flows across the health and social care sector, so that citizens will willingly share their data in the knowledge that it will be kept confidential and secure, and will only be shared when appropriate, with their consent and to their benefit *(Information and Technology for Better Care).*

	Deliverables and Commitments	Lead Portfolio	Target Date
1.1	We will implement the delivery plan to meet the Secretary of State's priorities regarding safe, legal and effective data sharing, including the National Strategic Consent Model.	**Information and Analytics**	March 2017
1.2	We will develop identity verification solutions to support health and social care workers and to progress patient/citizen identity policy objectives.	**Operations and Assurance**	March 2017
1.3	We will develop an operating model for a centrally-provided cyber-security remediation support service, made available to health and social care organisations for on-the-ground support in the event of a cyber-security incident.	**Operations and Assurance**	March 2017
1.4	We will provide expert information governance advice for the health and social care system through the Information Governance Expert Advisory Team.	**Clinical**	March 2017
1.5	We will implement a strategic review of the IG Toolkit and development of a replacement.	**Clinical**	March 2017

STRATEGIC OBJECTIVE 2: ESTABLISH SHARED ARCHITECTURE AND STANDARDS SO EVERYONE BENEFITS

We will create a new architecture for the sector's technology and data services and extend a framework of standards to encourage interoperability and the development of new, digitally enabled services *(Information and Technology for Better Care)*.

Deliverables and Commitments		Lead Portfolio	Target Date
2.1	We will establish and operate the Technical and Data Design Authority across the National Information Board member organisations	**Operations and Assurance**	December 2016
2.2	We will provide releases of, and support for implementation of, the Pathology Bounded Code List and the Digital Imaging Dataset.	**Provider Support and Integration**	March 2017
2.3	We will provide releases of, and support for implementation of, the Clinical Classifications (ICD-10, OPCS).	**Provider Support and Integration**	March 2017
2.4	We will provide releases of, and support for implementation of, Clinical Terminologies Read and SNOMED CT.	**Provider Support and Integration**	March 2017
2.5	We will provide releases of, and support for implementation of, the NHS Dictionary of Medicines and Devices.	**Provider Support and Integration**	March 2017
2.6	We will provide releases to the NHS Data Dictionary core products.	**Provider Support and Integration**	March 2017
2.7	We will develop inpatient based episode discharge summaries (Transfer of Care) using the Academy of Medical Royal College Headings.	**Provider Support and Integration**	March 2017
2.8	We will maintain and develop Interoperability specifications.	**Provider Support and Integration**	March 2017

STRATEGIC OBJECTIVE 3: IMPLEMENT NATIONAL SERVICES THAT MEET NATIONAL AND LOCAL NEEDS

Where there is a clear advantage in a national, integrated approach, we will continue to build and operate national technology and data services for the benefit of citizens and health and care organisations. Where necessary to fulfil the commitments in the NIB Framework, we will integrate some of these national systems to create a new information and transaction service for citizens, including service users and carers *(Information and Technology for Better Care)*.

Deliverables and Commitments		Lead Portfolio	Target Date
3.1	NHSmail2: we will deliver 4GB mailboxes, instant messenger and an improved portal to NHSmail users, and exit the current NHSmail operational service.	**Health Digital Services**	August 2016
3.2	We will deliver national open standard API's for appointments booking and for GP record access and Spine services for supporting interoperability (GP Connect), so that patients and clinicians across all care settings can access GP services and information to provide better care to patients.	**Health Digital Services**	December 2016
3.3	Electronic Referrals System (e-RS): we will aim to ensure that 60% of citizens' first outpatient referrals and bookings are completed using e-RS, rather than paper/fax/manual means.	**Health Digital Services**	September 2016
3.4	Electronic Prescription Service (EPS): we will realise the benefits of EPS for citizens, prescribers and the prescription reimbursement agency by ensuring at least 60% of all prescription items in England are prescribed, dispensed and claimed using the service.	**Health Digital Services**	March 2017
3.5	Summary Care Record (SCR): we will alleviate the pressure on unplanned and emergency care services by providing the SCR to 100% of community pharmacists that want access.	**Health Digital Services**	March 2017
3.6	We will deliver the electronic patient record transfer capability at an increased number of GP Practices in order to make more time available to busy GP practices and improve the patient experience of primary care.	**Health Digital Services**	March 2017
3.7	NHS Choices: we will maintain usage levels of the NHS Choices service at around 48–50 million visits per month, continuing to deliver potential benefit/s of the service e.g. Prevent ill health and promote good health.	**Health Digital Services**	March 2017
3.8	We will optimise the benefits to citizens and heath care professionals through the delivery of all existing services in accordance with agreed customer requirements e.g. NHS Choices, CQRS, GPES.	**Health Digital Services**	March 2017
3.9	We will provide Spine development services in support of NHs Digital delivery programmes and to increase the number of external organisations able to connect and develop services on behalf of health and social care providers.	**Operations and Assurance**	March 2017
3.10	We will deliver the underpinning technology to support Paperless 2020 built on Spine technology, according to (and dependent upon) clear requirements being articulated by the programmes	**Operations and Assurance**	March 2017

STRATEGIC OBJECTIVE 4. SUPPORT ORGANISATIONS TO GET THE BEST FROM TECHNOLOGY, DATA AND INFORMATION

We will help local health and social care organisations maximise the value of their information technology investments, and when asked, help them decide on future investments and implementations. We will encourage local innovation that delivers new forms of health and care services, and take steps to foster broader adoption *(Information and Technology for Better Care)*.

	Deliverables and Commitments	Lead Portfolio	Target Date
4.1	We will launch the new Health and Justice Information Service for prisons, immigration removal centres, youth institutes and secure children's homes - in conjunction with partner organisations including NHS England and the Ministry of Justice.	**Provider Support and Integration**	March 2017
4.2	We will continue to lead HSCICs delivery profile of social care integration, specifically the Social Care Informatics Project to develop information exchanges between adult social care and the NHS.	**Provider Support and Integration**	September 2016
4.3	We will deliver high-level intent and guidance for NHS Wi Fi access to support care providers to make WiFi available to service users and staff.	**Provider Support and Integration**	October 2016
4.4	We will develop an agreed end-to-end solution and implementation model to support the delivery of the new patient opt-out model in accordance with the requirements of the National Data Guardian's review.	**Provider Support and Integration**	March 2017
4.5	We will support all organisations required to exit the CSC Local Service Provider contract in 2016/17 to do so. (Lorenzo sites deploying Phase 2 or the ePrescribing module will do so to their agreed plans.)	**Provider Support and Integration**	March 2017
4.6	We will support NHS England and local authorities to achieve further significant levels of deployment of the Child Protection Information Sharing system.	**Provider Support and Integration**	March 2017
4.7	We will continue delivery of the Health and Social Care Network (HSCN) and work toward the closure of the existing N3 national broadband network for NHS organisations.	**Provider Support and Integration**	March 2017
4.8	We will provide subject matter expertise input and consultancy for the Ministry of Defence NHS integrated electronic health record and connectivity programmes.	**Provider Support and Integration**	March 2017
4.9	We will work with partners to establish the Driving Digital Maturity Programme fully, ensuring that funding and central support mechanisms support ambitions set out in local digital roadmaps and align with national standards and priorities.	**Provider Support and Integration**	March 2017
4.10	We will ensure that the agreed programme for Workforce and Professional Capabilities is delivered jointly with Health Education England.	**Provider Support and Integration**	March 2017

STRATEGIC OBJECTIVE 5: MAKE BETTER USE OF HEALTH AND CARE INFORMATION

We will analyse, use, and make available more data, information and insights about the health and social care sector. Where there is a clear benefit to the health and social care of citizens, we will supply sophisticated analytical technology to all-comers. This work will allow citizens to make informed choices about their own care. It will help care professionals make better and safer decisions, support policymakers, and facilitate better commissioning of health and care, and provide research organisations with the data they need *(Information and Technology for Better Care)*.

	Deliverables and Commitments	Lead Portfolio	Target Date
5.1	We will publish the Local Payment Grouper suite to support development and implementation of national reimbursement policy for 2017/18.	**Information and Analytics**	March 2017
5.2	We will develop and publish the Costing Grouper and accompanying enhanced classification to support evolution and implementation of national costing policy for 2016/17.	**Information and Analytics**	January 2017
5.3	We will roll out the Data Access Request Service to include all identifiable NHS Digital data disseminations.	**Information and Analytics**	March 2017
5.4	We will implement service improvements and a revised service model for Primary Care Registration.	**Information and Analytics**	July 2016
5.5	We will deliver the key national data flows, analysis and statistical services, where required developing new services or enhancing existing services.	**Information and Analytics**	March 2017
5.6	We will influence improvements in the quality of data available for decision making through the provision of consistent, comprehensive and accessible Data Quality information	**Information and Analytics**	March 2017
5.7	We will establish the 'Data Content' programme within Paperless 2020 Domain H	**Information and Analytics**	September 2016
5.8	We will complete start up activities for the proposed Community dataset in line with Paperless 2020 Domain H priorities.	**Information and Analytics**	December 2016
5.9	We will complete Patient-Level Information Costing Systems (PLICS) pilot in line with Paperless 2020 Domain H priorities.	**Information and Analytics**	December 2016

STRATEGIC OBJECTIVE 6: TRANSFORMING THE WAY WE ENGAGE AND WORK

We are introducing new models of relationship management and customer service to enable us to understand better the needs of the health and care system and to work more effectively with our partners and stakeholders in future *(Information and Technology for Better Care).*

We are putting in place support for the development of our people and mechanisms to help them work more flexibly and focus better on the needs of our partners and stakeholders. We will reduce bureaucracy, help facilitate innovative ways of working and attract new skills. This will be balanced by a greater focus on quality and, anticipating future financial pressures, on improving productivity *(Information and Technology for Better Care).*

Deliverables and Commitments		Lead Portfolio	Target Date
6.1	We will build NHS Digital's reputation with key stakeholder groups through successful delivery and development of an enhanced client engagement and external relations function	**Customer Relations**	March 2017
6.2	We will create a Strategic Supplier Management function to effectively engage with the technology supplier market, create improved partnerships and support market development towards health and care digital priorities.	**Customer Relations**	March 2017
6.3	We will successfully launch the new NHS Digital name and visual identity to staff and stakeholders, including the launch of a new NHS Digital website, new staff website and social newsroom	**Customer Relations**	March 2017
6.4	We will deliver a refreshed communications strategy in support of NHS Digital's new priorities and to build the organisation's 'voice' and reputation through thought leadership and innovation.	**Customer Relations**	March 2017
6.5	We will implement, embed and improve the organisation's new operating model.	**Workforce**	March 2017
6.6	We will secure, deploy and transform our workforce.	**Workforce**	March 2017
6.7	We will implement and embed a cost improvement programme to ensure efficiency and value for money across the organisation.	**Finance and Corporate Services**	March 2017
6.8	We will provide cost effective office accommodation and efficient corporate services that meet business needs, which support the transformation aims of the organisation and which support the delivery requirements of Paperless 2020.	**Finance and Corporate Services**	March 2017
6.9	We will implement a new commercial operating model across all commercial and procurement activity including updated policy, procedures, career framework and standardised systems, tools, and processes.	**Finance and Corporate Services**	March 2017

	Deliverables and Commitments	Lead Portfolio	Target Date
6.10	We will provide commercial support and direction to existing NHS Digital portfolios and to new Paperless 2020 domains and programmes.	**Finance and Corporate Services**	March 2017
6.11	We will implement new and updated systems, revised and improved governance arrangements, and new policies and processes to embed and support the new operating model for the organisation.	**Finance and Corporate Services**	March 2017
6.12	We will implement a new clinical informatics governance framework, with particular focus on clinical safety, clinical risk management, and clinical benefits.	**Clinical**	March 2017

Appendix 6: Our corporate key performance indicators (KPIs)

The organisation's corporate KPIs are reviewed routinely and some changes will come on stream during 2016/17.

Performance indicator		Description	Owner
1	**Programme Achievement**	This indicator provides a consolidated view of the delivery status of our portfolio of programmes, focussing on the overall delivery confidence, and including aggregated findings from gateway reviews. During 2016/17 this will be updated to focus on the Paperless 2020 programmes	**Director of Programmes**
2	**IT Service Performance**	This indicator reports on the performance of information technology services for health and care providers, looking at service availability against targets, incident response times, and the prevalence of high severity service incidents.	**Director of Operations and Assurance Services**
3	**Organisational Health**	This indicator covers a number of individual measures, including workforce planning and recruitment, staff turnover, staff engagement, training and development, personal development reviews, and sickness absence rates.	**Director of Workforce**
4	**Data Quality**	This indicator looks at the quality of data received by NHS Digital from health and care providers and the effectiveness of our data quality processes. During 2016/17 this will be updated to reflect the information captured via our new Data Quality Maturity Index.	**Director of Information and Analytics**
5	**Reputation**	This indicator combines a number of individual measures to give a composite view of reputation, including outcomes of stakeholder and staff surveys, media coverage, social media sentiment, and complaints handling.	**Director of Digital Transformation**
6	**Financial Management (three indicators)**	These three indicators cover the management of our organisational finances, Department of Health revenue streams, and Department of Health capital streams. The indicator reports on in-year spend against budgets and forecast year-end outturn.	**Director of Finance and Corporate Services**
7	**Risk Management**	This indicator covers management of the organisations strategic risk areas, providing for each an assessment of the current risk exposure and the status of mitigation actions.	**Director of Finance and Corporate Services**
8	**Information Governance Incidents**	This indictor gives a composite view of information security incidents. It covers incidents internal to NHS Digital, incidents arising from supplier compliance issues, and incidents within the health and care system but which are external to this organisation.	**Director of Operations and Assurance Services**

Appendix 7: Our strategic risk framework

The organisation's strategic risk areas are under review and some changes will come on stream during 2016/17.

	Strategic Risk Theme	Owner
1	Failure to deliver on our statutory, legal and financial obligations.	Director Finance and Corporate Services
2	Failure to protect data and/or succumb to IT/Cyber security threats.	Director of Operations and Assurance Services
3	Failure to safely collect, analyse and disseminate high quality and timely data and information, which meets customer expectations.	Director of Information and Analytics
4	Failure to demonstrate delivery of benefits from the programmes and services we offer.	Director of Programmes
5	Failure to secure, deploy, and develop our workforce and transform the organisation to deliver our future vision	Director of Workforce
6	Failure to maintain operational continuity of systems and infrastructure we are charged to deliver, to protect patient safety and critical services.	Director of Operations and Assurance Services
7	Failure to secure a positive, responsive and trustworthy reputation and maintain effective relationships with stakeholders.	Director of Digital Transformation
8	Failure to design and deliver systems that work or deliver as anticipated.	Chief Technology Officer

Board Meeting – Public Session

Title of paper:	**The NHS Digital Clinical Governance System**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 04 a (P1)
Paper presented by:	Prof Martin Servers, Lead Clinician and Caldicott Guardian
Paper prepared by:	Martin Severs Lead Clinician and Caldicott Guardian and Anne Cooper: Director of Clinical Governance
Paper approved by: (Sponsor Director)	Prof Martin Severs Lead Clinician and Caldicott Guardian and EMT
Purpose of the paper:	To describe the way that the Clinical Services Executive Portfolio is going to ensure: • NHS Digital's duty of care is explicitly assessed and improved • Structures and Processes are put in place to minimise clinical negligence risks • Clinical Safety is re-invigorated as a core NHS Digital system leadership function (Please note other functions of the Clinical Services Portfolio are outside the scope of this paper)
Justification for inclusion in private board:	NA
Additional Documents and or Supporting Information:	The NHS Digital Clinical Governance System
Please specify the key risks and issues:	As the focus of digital transformation engages more and more with clinical care and the patient themselves becomes more of an actor in their own care, then the clinical risks that accrue to the main digital delivery organisation namely NHS Digital rise. It is this risk that needs comprehensive management through a clinical governance system
Patient/public interest:	Direct
Supplementary papers:	The NHS Digital Clinical Governance System V1.0.docx
Actions required by the Board:	To support and confirm that the actions proposed and already underway are sufficient to mitigate the potential risks identified

NHS Digital

The NHS Digital Clinical Governance System

Martin Severs and Anne Cooper

7 September 2016

Information and technology
for better health and care

Contents

1. Purpose

This document outlines NHS Digital's procedures for the management of clinical governance and applies to the full range of activities of the organisation. Clinical governance is one function with the Clinical Services Executive Portfolio, this document is intended to describe that function and where it relates to other important functions.This purpose describes "what" will be done and "why" it is being done

2. Background

This paper is the Clinical Services Executive Portfolio response to three sets of challenges:

- HSCIC Statutory Powers & Clinical Negligence [ARC 15 03 05 (b)]
- An internal HSCIC Review of Clinical Safety
- Questions about the role of clinicians in programmes and services excluding their externalisation roles of interacting with stakeholders, users and customers

Clinical Governance is a broad term that usually encompasses a systematic range of actions from a health and care organisation that are aimed at assurance and improving the quality and safety of services. The official definition of Clinical Governance is specified as:

"A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish"

This can be translated into the following statement for NHS Digital given its unique context:

"A framework through which NHS Digital is accountable for continuously improving the quality of its services, programmes and safeguarding high standards of care when adverse incidents occur by creating an environment in which excellence in patient care and clinician benefit will flourish"

For completeness; quality has three dimensions:

- Clinical Effectiveness assuring that best evidence of what works is built in
- Clinical safety including the approved safety standards
- Patient satisfaction including access, continuity of care and co-ordination of care

Clinician benefit is the extent to which clinician functions are enhanced by the digital transformation or not. Clinician benefit should be described in a way which is reliable, understandable, measureable, behavioural and appropriate to clinicians.

3. Strategic Implications of taking a clinical governance approach in NHS Digital

In embracing clinical governance NHS Digital will need to put in place a number of new functions which will have structural implications, these new functions include:

- Advicing on clinical requirements of any serice or programme based on best evidence from the research and grey literature

- Assessing Programme Clinical Risk [in order to apply proportionate clinical resource to meet the required clinical governance activity]
- Assessing Service Clinical Risk [in order to apply proportionate clinical resource to meet the required clinical governance activity]
- Identifying intra-programme and intra-service clinical risk or clinical implications of a non-clinical risk and managing them according to the most up to date methods supported by the NHS Digital Audit and Risk Committee [ARC]
- Implementing best clinical evidence of clinical effectiveness and safety for service and programme design, test, deploy and go-live
- Having near miss and adverse event reporting and investigation processes which build on the high quality safety processes and incident management processes already in place.
- Ensuring patient satisfaction is captured and the duty of candour is demonstrated whenever appropriate
- Developing the new evidence base around clinician benefit for appropriate programmes and services
- Having robust clinical quality improvement plans for all services with a High or Very High Service Clinical Risk rating
- Using Programme and Service Risk to generate a major input in clinician resource planning
- Taking forward the issue of patient satisfaction [where appropriate] in a systematic and systemic manner

4. Clinical Services Executive Portfolio

The Clinical Services Executive Portfolio will be a corporate function which will have the following functions in or related to clinical governance:

- Complete the initial SCRi and PCRi's
- Design and manage the organisation wide clinical governance structures and processes including but not limited to audit, root cause analysis, SUI investigation, lesson learnt reporting etc
- Ensure existing clinical safety and incident risk management processes are optimally integrated with clinical governance and continuous improvement
- Complete the initial Clinician Benefit statement for new programmes and services and develop the evidence to support its continued use
- Support assignment managers including programme directors and their clinicians perform at the highest levels of quality and act as point of escalation for clinical quality or clinician benefit concerns which are not resolvable at the service or programme level

- Explicitly work with the Head of the Clinical Informatics Profession to drive accurate resource planning
- Explicitly work with the head of profession and the leads for revalidation on continuous professional development education and learning activities especially linked to clinical governance
- Produce the NHS Digital annual clinical governance report and support other executive portfolio directors in their clinical quality improvement plans for the relevant services

The following people will have the following leadership responsibilities in clinical governance [accepting they have other leadership roles for other functions]:

- Peter Short = PCRi, SCRi, and Clinician Benefit
- Anne Cooper = PCRi, SCRi and Clinical Governance processes and structures
- Manpreet Pujara = Clinical Safety and Clinical Incident Management

5. Assessing Programme and Service Clinical Risk [PCRi and SCRi]

5.1 Programme and Service Clinical Risk Assessment

It is a requirement that each programme and service (either at inception or in-flight if no previous review has taken place) will undertake a review of clinical risk using the risk assessment matrix (attached as appendix 1)[1]. It is important that this review ideally takes place at the start of any programme or work and appropriate clinical support is put in place at the beginning.

Although the generic risk assessment matrix was not specifically designed to assess the work of NHS Digital it provides a structured framework to assess the work of the organisation into areas of low, moderate, high and very high risk.

The risk assessment must include a suitably experienced senior clinical advisor and clinical domain experts.

The main domains from the risk assessment that are applicable are:

- Impact on the safety of patients, staff or public (physical/psychological harm)
- Adverse publicity/reputation (leading to reduced clinical confidence)
- Service/business interruption (leading to potential patient harm)

Where there are clusters of work (for example statistical data collections) that appeared to carry the same risk, these can be grouped for a single, common risk score. Externally facing services, i.e. those that provide services for the NHS as opposed to new products, as well as

[1] A piece of work is currently ongoing to establish whether this tool is optimum for services or whether the Gold Silver Bronze classification is superior [see appendix 2]

programmes should be assessed when it was possible to do so but exclusions must be agreed with the Director of Clinical Governance.

The risk matrix will be reviewed on an annual basis and evolve in line with the needs of the organisation. This activity will be led by the Director of Clinical Governance.

5.2 New programmes/services

With each new Portfolio Office work commission the clinical risk assessment process should be performed. This will prioritise proportionate ongoing clinical governance requirements. For some programmes, where there are clear links with the SCCI 0129 and SCCI 0160, Clinical Safety Standards (where new systems are being designed or deployed) these standards should be used to underpin the approach. It is also recommended that all programmes consider the use of a hazard log approach for documentation in line with the approach in SCCI0129.

5.3 Proportionate response/arrangements

The following table shows the expected response of programmes and services to clinical risk.

Assessed level of risk	Proportionate organisational response *
Low	For these programmes the clinical support is light touch with access to clinical advice from the professional pool.
Moderate	Trigger points are identified at first assessment (for example extension of programme content/delivery or a near miss incident) and if any of these occur the programme is expected to report these. Programmes should report all near misses when the procedure is in place. A named senior clinician, working with programme staff, undertakes an annual risk assessment to ensure there is no increase in level of risk.
High	Named clinician of appropriate background, seniority and experience is allocated to lead clinical input on the programme. This includes formally owning and maintaining a clinical risk register and reporting progress quarterly against mitigating actions on an annual basis to the Clinical Director. A formal documented annual risk assessment of the programme is undertaken in order to reallocate clinical resources if the programmes level of risk changes. The named clinician should be on the Programme Board and Service Management leadership structure. The responsibility for clinical risk and safety should be explicitly

	defined in programme structures and documentation. The named clinician will be expected to report (to Director of Clinical Governance) and investigate Serious Untoward Incidents.
Very High	Named senior clinical leadership with an appropriate professional background owns a clinical risk register and is responsible for the management of mitigation. Reports are provided to the SRO and programme director on a quarterly basis on progress. Senior clinical leadership should involve not only subject matter expertise but also business impact so that a complete picture, not a partial picture, is designed at outset. If NHS Digital owns the clinical risks a documented formal annual risk assessment of the programme is undertaken and this is reported to the Clinical Director and also includes an annual review meeting. Quarterly meeting take place with the Director of Clinical Governance to review the mitigation plan. The named clinician should be on the Programme Board or Service Management leadership structure. The responsibility for clinical risk and safety should be explicitly defined in programme structures and documentation. Where programmes or services have a Clinical Reference Group the senior clinicians should be a member and report the outcomes of assessments and work to that group. Clinicians will be expected to participate in deep dives and report and investigate Serious Untoward Incidents. The clinician responsible will be expected to answer all clinical complaints and be clinically accountable for the NHS Digital contribution and hence have an explicit agreed position on the NHS Digital duty of care with associated parties
	**Note: where clinical risk is wholly or jointly owned by an external partner this is formally documented and agreed with the Programme Director and SRO*

5.4 Ongoing PCRi or SCRi of existing portfolio and proportionate action

Where appropriate the programme should use the SCCI Clinical Safety Management Standards and hazard log approach and the risks should be recorded on the corporate risk register as a category of ‘clinical risk’.

Once the risk assessment is complete a review of clinical resources allocated to each programme/services should be undertaken and proportionate action taken in line with the above table. This will contribute to the assignment of clinical resources. Where a programme has clinical leadership from outside of NHS Digital, clinical risk must be assigned outside of the organisation and formally documented and agreed with the SRO.

It is important that nominated clinicians take direct responsibility for clinical risks and have in place an appropriate risk mitigation plan. This would be overseen by the Director of Clinical Governance and reported corporately alongside other risks and issues.

5.5 Role of clinicians on programmes

Clinicians working on programmes will be expected to lead the implementation of the clinical governance arrangements and this will be documented in work assignments and reviewed as part of personal development reviews. This means accurately documenting clinical risk and taking responsibility for mitigation plans and assuring action, working alongside programme leads. They would be expected to produce an annual clinical governance report and for services with a high or very high SCRi produce a clinical quality improvement plan. The clinicians would be expected to be responsible for ensuring the NHS Digital clinical duty of care is optimum. A generic role description of expected clinical activity including but not limited to clinical governance and clinician benefit will be produced as part of the clinical portfolio outputs

5.6 Relationship of risk assessment and clinical safety

There is a close relationship between the PCRi and SCRi and clinical safety. In many instances clinical safety assessments will also act as the programme clinical risk approach especially for new developments and services, in line with SCCI 0129 standards.

Clinical leads will be expected to provide clinical safety leadership for all programmes including presenting safety cases in the appropriate governance meetings. Clinicians will be responsible for making the decision, from a safety perspective whether programmes are safe to go live.

6. Clinical Workforce

Clinical governance also takes account of the quality of the clinical workforce. At NHS Digital processes will exist to ensure clinical staff are professionally led and properly supported in their professional development, ensuring they are able to make the best contribution.

NHS Digital has a Clinical Informatics Competency Framework which reflects the range of specialist skills clinicians at NHS Digital should have. The development of the clinical workforce will be co-ordinated by the Head of Profession and led by the senior professionals at NHS Digital. The development of clinicians will link directly to both their professional registration requirements and also the competency framework to ensure our existing workforce is appropriately skilled. It will be a mandatory requirement that all clinical staff attend the clinical safety training and an annual update.

Where clinical appointments are made to the organisation and also programmes, this will involve the Clinical Services Executive Portfolio clinical governance leaders and Executive Director. This applies for permanent appointments to the pool but also external clinicians on short term pieces of work.

NHS Digital will aim to include clinical safety as part of the induction for all staff.

7. Near miss and event reporting

In most health organisations where there is a risk that things can go wrong, there is a systematic process to collect information about what are termed near misses or where things do go wrong. These are collated and analysed and action taken to avoid ongoing risks and improve services where possible.

There are currently no formal internal mechanisms for staff to report, systematically, clinical events and near miss incidents at NHS Digital, which is then used to improve performance. Some processes exist but they are not robustly managed or analysed. This is not the same as the National Service Desk where live service issues are appropriately reported and dealt with through the Safety Management Process.

NHS Digital as a learning organisation will explore how it can better use near miss and event reporting to improve the quality of its products and services as part of its overarching clinical governance strategy. Updates on near misses and adverse events should be reported to the Executive Management Team quarterly.

8. Governance and Compliance

An update will be provided to the Executive Management Group Quarterly and the Audit and Risk Committee every year or sooner if required. The report will include an update on the clinical risk profile of the very high risk programmes and an overview of all clinical safety incidents that have occurred in the previous 12 months.

It is recommended that a non-executive director on the Board takes an interest and oversight function relating to clinical governance and clinical safety, working with the clinical director and team.

9. Management Responsibility

The Executive Clinical Director owns the clinical governance framework/policy and resulting corporate risk on behalf of the organisation. A clinical risk is recorded as part of a ‘Big 8 Strategic Risk’, in line with NHS Digital’s Corporate Risk Appetite model, and owned by the Clinical Director.

The Executive Clinical Director is supported by three directors as already described.

Named clinicians in programmes are responsible for governance and safety in their programmes including holding programme directors to account, decisions relating to safety in programmes and contributing to the management of clinical safety incidents in live service.

10. Externally facing Clinical Safety

NHS Digital will continue to maintain a positive external reputation for clinical safety through being transparent and sharing knowledge and expertise.

NHS Digital will seek to create a clinical safety resource where external stakeholders can learn about best practice and see examples of safety related work. This will include sharing of adverse events and any learning from these.

Appendix 1 - Risk Matrix

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Note: the above table can be tailored to meet the needs of the individual organisation.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Note: the above table can to be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 – 6	Moderate risk
8 – 12	High risk
15 – 25	Very high risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 (page 13) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Gold Silver Bronze Service Classification

SLA's for GSB services		Bronze	Silver	Gold	Platinum
Typical Service Characteristics and Criteria:		* HSCIC Internal services. * Used by HSCIC users only. * Can survive outages of days without significant impact. * Service Interruption results in no reputational damage.	* Data Capture, Batch Processing or Analytics services. * Used by HSCIC and/or NHS Backoffice users. * No frontline NHS or general public users. * Can survive outages of up to one business day without significant impact. * Service Interruption results in only minor reputational damage.	* Realtime or transactional services. * NHS frontline and/or general public users. * Outages of up to 4 hours can be managed with local processes and procedures. * Service Interruption results in significant reputational damage.	* Critical national services. * Used by NHS frontline users. * Outages cannot be tolerated. * Data loss cannot be tolerated. * Outages / Data loss may cause clinical safety issues. * Service Interruption results in severe reputational damage.
Operational Hours		8 - 5 Mon - Fri (exc BH)	24x7x365	24x7x365	24x7x365
Business Support Hours		8 - 5 Mon - Fri (exc BH)	8 - 6 Mon - Fri (exc BH)	24x7x366	24x7x365
Planned Maintenance downtime instances per period		2 per month	2 per month	1 per month	1 per quarter
Availability (in business support hours)		98%	99.50%	99.90%	99.90%
Unplanned downtime (mins per month)		234	65	43	43
Incident resolution Times					
Sev1		8 hrs (1 day)	4 hrs	4 hrs	2 hrs
Sev2		16 hrs(2 days)	8 hrs	8 hrs	4 hrs

Sev3		40hrs(5 days)	20 hrs (2 days)	10 hrs (Mon - Fri 8-6) (1 day)	8 hrs
Sev4		120hrs(15 days)	80 hrs(8 days)	50 hrs (Mon - Fri 8-6) (5 days)	30 hrs (Mon - Fri 8-6) (3 days)
Sev5		240 hrs(30 days)	200 hrs(20 days)	140 hrs (Mon - Fri 8-6) (14 days)	100 hrs (Mon -Fri 8-6) (10 days)
Problem Fix Times (per agreed release)					
Priority 1		30 working days	30 working days	30 working days	30 working days
Priority 2		60 working days	60 working days	60 working days	60 working days
Priority 3		120 working days	120 working days	120 working days	120 working days
Priority 4		240 working days	240 working days	240 working days	240 working days
Priority 5		360 working days	360 working days	360 working days	360 working days
Service Reporting		Ad hoc	Monthly	Monthly	Monthly
Service Requests		max 3 months	max 3 months	max 2 months	max 1 month
DR		Optional Bolt-on	Optional Bolt-on	10 hrs	4 hrs
RPO - Recovery Point Objective. How much data can the customer afford the app/service/system to lose in the event of a failure?		24 hours	24 hours	2 Hours	Zero
RTO - Recovery Time Objective The maximum tolerable length of time that the app/service/system can be down after a failure or disaster occurs.		TBD per service	TBD per service	10 hours	4 hours

Board Meeting – Public Session

Title of paper:	**Data Sharing Options Appraisal**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 05 a (P1)
Paper presented by:	Professor Martin Severs, Clinical Director and Caldicott Guardian
Paper prepared by:	Sonia Walters, Service Owner
Paper approved by: (Sponsor Director)	Professor Martin Severs – Clinical Director and Caldicott Guardian
Purpose of the paper:	Provide an options appraisal to the board to support decision making
Justification for inclusion in private board:	N/A
Additional Documents and or Supporting Information:	• Appendix 1 Bench-marked organisations • Appendix 2 Additional detail on the six options • Appendix 3 Quarterly update
Please specify the key risks and issues:	Obtaining suitably qualified staff in appropriate geographical locations
Patient/public interest:	Part of a service which provides audit reports which can be viewed on the NHS Digital website by the public
Supplementary papers:	No supplementary papers
Actions required by the Board:	Board is asked to support recommendations provided within the board paper

Data Sharing Audits

Options for increasing public trust

Sonia Walters

Published 22 August 2016

Information and technology
for better health and care

Contents

1 Executive Summary

NHS Digital audits recipients of its confidential information[1] to gain assurance that recipients are handling confidential information appropriately. The audits contribute to achieving the control required to conform to the Information Commissioner's Office (ICO) publication "Anonymisation: managing data protection risk code of practice".

The audits provide a comprehensive review of the controls, processes and procedures adopted by the recipients of confidential information from NHS Digital. They provide assurance that recipients comply with the terms of our data sharing framework contract, relevant data sharing agreements and our code of practice on confidential information. As such, they help NHS Digital build public trust in the way we handle confidential information. Audit reports are published on the NHS Digital public website[2].

Currently 30 recipients of confidential information are audited each year. They are selected for audit following either risk analysis or random selection. Audits cover information transfer, access control, use and benefits of data, data destruction, risk management and operational management and control. A separate one-day audit can provide assurance concerning data destruction and disposal.

This paper sets out a proposal to provide the public with even greater assurance of our dissemination of confidential information by increasing the capacity for audits and broadening the approach to auditing. The proposed approach increases the capacity of the internal audit function to 8 full time equivalent staff located around the country.

2 Background

NHS Digital provides confidential information to a wide variety of organisations to support specific health or adult social care purposes. Disseminations of these data are controlled through a Data Sharing Framework[3] Contract which uses standard terms and conditions with which all recipients must comply, and a Data Sharing Agreement[4] that is specific to each request for data. Recipients of confidential information are also required to have regard to the HSCIC Code of Practice on Confidential Information[5].

It is through the terms of the Data Sharing Framework Contract that NHS Digital has provision to conduct these audits to provide assurance that confidential information is handled appropriately. The audits contribute to our strategic risk theme to protect citizen's data.

---

[1] "confidential information" is—
(a) information which is in a form which identifies any individual to whom the information relates or enables the identity of such an individual to be ascertained, or
(b) any other information in respect of which the person who holds it owes an obligation of confidence.
Source: Health and Social Care Act 2012 Section 263

[2] www.digital.nhs.uk/dsa
[3] http://www.hscic.gov.uk/media/15728/DARS-Data-Sharing-Contract/pdf/HSCIC_Data_Sharing_Framework_Contract_Jan2015v_2_(restricted_editing).pdf
[4] http://www.hscic.gov.uk/media/15729/DARS-Data-Sharing-Agreement/pdf/Data_Sharing_Agreement_2015v2(restricted_editing).pdf
[5] http://www.digital.nhs.uk/cop

Currently there is capacity for 30 audits per annum with each typically taking 13-man days. There are 511[6] organisations receiving confidential information from NHS Digital under a Data Sharing Framework Contract as at July 2016. A number of organisations have multiple data sharing agreements; almost all data sharing audits to date have focused on organisations who have a single agreement.

At the May Board meeting, the Board requested a review of options to increase the assurance obtained, considering improving the current operating model, deliberation of cost recovery and consideration of different types of service providers.

3 Consultation and Benchmarking

Benchmarking discussions have involved a variety of external organisations. Two non-executive directors have provided further advice. The specialist nature of the data sharing activity has meant comparing 'like for like' between organisations has been challenging. The Information Commissioners Office (ICO) is the nearest comparative match. The ICO undertake up to 70 audits per annum using a team of 22 auditors and spend an average of 17 days per audit using three auditors.

Consultation and benchmarking with other government agencies has been difficult due to transformation projects in the Health Group Internal Audits, own audit function. As a result accurate and current information was unavailable. This transformation is not expected to be finalised until October this year.

Non-executive directors provided advice on a revised audit report and the risk based auditing approach to be undertaken. A risk-based approach has been explored with other organisations including the ICO and Canadian Statistics Agency audit functions.

The IG toolkit self-assessment provides one means of gaining limited assurance from many organisations receiving confidential information. Organisations with a current ISO 27001 certificate covering the handling of confidential information have confirmation that an accredited certification body has been assured that robust information security policies, processes and procedures are in place. This assurance provides a mechanism to reduce a two day audit to a one day audit.

4 Proposal

The current 511 organisations with Data Sharing Contracts enabling them to receive confidential information have been assigned into one of three risk-based categories:

- 189 receive high risk data, including Person Identifiable Data (PID)
- 256 receive high / medium risk including sensitive personal data that are anonymised in the context of the recipient, and
- 66 receive low risk, including non-sensitive personal data that are anonymised in the context of the recipient.

It is proposed that:

- recipients of person identifiable data receive a full audit every three years at a unit cost of £4.24k (£267k per annum).

- recipients of high / medium risk data receive a full audit every five years at a unit cost of £4.24k (£216k per annum).
- Additionally, recipients of person identifiable data, high and medium risk data receive a desktop review every 2 years at a unit cost of £0.24k (£35k per annum).
- recipients of low risk data receive a limited audit every 3 years at a unit cost of £1.89k (£42k per annum).

Over time, the medium category will move to a one-day audit, through follow-up audits, action plan reviews and the implementation of self-assessment.

The proposal will require an unbudgeted increase in the team of six additional full time equivalent staff. Staff costs will increase by £360k. This will be offset for each audit that identifies non-conformities through exercising our existing contract provision to recoup audit costs. Alternative approaches to recouping the costs of audits will be considered as part of the next review of the Data Sharing Framework Contract.

5 Implications

5.1 Strategy Implications

The proposal supports the NHS Digital Strategy and Business Plan. The audit team was established following an accepted recommendation in the Partridge report of 7th June 2014, which stated:

- NHS Digital to implements a robust audit function, which will enable ongoing scrutiny of how data is being used, stored and deleted by those receiving it.

The audit of recipients of our confidential information also contributes to the NHS Digital business plan 2015-2016 of:

- Building public trust and confidence in the processing and sharing of information, including responding to people's preferences for when their personal data can be shared,

And to the NHS Digital strategy 2015- 2020 of:

- Ensuring every citizen's data is protected.

5.2 Financial Implications

The total annual cost of the proposed service is £561k; the additional expenditure of £360k required to implement the proposal is unbudgeted.

For each audit that identifies non-conformities the cost of that audit will be recovered through provision in the data sharing framework contract. It is anticipated that the amount recovered will decrease over time as handling of confidential information by auditees improves.

5.3 Stakeholder Implications

The audits of recipients of our confidential information are part of a package of measures to provide the public with assurance concerning the handling of their confidential information. Audit reports are routinely published on the NHS Digital public website.

The majority of recipients of our confidential information have welcomed the audits and advised that they have had a positive impact in helping them to improve their processes, reducing the risk to our confidential information.

5.4 Handling

The increase in audits will improve NHS Digital confidence in the recipients of our data and enable stakeholders to share that increased confidence.

There will be a small impact upon the internal communications team following:

- An increase in reports to be published
- Any sensitive or adverse findings that may be identified and which may require careful handling.

6 Risks and Issues

The audits are identifying risks and issues within data sharing recipients' practices and enabling better understanding of the risk of sharing data with recipients and applicants.

Audits of the recipients of our confidential information are a specialist area; obtaining suitably qualified staff may prove difficult. Failure to achieve a balanced geographical profile of new recruits may lead to increased overheads and inefficiencies. Recruitment of people at NHS digital hub-sites or home based staff is necessary for achieving and improving upon the specified efficiencies and in reducing costs.

7 Corporate Governance and Compliance

Quarterly reporting on data sharing audits to the board is in place and this will continue. Assurance and compliance of organisations using our data appropriately is a key ingredient of the data sharing audits. The data sharing reports are routinely distributed to the Assurance and Risk Committee.

8 Management Responsibility

The Executive Director who has accountability for the proposal is Professor Martin Severs (Clinical Director and Caldicott Guardian). The senior manager with overall responsibility and dealing with the matter on a day-to-day basis is Nicholas Oughtibridge (Head of Information Standards: Quality, Assurance, Appraisal and Testing).

9 Actions Required of the Board

The Board is asked to support:

- the proposal to increase the number of audits of recipients of our confidential information from 30, two day audits per annum to a mix of one day and two day audits over a three and five year period supported by desktop reviews, and
- the allocation of an additional annual £360k budget for the implementation of the proposal.

Board Meeting – Public Session

Title of paper:	**Direction from NHS England for the NHS Diabetes Prevention Programme data collection**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 05 b (i) (P1)
Paper presented by:	Martin Severs, Interim Director of Information and Analytics, Medical Director and Caldicott Guardian
Paper prepared by:	Alyson Whitmarsh, Information Analysis Lead Manager, Clinical Audit Services Portfolio
Paper approved by: (Sponsor Director)	Martin Severs, Interim Director of Information and Analytics, Medical Director and Caldicott Guardian
Purpose of the paper:	To enable the views of the Board to be considered as part of the formal consultation on the Direction prior to it being signed by NHS England. This consultation is in line with our agreed process.
Additional Documents and or Supporting Information:	There are no additional documents and supporting information.
Please specify the key risks and issues:	GP Practice recruitment - In the event that an insufficient number of GP practices are recruited to participate in the NHS DPP pilot, there is a risk that the volume of data submitted to the pilot will not be large enough to allow robust analysis and make recommendations for next steps. NHSE have responsibility for recruiting practices.
Patient/public interest:	Indirect
Supplementary papers:	Appendix 1 - Diabetes Prevention Programme Audit Pilot directions NHS Digital draft v0.1 Appendix 2 - Diabetes Prevention Programme Audit Pilot Specificationv0.3 Appendix 3 - Diabetes Prevention Programme Audit Pilot Technical Output Specificationv0.3
Actions required by the Board:	Consider the draft Direction and to identify any issues or concerns as part of the formal consultation process.

NHS Digital

Direction from NHS England: NHS Diabetes Prevention Programme data collection

Formal consultation with the NHS Digital Board

7 September 2016

Information and technology
for better health and care

Contents

Executive Summary

NHS Digital has been commissioned by NHS England (NHSE) to run a clinical audit pilot in support of the NHS Diabetes Prevention Programme (NHS DPP). The pilot aims to understand more about the scope of the data available from primary care, in the identity and treatment of patients at high risk of developing Type 2 diabetes ('pre-diabetes patients')

A Direction from NHS England is needed to provide the legal basis for the data to flow. The draft Direction, and associated documentation which has been approved by Information Governance are included as Appendices

•

Background

The NHS DPP aims to identify those patients at high risk of Type 2 diabetes and refer them into an evidence-based behavioural intervention, such as helping them to lose weight and become more active in a structured way, in order to help them reduce their risk of developing diabetes. Previous studies have shown that those people that complete a behavioural intervention programme have a 26% lower incidence of developing type 2 diabetes compared to those undergoing normal care over an 18 month follow up period.[2]

Pre-diabetes is defined as: 'Patient diagnosed with non-diabetic hyperglycaemia or an HbA1c (blood glucose) of 42 – 47 mmol / 6.0 - 6.4% or fasting plasma glucose (FPG) of 5.5 – 6.9 mmol/l

The NHS DPP has produced guidance to support local health economies with primary care engagement as part of local engagement. This includes a description of the patient eligibility and clinical coding to be used in relation to the programme.

Guidance can be found here https://www.england.nhs.uk/ourwork/qual-clin-lead/diabetes-prevention/resources/

The Department of Health and NHSE have identified Type 2 diabetes prevention as one of the key priorities for action across the NHS. The Five Year Forward view, (NHS England 2014) sets out the strategy, in particular the need to reduce the costs associated with preventable illnesses through targeted programmes.

The pilot is time limited, with an evaluation report due March 2017. If the pilot is successful, it is planned that the dataset for the National Diabetes Audit Programme (NDA) will be extended to cover pre-diabetes patients and the NHS DPP.

NHSE have recently announced that the NDA will be carried out under a Direction from 2017

[2] *Source: '*A systematic review and meta-analysis assessing the effectiveness of pragmatic lifestyle interventions for the prevention of type 2 diabetes mellitus in routine practice'. Published by Public Health England 26 August 2015 https://www.gov.uk/government/publications/diabetes-prevention-programmes-evidence-review

It is envisaged that requirements for the DPP will be incorporated in to that as it is developed. Patients would be tracked during the lifetime of the NDA to understand at what point (if any) they transition from pre-diabetes to Type 2 diabetes and if there is any difference in prognosis for developing diabetes for those patients that completed the diabetes prevention programme compared to their counterparts that did not.

Recommendation

The Board is asked to consider this draft Direction and to identify any issues or concerns as part of the formal consultation process. This will provide the legal basis for collection of data to support the data collection.

Implications

Strategy Implications

NHS Digital's Strategy for 2015 – 2020 aims to deliver better use of health and care data which will help those involved to manage the system more effectively – activities such as this serve to support this aim.

The work supports our contribution to the Department of Health's Shared Delivery Plan Commitments, specifically theme 5. 'Preventing ill health and supporting people and communities to lead healthier lives'.

In addition NHS Digital's Business Plan for 2016/17 references the clinical audit service as a key way in which the organisation can do more by measuring what matters.

Financial Implications

This service is directly funded by the NHS England for £77,021 excluding VAT over 12 months). A POSA work package is in place for the current year. Funding is agreed until the end of March 2017 after which the results of the pilot will be reviewed to identify what the next steps should be for the addition of pre-diabetes patients to the National Diabetes Audit Programme.

The funding is largely for the staff resources needed to manage and deliver the data collection, analysis and reporting activities, IT system development to capture MIQUEST submissions, and a proportion of the income will be used to procure a supplier to support MIQUEST query development.

Stakeholder Implications

The NHS Diabetes Prevention Programme (DPP) is a joint commitment from NHS England, Public Health England and Diabetes UK. The pilot will be delivered through 20 to 25 GP practices in England. These practices will be recruited from either the sites that have already taken part as demonstrators for the NHS DPP, or those CCGs involved in the previous first wave of the NHS DPP and that have already established their intervention programme process. The NHS DPP will identify the practices for recruitment over August and September 2016. NHS England have suggested that the names of the practices recruited for the pilot will be listed in the Directions paperwork before approval from NHS England is received. The Direction will not be signed off by NHS England until a sufficient number of practices are recruited. The current commissioners, of the National Diabetes Audit Programme, (the Healthcare Quality Improvement Partnership) have been included in the discussions outlining possible plans to include additional data items in to the NDA, pending the outcome of the pilot.

Handling

Communications will be developed, agreed and issued by NHS Digital and NHS England. The lead organisation will depend on the audience and the key messages to be delivered. A communications plan will be developed. Communication will take various forms and include direct communication with providers; website development; stakeholder updates and promotion through PHE and Diabetes UK.

Patient information leaflets and posters for the recruited GP practices will be developed so that GP practices can inform their patients that they are taking part in the DPP-NDA Pilot.

Risks and Issues

GP Practice Recruitment - In the event that an insufficient number of GP practices are recruited by Public Health England (PHE) to participate in the NHS DPP pilot, there is a risk that the volume of data submitted to the pilot will not be large enough to allow robust analysis. This will result in lack of clarity on whether there is data recorded routinely in GP practices for pre-diabetes patients and whether the new read codes for the prevention programme can be extracted. This will be mitigated through by working closely with PHE to monitor the recruitment process and agree further actions if necessary

GP Practice Recruitment - In the event that the GP practices recruited to the pilot do not have well established processes in place for the intervention programme and patients that have completed the programme we will not have sufficient data to test that all the new prevention programme read codes are being used (offered, attended, completed programme). This will result in the pilot not being able to clearly demonstrate whether the new read codes can be extracted from GP practices successfully. This will be mitigated through ensuring that PHE target areas for recruitment that have an established process in place and include some of the demonstrator sites.

GP Practice Resources - In the event that the GP practices recruited to participate in the NHS DPP pilot do not have sufficient resource capacity to support the pilot, there is a risk that that the volume of data submitted to the pilot will not be large enough to allow robust analysis. This will result in lack of clarity on whether there is data recorded routinely in GP practices for pre-diabetes patients and whether the new read codes for the prevention programme can be extracted. This will be mitigated through monitoring data submissions and working with PHE to agree further actions if necessary

Data Quality - In the event that pre-diabetes is not recorded in a standard format in GP practices there is a risk that we may under report the number of people with pre-diabetes. This will result in being unable to provide an accurate number of patients with pre-diabetes when added to the NDA specification for national data collection. This will be mitigated by ensuring that there is clinical input into the specification.

Corporate Governance and Compliance

NHS DPP has a signed POSA work package and has a current entry on the Portfolio database. Information Governance has approved the draft Direction.

Key progress indicators are outlined in the work package between NHS Digital and NHS England and monitored by the commissioner. These can also be reported to the NHS Digital Board.

Management Responsibility

- Martin Severs, Interim Director of Information and Analytics
- Daniel Ray, Director of Data Science, Information and Analytics Portfolio
- Alyson Whitmarsh, Clinical Audit & Registries Programme Manager, Information & Analytics Directorate

Actions Required of the Board

The Board are asked to consider the draft Direction and to identify any issues or concerns as part of the formal consultation process.

Appendices

Appendix 1 - Diabetes Prevention Programme Audit Pilot directions NHS Digital draft v0.1
Appendix 2 - Diabetes Prevention Programme Audit Pilot Specificationv0.3
Appendix 3 - Diabetes Prevention Programme Audit Pilot Technical Output Specificationv0.3

D I R E C T I O N S

NATIONAL HEALTH SERVICE, ENGLAND

The Health and Social Care Information Centre (Establishment of Information Systems for NHS Services: Diabetes Prevention Programme Audit Pilot) Directions 2016

The National Health Service Commissioning Board gives the following Directions to the Health and Social Care Information Centre in exercise of the powers conferred by sections *254(1), (3) and (6)* of the Health and Social Care Act 2012.

In accordance with section 254(5) of the Health and Social Care Act 2012, the National Health Service Commissioning Board has consulted the Health and Social Care Information Centre before giving these Directions.

Citation, commencement and interpretation

1. These Directions may be cited as The Health and Social Care Information Centre (Establishment of Information Systems for NHS Services: Diabetes Prevention Programme Audit Pilot) Directions 2016 and shall come into force on **[date]**.

2. In these Directions–

"The 2012 Act"	means the Health and Social Care Act 2012[1];
"The Board"	means the National Health Service Commissioning Board[2];
"HSCIC"	means the Health and Social Care Information Centre[3];
"Relevant Organisation"	means a GP practice listed in section 5 of the Specification **[DN – to be included in the final draft of the Specification]**;

[1] 2012 c7
[2] The National Health Service Commissioning Board was established by section 1H of the National Health Service Act 2006 (2006 c 41.), and operates as NHS England.
[3] The Health and Social Care Information Centre is a body corporate established under section 252(1) of the Health and Social Care Act 2012

"Specification"	means the Diabetes Prevention Programme and National Diabetes Audit Pilot Requirement Specification that has been published by the Board version **N.N** dated **DD/MM/YY** (Document ID: DPP NDA Spec) and annexed to these Directions at Annex A or any subsequent amended version of the same document that is published by the Board;
"Technical Output Specification"	means the DPP-NDA Pilot Technical Output Specification (dataset) that has been published by the Board version **N.N** dated **DD/MM/YY** and annexed to these Directions at Annex B or any subsequent amended version of the same document that is published by the Board.

Establishing and Operating the Diabetes Prevention Programme Audit Pilot Information System

3. – (1) Pursuant to its powers under sections 254(1) and 254(6) of the 2012 Act, the Board directs the HSCIC to establish and operate a system for the collection of the information described in sub-paragraph (2) from the Relevant Organisations, such system to be known as "the Diabetes Prevention Programme Audit Pilot Information System".

(2) The information referred to in sub-paragraph (1) is the information described in the Technical Output Specification.

(3) The Board directs HSCIC to carry out the activities described in sub-paragraph (1) in accordance with the criteria defined in the Specification and in the Technical Output Specification.

S254(3) - Requirement for these Directions

4. In accordance with section 254(3) of the 2012 Act, the Board confirms that it is necessary or expedient for it to have the information which will be obtained through the HSCIC complying with these Directions in relation to the Board's functions in connection with the provision of NHS Services. In particular the information obtained through compliance with these Directions will facilitate or enable the achievement of the purposes that are described in the sections 3 and 4 of the Specification**.**

Fees and Accounts

5. Pursuant to sub-section 254(7) of the 2012 Act, HSCIC is entitled to charge the Board a reasonable fee in respect of the cost of HSCIC complying with these

Directions and the Board acknowledges such right and agrees to meet such reasonable fee charged by HSCIC.

6. The HSCIC must keep proper accounts, and proper records in relation to the accounts, in connection with the Diabetes Prevention Programme Audit Pilot Information System.

Review of these Directions

7. These Directions will be reviewed when the Board approves any amendment to the Specification or Technical Output Specification. This review will include consultation with the HSCIC as required by sub-section 254(5) of the 2012 Act.

Signed by authority of the NHS Commissioning Board

Sir Bruce Keogh
Caldicott Guardian

[INSERT DATE]

Annex A – Diabetes Prevention Programme Audit Pilot Specification

Annex A - National Prevention Programm

Annex B – Diabetes Prevention Programme Audit Pilot Technical Output Specification

DPP-NDA Pilot Technical Output Spe

Diabetes Prevention Programme and National Diabetes Audit Pilot

Requirement Specification

Document filename: Diabetes Prevention Programme and National Diabetes Audit Pilot v0.3 270716	
Programme: CARMS	**Project: Diabetes Prevention Programme & National Diabetes Audit Pilot**
Document Reference: DPP NDA Spec	
Project Manager: Cher Cartwright	**Status: Draft**
Owner: Alyson Whitmarsh	**Version: 0.3**
Author: Cher Cartwright	**Version issue date: 27th July 2016**

Document Management

Revision History

Version	Date	Summary of Changes
0.1	July 2016	Draft version of specification
0.2	July 2016	Updated version following review by Ben McGough & Alyson Whitmarsh
0.3	July 2016	Updated version following review by Richard Sewart

Reviewers

This document must be reviewed by the following people: author to indicate reviewers

Reviewer name	Title / Responsibility	Date	Version
Ben McGough	Strategy Directorate – Public Health England	July 2016	0.1
Alyson Whitmarsh	Programme Manager – HSCIC Clinical Audit	July 2016	0.1
Richard Sewart	NHS England - Data Sharing and Privacy Specialist	July 2016	0.2

Document Control:

The controlled copy of this document is maintained in the NHS Digital corporate network. Any copies of this document held outside of that area, in whatever format (e.g. paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

Contents

1. Introduction

The National Diabetes Audit (NDA) was established in 2003 and forms part of the National Clinical Audit Programme funded by NHS England and commissioned by the Healthcare Quality Improvement Partnership (HQIP). NHS Digital are currently contracted until June 2017 to deliver the NDA.

NHS Digital provides data collection, data analysis and report publication to the audit with a number of annual reports being published each year covering a range of process and outcome measures. Diabetes UK provide stakeholder engagement support and management of the Advisory Groups and Partnership Board membership and secretariat duties. Currently, NHS Digital act as Data Processors for the Audit and HQIP as Data Controllers for the Audit. Clinical leadership is provided by Dr Bob Young, Consultant Diabetologist from Salford Royal Foundation NHS Trust. Additional clinical input into the audit is also provided by Advisory Groups for each work-stream of the Audit which is comprised of members from a range of clinical professions.

The NHS Diabetes Prevention Programme started in 2016, and is being rolled out in stages across all Clinical Commissioning Groups (CCGs) in England. The first wave covers 27 CCGs and 20,000 intervention programme places are being made available. The aim is to roll out to the whole country by 2020 with an expected 100,000 referrals available each year after.

The long-term aim is for the NDA specification to be expanded to include patients with pre-diabetes. These patients will be tracked over time to understand if there is any difference in prognosis for developing diabetes for those patients that completed the diabetes prevention programme compared to their counterparts that did not. The DPP-NDA Pilot is being undertaken to understand more about the scope of the data available in GP practices for pre-diabetes patients and if it can be collected as part of the NDA.

This Direction refers to the DPP-NDA Pilot to test the data extraction in relation to individuals with pre-diabetes. If the pilot proves successful as part of the re-commissioning work for the NDA it is expected that a further Direction will be sought that covers the current NDA and the enhancement of the specification to include pre-diabetes patients (method to be determined).

2. The National Diabetes Audit

The National Diabetes Audit (NDA) is part of the National Clinical Audit Programme and measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales. The NDA collects and analyses data for use by a range of stakeholders to drive changes and improvements in the quality of services and health outcomes for people with diabetes. The NDA started in 2003 with what is referred to as the NDA Core audit, and over the years has grown to encompass new work-streams for specialist areas of diabetes care; these include Inpatient Care, Pregnancy, Foot-care, Insulin Pumps and Transition from paediatric to adult services.

The NDA Core audit answers four key questions:

1. Is everyone with diabetes diagnosed and recorded on a practice diabetes register?
2. What percentage of people registered with diabetes received the nine NICE key processes of diabetes care?
3. What percentage of people registered with diabetes achieved NICE defined treatment targets for glucose control, blood pressure and blood cholesterol?
4. For people with registered diabetes what are the rates of acute and long term complications (disease outcomes)?

To answer the above points the NDA Core audit publishes annual reports each year. These are produced at GP practice, Specialist Service, CCG and National level.

The NDA aims to improve the quality of patient care by enabling NHS organisations to, compare their outcomes of care with similar NHS organisations, identify and share best practice, identify gaps or shortfalls in commissioning services, assess local practice against NSF for diabetes and NICE guidelines and drive service improvement and provide a more comprehensive picture of diabetes care and outcomes in England and Wales

Through participation in the audit, local services are able to benchmark their performance and identify where they are performing well, and improve the quality of treatment and care they provide. On a national level, wide participation in the audit also provides an overview of the quality of care being provided in England and Wales.

3. NHS Diabetes Prevention Programme (DPP)

Non-diabetic hyperglycaemia, also known as pre-diabetes or impaired glucose regulation, refers to raised blood glucose levels, but not in the diabetic range. People with pre-diabetes are at increased risk of developing Type 2 diabetes. They are also at increased risk of other cardiovascular conditions.

There are currently 5 million people in England at high risk of developing Type 2 diabetes. One in three people will be obese by 2034 and one in ten will develop Type 2 diabetes. However, evidence exists which shows that many cases of Type 2 diabetes are preventable. There is also strong international evidence which demonstrates how behavioural interventions, which support people to maintain a healthy weight and be more active, can significantly reduce the risk of developing diabetes.

The NHS Diabetes Prevention Programme (DPP) is a joint commitment from NHS England, Public Health England and Diabetes UK. DPP will identify those people with pre-diabetes that are at high risk of developing Type 2 diabetes and refer them onto an evidence-based behaviour change programme to help reduce their risk, referred to here as an intervention programme.

Seven clinical commissioning groups (CCGs) and Local Authorities have been acting as demonstrator sites and have been testing innovative approaches to programme delivery for the last year and this learning has shaped the final DPP programme to get the best results for patients.

The DPP is being rolled out across England. In 2016 the first wave of 27 areas covering approximately 26 million people will have a service available and estimate up to 20,000 intervention places will have been taken up. The programme will roll out to the whole country by 2020 with an expected 100,000 referrals available each year after.

The long term plan is for the specification for the NDA to be extended to cover pre-diabetes patients and the NHS Diabetes Prevention Programme. Patients would be tracked during the lifetime of the audit to understand at what point (if any) they transition from pre-diabetes to Type 2 diabetes. The current NDA specification also collects information for annual care checks, for example blood pressure, blood glucose, BMI and cholesterol.

The incorporation of pre-diabetes patients into the NDA will allow us to answer the following questions for pre-diabetes patients:-

1. How many people are diagnosed as having pre-diabetes in England?
2. What are the demographics of people with pre-diabetes (age, sex, ethnicity, social deprivation)?
3. How many people were offered, attended or have completed an intervention programme?
4. How many people had annual care checks for BMI, HbA1c, cholesterol and blood pressure?
5. Does completing an intervention programme lead to a reduction in blood pressure, HbA1c or BMI?
6. Does completing an intervention programme reduce the risk of developing diabetes and cardiovascular disease? (2yr, 3yr, 5yr, 10yr follow up)

4. Aim of the DPP-NDA Pilot

The aim of the DPP-NDA pilot is to develop a data specification that can be collected for pre-diabetes patient and incorporated in to the NDA data specification. The DPP-NDA Pilot will test the proposed data specification within approximately 20-25 practices in England to understand if the data can be collected, if the data items are well populated and if the new read codes for the DPP programme are being used. As part of the pilot next steps will be developed for including pre-diabetes patients in the NDA.

The pilot is important as we want to be assured that coding is being adhered to so that we do not over or more likely under-report activity through the national audit. Under-reporting has been an issue in the reporting of structured education in the NDA.

5. Relevant Organisations

The DPP-NDA pilot will recruit between 20 to 25 practices in England that have either participated as a demonstrator site or are in the first wave of roll out and are well established with their intervention programme process. The National Diabetes Prevention Programme are responsible for the recruitment of the practices and this will take place over the Summer of 2016. (*We will update the final version of the specification to include the recruited practices before final sign off by NHS England).*

6. Informatics

The NDA Core Audit collects data from GP Practices. For the NDA extraction a primary care specification is developed detailing the data items to collect and the specific read codes to extract. MiQuest queries are also developed. The GPSoC framework is used to contract the main clinical system suppliers (EMIS, TPP, INPS and Microtest) to develop an extraction process for their practices so that they can take part in the NDA. For EMIS and INPS this involves in house queries that can be run specifically on that clinical system. TPP perform an automatic bulk extraction and Microtest automatically run the MiQuest queries for their practices. For all other clinical systems, and those TPP systems that miss the automatic extraction, MiQuest queries are available for practices to download and run on their clinical system. For the Miquest queries and the in-house system queries a csv file is produced which practices submit to the NHS Digital Clinical Audit Platform, this is through a secure web portal called Data Landing.

The benefit of MiQuest queries are they are not system specific and can be run on any clinical system, they are also well established and robust, therefore data quality is usually of a high standard. For these reasons, MiQuest queries will be used for the DPP-NDA pilot. The data controller for the DPP-NDA Pilot will be NHS England and HSCIC, who will act as joint data controllers.

The data from the recruited practices will be analysed to understand demographic information for people with pre-diabetes (ethnicity, age, gender), whether checks have been carried out for blood glucose, blood pressure, BMI, cholesterol and smoking, how many patients have been referred to the intervention programme and how many are attending or have completed the programme.

Aggregate intervention programme data for the recruited GP practices will also be sought from the Clinical Support Unit, commissioned to provide informatics support to the PHE/NHSE for the DPP, to compare how many people have been referred/attended the intervention programmes to see if data is being passed back to GP practices and if the read codes are being used. NHS England and the Education Providers are data controllers for this data, we will work with both parties to gain appropriate access.

7. Fair processing

Patient information leaflets and posters for the recruited GP practices will be developed so that GP practices can inform their patients that they are taking part in the DPP-NDA Pilot.

8. Burden Assessment

As part of the study the recruited practices will also be asked to complete a burden assessment for the time and costs for taking part in the DPP-NDA Pilot. This assessment will be used as a basis for understanding the cost implications for conducting the data extraction and fair processing activities. The long-term plan is that pre-diabetes is added to the NDA specification, there will be limited additional burden for adding pre-diabetes to the NDA as system suppliers set the extraction criteria, the operational procedures for GP Practices to run the data extraction will remain the same and no additional requirements from GP practices will be needed to include pre-diabetes patients within the extract. There will be some additional burden for fair processing activities to cover pre-diabetes patients. There are a number of different methods for data extraction for the NDA and the method of extraction is dependent upon the clinical system of the GP practice. This assessment will only give us the time and costs associated with extracting via MiQuest queries. Further assessments will be needed to understand the costs associated with extracting for other clinical systems for the NDA.

9. The Dataset

The dataset has been reviewed by NHS Digital, Public Health England and the Clinical Lead for the NDA. A list of data items collected can be found in the DPP-NDA Pilot Technical Output Specification (dataset) v0.3.

10. Outputs

A summary statistics report covering the recruited practices will be produced. The report will include information for the number of patients with pre-diabetes along with information for whether care processes have taken place and the corresponding readings. The report will also look at how many people have been referred to the intervention programme and then went on to attend or have completed the intervention programme. This will be compared to the information gathered directly from the education providers by the Clinical Support Unit for the recruited practices to see what proportion of those referred and attended has been recorded in the GP Practice. This will allow us to assess whether the new read codes are being used in the GP practice and whether the education providers are passing information back to practices.

A lessons learned/next steps report will be developed that details a review of the pilot and next steps for how we include pre-diabetes patients in the NDA specification. The report will also detail the results of the burden assessment as part of the review.

Both reports will be completed by the end of March 2017. The summary statistics report will also be published on the NHS Digital website.

11. Timescales

The DPP-NDA Pilot is a one-off study that will take place between April 2016 and March 2017. The results of the Pilot will be used to decide what the next steps are for the addition of pre-diabetes patients to the NDA specification. The final reports will be produced by the end of March 2017.

Diabetes Prevention Programme and National Diabetes Audit Pilot (DPP-NDA Pilot)

Background
This document forms the DPP-NDA PilotTechnical Output Specification (dataset) as detailed in the The Health and Social Care Information Centre (Establishment of Information Systems for NHS Services: Diabetes Prevention Programme Audit Pilot) Directions 2016.

The Primary Care Extraction Specification for the National Diabetes Audit 2015-16 should be used as a template for the development of the primary care extraction specification for the DPP-NDA Pilot. Where data Items are also collected as part of the NDA the same read codes should be applied to the DPP-NDA Pilot including a refresh to update for any new read codes released since March 2016 or changes to clinical interpretation.

Cohort of Patients
All patients diagnosed with pre-diabetes (and no diabetes diagnosis confirmed) before 31 October 2016 should be included in the specification

Do not include:
Any patients that have dissented from secondary use of general pratitioner patient identifiable data with no subsequent dissent withdrawn code
Any patients that have dissented from National Audits unless there is a subsequent informed consent to national audit code

Data Items to collect
All the data items on the Data Items tab should be included in the specification

New Read Codes
There were new read codes introduced in April 2016 to cover non-diabetic hypoglycaemia and also the new prevention education programme. These codes have been supplied along with which data item they should be applied to

Document Version
DPP-NDA Pilot Technical Output Specification (dataset) v0.3

Version No	Date	Updated by
0.1	11/07/2016	Cher Cartwright
0.2	14/07/2016	Cher Cartwright
0.3	27/07/2016	Cher Cartwright

Data Item	Description	Date validation	Already collected as part of the NDA (Y/N)	New read codes developed for April release
NHS Number	NHS number of the patient		Y	
Date of Birth	Date of Birth of the patient		Y	
Postcode	Postcode of the patient		Y	
Gender	Gender of the patient		Y	
Ethnicity	The latest ethnic group code recorded		Y	
dissent from disclosure of personal confidential data by HSCIC	the code and date of the latest dissent from disclosure of personal confidential data by HSCIC recorded at any time up until the run date that has not been superseded by an appropriate withdrawn dissent code		Y	
GP Code	the national practice code for the practice		Y	
Pre-diabetes Diagnosis code	the latest diagnosis code for pre-diabetes where this has been specified as impaired glucose regulation or non-diabetic hyperglycaemia with no subsequent code for diabetes	diagnosed before 31/10/16	N	See Tab
Pre-diabetes Diagnosis date	The earliest date of diagnosis for pre-diabetes	diagnosed before 31/10/16	N	
BMI	The value and date of the latest entry for body mass index	before 31 /10/16	Y	
Blood Pressure	The value and date of the latest entry for blood pressure	before 31 /10/16	Y	
HbA1c	The value and date of the latest entry for HbA1c	before 31 /10/16	Y	
serum creatinine	The value and date of the latest entry for serum creatinine	before 31 /10/16	Y	
urinary albumin/creatinine ratio	The value, date and code of the latest entry for urine albumin/creatinine ratio results	before 31 /10/16	Y	
persistent proteinuria	the first code representing the earliest persistent proteinuria diagnosis ever	before 31 /10/16	Y	
serum total cholesterol	the value and date of the latest entry for serum total cholesterol	before 31 /10/16	Y	
Smoking status	the code and date of the latest smoking status recorded	before 31 /10/16	Y	
Offered intervention programme	the code and date of the latest referral to the intervention programme	before 31 /10/16	N	See Tab
Attended intervention programme	the code and date of the latest referral to the intervention programme	before 31 /10/16	N	See Tab
Completed intervention programme	the code and date of the latest completed intervention programme	before 31 /10/16	N	See Tab
ischaemic heart disease diagnosis	the code and date of the earliest ischaemic heart disease recorded	before 31 /10/16	Y	
learning disability	latest code and date for learning disability	before 31 /10/16	Y	

Data Item	V2 Code	V3 Code	Descripton
pre-diabetes diagnosis	C317.	XaaeP	Non-diabetic hyperglycaemia
offered intervention programme	679m4	XaeDH	Referred to NHS Diabetes Prevention Programme
offered intervention programme	679m3	XaeDG	Referral to NHS Diabetes Prevention Programme declined
Attended intervention programme	679m2	XaeD0	NHS Diabetes Prevention Programme started
Attended intervention programme	679m0	XaeCw	NHS Diabetes Prevention Programme not completed
Completed intervention programme	679m1	XaeCz	NHS Diabetes Prevention Programme completed

Board Meeting – Public Session

Title of paper:	**Direction from Department of Health for 'GP metrics' data extraction**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 05 b (ii) (P1)
Paper presented by:	Martin Severs (Interim Director of Information and Analytics, Medical Director and Caldicott Guardian, NHS Digital)
Paper prepared by:	Dave Roberts (Head of Business and Operational Delivery, Primary Care Domain, NHS Digital)
Paper approved by: (Sponsor Director)	Martin Severs (Interim Director of Information and Analytics, Medical Director and Caldicott Guardian, NHS Digital)
Purpose of the paper:	Provide the NHS Digital Board with the information necessary to consider the Direction that is required to support GP metrics and approve its acceptance.
Additional Documents and or Supporting Information:	Full URLs for each of the footnotes included in the NHS Digital Board paper are listed below: Government's mandate to NHS England for 2016-17: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494485/NHSE_mandate_16-17_22_Jan.pdf NHS Five Year Forward View: https://www.england.nhs.uk/ourwork/futurenhs/ National Information Board (NIB) Framework: https://www.gov.uk/government/news/introducing-personalised-health-and-care-2020-a-framework-for-action https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/437067/nib-delivering.pdf
Please specify the key risks and issues:	The NHS Digital Board accepting the Direction at the Board meeting on 7 September 2016 will allow a Data Provision Notice to be issued six weeks ahead of December 2016, which is when the first data extraction is scheduled. Waiting until the November Board meeting (30 November 2016) for the Direction to be accepted by the NHS Digital Board would mean that the earliest that the data could be extracted would be mid-January 2017, which would delay the first dissemination being sent to

	GPs due to the time needed for processing and analysing the data following its extraction.
Patient/public interest:	Indirect.
Supplementary papers:	There are two supplementary papers that the NHS Digital Board should consider: 1. Direction from DH for GP metrics 2. Appendix A: GP metrics supporting information (this is the Appendix document for the Direction itself)
Actions required by the Board:	**The NHS Digital Board is asked to accept the Direction from DH for GP metrics at the Board meeting on 7 September 2016.**

NHS Digital

Direction from the Department of Health

GP Metrics data extraction

7 September 2016

Information and technology
for better health and care

Contents

Executive Summary

The Department of Health (DH) wish to Direct NHS Digital to extract primary care data, and link these data to secondary care data where required, for a given set of metrics at the individual general practitioner (GP) level, and disseminate data back to GPs[1]. Under this Direction (see Annex A), the data will not be published. This paper provides the NHS Digital Board with the information necessary to consider the Direction that is required to support this programme of work and approve its acceptance.

Background

The Government's mandate to NHS England for 2016-17[2] includes a deliverable to work with NHS Digital to provide GPs with aggregated information on the care provision for their patients. DH and NHS England will work with NHS Digital to achieve this deliverable. NHS Digital's General Practice Extraction Service (GPES) will extract the necessary primary care data for the 12 agreed metrics, one of which will require data from secondary care for linkage purposes. Patient / record level data will be extracted from GP clinical systems and Hospital Episode Statistics (HES) and NHS Digital will therefore uphold Type 1 objections. The existing 'usual GP' data field within the GP clinical systems, which may or may not represent a patient's named accountable GP, will be used to breakdown the metrics at the individual GP level. This methodology was agreed between DH and NHS Digital, and was supported by the Secretary of State for Health, ahead of the first GP metrics Programme Board meeting on 10 August 2016. This methodology and data quality will be reviewed following the first extraction and dissemination of data.

A Direction, issued under section 254 of the Health and Social Care Act 2012 (the Act), from DH to the NHS Digital is required to ensure the legal extraction of the primary care data from general practices and the appropriate processing and analysis of the data that are disseminated back to GPs. Under section 261(3) of the Act, the data will only be disseminated to GPs. The legal basis under which the Direction is given will preclude NHS Digital from further publishing / disseminating the data other than what is Directed (i.e. disseminating the data back to GPs). Each GP will only be provided with aggregate level data for their own patients so Type 2 objections do not apply to the dissemination. GPs will not be provided with any patient level data.

Funding is currently in place for NHS Digital to extract and report two disseminations of data to GPs (see 4.2 Financial Implications). The reason for this is to facilitate testing of the methodology of extracting data at the individual GP level and the quality of the data that are extracted. DH is keen to develop a methodology for producing such metrics recognising that the first sets of data are likely to be experimental and will need to be improved in time in light of learning. Therefore, the initial funding aims to:

- Facilitate testing of the methodology and enable technical end to end testing of data extraction and dissemination at the individual GP level.
- Analyse data quality of the extract across the GP community and highlight next steps to improve data quality.

[1] The data dissemination reporting mechanism is to be confirmed; the data may be disseminated to GPs or general practices but this document refers to the data being disseminated to GPs for ease.
[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494485/NHSE_mandate_16-17_22_Jan.pdf

- Engage in active dialogue with the GPES team and general practice system suppliers to understand tactical and strategic options for future delivery.
- Engage with GP representative bodies and senior stakeholders to understand how GP metrics can best support improvements in patient care and how the use of such data can be improved over time.

Recommendation

The recommendation is for NHS Digital Board to accept the Direction from DH for GP metrics at the Board meeting on 7 September 2016.

Implications

Strategy Implications

GP metrics is listed as one of the 2016-17 deliverables in the Government's mandate to NHS England for 2016-17[2] as this states to "Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists." This deliverable supports objective 6 (i.e. to improve out-of-hospital care) in the mandate[2], which itself supports the delivery of the NHS Five Year Forward View[3] and a seven-day NHS. GP metrics also falls under the 'transforming general practice' and 'out of hospital care and integration with social care' Domains of the National Information Board (NIB) Framework[4][5], which aims to support delivering the NHS Five Year Forward View.

Financial Implications

DH is funding the GP metrics programme of work. NHS Digital received a Work Package from DH that provides full details of the funding that is in place. This Work Package was approved by NHS Digital's Investment Sub-Group (ISG) on 22 August 2016. A Project Brief will be submitted to ISG six to eight weeks after this initial meeting.

Funding is currently in place for NHS Digital to extract and report two disseminations of data to GPs; the first dissemination is required by January 2017 and the second dissemination is required by April 2017; the first and second data extractions are scheduled to take place in December 2016 and March 2017, respectively.

Following the first data extraction and dissemination of data to GPs in January 2017, DH will be keen to consider next steps in light of feedback and learning. The intention is for the data extraction and dissemination to take place on a quarterly basis and for this to form business as usual for NHS Digital. Further funding will be required to support this.

Stakeholder Implications

DH convened a reference group to inform the development of the chosen metrics. This brought together professional and technical advisers from NHS England, the Care Quality Commission (CQC), NHS Digital and the National Institute for Health and Care Excellence (NICE), together with an independent GP academic. Following a report by the Health Foundation last autumn which made recommendations to DH on quality indicators within

[3] https://www.england.nhs.uk/ourwork/futurenhs/
[4] https://www.gov.uk/government/news/introducing-personalised-health-and-care-2020-a-framework-for-action
[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/437067/nib-delivering.pdf

general practice, NHS England has been working on a series of 'sentinel' indicators to be published on MyNHS at the general practice level. DH has also been working with NHS England as this work develops so that the individual GP level metrics can align where possible.

As part of the Standardisation Committee for Care Information (SCCI) process, there will be a targeted consultation with the Joint GPC and Royal College of General Practitioners (RCGP) IT subcommittee for GP metrics. This will provide professional assurance for GP metrics ahead of this being considered by SCCI at the meeting on 31 August 2016.

Handling

Following the acceptance of the Direction by the NHS Digital Board, a Data Provision Notice will be issued to all general practices in England at least six weeks prior to the first data extraction taking place. Issuing this Data Provision Notice will provide the legal basis for the data extraction and will mandate general practices to comply with this extraction in the form, manner and period of the collection (as specified in the Data Provision Notice).

Information on how general practices will comply with the Data Provision Notice will also be sent to general practices via NHS Digital's Calculating Quality Reporting Service (CQRS); further communications will also be included in the NHS Digital General Practice bulletin.

DH is responsible for all external communications regarding GP metrics; this includes communications surrounding the purpose and direction of travel of this programme of work. DH will work with NHS England on the engagement and consultation with general practices surrounding this work through the appropriate professional bodies and will be keen to build on learning from the first extract.

Risks and Issues

As DH is Directing NHS Digital to establish the GP metrics data collection, a Data Provision Notice needs to be issued to all general practices in England at least six weeks prior to the data being extracted. A Data Provision Notice can only be issued following the Direction (see Annex) being accepted by the NHS Digital Board. The NHS Digital Board accepting the Direction at the Board meeting on 7 September 2016 will allow a Data Provision Notice to be issued six weeks ahead of December 2016, which is when the first data extraction is scheduled.

Waiting until the November Board meeting (30 November 2016) for the Direction to be accepted by the NHS Digital Board would mean that the earliest that the data could be extracted would be mid-January 2017, which would delay the first dissemination being sent to GPs due to the time needed for processing and analysing the data following its extraction.

Corporate Governance and Compliance

As mentioned above, the Work Package for GP metrics was approved by NHS Digital's ISG.

GP metrics will go through the SCCI process and is due to be considered at the SCCI meeting on 31 August 2016. The SCCI process will involve a detailed burden assessment from the Burden Advice and Assessment Service (BAAS). This will consider the overall burden to GPs / general practices for both the extraction of the data and the dissemination of the data, as well as any additional burden (such as the burden placed on GPs / general practices in improving the quality of the data following the data being disseminated back to GPs).

The metrics will also be taken through the Indicator and Methodology Assurance Service (IMAS), which is hosted by NHS Digital.

The GP metrics programme of work is governed through a Programme Board, which includes senior representatives from DH, NHS Digital and NHS England. A Project Team is also in place for this work.

Management Responsibility

DH

- Senior Responsible Owner: Jonathan Marron (Director, Community, Mental Health and 7 Day Services, Department of Health)

NHS Digital

- Executive Director: Prof. Martin Severs (Interim Director of Information and Analytics, Medical Director and Caldicott Guardian, NHS Digital)
- Executive Director: Prof. David Hughes (Information and Analytics, NHS Digital)[6]
- Head of Business and Operational Delivery: Dave Roberts (Primary Care Domain, NHS Digital)
- Programme Manager: Tim Chearman (LSP Directorate Central Services, NHS Digital)

NHS England

- Senior Clinical Advisor: Dr Arvind Madan (Director of Primary Care, NHS England)

Actions Required of the Board

The NHS Digital Board is asked to accept the Direction from DH for GP metrics at the Board meeting on 7 September 2016.

[6] Prof. David Hughes joined NHS Digital as the Executive Director of Information and Analytics on 22 August 2016. Prior to this, Prof. Martin Severs was the Interim Director of Information and Analytics. There will be a period of handover between Prof. Martin Severs and Prof. David Hughes.

Department of Health

Andy Williams
Chief Executive,
Health and Social Care Information Centre
1 Trevelyan Square, Boar Lane
Leeds
LS1 6AE

[#] August 2016

Dear Andy

I am writing to provide a Direction to the Health and Social Care Information Centre (HSCIC), also known as NHS Digital, to establish and operate a system for the collection and analysis of individual GP level data.

This Direction is given in exercise of the powers conferred by sections 254(1) and (6), 260(2)(d), 261(3), 274(2) and 304(9), (10) and (12) of the Health and Social Care Act 2012[1] and Regulation 32 of the National Institute for Health and Social Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013[2].

The HSCIC is Directed to not publish information collected or produced by complying with this Direction, in accordance with section 260(2)(d). By virtue of section 261(3), The HSCIC is required to disseminate Information, which is prohibited from publishing under section 260(2) (d), only as specified in Appendix A.

The information to be collected is required in order to provide GPs with data for named patient lists. This will support one of the objectives in the Government's mandate to NHS England for 2016-17 by enabling GPs to review and improve the quality of care and outcomes for their named patients.

This Direction is to be known as the [DH to insert name] Direction and come into force on [insert date]. The information collections are to be completed by August 2017. A new Direction will be issued for any future information collections necessary for this programme of work.

Under section 254 of the 2012 Act, the HSCIC is required to:

- Extract patient level primary care data via GPES for a set of 12 metrics[3]; see Appendix A
- Validate the extracted data; see Appendix A
- Link the extracted primary care data with secondary care data - noting only 1 metric of the 12 is being linked to secondary care data; see Appendix A

[1] 2012 c.7

[2] S.I. 2013/259

[3] See Appendix A for further detail on the metrics and the extraction method

- Produce reports per general practice to include the metrics for all of the individual GPs who are registered as working at that general practice. The reports will follow the Information Commissioners Office (ICO's) Anonymisation Code of Practice whereby the data will be supplied in an aggregate form; see Appendix A

Please accept this letter as a Direction given under subsection (1) of section 254 of the 2012 Act to the HSCIC to exercise the functions in relation to the informatics support service for the collection and analysis of individual GP level data.

In line with patient rights contained within the NHS Constitution, the HSCIC will ensure it respects the rights of individual patients to request that their confidential information is not used beyond their own care and treatment and to have their objection considered. To support this patients are able to register an opt-out with their general practice to prevent their confidential personal information being released outside of the GP Practice (known as a Type 1 opt-out) where it is for purposes other than direct patient care.

The HSCIC has been Directed by the Department of Health to collect patient data for GP Metrics as outlined in Appendix A. This will be extracted using the General Practice Extraction Service (GPES) and the business rules for the extract will ensure Type 1 opt-outs are upheld.

In accordance with s254(5) the HSCIC has been consulted before this Direction has been given.

Yours sincerely

Director name

Director title

..Ends

NHS Digital

Information and technology
for better health and care

Contents

List of 12 agreed metrics

The proposed metrics are listed below.

Please note that the finalised wording of these metrics is yet to be agreed. There are also a number of challenges with two of the metrics (i.e. metric 4 and metric 11), both of which are highlighted in yellow below. It is anticipated that both of these metrics will require additional development time and will therefore not be included in the initial data extraction.

4 metrics covering public health

1. Flu vaccinations – coverage of over 65s
2. Flu vaccinations – coverage of other at-risk groups
3. Percentage of women aged 25-64 with record of a cervical smear
4. Percentage of children aged up to the age of 2 with record of childhood immunisations (composite)

4 metrics covering the management of long term conditions

5. Percentage of patients with hypertension with blood pressure 150/90mmHg or less
6. Percentage of patients with atrial fibrillation currently treated with anticoagulation therapy
7. Percentage of diabetes patients whose last glucose reading (HbA1c) is 64 mmol/mol or less
8. Percentage of COPD patients with a confirmed diagnosis by a post bronchodilator spirometry

3 metrics covering mental health and dementia

9. Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the preceding 12 months
10. Percentage of patients with dementia with face-to-face review in the last 12 months
11. Percentage of patients with serious mental illness with cardiovascular disease risk assessment in the last 12 months

1 metric covering emergency admissions and bed days

12. Emergency Admissions for 19 Ambulatory Care Sensitive Conditions*

* This metric will cover the 19 ambulatory care sensitive conditions, as taken from the "Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions" data briefing paper published by The Kings Fund[1].

This data briefing paper defines ambulatory care sensitive conditions as:

[1] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf

> *"conditions for which effective management and treatment should prevent admission to hospital. They can be classified as: chronic conditions, where effective care can prevent flare-ups; acute conditions, where early intervention can prevent more serious progression; and preventable conditions, where immunisation and other interventions can prevent illness."*

The 19 ambulatory care-sensitive conditions are listed below:

Vaccine-preventable:

- Influenza and pneumonia
- Other vaccine-preventable conditions

Chronic:

- Asthma
- Congestive heart failure
- Diabetes complications
- Chronic obstructive pulmonary disease (COPD)
- Angina
- Iron-deficiency anaemia
- Hypertension
- Nutritional deficiencies

Acute:

- Dehydration and gastroenteritis
- Pyelonephritis
- Perforated/bleeding ulcer
- Cellulitis
- Pelvic inflammatory disease
- Ear, nose and throat infections
- Dental conditions
- Convulsions and epilepsy
- Gangrene

Data extraction details

The 11 metrics covering public health, management of long term conditions and mental health and dementia only require extracting primary care data from general practice clinical systems.

The 1 metric covering emergency admissions and bed days requires extracting primary care data from general practice clinical systems and linking these data to secondary care data from the Hospital Episode Statistics (HES) Admitted Patient Care data extract. This data linkage will be performed using patient NHS Number.

The primary care data for all 12 of the metrics will be extracted via NHS Digital's General Practice Extraction Service (GPES).

The extraction details of the primary care data are provided below.

Primary care data extraction

The primary care data extraction will be entirely patient level.

Patient level data in the form of a list of NHS Numbers are required due to the data linkage between the primary care data and the HES data using NHS Number. This data linkage only affects the 1 metric covering emergency admissions and bed days; the 11 metrics covering public health, management of long term conditions and mental health and dementia only require aggregate level data in the form of counts of patients who fall into the numerator and denominator for each of these metrics. However, the primary care data extract will be entirely patient level because it is currently not technically possible to extract aggregate data at the level of individual GP. NHS Digital are currently working on a technical solution for this issue. The aggregate data that are required for the 11 metrics covering public health, management of long term conditions and mental health and dementia will be derived from the patient level data that are extracted.

GPES will return a list of NHS Numbers of all of the patients that fall into the numerator and denominator for each of the 11 metrics covering public health, management of long term conditions and mental health and dementia, broken down by individual GP. A count of these NHS Numbers will determine the numerator and denominator for each of these 11 metrics, which will be broken down by individual GP. This aggregation will take place following the patient level data being returned to GPES.

For the 1 metric covering emergency admissions and bed days, GPES will return the NHS Numbers of all of the patients that are assigned to each individual GP within the general practice and that have not already been captured in the 11 metrics covering public health, management of long term conditions and mental health and dementia.

Determining which patients are linked to which individual GP will be done by using the GP_USUAL data field from the GPES Patient Table. The GP_USUAL data field is defined as "doctor usually seen by" and the data item returned in this field is detailed as being the NHS specified doctor number, which is expected to be either the GMC reference number or the GMP reference number.

For each data extraction, GPES will extract one data file per general practice. This will be a full patient level extraction that will include the NHS Numbers of all of the patients that fall into the numerator and denominator of each of the 11 metrics covering public health, management of long term conditions and mental health and dementia, as well as NHS Numbers of all of the patients that are not captured by these 11 metrics; these NHS Numbers will be broken down by individual GP. Only patients who are registered at the general practice will be included in the data file. GP practice code does not need to be extracted as this will be included separately in the data file that is returned to GPES.

Secondary care data extraction

Secondary care data are required for the 1 metric covering emergency admissions and bed days.

The secondary care data will come from the HES Admitted Patient Care data, which is already held by NHS Digital. The HES data used will only include patients who:

- were admitted to hospital as an emergency (as determined by the field name 'Method of admission' – i.e. ADMIMETH)

AND

- have a primary diagnosis of one of the 19 ambulatory care sensitive conditions (as determined by the field name 'All Diagnosis codes' – i.e. DIAG_01)

These data will then be linked to the primary care data in order to determine which patients assigned to a usual GP were admitted as an emergency to hospital for each of the 19 ambulatory care sensitive conditions (see Data processing section below). Note that a patient may be admitted for multiple ambulatory care sensitive conditions or may be admitted for the same ambulatory care sensitive condition on more than one occasion; this will be detailed in the reports that are sent back to GPs.

Data processing details

The primary care data will be extracted via GPES. One Extensible Markup Language (XML) file per general practice (approximately 7,800 in total) will be returned to to GPES; these files will then be loaded into NHS Digital's Data Management Environment (DME). DME involves four steps:

Step 1) Load

Each of the 7,800 XML files will be loaded into a holding table; a report will be produced on how many files were successfully loaded and how many files failed to load.

A clone of the secondary care data from the HES Admitted Patient Care data will also be loaded into DME; a report will be produced on the number of records in this HES data.

Step 2) Validate

The validation of the primary care data in DME will take place at the field level for the following data fields:

- GP_USUAL: this will involve checking that codes recorded in this data field are valid GMC reference numbers or GMP reference numbers.
- NHS_Number: this will invovle checking that the NHS Numbers are valid as per the standard NHS Number validation algorithm.
- GP_Practice_Code: this will involve checking that the codes recorded in this data field are valid general practice codes, whereby the general practice is active and open.

Other GPES specific fields, including the Local ID, Query ID and Record ID, will also be validated. A report will be produced on any validation failures; this information will also be included in the reports that are sent back to GPs.

The HES Admitted Patient Care data extract will have already been validated prior to being loaded into DME so the clone of this data extract will not require any further validation in DME.

Step 3) Transform

All of the codes in the GP_USUAL data field will be mapped to GMC reference numbers using reference data.

A reporting table will then be produced; this will include the following data fields:

- GMC reference number (this was derived in the first part of the Transform step).
- Metric_ID
- NHS Number

The primary care data will be transformed as required in order to produce aggregated counts of patients for the numerators and denominators for each of the 11 metrics covering public health, management of long term conditions and mental health and dementia.

The primary care data will be linked to the secondary care data for the 1 metric covering emergency admissions and bed days. Linkage of primary care and HES data will be carried out on an exact match of NHS numbers only. It was decided to only use NHS number due to the good quality and coverage of NHS numbers in both data sets. An inner join will be used to link the primary care and HES data sets, where the join condition will be matching NHS numbers. This will give a many to one, one to one and one to many match for some NHS numbers which will then be processed accordingly for the output of this metric. Multiple instances of the same NHS Number will be present in the HES data due to patients being admitted for different ambulatory care sensitive conditions or being admitted for the same ambulatory care sensitive condition on more than one occasion.

Step 4) Release

The data will be imported into a Microsoft Structured Query Language (SQL) Sever database so that the Microsoft SQL Server Reporting Services (SSRS) reports can then be produced.

The output from the data validation step will also be stored in a Microsoft SQL database. Data will be stored for a maximum of 1 year before being deleted but this will be reviewed after the initial 2 extractions have taken place.

Data reported to GPs

Each GP will only be provided with aggregate level data for their own patients; they will not be provided with any patient level data.

Primary care metrics

The 11 metrics covering public health, management of long term conditions and mental health and dementia will not involve any linkage to secondary care HES data as they will only concern primary care data extracted via GPES. These 11 metrics will be reported as percentages, together with the underlying numerators and denominators, for each individual GP. Using metric 5 (i.e. Percentage of patients with hypertension with blood pressure 150/90mmHg or less) as an example:

> There are two GPs (i.e. GP-A and GP-B) within a general practice.
>
> GP-A has 100 patients with hypertension and, of those 100 patients, 80 with blood pressure 150/90mmHg or less.
>
> GP-B has 100 patients with hypertension and, of those 100 patients, 65 with blood pressure 150/90mmHg or less.
>
> The report would show that for GP-A, 80% (i.e. 80 out of 100) of their patients with hypertension have a blood pressure 150/90mmHg or less, and for GP-B, 65% (i.e. 65 out of 100) of their patients with hypertension have a blood pressure 150/90mmHg or less.

Secondary care metric

The 1 metric covering emergency admissions and bed days is the only metric that involves linkage to secondary care HES data. This metric involves linking all patients that are registered at a general practice to the HES Admitted Patient Care extract using NHS Number. This HES extract will only concern patients who were admitted to hospital as an emergency and had a primary diagnosis of one of the 19 ambulatory care sensitive conditions.

Linking this HES data to the list of all patients registered at a general practice will allow the following to be reported to general practices:

- The number (and percentage) of patients who were admitted to hospital as an emergency for one or more of the 19 ambulatory care sensitive conditions; e.g. a GP has 1,000 patients assigned to them, 120 of which were admitted to hospital as an emergency for at least one of the 19 conditions. The numerator (i.e. 120), denominator (i.e. 1,000) and percentage (i.e. 12 per cent) will be reported.
- The number of emergency admissions to hospital for each of the 19 ambulatory care sensitive conditions[2]; note that patients may have multiple admissions for the same condition.

[2] Please note that this is to be confirmed.

As with metrics 1 – 11, the data for metric 12 will be broken down by individual GP.

Contextual information

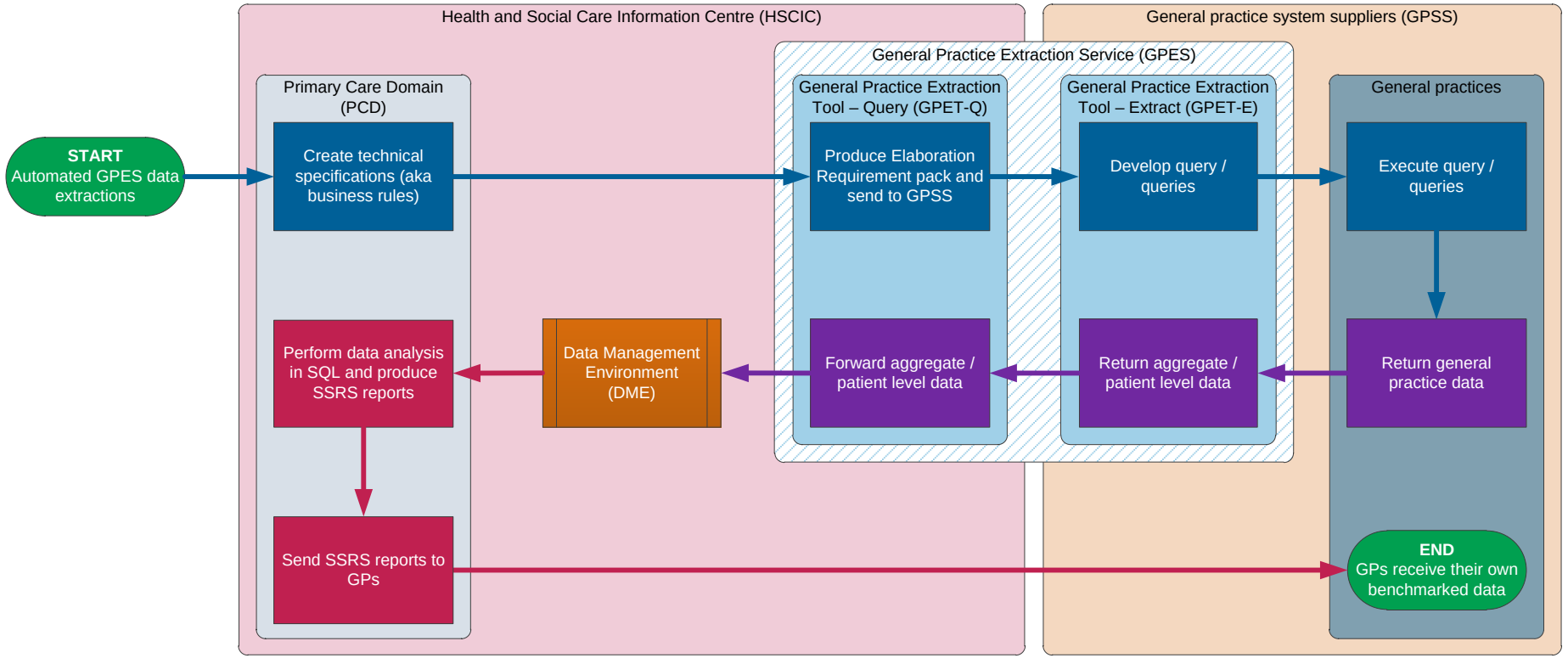
As GPES have never before extracted data at the level of the individual GP, the reports will also include contextual information, including:

- The total number of patients registered at the general practice.
- The number of patients assigned to the individual GP (as determined from the GP_USUAL data field).

Data flow process map

The purpose of this process map if to provide a high level overview of the steps involved in extracting and disseminating the data.

Steps that take place prior to the data being extracted are coloured in **Prussian Blue**.
Steps showing the data flowing into the HSCIC are coloured in **Violet**.
Steps showing the data flowing out of the HSCIC are coloured in **Deep Rubine**.



Board Meeting – Public Session

Title of paper:	**Direction from Department of Health for the Out of Area Treatment CAP collection**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 05 b (iii) (P1)
Paper presented by:	Martin Severs, Interim Director of Information and Analytics, Caldicott Guardian and Lead Clinician
Paper prepared by:	Alyson Whitmarsh, Information Analysis Lead Manager, Clinical Audit Services Portfolio
Paper approved by: (Sponsor Director)	Professor Martin Severs, Interim Director of Information and Analytics, Caldicott Guardian and Lead Clinician
Purpose of the paper:	To enable the views of the Board to be considered as part of the formal consultation on the Direction prior to it being signed by Department of Health. This consultation is in line with our agreed process.
Additional Documents and or Supporting Information:	There are no additional documents and supporting information.
Please specify the key risks and issues:	Timeliness - In the event that Directions are not in place by the end of September and the data is not collected from October 2016; DH would have to wait for changes submitted on OATs to go through the MHSDS annual update process and therefore will not be reported on until June 2017 at the earliest opportunity. Financial - Funding is in place but final approval from DH of the business case has not yet been received. Burden - The burden assessment and standards assurance is ongoing
Patient/public interest:	Indirect
Supplementary papers:	• Appendix 1 - Collection of OATs for Adults in Acute Mental Health Inpatient Services Direction_v0.1 • Appendix 2- Out of Area Treatments written specification • Appendix 3 - OATs technical specification (dataset)_v2.5
Actions required by the Board:	The Board is asked to support the draft direction but note the delivery timescales may be affected by the formal consultation process and specific assurance processes including burden assessment and standards assurance.

NHS Digital

Direction from the Department of Health: Interim Out of Area Treatment (OAT) Collection Direction

Formal consultation with the NHS Digital Board

7 September 2016

Information and technology
for better health and care

Contents

Executive Summary

NHS Digital has been asked by Department of Health to run an interim Out of Area Treatments (OATs) collection. NHS Digital will be directed, under the Health and Social Care Act 2012, by the Department of Health to provide the legal basis for the data to flow.

The collection aims to improve patient care by enabling NHS organisations and Independent Sector providers to compare their figures with similar NHS organisations enabling the identification and sharing of best practice. Nationally, this will provide an overview of the number of OATs in England.

A Direction from Department of Health is needed to provide the legal basis for the data to flow. The draft Direction, and associated documentation which has been approved by Information Governance are included as Appendices.

Background

OATs have been of increasing concern for mental health patients in acute inpatient care over recent years. For the purpose of collecting the most accurate data in this complex area an inappropriate "out of area treatment" is defined as:

A situation in which a person with assessed acute mental health needs, who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual local network of services (an inpatient unit that does not usually admit people living in the catchment area of the person's local community mental health service), and where the person cannot be visited regularly by their care co-ordinator.

The Crisp Commission report published in February 2016, which reviewed the provision of acute inpatient psychiatric care for adults, recommended that the collection, quality and use of data should be radically improved so it can be used to improve services and efficiency, ensure evidence-based care is delivered, and improve accountability. As OATs impede recovery of mental health patients the Department of Health's policy aim is to reduce and eliminate their inappropriate use. In 2015, the Department, along with NHS England, NHS Improvement and NHS Digital, set up a Task and Finish group to set out how they will reduce OATs and monitor progress. In April 2016, Alistair Burt, former Minister of State for Community and Social Care, announced a national ambition to eliminate inappropriate OATs in mental health services for adult acute inpatients by 2020/21.

OATs information will be collected via the Clinical Audit Platform (CAP) for one year as an interim measure and then in the Mental Health Services Dataset (MHSDS), which has dataset changes currently scheduled from April 2017. The interim CAP collection will be aligned as far as possible with data definitions being used for the MHSDS changes.

Recommendation

The Board is asked to support the current draft direction but note the delivery timescales may be affected by the formal consultation process and specific assurance processes including burden assessment and standards assurance. The directions will provide the legal basis to support the data collection.

Implications

Strategy Implications

The NHS Digital Strategy for 2015 – 2020 aims to deliver better use of health and care data which will help those involved to manage the system more effectively – activities such as this serve to support this aim. This collection meets one of NHS Digital's business plan priorities to support the information and analytical requirements to support new and emerging policy regarding new care models. It meets our statutory obligation to manage the collection, storage, processing and publication of national health and care information, as directed by the Secretary of State. Furthermore, it demonstrates NHS Digital's contribution towards the Five Year Forward View for Mental Health.

Financial Implications

The funding will be provided by Department of Health to support the collection and analysis of patient confidential data. This has been costed at £97,706 excluding VAT. The DH business case to support this work is to be agreed. The business case was considered in July by DH's Finance Business Partners and resulting questions have been addressed. Funding is in place but final approval of the business case has not yet been received.

The funding is largely for the staff resources needed to manage and deliver the data collection, analysis and reporting activities with a small amount to make amendments to the collection platform.

Planning and initiation is taking place from July 2016. The anticipated data collection is in autumn 2016, with monthly reports produced from November 2016. Close down is expected in November 2017. A POSA work package will be in place for the current year. Funding is agreed for a 12 month collection after which the MHSDS changes will have been made to collect the OATs information.

Stakeholder Implications

NHS Digital will collect information from providers of Mental Health services (NHS and Independent sector). This includes 55 Mental Health Foundation Trusts, 16 Mental Health Non-Foundation Trusts and 27 Independent Sector Providers of Mental Health care.

The design of the OATs collection was initially scoped by NHS England, NHS Improvements, NHS Digital and DH as part of the work on out of area treatments. Two workshops were held with providers and commissioners of adult mental health services who helped with deciding what data items should be collected and the potential burden on providers for each item. The list of items was agreed and then a survey was sent out to a number of providers, who assessed the burden of the data collection as a whole in terms of staff time and additional costs. Department of Health are now in the process of piloting this collection with a number of providers in order to further assess the burden. In terms of pilot testing, they have tested the key data items, for example, OATs flag and bed types list, with providers through the NHS Benchmarking Network and provider networks. The OATs definition has also been tested with providers over the last year by Department of Health. A burden assessment is

ongoing by the Burden Advice and Assessment Service (BAAS). The BAAS assessment will continue in parallel with the development activities for the OATs collection in order to ensure that the timescales can be met.

Handling

Communications will be developed, agreed and issued by NHS Digital and Department of Health. A communications plan will be developed to support this work. A patient information leaflet will be developed so that patients can be informed about how their data will be used in order meet fair processing best practise guidelines. Communication is expected to take various forms and include direct communication with providers; website development and stakeholder updates. Corporate communications team will be approached to support.

Risks and Issues

Data quality - In the event that OATS data is not recorded against the appropriate reason, there is a risk that either under or over reporting of the number of people being placed as an inappropriate OAT will occur. This will result in being unable to provide an accurate number of patients being treated inappropriately out of area. This will be mitigated by supplying information for providers such as detailed flowcharts, definitions and FAQs.

Timeliness – In the event that Directions are not in place by the end of September and the data is not collected from October 2016; DH would have to wait for changes submitted on OATs to go through the MHSDS annual update process and therefore will not be reported on until June 2017. NHSE have already asked CCGs to reduce OATs during Q4 of 2016/17. It is a priority for DH that the data on OATs is made available this year in order to drive best practice and to eliminate out of area treatments as quickly as possible. This will be mitigated by close daily communications to resolve issues quickly.

Financial – In the event that the DH Business case is not approved, scoping work and potentially development work will have been started. This will be mitigated by not starting development and further communication work until the business case has been approved. The business case was considered in July by DH's Finance Business Partners and they are addressing some outstanding questions. Funding is in place but final approval of the business case has not yet been received.

Work package - In the event that during the development of the POSA, other requirements arise; there is a risk that the direction may not be aligned. In order to mitigate this risk, we are currently working with DH colleagues to finalise the content, which we are aiming to do before the September board meeting.

Burden – The burden assessment is ongoing by the Burden Advice and Assessment Service. A burden assessment report will be submitted to the SCCI meeting on 31st August 2016 with the current findings. The assessment will continue with a subsequent report submitted for the September SCCI meeting. In order to mitigate risk of high burden, the dataset has been reduced and the collection is short term (12 months). Furthermore the collection system is easy to use and we will provide support and guidance during the collection period.

Corporate Governance and Compliance

NHS Digital and Department of Health are currently working on the POSA work package; the OATs collection has a current entry on the Portfolio database. Information Governance has approved the draft Direction.

Key progress indicators are outlined in the work package between NHS Digital and Department of Health and monitored regularly. These can also be reported to the NHS Digital Board.

Management Responsibility

- Alyson Whitmarsh, Clinical Audit & Registries Programme Manager, Information & Analytics Directorate
- Julie Henderson, Head of Analytical Services, Information & Analytics Directorate
- Daniel Ray, Director of Data Science, Information and Analytics Portfolio
- Martin Severs, Interim Director of Information and Analytics, Medical Director and Caldicott Guardian

Actions Required of the Board

The Board are asked to consider the draft Direction and to identify any issues or concerns as part of the formal consultation process.

Appendices

Appendix 1 - Collection of OATs for Adults in Acute Mental Health Inpatient Services Direction_v0.1

Appendix 2- Out of Area Treatments written specification

Appendix 3 - OATs technical specification (dataset)_v2.4

Department of Health

Andy Williams
Chief Executive,
Health and Social Care Information Centre
1 Trevelyan Square, Boar Lane
Leeds
LS1 6AE

2 August 2016

Dear Andy

I am writing to provide a Direction to NHS Digital (previously HSCIC) to establish and operate an informatics support service for the collection of information about out of area treatments (OATs) for adults in acute mental health inpatient services. Alistair Burt, former Minister of State for Community and Social Care, announced in April 2016 a national ambition to eliminate inappropriate OATs for adult acute inpatients by 2020/21.

An inappropriate "out of area treatment" is defined as a situation in which a person with assessed acute mental health needs, who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual local network of services (an inpatient unit that does not usually admit people living in the catchment area of the persons local community mental health service), and where the person cannot be visited regularly by their care co-ordinator.

This Direction is given in exercise of the powers conferred by sections 254(1) and (6), 274(2) and 304(9), (10) and (12) of the Health and Social Care Act 2012[1] and Regulation 32 of the National Institute for Health and Social Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013[2].

This Direction is to be known as the Collection of OATs for Adults in Acute Mental Health Inpatient Services Direction, and comes into force on [insert date].

Under section 254 of the 2012 Act, NHS Digital is required to:

- Collect data that includes administrative information, information about the reasons for admission, and diagnostic information about adults who receive acute inpatient care in mental health services. This data will be aggregated at provider and CCG level and all data in accordance with NHS Digital's mandatory standards or Anonymisation Standard for Publishing Health and Social Care Data will be anonymised when published on NHS Digital's website. The Department has agreed for this information to be published on a monthly basis for 12 months.
- Share aggregate data at CCG provider level collected under this direction, in accordance with NHS Digital's mandatory standards or Anonymisation Standard for Publishing Health

[1] 2012 c.7

[2] S.I. 2013/259

and Social Care Data, with the Department of Health, NHS England, NHS Improvement, NHS organisations and Independent Sector Providers responsible for commissioning and providing acute mental health services in England.

NHS Digital must take steps to ensure that no data collected under these directions are shared or published by any means which may lead to the identification of an individual.

Please accept this letter as a direction given under subsection (1) of section 254 of the 2012 Act to the Health and Social Care Information Centre to exercise the functions in relation to the informatics support service for the collection of information about OATs for adults in acute inpatient care for mental health services.

In accordance with s254(5) NHS Digital has been consulted before this Direction has been given.

Yours sincerely

Emily Antcliffe
Deputy Director
Mental Health Strategy and Policy

Department of Health

Out of Area Treatments Data Collection

Requirement Specification

Mental Health Strategy and Policy

Contents

1. Introduction

Out of Area Treatments (OATs) have been of increasing concern for mental health patients in acute inpatient care over recent years. As OATs impede recovery of mental health patients, the Department of Health's policy aim is to reduce and eliminate their use. In 2015, the Department, along with NHS England, NHS Improvement and NHS Digital, set up a Task and Finish group to set out how we will reduce OATs and monitor progress.

In April 2016, Alistair Burt, former Minister of State for Community and Social Care, also announced a national ambition to eliminate inappropriate OATs in mental health services for adult acute inpatients by 2020/21. Clinical Commissioning Groups (CCGs) have already been asked to accurately measure OATs locally, and have a plan in place to reduce OATs during Q4 2016/17. However, in order to monitor delivery of this ambition, we need more accurate data on OATs.

For the purpose of collecting the most accurate data in this complex area an inappropriate "out of area treatment" is defined as:

> *A situation in which a person with assessed acute mental health needs, who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual local network of services (an inpatient unit that does not usually admit people living in the catchment area of the person's local community mental health service), and where the person cannot be visited regularly by their care co-ordinator.*

A reduction in OATs and the improvement of data have been called for in a number of reports. The Crisp Commission report published in February 2016, which reviewed the provision of acute inpatient psychiatric care for adults, recommended that the collection, quality and use of data should be radically improved, so it can be used to improve services and efficiency, ensure evidence-based care is delivered, and improve accountability. Part of this recommendation was for reviewing the Mental Health Services Dataset (MHSDS) to ensure it is fit for purpose for monitoring and evaluating the acute care pathways, along with developing performance measures that enable local and national analysis of the state of acute MH care. Crisp also recommended that the practice of sending ill patients long distances for non-specialist treatment should be phased out nationally. Part of this recommendation was for data collection and analysis to monitor the number, nature and causes of OATs.

The NHS Providers report, *Right Place, Right Time, BetterTransfers of Care: a Call to Action,* highlighted the need for a clear definition of an OAT and clarity around what is counted as an OAT in order to make meaningful comparisons, and to identify and share best practice. The recommendations of the independent Mental Health Taskforce report also called for the elimination of OATs, and now form part of NHS England's Five Year Forward View. These documents all support improved MH data and call for the elimination of OATs.

The data collection that the Department are commissioning NHS Digital's Clinical Audit team to undertake will ultimately benefit patients by improving patient care, and to drive best practice. This can only happen with supported action in the system, so it is key for patients that progress on OATs is being routinely reported, in order to drive change locally and to stop inappropriate practice.

2. The Out of Area Treatments Data Collection

The OATs data collection will aim to measure the number of inappropriate OATs, the effects of OATs on a patient's care and the cost of these placements. NHS Digital will collect and analyse national data for use by the Department, a range of stakeholders and the wider public.

The OATs data collection will aim to answer the following questions:

1. Why are people being treated out of area?
2. How many people are treated out of area by reason?
3. How far are patients being treated away from home?
4. What is the average length of stay of patients out of area?
5. What is the cost per bed type of a patient being treated out of area?
6. What are the differences in OATs and the effects of OATs by bed types?

To answer the above questions, NHS Digital will publish monthly reports at provider and national level.

The OATs collection aims to improve patient care by enabling NHS organisations and Independent Sector providers to compare their figures on OATs with similar NHS organisations enabling the identification and sharing of best practice. Nationally this collection will provide an overview of the number of OATs in England and will enable the Department to monitor the national ambition to eliminate OATs by 2020/21.

3. Relevant Organisations

The OATs data collection aims to collect data from 98 providers of mental health services. This includes 55 Mental Health Foundation Trusts, 16 Mental Health Non Foundation Trusts and 27 Independent Sector Providers.

4. The Dataset

The dataset has been reviewed by the Department, NHS Digital, NHS England and key data items have been tested with NHS Improvement, Providers and Commissioners, as well as the Department, NHS Digital NHS England. A list of data items to be collected can be found in Appendix 3.

5. Burden Assessment

As part of the Standardised Committee for Care and Information (SCCI) process, visits were made to provider trusts in order to assess the burden placed on providers by taking part in the OATs data collection. This assessment will be used as a basis for understanding the cost implications for conducting the data extraction from providers, as well as if the items included for collection and the submission process will be burdensome for providers. This assessment has not yet concluded, but will give us the time and cost associated with providers submitting data for the collection.

As well as this we have extensively tested the OATs definition with providers, commissioners, experts and users with experience to ensure the definition and the reasons for OATs are easy to understand and reflect providers understanding. We have also tested the OATs collection data items with providers through a number of Workshops and WebEx's to ensure we collected data that would be possible for providers to submit. In addition, the list of bed types included in the data collection have been tested through an NHS Benchmarking consultation.

6. Outputs –

A monthly summary statistics report will produce aggregate level data and will cover:

- The number of people out of area by reason.
- The number of people subject to the MHA when placed out of area (by reason).
- Average length of stay for patients out of area.
- Patients out of area by diagnosis.
- Patients out of area by gender.
- Average cost of each bed placement out of area.

The report will publish key data items by bed type and by provider. We expect NHS Digital to produce a table for reporting as below:

Origin Geography (would want to be able to cut both ways)	Number of OATs	Average Length of Stay OATS	Of which diagnosis x/y/z	Of which reason x/y/z	Average cost per bed type	Total cost	Of which destination provider x, y, z,
CCG a							
CCG b							
Provider A							
Provider B							

A data quality report will also be produced monthly covering the quality, coverage and completeness of data.

Both reports will be produced monthly over a 12 month period. These reports will be published publically on NHS Digitals website.

No Data should be published that may lead to the identification of an individual and should only be aggregated at provider and CCG level.

7. Timescales

The OATs data collection is a one-off 12 month collection that will aim to take place between October 2016-October 2017, with first reports planned for November 2016 and final reports expected November 2017.

Bethany Kenny
Department of Health
Mental Health Strategy and Policy

hscic Health & Social Care Information Centre

Out of Area Treatments Interim Audit Dataset

Version 0.1 for issue

This specification shows the overall structure of the audit under the **Model tab** and important information regarding how files should be named.
The **Data Items tab** shows the allowed values, business rules and validation for each item.
The **Reference Data tab** shows the values contained in the drop down lists

Sample csv formats are shown in xxx tabs.

Change Log:		
V0.1	Initial draft	02/06/2016

Record Tree

Patient [NHS Number] Edit Record Delete Record Add Treatment

Treatment: Admission [Date of Admission], Discharged [Date of Discharge/Transfer] View Record Delete

Treatment: Admission [Date of Admission] Edit Record Delete

Need to consider:
When/if records become read only once discharged?
Can you add new treatment if the previous one is still open?
Rules around which orgs can edit records?

Field	Model	Type	Reference Data	Required	Used for Update	Help Text	Validation Action	Validation Rule
NHS number	Patient	Long		Y	Y	NHS number of the patient.	Reject	Mandatory. Is a valid NHS number (n10).
First name	Patient	String						
Surname	Patient	String						
Date of birth	Patient	Date		Y	Y	Mandatory field. Date format dd/mm/yyyy.	Reject	Mandatory. Date format dd/mm/yyyy 01/01/1900 >= DOB <= Submission Date
Gender	Patient	List	Gender			This is the person stated gender which is self declared or inferred by observation for those unable to declare their gender.		
Sending organisation	Treatment	List		Y	Y	The organisation code of the organisation that is sending the patient to another Health Care Provider.		
Postcode of usual address	Treatment	String				The postcode of the patients usual address.		
Referred out of area reason	Treatment	List	ReferredOutOfAreaReason			The reason that a person with assessed acute mental health needs who requires adult mental health acute inpatient care is referred to a unit that does not form part of the usual local network of services.		
Receiving Organisation	Treatment	List				The organisation code of the organisation that is receiving the patient from another Health Care Provider.		
Out of area placement admission date	Treatment	Date		Y	Y	The date the patient was admitted to the receiving organisation.		
Detained under Mental Health Act at time of transfer	Treatment	List	MHAStatus					
Primary diagnosis	Treatment	List	TBC			This is the primary diagnosis of the patient, from a specific classification or clinical terminology, for the main condition treated or investigated during the relevant episode of healthcare, and where there is no definitive diagnosis, the main symptom, abnormal findings or problem.		
Out of area placement bed type	Treatment	List	BedType			The type of hospital bed which the patient occupies.		
Out of area placement discharge date	Treatment	Date						
Cost per bed day	Treatment	Integer						
Postcode of receiving provider	Treatment	String				The postcode of the unit the patient has been admitted to.		

ListName	Coding	Description
Gender	1	Male
	2	Female
	9	Indeterminate
	X	Not Known
ReferredOutOfAreaReason	10	Unavailability of bed
	11	Safeguarding
	12	Offending restrictions
	13	Staff member or family/friend
	14	Patient choice
	15	Admitted while away from home
	99	Not Known (Not Recorded)
MHAStatus	1	Yes
	2	No
Primary Diagnosis		TBC
BedType	10	Acute adult mental health care
	11	Acute older adult mental health care (organic and functional)
	12	Psychiatric Intensive Care Unit (acute mental health care)
	16	Low secure/locked rehabilitation
	17	High dependency rehabilitation
	18	Long term complex rehabilitation/ Continuing Care

Parent	Child	SingleOrCollection
Patient	Treatment	Collection

Board Meeting – Public Session

Title of paper:	**National Pandemic Flu Directions**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 06 b (iv) (P1)
Paper presented by:	Rob Shaw Chief Operating Officer
Paper prepared by:	Ian Lowry – Programme Director
Paper approved by: (Sponsor Director)	Rob Shaw Chief Operating Office
Purpose of the paper:	This paper has been prepared in support of the review and proposed endorsement for the Directions in relation to the management of the front office application infrastructure for the National Pandemic Flu Service.
Additional Documents and or Supporting Information:	Directions from SoS
Please specify the key risks and issues:	Main Risks associated with the service 1. The service fails to meet the operational requirements in the event of a new pandemic 2. Patient data is exposed in the operation of the service (as a result of technical failure) 3. Impact of the service being mobilised on the operation of NHS Digital
Patient/public interest:	Direct
Supplementary papers:	
Actions required by the Board:	endorses the Directions

NHS Digital

National Pandemic Flu Service

Directions for Endorsement

7 September 2016

Information and technology
for better health and care

Contents

Executive Summary

This paper has been prepared in support of the review and proposed endorsement for the Directions in relation to the management of the front office application infrastructure for the National Pandemic Flu Service. And in accordance with the requirement for formal consultation, prior to the final issue of the Direction on behalf of the Secretary State for Health.

Background

The Directions have been prepared to direct NHS Digital to manage the operation of the National Pandemic Flu 'front office' application services in the event of the service being mobilised (i.e. activated from a dormant state), including the implementation of further changes to the design of the service.

The National Pandemic Flu Service is a reactive solution developed to manage the additional pressure on front-line healthcare services in the event of an influenza pandemic. The service is managed by Public Health England (PHE) on behalf of the Secretary of State for Health.

NHS Digital were commissioned at the request of Public Health England (and the Department of Health) to design and develop new 'front office' application services for the National Pandemic Flu Service in April 2015.

The key architectural and design challenges for the service are that it needs to be able to meet unpredictable demand, while being dormant for a majority of the time. And the core of the solution has to be able to accommodate a flexible clinical algorithm which can be modified quickly in the event of a potentially rapidly changing environment.

The new platform was released in December 2015 and comprises of a range of web-application portals tailored for use by citizens, call-centres and GP\Healthcare workers to assess symptoms in the event of an influenza pandemic and where necessary, allow a citizen to collect anti-viral medication. Further development of the platform is in progress at present to enhance the solution to include requested reporting functionality and manage the transition to a new Hosting provider in advance of the deployment of a new algorithm for the service. Once these activities have been completed the platform is expected to be placed into a dormant state.

In the event of mobilisation, NHS Digital will be responsible for the operational management of the front office application platform; providing technical and operational support services in partnership with PHE who retain ownership of the service. This includes the provision of technical support for the invocation and monitoring of the platform in a 'live' state, service management of the hosting provider contracted by PHE and data analysis\reporting.

Recommendation

Recommended that the Board endorses the proposed Directions for the National Pandemic Flu Service; noting that the text has been reviewed by the Information Governance and Legal representatives on behalf of NHS Digital.

Please note that Public Health England is the responsible Information Asset Controller for the service and that the role of NHS Digital will act in the capacity of a data processor only, in the event that the NPFS front office solution is mobilised. This is declared in the Directions (function 5) and the underpinning Data Management Agreement for the NPFS front office service.

Implications

Strategy Implications

The service aligns with strategic aims of delivering national services that serve the needs of the NHS and the implementation of common standards and architecture. Further the service delivered by NHS Digital has been designed to enable the service to get the best out of technology, data and information in the operation of the service (while minimising the costs).

The Front Office for the National Pandemic Flu service is a national technology service for the provision of patient care in the event of a pandemic event (i.e. national emergency). The service is designed to minimise the impact upon and protect the front line services of the NHS (including the Home Countries) through providing a trusted service for information and the dispensing of anti-viral medicines to the general population, in the event of a future pandemic event.

The solution has been designed to build on the standards and approach adopted in the delivery of the Core Spine services, utilising shared\common architecture with the national infrastructure services under the management of the Operations and Assurance Services domain.

Financial Implications

There are no direct financial implications for the endorsement of the Directions.

The agreed operating and development budget for the provision of services for the management of the NPFS front office application are agreed in accordance with the terms of the Memorandum of Understanding (MOU) between HSCIC and the Secretary of State for Health dated 8th January 2016.

Under the terms of the MOU annual work-packages are agreed for the management of the service with funding provided by Public Health England (the agency responsible for the NPFS) with new requirements commissioned under change control. In the event of a Pandemic event necessitating the mobilisation of the service, NHS Digital will be required to accept the operating costs incurred in the short term prior to the agreement of a retrospective work package to cover the costs incurred.

At present there are two active work-packages, the first for the operational and support and service for the dormant state of the service and an application development and hosting work request for the application backlog and changes required for the hosting provision.
Charges are levied in line with the full cost recovery rates plus any associated expenditure required (i.e. licences) with monthly invoices raised for the dormancy

charges and quarterly invoices for the time and material costs associated to the development activities.

Stakeholder Implications

Not applicable – paper concerns the proposed text for agreement of the Directions for provision of services to support the delivery of the National Pandemic Flu Service.

Handling

Not applicable; the media management and communications strategy\approach for the National Pandemic Flu Programme is owned and managed by Public Health England.

Risks and Issues

The principal risks for NHS Digital concern the impact on operations of services in the event of a pandemic being declared (given the need to prioritise the service at that time) and the scope for reputational damage given the profile of the service.

On paper this is offset by PHE being both the data controller and owning the contract for the Cloud hosting provider; but NHS Digital will be managing the operation of the front office service platform, the primary public and call-centre interface in the event of a pandemic.

Risk Description	Mitigation
The service fails to meet the operational requirements in the event of a new pandemic	The new platform that replaces that platform built in response to the 2009 pandemic, is informed by the need to both provide a flexible solution that will allow new clinical algorithm to be applied in response to the pandemic (a refreshed algorithm is to be applied in 2016) and has been designed to enable the service to scale to a size that exceeds the previous solution up to 100x in scale at the point of need.
Patient data is exposed in the operation of the service (as a result of a technical failure)	The solution has been designed in accordance with the data protection standards required of all NHS Digital managed services and will remain subject to periodic penetration testing during the annual test windows for the ‘dormant’ system; so as to address any new\emergent threats identified after the completion of the current development phase.
Impact of the service being mobilised on the operation of NHS Digital	In practice, irrespective of whether of NHS Digital operated the platform or not in the event of a pandemic notice we would be required to activate the business continuity plans for the organisation and the services that we manage on behalf of the NHS to minimise the risk (i.e. effective change freeze) and reallocate of key resources to all high priority services. Planning for this, will furthermore be reviewed and assured now as part of the mobilisation test activities undertaken for the NPFS.

Corporate Governance and Compliance

Prior to the submission to the Board, the Directions have been subject to the review and agreement of the wording applied by the Information Governance team (and their counterparts in the Department of Health) and NHS Digital commercial\legal review.

The first draft of the Directions was rejected in order to provide more detailed clarification on the data controller role not residing with NHS Digital and add further details on what information is collected (Annex 2).

In respect to the operation of the service, while responsibility (and governance) of the NPFS service is retained by Public Health England, NHS Digital do have a presence on the NPFS Programme Board.

For your information, the plans for the NHS Digital mobilisation and operational management responsibilities will be subject to regular review and in conjunction with Public Health England assurance\dress rehearsal tests at a minimum once per annum (2 test windows are provisionally reserved per calendar year).

Management Responsibility

The Executive Director accountable for the NHS Digital responsibilities in the event of mobilisation of the service is Rob Shaw (Chief Operating Officer). On a day-to-day basis the senior manager who will be responsible for the delivery of the services is Sean Walsh; for the activities required of the Digital Delivery Centre and Service Management functions.

Actions Required of the Board

To endorse the Directions, for the delivery and management of the National Pandemic Flu (front office) Service in a dormant state (includes management of updates to the platform) and as required, the operational management of the service, in the event of a Pandemic mobilisation notice being issued.

NATIONAL HEALTH SERVICE, ENGLAND

The Health and Social Care Information Centre (National Pandemic Flu Service Digital Services) Directions 2015

The Secretary of State gives the following Directions in exercise of the powers conferred by section 254(1) and (6), section 274(2) and section 304(9), (10) and (12) of the Health and Social Care Act 2012(**a**) and regulation 32 of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013(**b**).

In accordance with section 254(5) of that Act, the Secretary of State has consulted the Health and Social Care Information Centre before giving these Directions.

Citation, commencement and interpretation

1.—(1) These Directions may be cited as the Health and Social Care Information Centre (National Pandemic Flu Service Digital Services) Directions 2015 and come into force on [insert date].

(2) In these Directions—

"Framework Agreement" means the framework agreement between the Department of Health and HSCIC dated 16 April 2014;

"HSCIC" means the Health and Social Care Information Centre(**c**);

"MoU" means the Memorandum of Understanding entered into between the HSCIC and the Secretary of State for Health in relation to the provision of the National Pandemic Flu Service Digital Services dated [30th November 2015];

"National Pandemic Flu Service Digital Services" or "NPFS Digital Services" means the services to perform the functions as described in Annex 1 to these Directions; and

"the Secretary of State" means the Secretary of State for Health, acting through its executive agency Public Health England.

Information systems for National Pandemic Flu Service Digital Services

2.—(1) The Secretary of State directs HSCIC to establish and operate such systems for the collection and analysis of information (defined in Annex 2) as are necessary for it to deliver the National Pandemic Flu Service Digital Services, as defined in Annex 1.

(2) The Secretary of State directs HSCIC to exercise the functions described in sub paragraph (1) in accordance with the terms of the MoU which will provide further detail and definition of the functions required and the terms on which these functions should be exercised.

(3) In exercising the functions described in sub-paragraph (1), HSCIC must have regard to such priorities, policies, advice or guidance of the Secretary of State as the Secretary of State may notify in writing to HSCIC.

(**a**) 2012 c.7.
(**b**) S.I. 2013/259.
(**c**) The Health and Social Care Information Centre is a body corporate established under section 252(1) of the Health and Social Care Act 2012.

Systems delivery functions for National Pandemic Flu Service Digital Services

3.—(1) The Secretary of State directs HSCIC to exercise such systems delivery functions of the Secretary of State as are necessary for it to deliver the National Pandemic Flu Service Digital Services.

(2) The Secretary of State directs HSCIC to exercise the functions described in sub paragraph (1) in accordance with the terms of the MoU which will provide further detail and definition of the functions required and the terms on which these functions should be exercised.

(3) In exercising the functions described in sub paragraph (1), HSCIC must have regard to the Framework Agreement and to such priorities, policies, advice or guidance of the Secretary of State as the Secretary of State may notify in writing to HSCIC.

(4) The Secretary of State shall make payments to HSCIC for things done in the exercise of the functions required by this Direction as per the terms of the MOU. Signed by the authority of the Secretary of State for Health.

Name

Address

Member of the Senior Civil Service

Date

Department of Health

ANNEX 1: Functions to be provided by HSCIC for the NPFS Digital Service

- **Function 1: Build of public facing aspects of the NPFS Online Solution -** leading to the development of a high quality and robustly tested, scalable, customer facing solution.

- **Function 2: Input into the design and development of the back office aspects of the technical solution**-.

- **Function 3: Management of the NPFS Online service whilst in dormancy -** including regular testing, assurance and system updates.

- **Function 4: Management of the NPFS Online service whilst in active deployment -** including the provision of development and operational resources, at scale, to enable an effective online response to a pandemic which for the avoidance of doubt shall not include the command and control operational response.

- **Function 5**: **Data Processing -** HSCIC is providing a data processing function in capacity as a data processor only. HSCIC is directed to not further process, publish or disseminate any data it collects to provide the NPFS function, other than in accordance with the instructions in the direction (Health and Social Care Information Centre (National Pandemic Flu Service Digital Services) Direction 2015) and this annex to the direction.

ANNEX 2: Information Collected

In order to provide the NPFS service information will be collected from each patient. The precise detail of the information collected will vary from patient to patient depending on their responses to key questions. It may also change from time to time as detail of the underlying clinical algorithm is adjusted. Currently information required includes:

- Are they a resident or foreign visitor
- Their first name and surname
- Their date of birth
- Their gender
- Their current symptoms
- Their history of any serious medical conditions
- Their postcode (Full address may be required)

Board Meeting – Public Session

Title of paper:	**Patient Level Information Costing Systems (PLICS)** **Briefing on Mandatory Request from NHS Improvement**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 05 b (v) (P1)
Paper presented by:	Jackie Shears, Programme Director
Paper prepared by:	John Winter, Programme Manager
Paper approved by:	Rob Shaw, Chief Operating Officer
Purpose of the paper:	To seek Board ratification of the approval of the response to the Mandatory Request received from NHS Improvement on July 6th 2016, following Chairs Action
Additional Documents and or Supporting Information:	No additional information
Please specify the key risks and issues:	This relates to collection of a new patient identifiable data set, requiring the usual approvals and agreements This relates to a pilot data collection, utilising funding from care.data, but there is no financial provision for revision of the data set once delivered, or for extension of the pilot to cover other trusts Timeframes are extremely tight, and while resource is in place and progress is on track, wider staff and expertise within the business will require active prioritising to support meeting the delivery targets.
Patient/public interest:	• Indirect – forms a fundamental part of the NHS Cost Transformation Programme as part of the Five Year forward view
Supplementary papers:	No supplementary papers
Actions required by the Board:	Approve/endorse the planned draft response to the Mandatory request and associated implications

NHS Digital

Patient Level Information Costing (PLICS)

Briefing on Mandatory Request from NHS Improvement – Updated following Chairs Action

7 September 2016

Information and technology for better health and care

Contents

Executive Summary

This paper was submitted for Board approval by Chairs Action on 28th July 2016.

It was approved on August 2nd 2016 and is brought to the board for formal ratification of that decision.

Section 255 The Health and Social Care Act (2012) provides for

"(1) Any person (including a devolved authority) may request the Information Centre to establish and operate a system for the collection or analysis of information of a description specified in the request"

And,

"(3) The Information Centre must comply with a mandatory request unless the Centre considers that the request relates to information of a description prescribed in regulations."

HSCIC received its first Mandatory Request, from NHS Improvement, on July 6th 2016. It relates to the collection of Patient Level Information and Costing System data (PLICS). A copy is provided in Appendix A.

The Board is asked to review the attached paper and formally ratify response to the Mandatory Request, enclosed in Appendix B. The paper has been updated to include clarifications requested/provided to members of the board as part of the Chairs Action.

Background

The PLICS pilot is an enabling part of an overall sector Costing Transformation Programme to deliver productivity and efficiency savings identified in the Five Year Forward View, through a step change in the quality of costing information.

It will enable improvements in cost management and efficiency; cost benchmarking, sector development and price system efficiency.

NHS Digital involvement commenced initially in October 2015, with a New Work commission to examine the collection of PLICS data. Involvement at this stage was a relatively limited level until May 2016 when it was agreed by the Data Domain of Paperless 2020 that PLICS data collection should be prioritised and funded for delivery as part of the Data Content Programme in 2016/17.

This allowed work to accelerate but the Mandatory Request underpinning all activity was not received until July 14th. It is dated 6th July, which reflects first issue but lawyers identified some issues and required resubmission on July 14th.

Thereafter a response to the Mandatory Request could be drafted, for board review, along with full analysis of timelines and activities to provide a full assurance to the board and highlight appropriate risks. This was issued for Board approval by Chairs Action, in agreement with the Chair and the secretariat, as urgent review was required but the July 28th Board agenda was already very full.

The pilot includes live patient identifiable PLICS data collection, data linkage processes, data quality and validation and then data supply. HSCIC will collect and then link and process the data and then provide the data, anonymised in accordance with the ICO code, to NHS Improvement for onward processing and analysis. It consists of collections from seven acute providers. Data collection is scheduled during September 2016, with testing of the various individual infrastructure and processes

taking place during July and August 2016 to prove the solution and de-risk the system delivery when live data is collected in September.

This work has been subject to previous HSCIC approvals including:

- A New Work Commission which was approved in October 2015 for the PLICS pilot project, and,
- Subsequently, a Project Brief including strategic justification approved by CAB in April 2016.

In May 2016 it was agreed by the Data Domain within the Paperless 2020 Portfolio that PLICS data collection should be prioritised and funded for delivery as part of the Data Content Programme in FY16/17.

The Board is asked to note that:

- This is the first Mandatory Request HSCIC has received.
- The Mandatory Request has gone through relevant NHS Improvement governance processes, including consulting with their lawyers.
- HSCIC has been consulted on this Mandatory Request.
- HSCIC's lawyers reviewed a draft Mandatory Request, with amendments subsequently reflected in the version HSCIC received of 6th July 2016.
- Plans are in place for HSCIC to consult with representatives of persons from whom any information will be collected.
- Resource is in place to meet the request.
- Whilst specific development work is required at HSCIC to meet the requirements of the pilot, this is on existing HSCIC systems and services.
- The data to be collected is live data. Access to the data is subject to the Data Access Advisory Group (DAAG) process to ensure relevant scrutiny and assurance, as delegated by the board. Pre-DAAG approval has been received.
- No data has been collected prior to requesting Board Approval.
- This Mandatory Request ONLY covers collection of the pilot data. Any further collections will be subject to a further Mandatory Request and will be brought to the Board accordingly.
- This collection does involve live patient identifiable data, collected by HSCIC and then anonymised in line with the ICO code. The data will be passed on in this anonymised form and there is no expectation that any means to enable re-identification will be asked for, or provided to NHS Improvement, nor that NHS improvement will be able to effect re-identification in any way.

Recommendation

Options to 'Do Nothing' or 'Defer the decision to the September Board' are not preferred options due to the urgent timescales for delivery of the pilot data and the reputational risk associated.

The Board was asked to endorse the response set out to the mandatory request.

Implications

Strategy Implications

The information gathered from the Costing Transformation Programme will be used to enable NHS Improvement to perform its pricing and licensing functions under the HSCA more effectively. It will;

- inform new methods of pricing NHS services;
- inform new approaches and other changes to the design of the currencies used to price NHS services;
- inform the relationship between provider characteristics and cost;
- help trusts to maximise use of their resources and improve efficiencies, as required by the provider licence;
- identify the relationship between patient characteristics and cost; and
- support an approach to benchmarking for regulatory purposes.

Within HSCIC, this work fits with the strategy and purpose to be the organisation that collects and disseminates health and care data. NHS Improvement is a key partner for HSCIC.

It is beneficial for the system overall to use existing HSCIC tools, technology and knowledge to collect this data and the work is included as a specific objective for Domain H of Paperless 2020 delivery.

HSCIC involvement in collecting the pilot data is likely to help in understanding the dataset further, in preparation for the proposed national collection of PLICS data in subsequent years as part of the Costing Transformation Programme.

Financial Implications

NHS England has agreed to cover the costs of completing the pilot collection which is anticipated to be £210K Revenue (including VAT) up to the end of October. This funding will come from underspend on the care.data programme. No commitment has been made to fund any work on the collection of PLICs data beyond the pilot at this time.

Stakeholder Implications

Work is ongoing with NHS Improvement, as part of the pilot project to implement the systems required. HSCIC will consult with representatives of persons from whom any information will be collected.

Handling

No media implications are anticipated because this is a small scale pilot with only seven Trusts, who have volunteered for the data collection.

NHS Improvement is managing the communications with these Trusts, as part of the wider Costing Transformation Programme. HSCIC will provide technical expertise as an input to these where required, in order to implement the required systems and de-risk the collection process with pilot Trusts.

Risks and Issues

The risk of implementing a solution which is not fit for purpose is being mitigated by HSCIC and NHS Improvement working closely together in implementing the necessary systems; this includes agreeing business requirements, careful analysis of likely PLICS file sizes against the capacity of the HSCIC technical solution and iterative impact assessment and refinement of the pilot data set specification.

The financial provision only covers this pilot data collection. There is no financial provision covering extension or revision of the data set for the pilot, once the data has been delivered. Such activity would require a further Mandatory Request and associated funding.

This work has extremely tight timescales, with data delivery to NHS I required in September. While this is achievable and resources are in place, it will require continued, focused prioritisation of relevant supporting staff, expertise and groups from across the business over the next 2 months to ensure the tight timeframes are achieved.

Corporate Governance and Compliance

A PLICS Project board is in place, along with weekly pilot delivery meetings to the end of the pilot collection period. This allows all parties to identify and resolve any technical issues at an early stage and de-risk the data collection and analysis process.

The HSCIC Data Access Advisory Group is aware and expecting a submission, subject to Board approval of the planned response to the Mandatory Request.

Management Responsibility

The Executive Director who will have accountability for this work is the Executive Director for Information and Analytics, currently Professor Martin Severs.

The senior manager who will have overall responsibility and will deal with the matter on a day to day basis is Jackie Shears – Programme Director, Data Content.

Actions Required of the Board

The HSCIC Board is asked to approve the response to the Mandatory Request as set out in Appendix B, which will lead to the establishment and operation of a system for the collection and analysis of PLICS data as per the Mandatory Request of 6th July from NHS Improvement.

This approval is requested urgently to allow sufficient time for system testing through the remainder of July and August 2016, in advance of the collection which is scheduled to commence in early September 2016.

Appendix A – Mandatory Request

NHSI
Wellington House,
133-155 Waterloo Road,
London,
SE1 8UG

Health and Social Care Information Centre
1 Trevelyan Square
Boar Lane
Leeds
West Yorkshire
LS1 6AE

6th July 2016

Dear Andy Williams

NHSI's Mandatory Request to the Health and Social Care Information Centre

I am writing to the Health and Social Care Information Centre (HSCIC) on behalf of Monitor (referred to in the rest of this letter as "NHS Improvement") to make a mandatory request under section 255 and section 256(2)(a) of the Health and Social Care Act 2012 (HSCA) to establish and operate a system for the collection and analysis of Patient level Costing Information Systems data ("PLICS"). I've set out below full details of the relevant functions of NHS Improvement and the data collection required.

NHS Improvement's functions
Under Chapter 4, Part 3 of the HSCA, NHS Improvement, working with NHS England, is responsible for developing, publicising and enforcing the national tariff, which sets out the price payable by commissioners for NHS services.
NHS Improvement is also responsible for licensing providers of NHS services under Chapter 3, Part 3 of the HSCA. The licence includes a set of standard licence conditions, including:

- conditions applicable to foundation trusts relating to governance arrangements (e.g. there is a requirement for licensees to establish and implement systems and/or processes to ensure compliance with licensee's duty to operate efficiently, economically and effectively); and
- conditions that enable us to fulfil our duties in partnership with NHS England to set prices for NHS care by requiring providers to collect costing information.

Three licence conditions relate to costing:

Pricing condition 1: Recording of information. Under this licence condition, we can require licence holders to record information, including cost information, in line with our published guidance. Such information must be recorded using our 'approved reporting currencies' and in accordance with our *Approved costing guidance*.

Pricing condition 2: Provision of information. Having recorded the information in line with pricing condition 1, licence holders can be required to submit this information to us, as well as other information and reports we may require for our pricing functions.

Pricing condition 3: Assurance report on submissions to NHS Improvement. It is important for price setting that the information submitted is accurate. This condition allows us to require licence holders to submit an assurance report confirming that the information they have provided is accurate.

Although NHS trusts do not have to hold a provider licence, they too must comply with the requirements of these licence conditions under the NHS Trust Development Authority's regime for NHS trusts.

NHS Improvement has a general power under paragraph 15 of Schedule 8 to the HSCA to do anything which appears to it to be necessary or expedient for the purposes of, or in connection with, the exercise of our function.

Costing Transformation Programme
Understanding how providers spend money is essential in tackling short-term deficits; supporting the development of new models of care and reducing the variation in resource utilisation.

Benchmarking using current Reference Cost data cannot identify precisely where there is potential for efficiency gains. Such data is limited in its ability to reflect the complexity of patient care and identifying cost variation between individual patients. By introducing a standardised method of reporting cost information at patient level this can be rectified. This is known as Patient Level Costing Information Systems (PLICS).

NHS Improvement's Costing Transformation Programme (CTP), was established to implement PLICS across Acute, Mental Health, Ambulance and Community providers. The programme entails:

- Introducing and implementing new standards for patient level costing;
- Developing and implementing one single national cost collection to replace current multiple collections;
- Establishing the minimum required standards for costing software and promoting its adoption; and
- Driving and encouraging sector support to adopt Patient Level Costing methodology and technology.

The information gathered from this programme will be used to enable NHS Improvement to perform its pricing and licensing functions under the HSCA more effectively. It will:

- inform new methods of pricing NHS services;
- inform new approaches and other changes to the design of the currencies used to price NHS services;
- inform the relationship between provider characteristics and cost;
- help trusts to maximise use of their resources and improve efficiencies, as required by the provider licence;
- identify the relationship between patient characteristics and cost; and
- support an approach to benchmarking for regulatory purposes.

Mandatory request
Under section 255 of the HSCA, we hereby request that the HSCIC establishes and operates a system for the collection and analysis of PLICS data.

The system to be implemented will need to have the following functionality:

- Data collection- ability for providers to submit PLICS data direct to HSCIC;

- Data linkage – ability to link PLICS data with Hospital Episode Statics (HES) data (NIC- 15814 -C6W9R);
- Data Quality and validation; and
- Data Supply - provide pseudonymised PLICS data to NHS Improvement for onward processing and analysis.

There are three 'levels' of data requiring collection by HSCIC as part of the Costing Transformation programme, collectively these will form the data extract being sought by NHS Improvement.

The three levels referred to above are:

- Message Header Information
- Activity Records; and
- Activity Costs Records

Detailed data levels can be found at Annex A.

To facilitate the development of a successful PLICS data collection system in the first instance, NHS Improvement has a number of volunteer providers (see below) who have agreed to participate in a pilot collection between June and September 2016.

- Buckinghamshire Healthcare NHS Trust
- Guy's and St Thomas' NHS Foundation Trust
- The Royal Free London NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- The Royal Orthopaedic Hospital NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- Chelsea and Westminster NHS Foundation Trust

Information gathered during this pilot collection will be used to test the ability of the system to successfully collect, collate, link, pseudonymise and validate data. Furthermore the pilot will look to establish clear mechanisms for safely transferring data to NHS Improvement.

In concluding the pilot collection, NHS Improvement request the HSCIC to continue to establish and operate a system collecting PLICS data from other trusts providing acute care throughout 16/17 unless it is deemed by the NHSI Costing Director that the 'pilot' system for collection and analysis was deemed unsuccessful. In the event of a decision being taken whereby the continued collection of data under this request is deemed unsuccessful, NHSI shall request in writing the cessation of this request.

We have set out above how the collection of PLICS data is relevant to our pricing functions. We consider that the information which could be obtained by complying with the request is information which it is necessary or expedient for NHS Improvement to have in relation to its discharge of its duties:

(a) in relation to the pricing of health care services provided for the purposes of the NHS; in particular, its duty to prepare and publish the national tariff (section 116 and 118 of the HSCA);

(b) in relation to the licensing of providers of NHS services; in particular, its duty to oversee and enforce the licence (see Part 3 of Chapter 3 of the HSCA); and

(c) generally in relation to the exercise of its functions, in particular its duty under section 62(1) of HSCA in exercising its functions to protect and promote the interests of people who use health care services by promoting provision of health care services which is economic, efficient and effective, and maintains or improves the quality of the services.

"Monitor" is listed as a "principal body" under section 255(9) of the HSCA. This request therefore meets the requirements for a mandatory request.

Prior to making this request, NHS Improvement has liaised and worked with the HSCIC as required by 257(4) of the HSCA 2012 and recognises this request must go through an established system of approvals within the HSCIC.

In making this Mandatory Request under section 255 of the HSCA, Monitor wishes to use section 262 (2) (a) of the HSCA to request that the Information Centre (HSCIC) not exercise the power conferred by section 261(4) in relation to information which it obtains by complying with this request.

NHSI hereby acknowledges that data provided by HSCIC in response to this request is subject to the obligations placed upon it in respect of the Direction from Secretary of State for Health to process Type 2 objections.

NHSI hereby recognises that in submitting this request under section 255 of the HSCA, the HSCIC is entitled to charge a reasonable fee pursuant to section 257 (3) in respect of the cost of establishing a system to collect and analyse data on behalf of NHSI.

Yours sincerely

Richard Ford

Costing Director, Pricing

Annex A
Costing Transformation Programme collection requirements
The HSCIC are being asked to collect information on three levels that, collectively, form the extract being sought by NHS Improvement.

- The message header
- The activity records
- The activity cost records

Message Header information
The message header is used to describe the contents of the extract

Field Name	Description
Organisation Code (code of submitting organisation)	The organisation code of the health care provider, acting as the physical sender of the data extract
Reporting Period Start	The start of the reporting period the extract covers
Reporting Period End	The end of the reporting period the extract covers
Extract Creation Date Time	The date and time the extract was created
Feed Type	The data set the extract covers
Number of Activity Records	The total number of activity records included in the extract
Number of Cost Records	The total number of cost records included in the extract

Activity Records
The activity records detail the characteristics of each patient episode and attendance.

Field Name	Description
Organisation Code (Code of Provider)	The organisation code of the health care provider, providing the service
CDS Unique Identifier *	A Commissioning Data Set data element providing a unique identity for the life-time of an episode carried in a Commissioning Data Set message
Activity Identifier *	A unique number or set of characters that is applicable to only one activity for a patient within an organisation
Hospital Provider Spell Number *	A unique identifier for each hospital provider spell. The identifier is present across all inpatient episodes
Episode Number	Field used to uniquely identify episodes, and is the sequence number for each consultant episode within a Hospital Provider Spell
NHS Number *	The primary identifier of a patient
Contracted out Indicator	Flag to indicate whether patient activity was

	contracted out. For patients where activity WAS contracted out use the code '1', otherwise use '0'
Activity HRG code	Episodic Reference Cost HRG code generated from local use of the 2015/16 reference cost grouper
Spell HRG code	Spell Reference Cost HRG code generated from local use of the 2015/16 reference cost grouper
Episode Type	A field to indicate whether the inpatient consultant episode completed within the financial year
Activity Start Date and Time	The date and time the activity started
Activity End Date and Time	The date and time the activity ended
Age	Patients age on admission or attendance
Person Stated Gender Code	The stated gender of a person
Patient Classification	Only applicable for APC records. The field is derived from the Admission Method, Intended Management and the duration of stay within the provider
Admission Method	Only applicable for inpatient activity, the method of admission to a hospital provider spell
Attended or Did Not Attend	Only applicable for OPD records. The field indicates whether an appointment took place or not
Treatment Function Code	The code that is used to report the specialised service within which a patient is treated
Patient Pathway Identifier *	The field together with the organisation code of the issuer, uniquely identifies a patient pathway

*The values in these fields will not be received by NHS Improvement in identifiable format. These values will be provided by the HSCIC already pseudonymised.

Activity Cost Records

Each activity record will have one or more costs associated with it, which may be indirect or direct.

Field Name	**Description**
Resource ID	Unique identifier to report resources
Activity ID	Unique identifier to report activities
Resource Group ID	An aggregation of resource IDs into logical groupings, to report resources at an aggregated level
Activity Group ID	An aggregation of activity IDs into logical groupings, to report activities at an aggregated level

Activity Count	Sum of the number of activities performed
Cost	The financial value of the resources consumed by the activities carried out

Appendix B - Response to Mandatory Request dated 6th July 2016

PLICS Mandatory Request Response 9-

NHS Digital

1 Trevelyan Square
Boar Lane
Leeds LS1 6AE

0300 303 5678

To: Richard Ford

CC: Colin Dingwall
Ronan O'Connor
Peter Sinden
Jackie Shears
Eve Roodhouse
Professor Martin Severs

9 August 2016

Dear Richard,

Thank you for the Mandatory Request of 6th July under section 255 and section 256(2)(a) of the Health and Social Care Act 2012 to establish and operate a system for the collection and analysis of "PLICS" - Patient-Level Information and Costing Systems data.

The request was accepted by the HSCIC Board of Directors on Tuesday 2 August and I can confirm that HSCIC is working to establish and operate a system for the collection and analysis of "PLICS" data.

I have copied in Ronan O'Connor at NHS England into my response to you. As you know, HSCIC will be funded for this work via an allocation under the National Information Board (NIB) Domain H Data Content Programme. NHS England has agreed to cover the costs of completing the pilot collection which is anticipated to be £210K Revenue up to end October 2016. No commitment has been made to fund any work on the collection of PLICS data beyond the pilot at this time.
For the volunteer providers who have agreed to participate in a pilot collection between June and September 2016 (namely);

- Buckinghamshire Healthcare NHS Trust
- Guy's and St Thomas' NHS Foundation Trust
- The Royal Free London NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- The Royal Orthopaedic Hospital NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- Chelsea and Westminster NHS Foundation Trust,

HSCIC shall collect PLICS data from these trusts as per the Mandatory Request. The Costing Transformation Programme: 2015/16 Acute Development Cost Collection Guidance sets out the collection period, which is also set out below:

The collection year begins on 1 April 2015 and ends on 31 March 2016. All episodes and attendances completed within the collection year or episodes still open at the end of the collection year are in scope of this collection.

NHS Digital

This includes:

- all episodes and attendances that start and end between 1 April 2015 and 31 March 2016 (any A&E attendances ending after 23:59:59 on 31 March 2016 should be excluded from this collection year and reported in the 2016/17 collection)
- all episodes that start between 1 April 2015 and 31 March 2016 and are incomplete as at 31 March 2016
- all episodes that start before 1 April 2015 but end between 1 April 2015 and 31 March 2016
- all episodes that start before 1 April 2015 and are incomplete as at 31 March 2016.

Only resources used and activities undertaken within the collection year should be included, regardless of when the episode started or ended.
Regarding: *"In concluding the pilot collection, NHS Improvement request the HSCIC to continue to establish and operate a system collecting PLICS data from other trusts providing acute care throughout 16/17 unless it is deemed by the NHSI Costing Director that the 'pilot' system for collection and analysis was deemed unsuccessful. In the event of a decision being taken whereby the continued collection of data under this request is deemed unsuccessful, NHSI shall request in writing the cessation of this request."*

We wish in response to highlight that:

- It is helpful for HSCIC to know for planning purposes that NHS Improvement intends for PLICS data to be collected from other Trusts providing acute care throughout 16/17.
- HSCIC would require the detail of these other trusts (at a suitable point in the future such that the systems can be implemented) via a further Mandatory Request.
- As funding from NHS England is provided only until the end of the pilot collection (as set out above), HSCIC would need further funding to cover the work involved in meeting any such further Mandatory Request.
- HSCIC expect that the HSCIC SIRO and/or Caldicott Guardian would be consulted on and input to any decision to delay or stop the PLICS collection (in the event they had any material concerns regarding it).

Best wishes

Andy Williams
Chief Executive

Board Meeting – Public Session

Title of paper:	**Board and Board Sub-Committee Terms of Reference (ToR) Annual Review 2016-17**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 05 d (P1)
Paper presented by:	Chair
Paper prepared by:	Annabelle McGuire Secretary to the Board and Head of Corporate Governance
Papers approved by:	The Chair and the relevant sub-committee Chairs
Purpose of the paper:	The Terms of Reference (ToR) for the Board and its sub-committees have been reviewed as part of the annual review and a number of changes have been proposed. There are two versions of the Board ToR included one with tracked changes, so the changes can be easily identified, and one without tracked changes in the NHS Digital format. Board approval is sought for the revised (ToR) for the Board and the following committees: • NHS Digital Board • Assurance and Risk Committee (ARC) • Information Assurance and Cyber Security Committee (IACSC) • Remuneration Committee
Key risks and issues:	It is important that these documents are kept up to date and relevant to reflect changes in the organisation to ensure that business is transacted and/or conducted correctly.
Patient/public interest:	The documents record the responsibilities and delegations for NHS Digital's Board and its sub-committees. They set out the terms of reference under which the statutory meetings of NHS Digital operate.
Actions required by the Board:	Board approval is sought for the revised ToR of the Board and the Board's sub-committees

NHS Digital

Board Terms of Reference and Code of Practice

Date: 2016-17

Information and technology
for better health and care

Contents

1 Constitution

NHS Digital legally known as the Health and Social Care Information Centre (NHS Digital) was established on 01 April 2013 as an executive non-departmental public body (ENDPB) under the Health and Social Care Act 2012.

As an ENDPB, the organisation is accountable to the Secretary of State for Health for discharging its functions, duties and powers effectively, efficiently and economically.

2 Membership

The Board of NHS Digital must comprise:

- At least six non-executive members including the Chair
- Not more than five other executive members who are employees of NHS Digital and are appointed by the non-executive members. One of the executive members must be appointed as the Chief Executive Officer (CEO) but the appointment may not be made without the approval of the Secretary of State. The first CEO was appointed by the Secretary of State.

Further details including the conduct of meetings and the roles and responsibilities of the Chair, Board, CEO and the Senior Independent Director are set out in the Corporate Governance Manual.

The NHS Digital Secretary to the Board will minute the Board meetings.

3 Quorum

Meetings are quorate when at least one-third of the membership is present (including at least two non-executives, one of whom must be the Chair or Vice-Chair).

4 Attendance

Board meetings will be attended by other members of the Executive Management Team (see appendix A) in addition to Board members. They will not have voting rights.

Whilst in office a Board Member is expected to attend the majority of statutory Board meetings. A Board Member may be removed from office if he/she is absent from more than two consecutive statutory meetings (or more than three meetings in any twelve month period) unless at the Chair's discretion the absence is due to illness or another reason agreed by the Chair. In such circumstances the Chair can allow a Board Member to remain in post.

Observers, such as members of the public, the Department of Health Sponsor team, representatives of other stakeholder organisations and representatives of the press can also attend the meetings.

5 Access

Observers may attend all formal meetings of NHS Digital Board but will be required to withdraw upon the Board or Committee resolving:

'that pursuant to the Public Bodies (Admission to Meetings) Act 1960 that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest' (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960)'

Observers wishing to attend must register their interest via the NHS Digital web site at least three working days before the meeting.

Agendas and papers for the public session of the Board will be available on the NHS Digital website five working days before the meeting date. Queries about the public session can be raised by notifying the Secretary to the Board (execofficeteam@hscic.gov.uk) beforehand so that these, at the discretion of the Chair, may be covered as part of the Board discussion.

A short time will also be built in at the end of each meeting to take questions from any observers that have been notified to the Secretary to the Board, and as agreed by the Chair, prior to the meeting.

From time to time, the Board might need to consider commercial or staff in confidence agenda items that cannot be discussed in public. In that event a private session will also be held without any observers.

6 Frequency

The Board will meet at least six times a year in public.

7 Appendix A

7.1 Current Members of the Board

7.1.1 The Non- Executive Board Members:

- Noel Gordon - Chair
- Sir Nick Partridge - Vice Chair
- Sir Ian Andrews – Senior Independent Director
- Sir John Chisholm
- Professor Maria Goddard
- Dr Sarah Blackburn

7.1.2 The Executive Members of the Board:

- CEO
- Chief Operating Officer
- Director of Workforce
- Director of Finance and Corporate Services
- Director of Director of Digital Transformation

7.1.3 Ex Officio Members of the Board (without voting rights):

- Tamara Finkelstein - Director General for Community Care at the Department of Health
- Professor Keith McNeil - Chief Clinical Information Officer (CCIO)
- Professor Martin Severs – Medical Director and Caldicott Guardian, NHS Digital

7.1.4 Other Members of the Executive Management Team:

May attend the Board at the discretion of the Chair:

- Director of Provider Support and Integration
- Director of Programmes
- Director of Information and Analytics

NHS Digital

Health and Social Care Information Centre
(NHS Digital)

Board Terms of Reference
and Code of Practice

Date: 2016-17

Contents

1 Constitution

NHS Digital legally known as the Health and Social Care Information Centre (NHS Digital) was established on 01 April 2013 as an executive non-departmental public body (ENDPB) under the Health and Social Care Act 2012.

As an ENDPB, the organisation is accountable to the Secretary of State for Health for discharging its functions, duties and powers effectively, efficiently and economically.

2 Membership

The Board of NHS Digital must comprise:

- At least six non-executive members including the Chair
- Not more than five other executive members who are employees of NHS Digital and are appointed by the non-executive members. One of the executive members must be appointed as the Chief Executive Officer (CEO) but the appointment may not be made without the approval of the Secretary of State. The first CEO was appointed by the Secretary of State.

Further details including the conduct of meetings and the roles and responsibilities of the Chair, Board, CEO and the Senior Independent Director are set out in the Corporate Governance Manual.

The NHS Digital Secretary to the Board will minute the Board meetings.

3 Quorum

Meetings are quorate when at least one-third of the membership is present (including at least two non-executives, one of whom must be the Chair or Vice-Chair).

4 Attendance

Board meetings will be attended by other members of the Executive Management Team (see appendix A) in addition to Board members. They will not have voting rights.

Whilst in office a Board Member is expected to attend the majority of statutory Board meetings. A Board Member may be removed from office if he/she is absent from more than two consecutive statutory meetings (or more than three meetings in any twelve month period) unless at the Chair's discretion the absence is due to illness or another reason agreed by the Chair. In such circumstances the Chair can allow a Board Member to remain in post.

Observers, such as members of the public, the Department of Health Sponsor team, representatives of other stakeholder organisations and representatives of the press can also attend the meetings.

5 Access

Observers may attend all formal meetings of NHS Digital Board but will be required to withdraw upon the Board or Committee resolving:

'that pursuant to the Public Bodies (Admission to Meetings) Act 1960 that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest' (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960)'

Observers wishing to attend must register their interest via the NHS Digital web site at least three working days before the meeting.

Agendas and papers for the public session of the Board will be available on the NHS Digital website five working days before the meeting date. Queries about the public session can be raised by notifying the Secretary to the Board (execofficeteam@hscic.gov.uk) beforehand so that these, at the discretion of the Chair, may be covered as part of the Board discussion.

A short time will also be built in at the end of each meeting to take questions from any observers that have been notified to the Secretary to the Board, and as agreed by the Chair, prior to the meeting.

From time to time, the Board might need to consider commercial or staff in confidence agenda items that cannot be discussed in public. In that event a private session will also be held without any observers.

6 Frequency

The Board will meet at least six times a year in public.

7 Appendix A

7.1 Current Members of the Board

7.1.1 The Non- Executive Board Members

- Noel Gordon - Chair
- Sir Nick Partridge - Vice Chair
- Sir Ian Andrews – Senior Independent Director
- Sir John Chisholm
- Professor Maria Goddard
- Dr Sarah Blackburn

7.1.2 The Executive Members:

- CEO
- Chief Operating Officer
- Director of Workforce
- Director of Finance and Corporate Services
- Director of Director of Digital Transformation

7.1.3 Ex Officio Members (without voting rights):

- Tamara Finkelstein - Director General for Community Care at the Department of Health
- Professor Keith McNeil - Chief Clinical Information Officer (CCIO)
- Professor Martin Severs – Medical Director and Caldicott Guardian, NHS Digital

7.1.4 Other members of the Executive Management Team:

May attend the Board at the discretion of the Chair

- Director of Information and Analytics
- Director of Provider Support and Integration
- Director of Programmes

NHS Digital Assurance and Risk Committee

Terms of Reference

Date: 2016-17

Information and technology
for better health and care

Contents

1 Introduction

These terms of reference conform to the good practice provided described in the Department of Health and HM Treasury Audit Committee Handbooks.

2 Constitution

The NHS Digital Board (''the Board'') hereby resolves to establish a Committee of the Board to be known as the Assurance and Risk Committee (ARC).

3 Membership

The Assurance and Risk Committee membership will be appointed by the Board from amongst the independent non-executive Directors of the NHS Digital and will comprise of four Non-Executive members.

- The Chair of the NHS Digital Board will not be a member of the Assurance and Risk Committee.
- The Board will appoint the Chair of the Committee from amongst the independent non-executive Director members
- The Chair's appointment will be reviewed on an annual basis.
- The Chair of the Information Assurance and Cyber Security Committee will be a member of the ARC

4 Quorum

A quorum will be three members – one of whom must be the Committee Chair.

5 Attendance

The Chief Executive, Director of Workforce, Director of Finance and Corporate Services, Chief Operating Officer (to provide cover for information governance and information risks, and who is NHSD's Senior Information Risk Owner) and representatives from internal and external Audit, will normally attend the committee meetings.

- At least once a year the Assurance and Risk Committee will meet with external and internal auditors without any Executive Board Director present.
- A representative from the Department of Health sponsor team may also be invited to attend.

The secretary of the Assurance and Risk Committee will be the NHS Digital Secretary to the Board and Head of Corporate Governance. A suitably trained and qualified member of the secretariat team may deputise as required. The secretariat function will be supported by the NHS Digital Corporate Risk and Assurance function.

6 Access

Representatives of internal and external audit and the Local Counter Fraud Specialist will have free and confidential access to the Chair of the Committee.

7 Frequency

Meetings shall be held not less than four times a year, but may meet more regularly if circumstances require. The external or internal auditors may request a meeting if they consider it necessary.

8 Authority

The Assurance and Risk Committee is authorised by the Board:

- To investigate any activity within the terms of reference. It is authorised to seek any information that it requires from any employee and all employees are directed to cooperate with any request made by the Assurance and Risk Committee
- To obtain outside legal or independent professional advice, at the NHS Digital's expense, and to secure the attendance of external specialists with relevant experience and expertise if it considers this necessary.

9 Duties

The duties of the Assurance and Risk Committee are:

9.1.1 Internal Control and Risk Management

The Assurance and Risk Committee shall review and monitor the effectiveness of the system of integrated governance, risk management and internal control including information governance, security and data quality risks.

In particular, the Assurance and Risk Committee will review the adequacy of and make recommendations to the Board as appropriate on:

- All risk and control related disclosure statements, (in particular the Annual Governance Statement) together with any accompanying Internal Audit statements, prior to the endorsement of the Board

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The structures, processes and responsibilities for identifying and managing key risks facing the organisation
- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in the Controls Assurance Standards and other relevant guidance
- The operational effectiveness of policies and procedures
- The policies and procedures for all work related to fraud, corruption and whistleblowing – including appointment of a Local Counter Fraud Specialist and to enable the Local Counter Fraud Specialist to attend Assurance and Risk Committee meetings when required.

In carrying out this work the Assurance and Risk Committee will primarily utilise the work of Internal Audit, external audit and other assurance functions. It will also seek reports and assurances from directors and managers as appropriate. It will record key risk management messages and decisions requiring attention in meeting minutes, for publication and dissemination across NHS Digital.

9.2 Internal Audit

The Assurance and Risk Committee will ensure that there is an effective Internal Audit function established by management that meets mandatory internal audit standards (Public Sector Internal Audit Standards) and provides appropriate independent assurance to the Chief Executive and Board. This will be achieved by:

- Reviewing and making recommendations to the Board on the appointment of the internal Audit service, the Chief Audit Executive, the audit fee and any questions of resignation and dismissal
- Reviewing the internal audit programme, considering the major findings of internal audit investigations (and management's response), and ensuring co-ordination between the internal and external auditors
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- Annual review of the effectiveness of the Internal Audit function.

9.3 External Audit

The Assurance and Risk Committee will review the work and findings of the external Auditor and take account of the implications and management responses to their work. This will include:

- Acknowledging the appointment of the External Auditor by the Comptroller and Auditor General
- Discussing with the external Auditor, before the audit commences, the nature and scope of the audit, ensuring co-ordination, as appropriate with other external bodies (e.g. shared services) and agreeing the audit fee
- Reviewing and making any recommendations to the Board as necessary on external Audit reports, including value for money reports and annual management letters, together with the management response.

9.4 Other Assurance Functions

The Assurance and Risk Committee will review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

In addition, the Assurance and Risk Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Assurance and Risk Committee's own scope of work.

9.5 Management

The Assurance and Risk Committee will request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

The Assurance and Risk Committee may call directors and managers to appear before it to account for:

- Audit reports raising significant concerns to explain the action being taken to address the concerns raised and the timescale for doing so.
- Non-delivery of agreed management actions to address audit concerns within the timescales set.
- Any other matters the Assurance and Risk Committee consider relevant in connection with risks and issues on the NHS Digital Strategic Risk Register and the effectiveness of their control.

9.6 Financial Reporting

The Assurance and Risk Committee will review the Annual Financial Statements and make recommendations to the Board focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Major judgemental areas
- Significant adjustments resulting from audit.

10 Reporting

The minutes of the Assurance and Risk Committee meetings will be formally recorded and submitted to the Board.

A briefing will be provided as a standing item on the Committee's agenda from the Chief Operating Officer on all risk and assurance issue discussions held by or arising from the Information Assurance and Cyber Security Committee.

The Assurance and Risk Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and adequacy of risk management in the organisation and the integration of governance arrangements.

The Assurance and Risk Committee will annually review its terms of reference and its own effectiveness and recommend any necessary changes to the Board.

NHS Digital

NHS Digital Information Assurance and Cyber Security Committee

Terms of Reference

Date: 2016-17

Information and technology
for better health and care

Contents

1 Introduction

These terms of reference have been produced based on the specimen good practice versions provided in both the Department of Health and HM Treasury Audit Committee Handbooks. They have been slightly amended to reflect the views and wishes of the Committee members.

2 Constitution

The NHS Digital Board hereby resolves to establish a Committee of the Board to be known as the Information Assurance and Cyber Security Committee (IACSC).

3 Membership

The Information Assurance and Cyber Security Committee will be appointed by the NHS Digital Board from amongst the independent non-executive Directors of the NHS Digital and will comprise three members. One of the non-executive Directors shall be the Chair of the NHS Digital Audit and Risk Committee.

The Chair of the NHS Digital Board will not be a member of Information Assurance and Cyber Security Committee. The NHS Digital Board will appoint the Chair of the Committee from amongst the independent non-executive Directors and this appointment will be reviewed on an annual basis.

4 Quorum

A quorum will be two members along with either the NHS Digital's Chief Operating Officer[1] or Caldicott Guardian.

5 Attendance

The Information Assurance and Cyber Security Committee will normally be attended by:

- The Chief Executive Officer;
- The Chief Operating Officer will cover information governance and information risks;
- The Director of Workforce;
- The Medical Director and Caldicott Guardian; and
- Cross-Government representatives, led by Cabinet Office including
- Communications and Electronic Security Group (CESG)

[1] Senior Information Risk Owner

- Office of Cyber Security and Information Assurance (OCSIA)
- Centre for the Protection of National Infrastructure (CPNI)
- Office of the Government Senior Information Risk Officer (OGSIRO)
- A representative from the Independent Information Governance Oversight Panel (IIGOP)
- A representative from the Department of Health Sponsor Team may also be invited to attend.

The Secretary of the Information Assurance and Cyber Security Committee will be a member of the Executive Office Secretariat team.

6 Access

Representatives of sub-groups of the Information Assurance and Cyber Security Committee will have free and confidential access to the Chair of the Committee.

7 Frequency

Meetings shall be held not less than four times a year, but will meet more regularly, initially as the delivery of the Cyber Security Programme (CSP) needs ongoing oversight or if other circumstances dictate.

8 Authority

The Information Assurance and Cyber Security Committee is authorised by the Board:

- To investigate any activity within the terms of reference. It is authorised to seek any information that it requires from any employee and all employees are directed to cooperate with any request made by the Information Assurance and Cyber Security Committee
- To obtain outside legal or independent professional advice, at the NHS Digital's expense, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

9 Duties

The duties of the Information Assurance and Cyber Security Committee can be categorised as follows:

9.1 Internal control and risk management responsibilities

The Information Assurance and Cyber Security Committee shall review and monitor the effectiveness of the system of integrated governance, risk management and internal control relating to information assurance; information governance; cyber and other security; and data quality.

Corporate Strategic and Operational risks are recorded on the Corporate Risk Registers and actively managed by the Executive team. The Information Assurance and Cyber Security Committee will provide oversight, review and challenge of the detailed Information Assurance/Information Governance/Cyber Security risks that are maintained across the organisation.

In particular, the Information Assurance and Cyber Security Committee will review the adequacy of and make recommendations to the Board or the Assurance and Risk Committee as identified below:

9.2 Assurance and Risk Committee

- Input and recommendations to risk and control related disclosure statements, (in particular the Annual Governance Statement) prior to the endorsement of the Board
- The operational effectiveness of policies and procedures

9.3 The NHS Digital Board

- The underlying assurance processes that indicate the degree of the achievement of corporate Information Assurance and Cyber Security objectives, the effectiveness of the management of threats and risks to NHS Digital information systems
- The structures, processes and responsibilities for identifying and managing key Information Assurance and Cyber Security risks facing the organisation
- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in the Controls Assurance Standards and other relevant guidance

In carrying out this work the Information Assurance and Cyber Security Committee will primarily utilise the work of the Information Assurance and Standards Assurance functions. It will also seek reports and assurances from directors and senior managers as appropriate.

9.4 Information Assurance

The Information Assurance and Cyber Security Committee will ensure that there is an effective Information Assurance function established by management that meets recognised industry and Government standards and provides appropriate independent assurance to the Chief Executive and Board. This will be achieved by:

- Reviewing and making recommendations to the Board on the structure, function and remit of the Information Assurance function.

- Reviewing the operation of Information Assurance functions, considering the major findings of investigations (and management's response), and ensuring co-ordination between relevant expertise areas.
- Ensuring that the Information Assurance function is adequately resourced and has appropriate standing within the organisation
- Annual review of the effectiveness of the Information Assurance function.

9.5 Cyber Security

The Information Assurance and Cyber Security Committee will review the work and findings of the Cyber Security Programme and take account of the implications and management responses to their work. This will include:

- Acting as an effective Programme Board providing the strategic direction for the Cyber Security Programme.
- Reviewing and making any recommendations to the Board as necessary on reports relating to Information Assurance and Cyber Security.

9.6 Other Assurance Functions

The Information Assurance and Cyber Security Committee will review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

The Information Assurance and Cyber Security Committee will ensure that the appropriate sub-groups are put in place for following Information Assurance functions:

- Data Access
- Corporate Information Security
- Programme Information Assurance
- Management Systems and Standards
- Other required bodies and legal boards

In addition, the Information Assurance and Cyber Security Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Information Assurance and Cyber Security Committee's own scope of work.

9.7 Management

The Information Assurance and Cyber Security Committee will request and review reports and positive assurances from directors and senior managers on the overall arrangements for governance, security and internal control.

The Information Assurance and Cyber Security Committee may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

10 Reporting

The minutes of the Information Assurance and Cyber Security Committee meetings will be recorded and maintained. The Chair of the Information Assurance and Cyber Security Committee will report verbally to each NHS Digital Board meeting with any required discussion points being raised to the private session of the Board.

The Information Assurance and Cyber Security Committee will report to the Board annually on its work in support of the Annual Governance Statement.

The Information Assurance and Cyber Security Committee will annually review its terms of reference and its own effectiveness and recommend any necessary changes to the Board.

The Non-Executive Director Chair of the Information Assurance and Cyber Security Committee will be a member of the Assurance and Risk Committee.

NHS Digital Remuneration Committee

Terms of Reference

Date: 2016-17

Information and technology
for better health and care

Contents

1 Constitution

The NHS Digital Board hereby resolves to establish a committee of the Board to be known as the Remuneration Committee. The Remuneration Committee will meet as required by the Chair of the Board but this would normally be at least three times a year.

2 Membership

The Remuneration Committee will be appointed by the Board from amongst the independent non-executive Directors of the NHS Digital and will consist of the Board Chair, who will act as Chair of the Committee and three non-executive directors.

3 Quorum

A quorum shall be the Chair and two non-executive directors.

4 Attendance

The Chief Executive and Director of Workforce will attend the meetings in an advisory capacity but will withdraw when a matter concerning their remuneration package or other matter of individual confidentiality is being discussed or documented.

The Secretary to the Board will attend to minute the meetings but will be required to withdraw when requested by the Chair.

5 Authority and Responsibility

The Board has delegated full responsibility to the Remuneration Committee to:

- Make recommendations to the Department of Health (DH) on the level of the remuneration packages of the CEO and other executive directors within the provisions of the Pay Framework for Very Senior Managers (VSMs) or successor arrangements
- Determine pay arrangements for medical and other staff groups who are not subject to Agenda for Change (AfC), VSM or TUPE protected terms and conditions of employment
- Maintain an overview of senior non-medical staff pay (currently defined as over £100,000 per annum, including any award of Performance Related Pay) to ensure that pay remains consistent with public pay policy
- Approve the level of any annual performance related pay awards to NHS Digital staff on ex-Civil Service terms and conditions
- Approve the annual performance objectives and targets of Executive Directors
- Monitor and evaluate the performance of VSMs and make recommendations to DH on any proposed annual performance pay awards within the total of VSM pay bill which

may be used for performance related pay (as set annually by DH, taking account of the recommendations of the Senior Salaries Review Body)

- Ensure that pay arrangements are appropriate in terms of Equal Pay requirements.
- Consider and approve redundancy payments and other (often TUPE related) exceptional matters
- Ensure that all matters relating to pay and conditions that require approval from the Department of Health Remuneration Committee or other external authority are submitted for approval and that the decisions of those bodies are appropriately implemented.
- Review and make recommendations on the size, composition and structure of the Board. Including assessment and making recommendations to the DH of the skills, knowledge and experience required for new Board appointments. This includes the Board succession planning process, including the pipeline of talent management.
- Oversee pay related diversity and inclusion matters in respect to protected characteristics within the workforce.
- Review at a minimum annually the expenses and subsistence claims of both Executive Directors and Non-Executive Directors.

6 Review

The membership and terms of reference of the Remuneration Committee will be reviewed annually.

Board Meeting – Public Session

Title of paper:	**Board Appointments**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 05 e (P1)
Paper presented by:	Chair
Paper prepared by:	Annabelle McGuire, Secretary to the Board and Head of Corporate Governance
Paper approved by: (Sponsor Director)	Chair Chief Executive Officer
Purpose of the paper:	The purpose of this paper is to propose appointments to NHS Digital's Board
Key risks and issues:	N/A
Patient/public interest:	Board Membership
Actions required by the board:	**The Board are requested approve these appointments.**

Board Appointments

NHS Digital Board Appointments

7 September 2016

Information and technology
for better health and care

Contents

Executive Summary

NHS Digital is led by its Board which is the senior decision making structure in the organisation and which is accountable to Parliament and the Secretary of State for Health. The Board is led by the Chair and comprises non-executive and executive members.

In line with NHS Digital's Standing Orders, as set out in the Corporate Governance Manual, appointments to the Board should be approved by the Board. This principle is consistent with NHS Digital's responsibilities as a public body and ensures it operates in an open, honest and transparent manner.

The establishment and constitution of NHS Digital (legally known as the Health and Social Care Information Centre) is set out in Schedule 18 of the Health and Social Care Act 2012. In accordance with Schedule 18 of the Health and Social Care Act 2012, the Board must comprise:

- At least six non-executive members including the Chair.
- Not more than five other executive members who are employees of the NHS Digital and are appointed by the non-executive members. One of the five executive members must be appointed as the Chief Executive.

Appointment of NHS Digital Executive Members of the Board

As specified in NHS Digital's Standing Orders and in accordance with Schedule 18 of the Health and Social Care Act 2012, the Board must comprise at least six non-executive members including the Chair and not more than five other executive members who are employed by NHS Digital. One of the five executive members must be appointed as the Chief Executive.

The proposal is to appoint the following executive members to the Board:

1. Chief Executive Officer
2. Director of Finance and Corporate Services
3. The Chief Operating Officer
4. Director of Digital Transformation
5. Director of Workforce

Board Action: The Board is requested to approve these appointments.

The Board is asked to note that all Executive Directors, including the Director of Provider Support and Integration, the Director of Programmes and the Director of Information and Analytics, will be invited to attend the non-statutory Board Development Days and all Board business hospitality events. All Executive Directors will continue with their current appointments to attend the Board sub-committees.

Ex-Officio NHS Digital Board Members

The Board proposes to appoint Tamara Finkelstein, Director General for Community Care, DH and Prof. Keith McNeill, Chief Clinical Information Officer, NHS England as ex officio members' of NHS Digital's Board.

As confirmed in a letter from the Permanent Secretary, DH to the former Chair dated 15 April 2016 these appointments and their participation in Board discussions (in both public and private session), will support closer system alignment between NHS Digital, NHS England and the DH on informatics matters.

As ex-officio Board members, the Director General for Community Care, DH and the NHS Chief Clinical Information Officer will not have formal voting rights on NHS Digitals Board; they are members of the Board in a consultative capacity.

This means there is no change to the independent process in place for the Board to make a resolution on any matter brought to it for formal decision. It is the Board Members i.e. Non-Executive and Executive Members of the Board who retain voting rights which are exercised where appropriate.

Board Action: The Board is requested to approve these appointments.

Appointment of the Medical Director and Caldicott Guardian

The Board proposes to appoint Professor Martin Severs, NHS Digital's Medical Director and Caldicott Guardian in an advisory capacity to NHS Digital's Board.

In a consultative role the Medical Director and Caldicott Guardian will not have formal voting rights on NHS Digital's Board.

Board Action: The Board is requested to approve this appointment.

Actions Required of the Board

- The Board is requested to approve these appointments.

Board Meeting – Public Session

Title of paper:	**NHS Digital Board Forward Business Schedule**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 05 f (P1)
Paper presented by:	Chair
Paper prepared by:	Annabelle McGuire, Secretary to the Board and Head of Corporate Governance
Paper approved by: (Sponsor Director)	None
Purpose of the paper:	This paper details the NHS Digital Board forward business schedule for the financial year 2016-17. Please note this schedule is subject to frequent change.
Key risks and issues:	N/A
Patient/public interest:	Corporate Governance – decision making
Actions required by the board:	**To note for information**

NHS Digital – Public Board Meeting Foreword Business Schedule 2016-17 [i]

04 May 2016 [ii]	08 June 2016	07 Sept 2016	30 Nov 2016	01 Feb 2017	28 Mar 2017
Board Business	***Board Business***	***Board Business***	***Board Business***	***Board Business***	***Board Business***
Register of Interests Minutes of previous meeting Progress on Action Points Board Forward Business Schedule 2016-17 Reports from Sub-Committees	Register of Interests Minutes of previous meeting Progress on Action Points Board Forward Business Schedule 2016-17 Reports from Sub-Committees	Register of Interests Minutes of previous meeting Progress on Action Points Board Forward Business Schedule 2016-17 Reports from Sub-Committees Terms of Reference for the Board and the Board sub-committees Board Appointments	Register of Interests Minutes of previous meeting Progress on Action Points Board Forward Business Schedule 2016-17 Reports from Sub-Committees Board Appointments	Register of Interests Minutes of previous meeting Progress on Action Points Board Forward Business Schedule 2016-17 and 2017-18 Reports from Sub-Committees	Register of Interests Minutes of previous meeting Progress on Action Points Board Forward Business Schedule 2017-18 Reports from Sub-Committees
Governance and Assurance	***Governance and Assurance***	***Governance and Assurance***	***Governance and Assurance***	***Governance and Assurance***	***Governance and Assurance***
Annual Review of Board Effectiveness Report 2015-16	* HSCIC Annual Report and Accounts for 2015-16	Directions: Diabetes Prevention Programme DH Directions: GP Metrics DH Directions: Clinical Audit Platform Collection National Pandemic Flu Directions NHS Improvement Mandatory Request for Patient Level Costing	Scheme of Delegated Financial Authorities 2016-17 (update) Directions: NHS Health Checks In England DH Directions: Emergency Care Dataset DH Directions: Troubled Families	Arrangements for the Annual Review of Board Effectiveness 2016-17 Directions	Corporate Governance Manual 2017-18 Scheme of Delegated Financial Authorities 2017-18 Directions
Operational Performance	***Operational Performance***	***Strategic Operational Delivery and Performance***	***Strategic Operational Delivery and Performance***	***Strategic Operational Delivery and Performance***	***Strategic Operational Delivery and Performance***
Board Performance Pack Transformation Programme Plan 2016-17 Data Release Audit Annual Report 2015-16	Board Performance Pack	Board Performance Pack *Corporate Business Plan 2016-17 (Final) Data Release Audit Status Report	Board Performance Pack Transformation Programme Mid-Year Report 2016-17 Equality and Diversity Update * Mid-year review of Corporate Business Plan 2016-17	Board Performance Pack Staff Survey Results 2016-17 Data Release Audit Status Report * Corporate Business Plan 2017-18 (Draft)	Board Performance Pack Transformation Programme Report 2016-17 Information Assurance and Cyber Security Annual Report 2016-17 * Corporate Business Plan 2017-18 (Final)
Strategy and Capability	***Strategy and Capability***	***Strategy and Capability***	***Strategy and Capability***	***Strategy and Capability***	***Strategy and Capability***
HSCIC Statutory Duty – Burden	Diagnostic Imaging Dataset Directions	Clinical Governance and Safety Paperless 2020 Update Report	NHS Digital Statutory Duty – Burden Data Strategy		
Client Engagement	***Client Engagement***	***System Wide Support and Engagement***	***System Wide Support and Engagement***	***System Wide Support and Engagement***	***System Wide Support and Engagement***
					Streamlining the Independent Information Governance Advice to NHS Digital Update
Papers for Information Only	***Papers for Information Only***	***Papers for Information Only***	***Papers for Information Only***	***Papers for Information Only***	***Papers for Information Only***
Forthcoming Statistical Publications Programme Definitions	Forthcoming Statistical Publications Programme Definitions External Information Management Strategy	Forthcoming Statistical Publications Programme Definitions	Forthcoming Statistical Publications Programme Definitions	Forthcoming Statistical Publications Programme Definitions	Forthcoming Statistical Publications Programme Definitions
April and May 2016	**June and July 2016**	**August and September 2016**	**October and November 2016**	**December 2016 and January 2017**	**February and March 2017**
Key Meetings	***Key Meetings***	***Key Meetings***	***Key Meetings***	***Key Meetings***	***Key Meetings***
• Executive Management Team – weekly • Board Development Day – 13 April 2016 • Assurance and Risk Committee – 24 May 2016 • Information Assurance and Cyber Security Committee – 3 May 2016 • Public Board Meeting – 4 May 2016	• Executive Management Team – weekly • Public Board (Accounts) - 08 June 2016 • Board Development Day – 27 July 2016 • Assurance and Risk Committee – 08 June 2016 • Information Assurance and Cyber Security Committee – • Remuneration Committee – 12 July 2016	• Executive Management Team - weekly • Public Board Meeting – 7 September 2016 • Assurance and Risk Committee – 31 August 2016	• Executive Management Team – weekly • Information Assurance and Cyber Security Committee - 03 October 2016 • Board Development Day 26 October 2016 • Public Board Seminar – 30 November 2016 • Assurance and Risk Committee - 16 November 2016 • Information Assurance and Cyber Security Committee -16 November 2016 • Remuneration Committee – 22 November 2016	• Executive Management Team – weekly • Board Development Day – 14 December 2016 • Assurance and Risk Committee – 18 January 2017 • Information Assurance and Cyber Security Committee -18 January 2017	• Executive Management Team – weekly • Public Board Meeting – 1 February 2017 • Board Development Day 01 March 2017 • Assurance and Risk Committee –15 March 2017 • Information Assurance and Cyber Security Committee -15 March 2017 • Remuneration Committee – 14 March 2017

[i] This is a living document and is subject to regular updates
[ii] Please see the final agenda for the full details of the items discussed at the statutory public Board meetings
* These documents may be embargoed and therefore not available publically

Board Meeting – Public Session

Title of paper:	Implementation of type 2 opt-outs and ICO Undertaking – Progress Update
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 02 07 a (P1)
Paper presented by:	Martin Severs, Medical Director and Caldicott Guardian
Paper prepared by:	Heather Pinches, Programme Manager National Opt-out Model Programme
Paper approved by: (Sponsor Director) (	Martin Severs, Medical Director and Caldicott Guardian
Purpose of the paper:	To provides an assurance update for the Board on progress in implementing type 2 opt-outs and the ICO Undertaking.
Justification for inclusion in public board:	This assurance paper is provided for transparency reasons as it relates to public commitments set out in a Direction from the Secretary of State and ICO Undertaking.
Additional Documents and or Supporting Information:	Direction to the Health and Social Care Information centre to process Type to Objections ICO Undertaking
Please specify the key risks and issues:	Overall progress is good but there remain some risks most notably related to the implementation of type 2 opt outs in Data Services for Commissioners Regional Offices by 14 October 2016. The SRO and Programme Board are monitoring these closely and contingencies are in place.
Patient/public interest:	Direct – the system being implemented upholds the patient's right to object to their information being shared for purposes beyond their direct care as set out in the NHS constitution and in line with legal frameworks.
Supplementary papers:	None
Actions required by the Board:	The Board are asked to note the progress update.

NHS Digital

Implementation of type 2 option-outs and ICO Undertaking

Progress update

7 September 2016

Information and technology
for better health and care

Contents

Executive Summary

From 29 April 2016 NHS Digital commenced the implementation of type 2 patient opt-outs across data disseminations in line with the policy set-out in the Direction from the Secretary of State (SoS). Related to this NHS Digital also signed an Undertaking with the Information Commissioner's Office (ICO) which set-out remedial actions around patient opt-outs which must be completed by 19 October 2016. This paper provides the Board with a brief update on progress in both these areas. Overall the Board can be assured that work is progressing well but there remain a few risks which are highlighted.

Background

- Since late 2013 patients have been able to register an opt-out to NHS Digital sharing their patient confidential data for purposes beyond their direct care, referred to as a type 2 opt-out. An initial Direction was issued, as discussed at the Board in September 2015, to provide the legal basis for NHS Digital to collect the patient opt-out data from GP's. A second Direction was issued in April 2016 to enable implementation of type 2 opt-outs which set out when opt-outs should and should not be applied. Opt-outs have been upheld since 29 April 2016 but the Direction gave an additional 6 months for implementation in a number of areas most notable across disseminations via Data Services for Commissioners Regional Offices (DSCROs).
-
- The time lag in implementing opt-outs has been investigated by the ICO who issued a formal Undertaking on 19 April 2016 setting out the actions they wanted to see progressed to ensure that the patients' rights to opt-out of the sharing of their information were upheld.

Recommendation

The activity to implement the Direction and ICO undertaking has been broken down into the following workstreams:

Technical Implementation

The programme has developed a Patient Objections System (POS) that teams within NHS Digital can access to "clean" data files prior to dissemination – this system completely removes the records of patients who have opted out. This system was developed and tested in-house and has, to date, performed well – as at 19 August 2016 the metrics for the system are as follows:

- Approx. 1100 files processed
- >2.6 billion records processed
- 61.7 million records removed as a result of type 2 opt out

GP Practice Participation

The POS is reliant on an up-to-date list of patients who have registered a type 2 opt-out which is collected from GP systems. Most of the data come through a monthly GPES collection with a manual system in place for those without access to GPES. Significant effort has been focused on improving the proportion of practices participating in the collection as without this NHS Digital is unable to respect patients' preferences. This has steadily

improved since the first collection in December 2015. A summary of the position as at 16 August is as follows:

- 51 practices (out of total 7454) are left to submit data and of these:
  - 9 have recently agreed to participate[1] and are expected to be included in the Sept extract.
  - Only 1 practice remains as a decliner - this compares to 27 in December 15.
  - 32 are still to participate (4 of these are previous decliners). These practices are being contacted again individually. This compares to 730 in December 15.
  - 9 non-GPES practices (out of a total of 21) – these practices are being contacted again individually.
- MoD is now configured and we are awaiting data submission.
- Health and Justice Service has been approached to re-engage with offender health organisations following an uplift of the Data Provision Notice on 27 May 2016 mandating them to provide data.
- Risk assessment work with offender health and MoD has indicated that the numbers of opt-outs are small but we continue to actively work to collect these data.
- There are a number of practices with high opt-out rates and we have had some discussions with these practices. It has been agreed that the safest option is to continue to uphold opt-outs unless and until these practices as data controllers are able to provide an updated list.

Overall this is the most complete GPES collection ever and includes data from over 99% of practices. The next step is to brief the ICO on actions undertaken and seek their view as to whether any further action needed.

DSCRO Implementation

For technical reasons data flows via DSCROs were given an additional 6 months to implement type 2 opt outs ie until 14 October 2016. The work is progressing well and a summary of the position as at 23 August is as follows:

- **Technical implementation** – there are 3 solutions being progressed:
  - Access to central POS – enabling DSCROs to access NHS Digital POS solution. At the current time all 10 DSCROs can access the system, 6 out of 10 have successfully tested this and the remaining 4 are on track to complete testing shortly. NB this solution is slow and does not meet DSCRO business needs but is being progressed as a back-up solution.
  - Local POS – a local version of the central POS is being developed and implemented within each DRSCO. IT development work is well underway and testing plans have been drafted. Testing is on schedule to be completed in early September in order to ensure assurance is received and to allow time for any remedial action to address any problems.
  - Bespoke Local POS – DSCROs are also developing their own bespoke local solutions that will enable different file types to be cleaned (eg excel spreadsheets) which the local and central POS cannot process. NHS Digital

[1] GPES collections require GP practices to actively “accept” the offer on the system to confirm their participation. Alternatively they can actively “reject” to decline to participate. Any that have neither accepted nor rejected are recorded as “still to participate”.

is supporting this by providing test data and will be assuring the output of each system.

- **DSCRO Data Sharing Framework Contract/Data Sharing Agreements (DSFC/DSA)** – ensuring the legal basis is place for DSCRO to disseminate data through review and re-issue of all DSFC and DSAs. As at 23 August:
  - All 209 CCG DSFCs are finalised and in place.
  - 16 combined class-action applications have been approved by DAAG to date, covering 95 CCGs out of 209 CCGs.
  - External IG Team are on target to review all CCGs' IG Toolkits.
  - An issue has been identified with CCG fair processing notices and further discussions are underway with IG and DAAG to resolve this and enable the processing of applications to remain on track.
- **Development of supporting policy and guidance** – this suite of documents sets out guidance on compliance with the ICO Code of Practice for anonymised data and the principles and process for re-identification where this is justified eg in support of direct care. These documents have been drafted and are in the process of being reviewed and signed off.

ICO Undertaking Patient Communications

All patient communication activity is completed this includes:

- New content was made live on NHS Choices on 22 June 2016
- At the same time, following advice from the Joint GP IT Committee, letters were sent to all GPs practices explaining the ICO position and providing core messages and suggesting these can be used on their Practice website and in any locally produced materials
- Healthwatch, Patient's Association and Patient Voice all circulated our patient message via their networks.

ICO undertaking Data Customer Communications

The Undertaking required us to contact all customers who received data between January 2014 – April 2016 which should have had type 2 opt-outs removed to inform them that they may have received data including records for patients who had chosen to opt out, asking them to destroy any un-used data and offering to resupply where necessary. In summary:

- We assessed all data releases over this period and wrote to 123 Medical Research Information Service (MRIS) studies and 28 non-MRIS customers.
- As at 23 August 2016 well over half have responded and arrangements are in hand to chase up the 47 MRIS studies and 9 non MRIS customers that have yet to respond.
- Three customer webinar sessions have been held with 28 attending. No material issues arose with only clarification of points of detail required.
- Following the initial mail out over 190 enquiries have been received, of which 28 have required detailed responses. Five enquiries remain to be responded to as of 23 August.
- So far 5 resupply of data requests have been received, 4 MRIS studies & 1 HES data, discussions in hand with DARS/MRIS teams to assess and fulfil.

- Sub licencing agreements – 4 agreements were assessed as enabling onward transmission of data with three requiring an additional letter. These are being followed up with the organisations individually.

Policy Issues

A range of policy issues have been resolved during the implementation phase but the final outstanding area is PHE. The MoU as currently drafted does not enable the type 2 policy position to be clearly identified and upheld and it does not satisfy all 12 of the controls needed to ensure ICO Code of Practice compliance for any anonymised flows. At the current time we are only disseminating data where there is an exemption provided within the Direction and discussions are on-going to PHE to resolve and recommence data flows as soon as we can.

Implications

Strategy Implications

This work enables NHS Digital to uphold the patient's right to object to their information being shared for purposes beyond their direct care as set out in the NHS constitution and in line with legal frameworks. The implementation of the opt-outs supports the priority in the NHS Digital strategy to ensure that every citizen's data is protected. Ensuring NHS Digital acts in accordance with patient wishes helps to build public trust in the organisation which will encourage the majority of the public to have the confidence to allow their data to be collected and used. The current type 2 policy was developed in line with the National Data Guardian review of consent/opt-out and is, as far as possible, aligned to the model that has been proposed.

Financial Implications

The Patient Objections Management Project, as part of the HSCIC Preferences for Data Sharing Programme, is established on the portfolio. A resource budget for the project team has been established through to October 2016 and funding is through GIA. There are likely to be some on-going budget impacts as we transition into business as usual operation. These are currently being assessed.

Stakeholder Implications

There are a number of wider stakeholders with an interest in this including NHS England, Public Health England, Care Quality Commission, Office for National Statistics, other Arm's Length Bodies and customers of HSCIC data disseminations such as the research community. NHS Digital has continued to actively work with these stakeholders to discuss and resolve issues as appropriate throughout the implementation phase.

Handling

A handling plan was developed for go-live in April and there was a low level of media interest with some further coverage following the launch of the National Data Guardian report in July. Plans were put in place to ensure additional capacity for patient enquires following go live but numbers have been minimal.

Risks and Issues

There are a small number of outstanding risks associated with the delivery of this piece of work:

- Progress with PHE remains slow and there is a range of information that remains outstanding. However at the current time a number of flows are suspended pending further information being received from PHE.
- DSCROs whilst progress is broadly on track there is a significant amount of work to do in a short period of time and there is little room for anything to go wrong. There are some capacity issues in supporting the assessment of fair processing notices for CCGs as well as potential issue with the programme of applications going through DAAG. The Programme Board continues to monitor progress closely.
- MedConfidential have made a complaint to the ICO around on-going disseminations of HES data which are released without opt-outs being upheld when we have assessed them as in compliance with the ICO Code of Practice (CoP) on anonymisation. We have offered out full support to the ICO in support of their investigation. The principle of being able to continue to flow complete data when it is anonymised in compliance with the ICO CoP is also fundamental to the implementation of the new model proposed by the national data guardian.

Corporate Governance and Compliance

There are no specific internal corporate governance implications, however, the signing of a formal Undertaking with the ICO commits the HSCIC to compliance within a six month window. Any breach of a signed Undertaking would bring a greater likelihood of further action with potential for a financial penalty as well as damage to our reputation.

Management Responsibility

The responsible Executive Director is Martin Severs, Medical Director and Caldicott Guardian. The Programme Head is Tim Magor.

Actions Required of the Board

The Board is asked to note update provided.

Board Meeting – Public Session

Title of paper:	Forthcoming Statistical Publications
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 07 b (P1)
Paper presented by:	N/A - For information
Paper prepared by:	Chris Roebuck, Director of Publications and Head of Profession for Statistics
Paper approved by: (Sponsor Director)	Martin Severs, Clinical Director and Caldicott Guardian
Purpose of the paper:	This paper describes HSCIC Official (and National) Statistics publications published in August 2016 and planned for September – October 2016, and media and web coverage for publications released between May and July 2016.
Justification for inclusion in public board:	Official and National Statistics are in the public interest; recording plans and analytics regarding these in the public arena adheres to the Government's transparency agenda.
Additional Documents and or Supporting Information:	List additional documents for reference or for supporting information, including where they can be accessed.
Please specify the key risks and issues:	N/A
Patient/public interest:	Overview of HSCIC Statistical Publications
Supplementary papers	N/A
Actions required by the Board:	For information

NHS Digital Statistical Publications

7 September 2016

Information and technology
for better health and care

Contents

Executive Summary

This paper describes:

- NHS Digital Official (and National) Statistics publications released during August 2016 and planned for September – October 2016;
- Media coverage for press released Official Statistics publications during May – July 2016;
- Web activity for publications released during May – July 2016.

Background to NHS Digital Official Statistics

- As at 22 August 2016, NHS Digital is responsible for 93 active (currently published or planned for future release) series of Official Statistics of which 29 are designated as National Statistics, which means that the UK Statistics Authority (UKSA) recognises them as being compliant with the Code of Practice for Official Statistics.
- During the 2015/16 financial year (01/04/15 to 31/03/16), NHS Digital published 294 statistical reports.
- Official Statistics are expected to evolve and improve over time, to meet the changing needs of our users, to improve their quality and utility and to respond to changes in their administrative and management data sources.
- "Experimental statistics" are new Official Statistics that are undergoing evaluation. A key part of this evaluation is user engagement whereby NHS Digital invites readers to comment on the publications, which helps to inform future releases.
- Most NHS Digital Official Statistics are published annually or more frequently. Generally, each edition is similar in content to previous versions but any substantial changes are noted below (note: no such changes are yet planned).
- National Statistics are identified below with [NS].

Consultation on NHS Digital statistics

- In order to modernise our suite of statistical publications in line with user needs and to realise budgetary savings NHS Digital has committed to over the next few years, we have launched a consultation on changes to them:
- http://digital.nhs.uk/article/7041/Consultation-on-changes-to-HSCIC-Statistics-201617---201819-Now-Closed
- It is a public consultation lasting 12 weeks, and covers NHS Digital statistical publications over the next three years so any subsequent changes are expected to be implemented between 2016/17 and 2018/19. An initial survey of our findings is due to be published in September.

Forthcoming and recently released publications

Official and National statistics

- Dates for forthcoming publications are confirmed approximately six to eight weeks ahead of publication; until this point, NHS Digital announces only the planned month of publication. Publications are announced on our release calendar: http://digital.nhs.uk/pubs/calendar
- This paper includes a list of recently released publications for August 2016, for consistency with the previous Board paper. Media and web statistics for August 2016 will be published in the Statistical Publications paper for the next NHS Digital Board meeting.

August 2016

New releases – None published in August.

Biennial – None published in August.

Annual

03 August 2016	Prescribing for diabetes in England - 2005/06 to 2015/16
04 August 2016	Guardianship under the Mental Health Act, 1983 - 2015/16 [NS]
10 August 2016	Patient-Led Assessments of the Care Environment (PLACE) - 2016 – England
11 August 2016	Finalised Patient Reported Outcome Measures (PROMs) in England - April 2014 to March 2015

Biannual – None published in August.

Quarterly

11 August 2016	Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England - April 2015 to March 2016
18 August 2016	NHS Outcomes Framework indicators - August 2016 release [NS]
18 August 2016	Statistics on NHS Stop Smoking Services in England - April 2015 to March 2016

Monthly

03 August 2016	Maternity Services Monthly Statistics - March 2016, Experimental statistics
04 August 2016	HES-DID Data Linkage Report - Provisional Summary Statistics, April 2015 to March 2016 (Experimental Statistics)
10 August 2016	NHS Safety Thermometer Report - England July 2015 - July 2016
12 August 2016	Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - July 2016

17 August 2016	Care Information Choices, England - August, 2016
17 August 2016	Provisional Accident and Emergency Quality Indicators for England - May 2016, by provider
17 August 2016	Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - June 2016
19 August 2016	Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), July 2016, Experimental Statistics
23 August 2016	Improving Access to Psychological Therapies Report - May 2016 Final, June 2016 Primary and most recent quarterly data (Quarter 4 2015-16)
23 August 2016	Mental Health Services Monthly Statistics - Final May, Provisional June 2016
24 August 2016	NHS Sickness Absence Rates - April 2016, Provisional Statistics
24 August 2016	NHS Workforce Statistics - May 2016, Provisional Statistics

Other

12 August 2016	GP Contract Services - GP Practices in England, 2014/15
25 August 2016	NHS Vacancy Statistics England - 2015-2016, Provisional Experimental Statistics

September 2016

New releases

29 September 2016	Children and Young People's Health Services Monthly Statistics - September 2015, Experimental

Septennial

29 September 2016	Adult Psychiatric Morbidity Survey - Survey of Mental Health and Wellbeing, England, 2014 [NS]

Biennial

14 September 2016	Dental Working Hours - 2014/15 and 2015/16 Initial Analysis

Annual

14 September 2016	Dental Earnings and Expenses - 2014-15 Initial Analysis
14 September 2016	GP Earnings and Expenses - 2014-15
15 September 2016	Personal Social Services Adult Social Care Survey, England - 2015-16
15 September 2016	Data on written complaints in the NHS - 2015-16 [NS]
21 September 2016	Investment in General Practice - 2011-12 to 2015-16, England, Wales, Northern Ireland and Scotland

21 September 2016 NHS Payments to General Practice - England, 2015/16

22 September 2016 NHS Immunisation Statistics, England - 2015-16 [NS]

23 September 2016 NHS Dental Statistics for England - 2015-16, Annual Report

27 September 2016 General and Personal Medical Services, England - As at 31 March 2016, Provisional Experimental statistics

28 September 2016 Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) - 2015-16

Biannual

27 September 2016 Healthcare Workforce Statistics - March 2016, Experimental

Quarterly

06 September 2016 CCG Prescribing Data - April to June 2016

08 September 2016 Statistics on Women's Smoking Status at Time of Delivery: England - Quarter 1, April 2016 to June 2016

15 September 2016 Data on written complaints in the NHS - 2016/17 Quarter 1, Experimental [NS]

16 September 2016 NHS Continuing Healthcare Activity - England, Quarter 1, 2016-17

22 September 2016 CCG Outcomes Indicator Set - September 2016 release

22 September 2016 Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, April 2015 - March 2016 [NS]

27 September 2016 NHS Staff Earnings Estimates - to June 2016, Provisional statistics

Monthly

06 September 2016 Female Genital Mutilation - April-June 2016, Experimental Statistics, Enhanced Dataset

07 September 2016 HES-DID Data Linkage Report - Provisional Summary Statistics, April 2016 (Experimental Statistics)

07 September 2016 Maternity Services Monthly Statistics - April 2016, Experimental statistics

08 September 2016 Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2015 to March 2016 - September 2016 Release

08 September 2016 Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2016

09 September 2016 Care Information Choices, England - September, 2016

09 September 2016 NHS Safety Thermometer Report - England August 2015 - August 2016

16 September 2016 Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - August 2016

20 September 2016 Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), August 2016, Experimental Statistics

20 September 2016 Mental Health Services Monthly Statistics - Final June, Provisional July 2016

20 September 2016 Provisional Accident and Emergency Quality Indicators for England - June 2016, by provider

20 September 2016 Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - July 2016

21 September 2016 Improving Access to Psychological Therapies Report - June 2016 Final, July 2016 Primary and most recent quarterly data (Quarter 4 2015-16)

27 September 2016 NHS Sickness Absence Rates - May 2016, Provisional Statistics

27 September 2016 NHS Workforce Statistics - June 2016, Provisional Statistics

Other - None planned for September.

October 2016

New releases - None planned for October.

Biennial

19 October 2016 Dental Working Hours - 2014/15 and 2015/16 Additional Analysis

Annual

05 October 2016 Community Care Statistics: Social Services Activity, England - 2015-16 Report [NS]

05 October 2016 Measures from the Adult Social Care Outcomes Framework, England - 2015-16

05 October 2016 Safeguarding Adults - 2015-16, Experimental statistics

11 October 2016 Estates Returns Information Collection - England 2015 - 16

18 October 2016 Psychological Therapies, Annual report on the use of IAPT services - 2015/16

19 October 2016 Dental Earnings and Expenses - 2014-15 Additional Analysis

19 October 2016 Sexual and Reproductive Health Services, England - 2015/16 [NS]

26 October 2016 Personal Social Services: Expenditure and Unit Costs, England - 2015/16 [NS]

27 October 2016	Quality and Outcomes Framework, Achievement, prevalence and exceptions data - 2015-16

Biannual - None planned for October.

Quarterly

18 October 2016	Numbers of Patients Registered at a GP Practice - October 2016
27 October 2016	Statistics on NHS Stop Smoking Services in England - April 2016 to June 2016

Monthly

06 October 2016	HES-DID Data Linkage Report - Provisional Summary Statistics, April to May 2016 (Experimental Statistics)
06 October 2016	Maternity Services Monthly Statistics - May 2016, Experimental statistics
11 October 2016	Care Information Choices, England - October, 2016
12 October 2016	NHS Safety Thermometer Report - England September 2015 - September 2016
13 October 2016	Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2015 to March 2016 - October 2016 Release
13 October 2016	Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2016 to May 2016
14 October 2016	Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - September 2016
20 October 2016	Mental Health Services Monthly Statistics - Final July, Provisional August 2016
20 October 2016	Provisional Accident and Emergency Quality Indicators for England - July 2016, by provider
20 October 2016	Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - August 2016
25 October 2016	Improving Access to Psychological Therapies Report - July 2016 Final, August 2016 Primary and Quarter 1 2016-17
25 October 2016	NHS Sickness Absence Rates - April 2016 to June 2016
25 October 2016	NHS Workforce Statistics - July 2016, Provisional Statistics
26 October 2016	Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), September 2016, Experimental Statistics

Other

12 October 2016	NICE Technology Appraisals in the NHS in England (Innovation Scorecard) - to March 2016

14 October 2016	GP Contract Services - GP practices in England, 2015/16
26 October 2016	Seven-day Services - England, April 2015 - March 2016, Experimental statistics

Clinical Audits

Clinical Audits are not currently classed as Official Statistics. The Code of Practice for Official Statistics is followed as best practice during the production cycle but the release practises differ.

August 2016

26 August 2016	National Bowel Cancer Audit - Organisational Survey

September 2016

08 September 2016	National Oesophago-Gastric Cancer Audit - The National Oesophago-Gastric 2016 Annual Report

October 2016

21 October 2016	National Pregnancy in Diabetes Audit - National Pregnancy in Diabetes Audit 2015

User and Media activity

The following tables show web and media coverage figures for Official (and National) Statistics released by NHS Digital between May and July 2016. Clinical Audits are not included.

Unique page views are the number of times the publication page was viewed during the two-week period following its release. Note that one user could generate more than one unique visit.

Media Units are the total articles or other media coverage for example print, online articles or broadcasts for the publication (each is counted separately i.e. an article appearing in both a newspaper's print and online instances will count as two citations) . The totals in the table include all media units for the month of publication up to the date of writing this paper (see header).

Bars in the tables below indicate the scale of interest generated by each publication.

May 2016

Publication	Date	Unique page views	Media units
Maternity Services Monthly Statistics - December 2015, Experimental statistics	04 May 2016	334	
Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - 2015/16	04 May 2016	374	
HES-DID Data Linkage Report - Provisional Summary Statistics, April to December 2015 (Experimental Statistics)	05 May 2016	45	
Learning Disability Services Quarterly Statistics - Commissioner Census (Assuring Transformation), Q4 2015/16, Experimental Statistics	06 May 2016	155	
NHS Safety Thermometer Report - England April 2015 - April 2016	11 May 2016	242	
Patient Reported Outcome Measures (PROMs) in England - Special Topic - Rates of Attrition 2013-14	12 May 2016	101	
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2014 to March 2015 - May 2016 release	12 May 2016	415	
Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England - April 2015 to December 2015	12 May 2016	838	

May 2016 – continued

		Unique page views	Media units
Care Information Choices, England - May 2016	17 May 2016	464	6
NICE Technology Appraisals in the NHS in England (Innovation Scorecard) - to September 2015	17 May 2016	537	
NHS Outcomes Framework indicators - May 2016 release [NS]	19 May 2016	226	
Learning Disability Services Monthly Statistics - Commissioner census (Assuring Transformation), April 2016, Experimental Statistics	20 May 2016	181	
Mental Health Services Monthly Statistics - February Final, March Provisional 2016	24 May 2016	429	
Improving Access to Psychological Therapies Report - February Final, March Primary 2016 and most recent quarterly data (Quarter 3 2015/16)	24 May 2016	456	
NHS Sickness Absence Rates - January 2016, Provisional Statistics	25 May 2016	111	
NHS Workforce Statistics - February 2016, Provisional statistics	25 May 2016	96	
Provisional Accident and Emergency Quality Indicators for England - February 2016, by provider	26 May 2016	78	
Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2015 - March 2016 (M12)	26 May 2016	68	
Statistics on Smoking, England - 2016 [NS]	27 May 2016	921	27
Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - April 2016	27 May 2016	368	

June 2016

Publication	Date	Unique page views	Media units
Learning Disability Statistics - Annual Overview - England 2015-2016	02 June 2016	493	9
CCG Prescribing Data - January to March 2016	02 June 2016	220	
Maternity Services Monthly Statistics - January 2016, Experimental statistics	03 June 2016	320	
Female Genital Mutilation - January-March 2016, Experimental Statistics, Enhanced Dataset	07 June 2016	399	
HES-DID Data Linkage Report - Provisional Summary Statistics, April 2015 to January 2016 (Experimental Statistics)	08 June 2016	59	
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2015 to January 2016	09 June 2016	360	
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2014 to March 2015 - June 2016 release	09 June 2016	97	
NHS Dental Statistics for England - 2015-16, Third quarterly report	09 June 2016	89	
Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - May 2016	10 June 2016	237	
NHS Safety Thermometer Report - England May 2015 - May 2016	10 June 2016	185	
NHS Surplus Land - 2015/16 England	15 June 2016	195	
Statistics on Women's Smoking Status at Time of Delivery: England - April 2015 to March 2016	16 June 2016	500	42
NHS Continuing Healthcare Activity - England, Quarter 4, 2015-16	16 June 2016	180	
Care Information Choices, England - June, 2016	17 June 2016	187	

June 2016 – continued

		Unique page views	Media units
Mental Health Services Monthly Statistics - Final March 2016	21 June 2016	559	
Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), May 2016, Experimental Statistics	21 June 2016	148	
Improving Access to Psychological Therapies Report - March Final, April Primary 2016 and most recent quarterly data (Quarter 3 2015/16)	21 June 2016	727	
NHS Workforce Statistics - March 2016, Provisional statistics	22 June 2016	112	
NHS Sickness Absence Rates - February 2016, Provisional Statistics	22 June 2016	180	
Hospital Episode Statistics: Deaths within 30 days of a hospital procedure or of an emergency admission to hospital - Financial year 2014/15	23 June 2016	148	
CCG Outcomes Indicator Set - June 2016 release	23 June 2016	683	
Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, January 2015 - December 2015 [NS]	23 June 2016	166	
Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2015 - March 2016 (M13)	23 June 2016	92	
Provisional Accident and Emergency Quality Indicators for England - March 2016, by provider	30 June 2016	156	
Statistics on Alcohol, England - 2016 [NS]	30 June 2016	1203	54
NHS Staff Earnings Estimates - to March 2016, Provisional statistics	30 June 2016	81	

July 2016

Please note that analytics for July releases were not collected between 1-15 August due to the domain name of the website: this affected web statistics from 18 July onwards, with increasing impact towards the end of the month.

Publication	Date	Unique page views	Media units
Prescriptions Dispensed in the Community, England - 2005-2015 [NS]	05 July 2016	517	37
Maternity Services Monthly Statistics - February 2016, Experimental statistics	06 July 2016	222	
NHS Safety Thermometer Report - England June 2015 - June 2016	06 July 2016	143	
Data on written complaints in the NHS - 2015/16 Quarter 4, Experimental [NS]	07 July 2016	267	
HES-DID Data Linkage Report - Provisional Summary Statistics, April 2015 to February 2016 (Experimental Statistics)	07 July 2016	64	
NICE Technology Appraisals in the NHS in England (Innovation Scorecard) - to December 2015	12 July 2016	263	
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2014 to March 2015 - July 2016 release	14 July 2016	63	
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2015 to February 2016	14 July 2016	265	
Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016	15 July 2016	55	
Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - June 2016	15 July 2016	253	
General Ophthalmic Services activity statistics - England, April 2015 - March 2016 [NS]	19 July 2016	89	
Numbers of Patients Registered at a GP Practice - July 2016	19 July 2016	486	

July 2016

		Unique page views	Media units
Care Information Choices, England - July, 2016	20 July 2016	112	
Female Genital Mutilation - April 2015-March 2016, Experimental Statistics, Enhanced Dataset	21 July 2016	1071	51
Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), June 2016, Experimental Statistics	21 July 2016	223	
Mental Health Services Monthly Statistics - Final April, Provisional May 2016	21 July 2016	278	
Improving Access to Psychological Therapies Report - April 2016 Final, May 2016 Primary and Quarter 4 2015/16	26 July 2016	454	
NHS Sickness Absence Rates - January 2016 to March 2016 and Annual Summary 2010-11 to 2015-16	26 July 2016	145	
NHS Workforce Statistics - April 2016, Provisional statistics	26 July 2016	115	
Provisional Accident and Emergency Quality Indicators for England - April 2016, by provider	27 July 2016	74	
Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - May 2016	27 July 2016	71	
General Practice Expenses, GMS and PMS Contracts in England - 2013-14	28 July 2016	90	
Statistics on Drug Misuse, England - 2016 [NS]	28 July 2016	605	71

Actions required of the Board

None – for information only.

Management Responsibility

Identify the executive director who will have accountability for the proposal as well as the senior manager who will have overall responsibility and will deal with the matter on a day to day basis.

Actions Required of the Committee

Insert the exact wording of the proposed resolution or recommendation that the Committee is being asked to consider. Specify succinctly what is being asked of the Committee, this must be clear, concise and unambiguous. This information may be presented using a bullet point list.

Board Meeting – Public Session

Title of paper:	**Programme Definitions**
Board meeting date:	07 September 2016
Agenda item no:	NHSD 16 03 07 c (P1)
Paper presented by:	Carl Vincent, Director of Finance and Corporate Services
Paper prepared by:	John Willshere, Portfolio Director
Paper approved by: (Sponsor Director)	Carl Vincent, Director of Finance and Corporate Services
Purpose of the paper:	To provide the Board with a summary of each programme listed on the programme dashboards.
Justification for inclusion in public board:	Provides the Board with a summary of each programme listed on the programme dashboards contained within HSCIC Board Performance Pack (public).
Additional Documents and or Supporting Information:	N/A
Please specify the key risks and issues:	The programme dashboards monitor the performance of each programme. This document gives a brief overview of what each programme was set up to do.
Patient/public interest:	The public interest is in ensuring NHS Digital manages its programmes in an effective way. This document gives patients and members of the public a useful overview of each programme on the dashboard.
Supplementary papers:	N/A
Actions required by the Board:	**For information only**

Portfolio Code	Portfolio item name	Portfolio Item Desc
P0050/00	Spine 2	The provision of the existing Spine Services to be re-procured using the new Government ICT strategy framework, using internal and 3rd party resources.
P0238/00	NHS e-Referral Service Programme (eRS)	The NHS e-Referral Service Programme will deliver an open, modern, electronic referral service, improving patient outcomes and delivering paperless referrals.
P0335/00	SUS Transition	Responsible for the delivery of interim tactical solutions to ensure business continuity from the end of the BT SUS contract. This will include system data and user transition.
P0208/00	GP systems of Choice Replacement (GPSoC)	To provide a contractual vehicle for the supply and development of GP clinical IT systems for all Practices in England, following expiry of the extended GPSoC call off agreements in March 2014.
P0325/00	Cyber Security Programme (CSP)	An Interim Cyber Security Review (ICSR) has established the readiness and capability of the HSCIC to proactively manage and respond to Cyber Security threats as part of a wider Information Assurance programme. A significant number of high impacting risks need to be addressed as a matter of urgency. This programme will address these risks.
P0190/00	Health & Social Care Network (HSCN)	Develop and deliver options appraisals with supporting impact assessments, leading to an appropriate business case for the procurement of a wide area network to meet the information needs of health, public health and social care through utilising in full or in part the Public Sector Network (PSN) framework, models and approaches. The HSCN project will deliver a Public Services Network for Health, which will be aligned and accredited to PSN standards.
P0196/00	NHSmail 2	The NHSmail 2 Project is to replace the existing NHSmail service. The project is tasked with procuring a new service and transitioning the users and services onto this service from the current Vodafone platform.
P0031/00	CSC LSP Delivery Programme	LSP Delivery Programme: Increased patient safety and quality of healthcare and also greater clinical effectiveness and administration efficiency.
P0026/00	NHS Choices	NHS Choices (www.nhs.uk) acts as the digital gateway and public front door to the NHS, transforming the delivery of health and social care to one that is patient-centred, personalised and accessible to all.
P0306/00	care.data	The care.data programme is an initiative that will ensure that there is more rounded information available to citizens, patients, clinicians, researchers and the people that plan health and care services. Our aim is to ensure that the best possible evidence is available to improve the quality of care for all.
P0004/00	Child Protection - Information Sharing (CP-IS)	The Child Protection - Information Sharing project will provide child protection information to unscheduled (emergency and urgent care) services in the NHS on the statutory position of children subject to a Child Protection Plan or Looked After Children on a Statutory Order. It is intended that the information will be fed from Children's Social Care systems and a solution will be developed that will enable unscheduled care setting systems within the NHS to view this information.
P0012/00	Electronic Transmission of Prescriptions (ETP)	The Electronic Transmission of Prescriptions (ETP) programme is delivering the Electronic Prescription Service (EPS) to GP practices, community pharmacies and dispensing appliance contractors across England. EPS enables prescribers (such as a GP or practice nurse) to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice, and then onward transmission to the NHS Prescription Services to support reimbursement. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. EPS is being delivered in two phases: • EPS Release 1 introduced the technical infrastructure to enable prescribers and dispensers to operate the EPS. EPS Release 1 was completed in 2008. • EPS Release 2 delivers enhanced functionality (such as electronic signatures and patient nomination of a preferred pharmacy) for users to gain tangible benefit from EPS. EPS Release 2 is currently being rolled out.
P0341/00	Social Care Informatics Project (SCIP)	The purpose of this project is to determine the feasibility, identify and prioritise candidate opportunities and develop an outline roadmap for the development of standards in Adult Social Care (ASC) for the increased collection and sharing of client level data.
P0453/00	National Data Service Development (NDSD)	HSCIC is working in collaboration with NHS England on a number of data related programmes. The National Data Service Development programme brings together the current Data Services for Commissioners (DSfC) and National Tariff System (NTS) Programmes and will include the development of the Data Services Platform (DSP).
P0181/00	South Acute Programme (SAcP)	18 NHS organisations are participating in the South Acute Programme working as six collaborative groups. Trusts within each collaborative are procuring common Commercial off the Shelf (COTS) clinical systems. These clinical systems are being selected to meet each groups local requirements and include full integrated Electronic Health Records, Clinical Portal, Electronic Document Management (EDM) and ePrescribing solutions.
P0182/00	South Ambulance Programme (SAmP)	To procure clinical solutions for the Southern Ambulance Trusts who do not currently have these solutions under the BT LSP solution.
P0183/00	South Community and Child Health Programme (SCP)	To procure clinical solutions for the Southern Community and Child Health Trusts who do not currently have these solutions under the BT LSP solution.
P0033/00	Picture Archiving and Communications (PACS) Exit Programme	Development and deployment of the PACS (Picture Archiving And Communication System). Overarching programme to manage the PACS sub-programmes.
P0207/00	Health & Justice Information Services (HJIS)	Health and Justice Information Services (HJIS) focuses on the future information services required to support the statutory responsibilities of NHS England (Health & Justice) in the direct provision and commissioning of healthcare for all places of detention, and Sexual Assault Referral Centres, in England.
P0037/00	Health and Justice Current Service (HJIS Current Service)	To deploy a clinical system to all prisons in the South and London so that they can link up with existing deployment plans in NME to form a national network. The system chosen TPP SystmOne, provides a single patient record which is allowing patients information to be transferred when they are moved around the prison estate. Thus providing continuity of care and improving health care for prisoners as well as working environment for staff.
P0301/00	Female Genital Mutilation Prevention (FGMP)	A work package to produce a feasibility study on information collection and sharing by the NHS on Female Genital Mutilation (FGM). To deliver an assessment of the feasibility of achieving the following objectives: - How can the NHS support the multi-agency objective of protecting and caring for those currently affected by, or at imminent risk of, FGM; - How can the NHS support the long term health education and health promotion components of a multi-agency strategy on the eradication of FGM
P0055/00	Maternity and Childrens Datasets (MCDS)	To collect and report on data for maternity, child health and adolescent mental health services.

The 'Project and Programmes Definitions' list will be refreshed and fully updated as P2020 initiation progresses and mapping of existing to new (P2020) portfolio items is confirmed