NHS Digital
Agenda: Part 1 (Public Session)
30 November 2016 – 10:30 to 12:45
Venue: NHS Digital, Hill Diggory, and Bevan rooms, Trevelyan Square, Leeds, LS1 6AE

Ref No	Agenda Item	Time	Presented By
NHSD 16 04 01	***Chair's Introduction and Apologies* (oral)**	10:30	Chair
NHSD 16 04 02	***Declaration of Interests and Minutes*** (a) Register of Interests (paper) – **for information** (b) Minutes of Board Meeting on 07 September 2016 (paper) – **to ratify** (c) Matters Arising (oral) – **for comment** (d) Progress on Action Points (paper) – **for information**	10:35	Chair
NHSD 16 04 03	***Strategic Delivery and Operational Performance*** (a) Board Performance Pack (paper) – **for information**	10:40	CEO
	(b) Transformation Update Report (paper) – **for information**		Director of Workforce
NHSD 16 04 04	***Strategy and Capability*** (a) Paperless 2020: Clinical Governance and Clinical Safety (paper) - **for approval**	11:10	Medical Director and Caldicott Guardian
	(b) NHS Digital Data Strategy (paper) – **for approval**		Director of Information and Analytics
	(c) Business Analysis (Front Door) Proposals (paper) - **for approval**		Director of Digital Transformation
NHSD 16 04 05	***Governance and Assurance*** (a) The process for managing Data Requests, Data Releases and Associated Audits (paper) – **for information**	11:45	Medical Director and Caldicott Guardian
	(b) NHS Digital Clinical Appraisal and Revalidation Policy (paper) – **for approval**		Medical Director and Caldicott Guardian
	(c) Corporate Governance Manual 2017-18 (paper) – **for approval**		Director of Finance and Corporate Services
	(d) **Directions for Acceptance:** i. Directions: Community Services Data Set Pilot ii. Mandatory request from the National Institute for Health and Care Excellence for 'Quality Outcome Framework Pilot 11' data extraction iii. Direction from Department of Health for NHS Health Check for adults aged 40 – 74 years' data extraction iv. Direction from Department of Health for Emergency Care Data Set pilot		Director of Information and Analytics
	(e) **Committee Reports:** i. Assurance and Risk Committee (ARC) Report: 16 November 2016 (oral) ii. Information Assurance and Cyber Security Committee (IACSC): 16 November 2016 (oral) iii. Remuneration Committee: 05 October 2016 (oral)		Committee Chair Committee Chair Chair
	(f) Board Terms of Reference (paper) – **for approval**		Chair

	(g) Board Forward Business Schedule 2016-17 (paper) – **for information**		Chair
NHSD 16 04 06	***Any other Business*** (subject to prior agreement with Chair)	12:40	Chair
	Close	12:45	
NHSD 16 04 07	***Background Paper(s)*** (for information only) (a) Direction: Breast and Cosmetic Implant Register Update (paper) – **for information** (b) Forthcoming Statistical Publications (paper) – **for information** (c) Programme Definitions (paper) – **for reference**		

Date of next meeting: 01 February 2017 London (venue to be confirmed)

Board meeting – Public Session

Title of paper:	**NHS Digital Board Members Register of Interests**
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 02 a
Paper presented by:	Chair
Paper prepared by:	Annabelle McGuire Secretary to the Board and Head of Corporate Governance
Paper approved by: (Sponsor Director)	Each Director is accountable for their declaration of interest
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	• Non-Executive Director, NHS England • Non-Executive Director, PSR (Payments Services Regulator • Chairman of Board of Trustees, Uservoice.org **Other Offices:** • Member, Audit Committee, University of Warwick • Member, Development Board, Age UK **Shareholdings:** • Accenture **Other relevant interests:** • Senior Advisor, Aleron
Sir Ian Andrews: Non-Executive Director Senior Independent Director	• Partner in IMA Partners (formerly trading as IMA Partners Ltd until February 2016) providing legal and management consultancy services to government, academia (KCL[1]) and Transparency International UK. **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[2] **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 examiner **Shareholdings:**

[1] King's College London
[2] Royal Institution of Chartered Surveyors

Name	Declared Interest
	• 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
Ex Officio Board Members	
Professor Martin Severs:	• Trustee of Dunhill Medical Trust, a research charity • Professor of Health Care for Older People with University of Portsmouth

Name	Declared Interest
Medical Director and Caldicott Guardian	(Honorary) **Other Offices:** • Member of National Data Guardian's 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	• Department of Health**,** Director General for Community Care **Directorships:** • New North London Synagogue (as Tamara Isaacs) • The Jewish Community Secondary School (as Tamara Isaacs).
Keith McNeill: Chief Clinical Information Officer, NHS England	Chief Clinical Information Officer, Health and Social Care **Directorships:** • Carers Queensland **Other Offices:** • Non-Executive Director Eastern Academic Health Science Network **Contracts held in last two years:** • Chief Executive, Addenbrookes Hospital Cambridge
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	• None

NHS Digital

Minutes of Board Meetings

Wednesday 07 September 2016

Part 1 - Public Session

Present:	
Non-Executive Director (Chair)	Noel Gordon
Non-Executive Director (Vice-Chair)	Sir Nick Partridge
Non-Executive Director	Dr Sarah Blackburn
Non-Executive Director	Sir John Chisholm (until 11:30am)
Non-Executive Director	Prof. Maria Goddard
Chief Executive Officer	Andy Williams
Chief Operating Officer	Rob Shaw
Director of Finance and Corporate Services	Carl Vincent
In attendance:	
Medical Director and Caldicott Guardian	Prof. Martin Severs
Secretary to the Board	Annabelle McGuire

1. **Chair's Introduction and Apologies** NHSD 16 03 01 (P1)

1.1 The Chair convened a meeting of the NHSD Digital Board. The Chair noted this was the first meeting for Tamara Finkelstein Director General for Community Care (Department of Health (DH)), and Keith McNeill NHS Chief Clinical Information Officer and welcomed them as members of the Board.

1.2 The Chair confirmed that Tamara Finkelstein Director General for Community Care DH, Keith McNeill NHS Chief Clinical Information Officer (CCIO), Sir Ian Andrews Non-Executive Director, Rachael Allsop the Director of Workforce, and Beverley Bryant the Director of Digital Transformation had registered their apologies for the meeting. The Chair noted that Sir John Chisholm would leave the meeting at 11:30am. He confirmed the meeting was quorate.

2. **Declaration of Interests and Minutes** NHSD 16 03 02 (P1)

2.1 (a) Register of Interest (paper): NHSD 16 03 02 (a) (P1)

The Board agreed the register of interests was correct.

2.2 (b) Minutes of Board Meeting on 08 June 2016 (paper): NHSD 16 03 02 (b) (P1)

The Board ratified the minutes of the meeting on 08 June 2016.

2.3 (c) Matters Arising (oral): NHSD 16 03 02 (c) (P1)

There were no matters arising raised.

2.4 (d) Progress on Action Points (paper): NHSD 16 03 02 (d) (P1)

The Board noted the progress on action points resulting from the previous meetings.

3. **Strategic and Operational Delivery Performance** NHSD 16 03 03 (P1)

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

The Chief Executive Officer (CEO) presented this item. The purpose was to provide the Board with a summary of NHS Digital's performance in July 2016. The CEO noted that the data quality, reputation and workforce key performance indicators remain under development. Discussion on these metrics would take place at the October Board Development Day. The CEO reported by exception on the indicators, this included programme achievement.

In respect of the organisational health indicator, he provided an update on resource management. The Board discussed capability and capacity within the workforce, and the plan for recruiting noting that commercial resourcing was a shortage area.

The Director of Finance and Corporate Services reported on the financial indicators, noting the level of uncertainty with the Paperless 2020 programmes, which is inherent in a complex set of programmes that are in early stages of development. The Board received and noted the update.

3.2 (b) Paperless 2020 Update Report (paper): NHSD 16 03 03 (b) (P1)

The Chief Operating Officer (COO) presented this item. The purpose was to provide the Board with an update on the delivery progress of Paperless 2020 and the outcome of a series of deep dives held in July 2016.
He spoke about the appointment of the senior responsible owners (SRO) for the programmes and the variable programme status. He considered the focus was firmly on delivery and the delivery of successful outcomes. He noted that Keith McNeill was CCIO for the health and social care system and his appointment was a positive attribute. The COO provided an update on streamlining of the overall governance and strengthening of reporting mechanisms.

The Chair noted it was important that the Board received summaries from the Digital Delivery Board, and the establishing of the reporting lines was critical to successful delivery. There was a need to include consideration of programme risks in the assurance functions of the NHS Digital Assurance and Risk Committee.

Action: Chief Operating Officer

The Board noted that a final and agreed list of Paperless 2020 programme SROs and delivery leads would be presented at the November Board.

Action: Chief Operating Officer

The Chair summarised the discussion noting the Board's critical role in scrutinising, and holding the Executives to account for the delivery of the Paperless 2020 programmes. The Board received and noted the update.

3.3 (c) Corporate Business Plan 2016-17 (paper): NHSD 16 03 03 (c) (P1)

The Chair presented this item. The purpose was to ratify the decision taken at the 27 July Board Development Day and formally approve the refreshed NHS Digital Corporate Business Plan 2016-17. The Board ratified the Chair's Action.

4 **Strategy and Capability** NHSD 16 03 04 (P1)

4.1 (a) Clinical Governance and Safety (paper): NHSD 16 03 04 (a) (P1)

The Medical Director and Caldicott Guardian presented this item. The purpose was to provide the Board with an update on the way that the Clinical Services Executive Portfolio will ensure that NHS Digital's duty of care is assessed and improved, structures and processes are put in place to minimise risk, and clinical safety is reinvigorated as a core NHS Digital system leadership function.

He noted that a system was in place for resource prioritisation of clinicians to programmes. The Board welcomed the embedding of clinical expertise within the Paperless 2020 programmes. He stated that NHS Digital is not registered as a service provider, and this needed to be expressed explicitly to clarify NHS Digital's role.

The Board requested a paper to map the new clinical governance and safety arrangements to the Paperless 2020 programmes at the November Board.

Action: Medical Director of Caldicott Guardian

The Medical Director and Caldicott Guardian stated that he understood the NHS CCIO was supportive of the work. The Board noted and received the update, observing the work would assist in mitigating large programme risks.

5 **Governance and Assurance** NHSD 16 03 05

5.1 (a) Data Release Audit Status Report (paper):NHSD 16 03 05 (a) (P1)

The Medical Director and Caldicott Guardian presented this item. The purpose was to provide the Board with an options appraisal to support decision making in respect of our audit strategy. NHS Digital conducts audits of recipients of its confidential information to gain assurance that recipients are handling confidential information appropriately. Dr Sarah Blackburn noted that the Non-Executive Directors (Dr Sarah Blackburn and Prof. Maria Goddard) had supported the development of the proposal.

The Chair noted the importance for the Board to understand the data release audit outputs overall and asked the Executive to be more specific about who would take responsibility for this aspect and how it would be managed.

Action: Medical Director and Caldicott Guardian

The Board stated it supported the recommendation of the National Data Guardian's review in respect of potential penalties. The Board received and noted the update, noting the funding deficit stated in the paper was a technicality.

5.2 **(b) Directions for Acceptance:** NHSD 16 03 06 (b) (P1)

(i) Directions: Diabetes Prevention Programme (paper):
The Medical Director and Caldicott Guardian presented this item on behalf of the Director of Information and Analytics. The Board, being satisfied with the information and assurances provided, accepted the Direction.

(ii) Department of Health Directions: GP Metrics (paper):
The Medical Director and Caldicott Guardian presented this item on behalf of the Director of Information and Analytics. The Board, being satisfied with the information and assurances provided, accepted the Direction.

(iii) Department of Health Directions: Interim Out of Area Treatment (OAT) Collection Direction (paper):
The Medical Director and Caldicott Guardian presented this item on behalf of the Director of Information and Analytics. The Board, being satisfied with the information and assurances provided, accepted the Direction.

(iv) National Pandemic Flu Direction (paper):
The Chief Operating Officer presented this item. The Board, being satisfied with the information and assurances provided, accepted the Direction.

(v) NHS Improvement Mandatory Request for Patient Level Costing (paper):
The Medical Director and Caldicott Guardian presented this item on behalf of the Director of Information and Analytics. The Board, being satisfied with the assurances and information provided, formally ratified the decision taken at the 27 July 2016 Board Development Day and accepted the mandatory request.

5.3 **(c) Committee Reports:** NHSD 16 03 06 (c) (P1)

(i) Assurance and Risk Committee (ARC) Report: 31 August 2016 (oral):
The Committee Chair introduced this item. The purpose was to provide the Board with an update from the last committee meeting held on 31 August 2016. The Committee had considered two strategic deep dives, and a number of papers on risk management and assurance.

The Committee had also received an update on the review of strategic risks and the Capability Review. A number of internal audit items and reports had been presented. The Committee had considered a Counter Fraud report and an update financial reporting from the Director of Finance and Corporate Services.

The Chair commented on the Assurance and Risk Committee's substantial and critical work, and thanked on behalf of the Board both of the sub Committee's Chairs and all those involved. The Board received and noted the update.

(ii) Information Assurance and Cyber Security Committee (IACSC): 04 August 2016 (oral):
The Chief Operating Officer introduced this item in the absence of the Committee Chair. The purpose was to provide the Board with an update from the last committee meeting held on 04 August 2016.

He noted the meeting had been well attended. The Committee had considered the National Data Guardian Review Report and recommendations. He noted there continued to be resource pressures, which were affecting the redesign of the Information Governance toolkit and delivery of the Cyber Security Programme. The Committee had considered the closure of the CareCert programme and an update on the Citizen Identity solution.

The COO said that there was recognition that the Information Assurance and Cyber Security Committee terms of reference would need to evolve to reflect changes in the informatics governance landscape and across Whitehall, including the formation of the National Cyber Security Centre (NCSC). The Chair asked that the Board have sight of any proposed change to the Committee and its terms of reference prior to implementation.

Action: Chief Operating Officer

The Chair said that the work of the Committee was critically important both internally and across the health and social care system. The Board received and noted the update.

(iii) Remuneration Committee: 12 August 2016 (oral):
The Chair introduced this item. The purpose was to provide the Board with an update from the last committee meeting held on 12 August 2016. He said that the Committee had considered a performance appraisal for all the Executive Directors including the CEO, and a subsequent submission on performance banding had been submitted to the Department of Health's Remuneration Committee. The Committee had also considered a refreshed succession plan for the top 30 to 35 most senior staff in the organisation. The Committee received and noted the update.

5.4 (d) Terms of Reference for the Board and Board sub-committees (papers): NHSD 16 03 05 (d) (P1)

The Chair presented this item. The purpose was to gain Board approval for the Board and sub-committee terms of reference. The Chair summarised the contents of the Board terms of reference. The Board approved the documents, noting further updates would come back to the Board.

5.5 (e)Board Appointments (paper): NHSD 16 03 05 (e) (P1)

The Chair introduced this item. The purpose was gain approval of the proposed Board appointments. The Board approved the appointments.

5.6 (f) Board Forward Business Schedule 2016-17: NHSD 16 03 05 (f) (P1)

The Chair introduced this item. The Board noted the Board's forward business schedule.

6 **Any Other Business (subject to prior agreement with chair):** NHSD 16 03 06 (P1)

- Non-Executive Director Sir Nick Partridge provided the Board with an update on the renaming of NHS Digital, which had included new signage, launch events, a new web site and new corporate templates. Work remained ongoing with a number of initiatives underway. This included work with the social care sector. A final steering group meeting would take place. The work had remained within the modest budget. Staff and external feedback had been positive. The Board thanked Sir Nick Partridge for overseeing the work and the whole communications team for their hard work and efforts.

- The Chair apologised for the use of previous nomenclature and terminology that had appeared in some of the Board documentation.

7 **Background Papers (for information)** NHSD 16 03 07 (P1)

8.1 (a) Type 2 Objections Including Information Commissioners Office Undertaking Update (paper): NHSD 16 03 07 (a) (P1)

The Board noted this paper for information.

8.2 (b) Forthcoming Statistical Publications (Paper): NHSD 16 03 07 (b) (P1)

The Board noted this paper for information.

8.3 (c) Programme Definitions (paper): NHSD 16 03 07 (c) (P1)

The Board noted this paper for information.

8 **Date of Next Meeting**

8.1 The next statutory Board meeting will take place on Wednesday 30 November 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
The Chair noted it was important that the Board received summaries from the Digital Delivery Board, and the establishing of the reporting lines was critical to successful delivery. There was a need to include consideration of programme risks in the assurance functions of the NHS Digital Assurance and Risk Committee.	**Chief Operating Officer**
The Board noted that a final and agreed list of Paperless 2020 programme SROs and delivery leads would be presented at the November Board.	**Chief Operating Officer**
The Board requested a paper to map the new clinical governance and safety arrangements to the Paperless 2020 programmes at the November Board.	**Medical Director of Caldicott Guardian**
The Chair noted the importance for the Board to understand the data release audit outputs overall and asked the Executive to be more specific about who would take responsibility for this aspect and how it would be managed.	**Medical Director of Caldicott Guardian**
The COO said that there was recognition that the Information Assurance and Cyber Security Committee terms of reference would need to evolve to reflect changes in the informatics governance landscape and across Whitehall, including the formation of the National Cyber Security Centre (NCSC). The Chair asked that the Board have sight of any proposed change to the Committee and its terms of reference prior to implementation.	**Chief Operating Officer**

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

Board meeting – Public Session

Title of paper:	**Update on action points from the previous meeting**
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 02 d
Paper presented by:	Chair
Paper prepared by:	Annabelle McGuire Secretary to the Board and Head of Corporate Governance
Paper approved by: (Sponsor Director)	Each action update is submitted and approved by the relevant Executive Director
Purpose of the paper:	To share an update on open action points from previous meetings for information. To ensure the completion of Board business.
Key risks and issues:	As stated in the action and commentary
Patient/public interest:	Corporate Governance best practice
Actions required by the board:	To note for information

Progress against Board meeting actions

Green = completed
Amber = on-going
Red = overdue

Meeting Date	Status	Summary of Action	Responsible Director	Commentary	Next Steps	Target Completion Date
06/08/2016	Green	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	Director of Information and Analytics	The revised Data Quality key performance indicator (KPI) was presented to the Executive Management Team (EMT) on 20 October 2016 and was discussed at the Board Development Day on 27 October 2016. The revised KPI will be presented to the Board on 30 November and the final KPI will be reported from December 2016.	Completed	30/11/2016
07/09/2016	Green	The Chair noted it was important that the Board received summaries from the Digital Delivery Board, and the establishing of the reporting lines was critical to successful delivery. There was a need to include consideration of programme risks and assurance by the NHS Digital Assurance and Risk Committee.	Chief Operating Officer	The Chief Operating Officer is presenting a Paperless 2020 deep dive report to the Assurance and Risk Committee on 16 November. This is aggregate and not programme level risks. Individual programme red risks tabled at the Digital Delivery Board will be made visible to NHS Digital's Board in the Programme updates.	Completed	30/11/2016

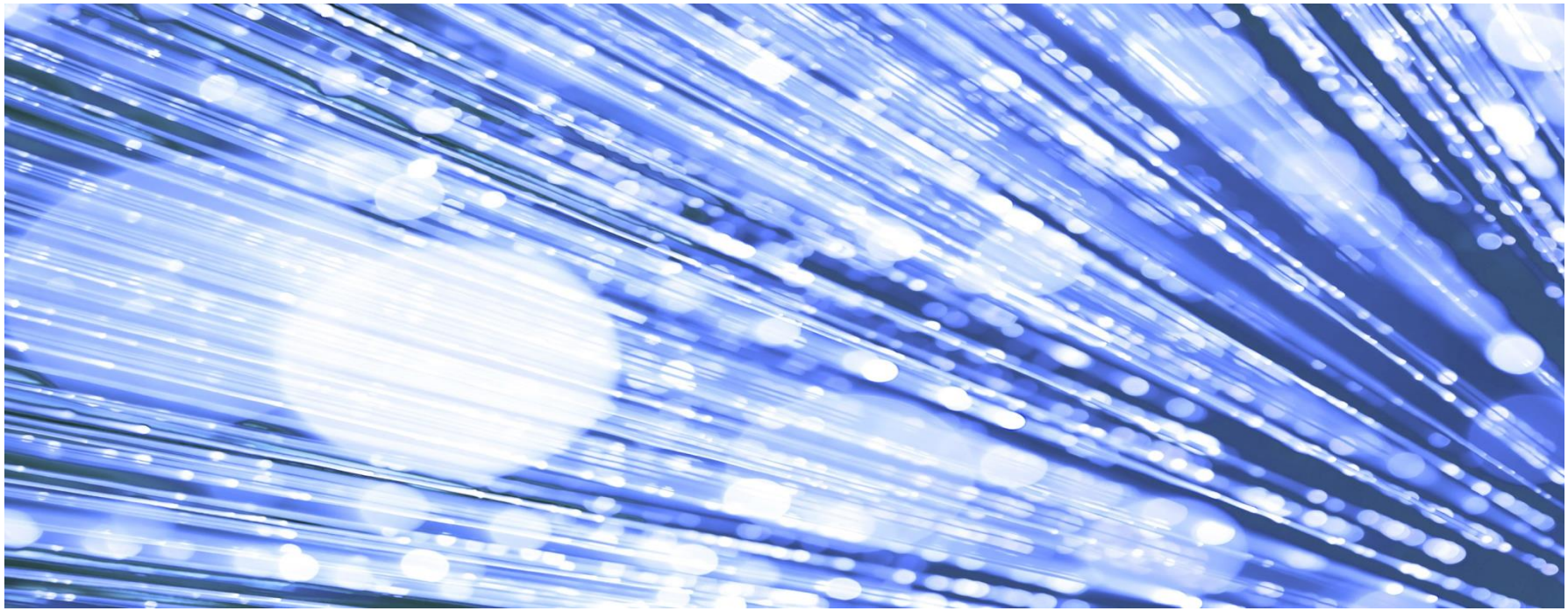
Meeting Date	Status	Summary of Action	Responsible Director	Commentary	Next Steps	Target Completion Date
07/09/2016	Green	The Board noted that the presentation of the finalised and agreed list of Paperless 2020 programme senior responsible owners and delivery leads at the November Board.	Chief Operating Officer	On the agenda	Completed	30/11/2016
07/09/2016	Green	The Board requested a paper to map the presented clinical governance and safety theoretical concepts to the Paperless 2020 programmes at the November Board.	Medical Director and Caldicott Guardian	On the agenda	Completed	30/11/2016
07/09/2016	Green	The Chair noted the importance for the Board to understand the data release audit outputs overall and asked who would take responsibility for this aspect and how it would be managed	Medical Director and Caldicott Guardian	On the agenda	Completed	30/11/2016

Board Meeting – Public Session

Title of paper:	**NHS Digital Board Performance Pack (public)**
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 03 a
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 October 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**

Board Performance Pack

October 2016 Data



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NHS Digital Performance Summary

Programme Achievement overall is reported as Amber-Green. Note that although the overall position is Amber-Green, delivery confidence across the portfolio of P2020 programmes is Amber. Across all reported programmes overall delivery confidence for October was 62.1%, an increase from 58.8% in September .

The Programme Achievement reporting comprises 28 P2020 programmes and 12 legacy programmes:

Delivery confidence across the P2020 programmes was 55.9% (Amber). One P2020 programme was reported as Red: Citizen Identity (P2020 Programme 1).

Delivery confidence across the legacy (non-P2020) programmes was 68.3% (Amber-Green). One legacy programme was reported as Red: Child Protection Information Sharing.

Benefits data is reported for a limited selection of programmes: this data indicates that, compared to the baselined business case figures, 82.6% of planned investment is forecast to take place and 85% of expected benefits are forecast to be realised as a result.

IT Service Performance is reported as Green. All services (56 of 56) achieved their availability target. All High Severity Service Incidents (34 of 34) were resolved within their target fix time. All services (10 of 10) achieved their response time target. Since the October reporting period, on 14 November a significant incident affected NHSMail, as widely reported in the media.

Organisational Health: reported as Amber. A key focus is the resourcing gap between workforce demand and supply. Work is ongoing to address this, including a significant recruitment campaign across the organisation and the Workforce and Resource Management teams working with portfolio leads to understand the staffing demands of Paperless 2020 programmes.

In order to support a longer-term, sustainable balance of demand and supply the organisation's Capability Review is now underway with a key aspect being the development of a workforce capability plan. Turnover rates continue to remain stable and within target for the month, with the number of early leavers with less than 2 years' service dropping slightly. The overall level of PDR completion compliance has again increased slightly.

Data Quality is a new KPI, and this month is reported as Amber. Of 26 datasets within the scope of NHS Digital's data quality assurance methodology, 19 require some improvement and 1 requires significant improvement. In terms of data quality across the health system, the latest Data Quality Maturity Index shows that while 58 providers (16%) achieve the gold standard, 48 (13%) require significant improvement and 8 (2%) provided data of unacceptable quality.

Financial Management (NHS Digital) is reported as Red: 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 7 this KPI is reported as Red, with a forecast surplus for the year of £8.4m.

Performance This Period					Performance Tracker: Rolling 12 months											
Performance Indicator	Owner	Current Period	Current Forecast	Previous Forecast	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Programme Achievement	James Hawkins	A/G	A/G	A	A/G	A/G	A/G	A/G	A/G	A/G	A/G	A/G	A/G	A/G	A	A/G
IT Service Performance	Rob Shaw	G	A	G	G	G	G	G	G	R	R	R	R	A	A	G
Organisational Health	Rachael Allsop	A	A	A	G	A	A	A	A	A	A	A	A	A	A	A
Data Quality	David Hughes	A	A	A	G	G	G	G	G	G	A/G	G	G	G	G	A
Financial Management: NHS Digital	Carl Vincent	R	R	R	A	A	R	R	R	N/A	G	G	G	R	R	R

KPI	Programme Achievement
KPI Owner	James Hawkins

Previous RAG	58.8%	A
Current RAG	62.1%	A/G
1 Month Future Forecast RAG	62.9%	A/G
2 Month Future Forecast RAG	65.0%	A/G
3 Month Future Forecast RAG	67.8%	A/G

Based on October 2016 Highlight Reports or P2020 Programme Initiation Progress Reports

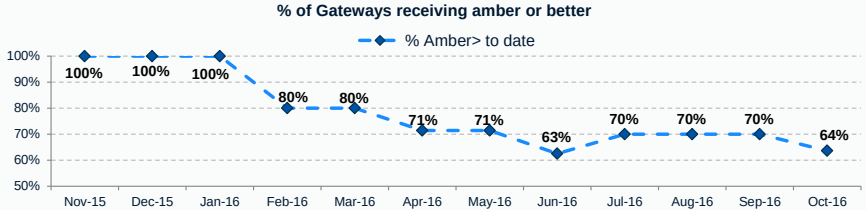
(The programme achievement KPI reporting comprises 28 P2020 programmes and 12 other existing or 'legacy' programmes.)

The overall KPI is reported as Amber-Green. Note that delivery confidence across the P2020 programmes is Amber; whereas delivery confidence across the legacy programmes is Amber-Green.

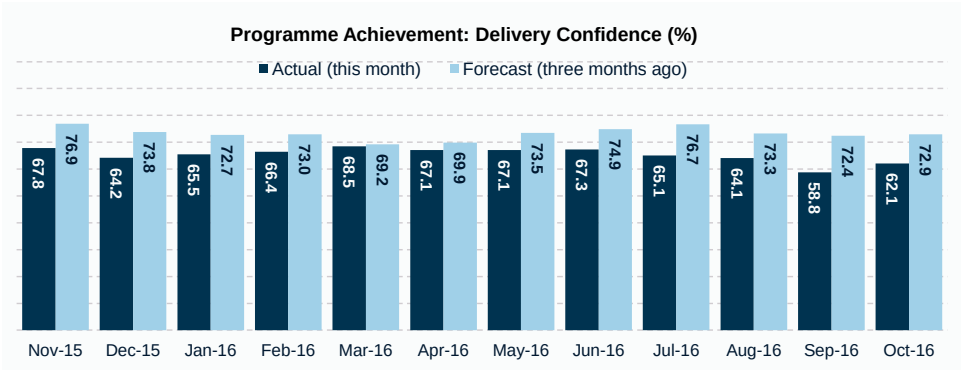
Across all reported programmes the overall delivery confidence for October was 62.1%, an increase from 58.8% in September.

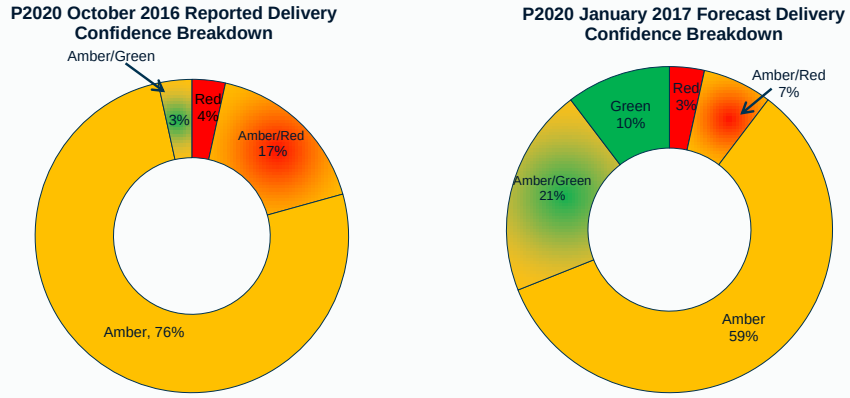
Delivery confidence across the P2020 programmes was 55.9% (Amber). One P2020 programme was reported as Red: Citizen Identity (P2020 Programme 1). Five others reported as Amber-Red.

Delivery confidence across the legacy (non-P2020) programmes was 68.3% (Amber-Green). One legacy programme was reported as Red: Child Protection Information Sharing. Two others reported as Amber-Red.



Gateway Reviews: A gateway review was carried out for HSCN in October.





Benefits Reporting

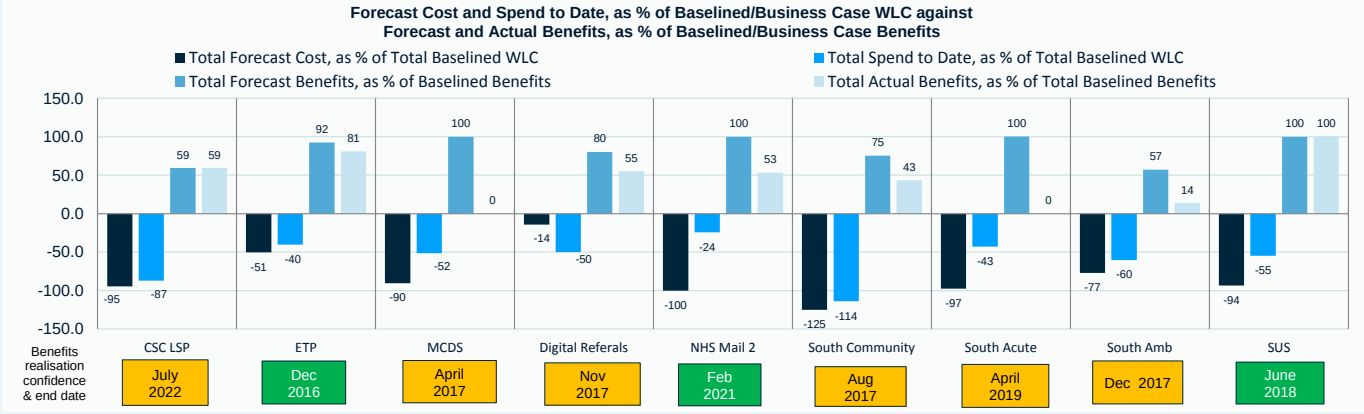
In October:

Average forecast cost as % of baselined / business case Whole Life Cost = 82.6%

Average spend to date as % of baselined / business case Whole Life Cost = 58.4%

Average forecast benefits as % of baselined / business case benefits = 85%

Average actual benefits realised to date as % of baselined / business case benefits = 45.1%



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

Previous RAG	A
Current RAG	G
Forecast RAG	A

Availability:

All 56 services measured achieved their availability target in October. This is an excellent achievement and is the third time in the last 12 months that all services have met their respective availability targets.

Fix Times:

34 HSSIs were logged in October 2016, compared to 38 in September and the 12-month average of 32.

All 34 logged HSSIs achieved their fix times, the second successive month where 100% of HSSIs have been fixed within target and the third month running when a Green RAG status has been achieved for the fix times indicator.

Note, however, that a Severity 1 HSSI was logged by INPS (In Practice Systems) on 18 October and is still open / ongoing at the time of report production (10 November). As per due process, this fix time failure for INPS will not be reported until the month in which it is resolved.

Five of the HSSIs logged in October were clinical safety incidents, one was a security incident, and two were logged as incidents with both clinical safety and security implications.

Response Times:

All 10 services reported against either achieved or exceeded their response times target.

Note noting that this is the first month on record in which this indicator has achieved a Green RAG status. This is a direct result of the efforts to resolve the response time failures experienced on the CQRS service provided by GDIT, these activities have included the investigation and identification of performance fixes and service level reviews.

Incidents of note outside the reporting period:

Since the October reporting period the following noteworthy Severity 2 HSSIs have been reported:

03 November: Accenture - some users unable to access their NHSmail account via Outlook Anywhere

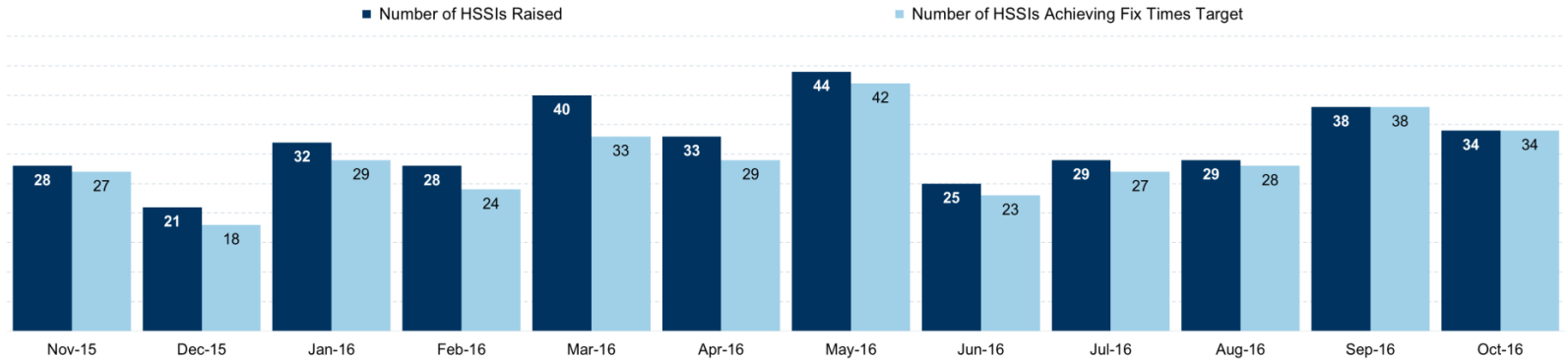
08 November: NHS Digital - users intermittently not presented with available slots in the e-Referral Service

14 November: A significant incident affected NHSMail, as widely reported in the media

Forecast

It is forecast that an AMBER RAG status will be achieved in November 2016.

Higher Severity Service Incidents: Achieving Fix Times Target



Performance Indicators	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
No. of Services achieving Availability target	59	57	56	56	56	57	55	60	56	53	54	56
No. of Services breaching Availability target, but not to a critical level	0	1	0	1	1	1	0	0	2	3	2	0
No. of Services breaching Availability target at a critical level	0	1	0	0	0	1	2	1	1	0	0	0
Total No. of Services measured for Availability Performance >>>>	59	59	56	57	57	59	57	61	59	56	56	56
No. of Services achieving Response Times target	16	16	15	14	14	13	15	15	13	10	9	10
No. of Services breaching Response Times target, but not to a critical level	1	1	2	0	0	0	0	1	1	0	0	0
No. of Services breaching Response Times target at a critical level	1	1	1	4	4	4	2	1	1	1	2	0
Total No. of Services measured for Response Times Performance >>>>	18	18	18	18	18	17	17	17	15	11	11	10
Total number of Higher Severity Service Incidents (HSSIs)	28	21	32	28	40	33	44	25	29	29	38	34
Total number of HSSIs achieving Fix Times target	27	18	29	24	33	29	42	23	27	28	38	34
% HSSIs achieving Fix Times target	96%	86%	91%	86%	83%	88%	95%	92%	93%	97%	100%	100%

Caveats:

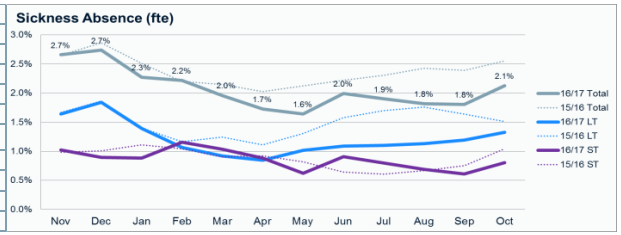
1. Availability data for Atos (GPET-Q) is to be confirmed as at 18/11 (latest Performance Monitoring Report not yet received).
2. HSSI data for Atos (GPET-Q) and EMIS (GPET-E) is to be confirmed as at 18/11 (latest Performance Monitoring Reports not yet received).
3. All data in this report is potentially subject to change, as it has yet to be fully reviewed by Service Owners and agreed with their Supplier counterparts, as part of their BAU monthly Service Review cycles.
4. If any changes are needed following the completion of all Supplier Service Reviews, these will be reflected in next month's KPI.

KPI: **Organisation Health**
Owner: **Rachael Allsop**

Overall Position: remains Amber and is forecast to remain so next month. A key focus is the resourcing gap between workforce demand and supply. Work is ongoing to address this, including a significant recruitment campaign across the organisation and the Workforce and Resource Management teams working with portfolio leads to understand the demands of Paperless 2020. To support a longer-term, sustainable solution to the balance of demand and supply the Capability Review is underway, with a key aspect being the development of a workforce capability plan. Turnover rates remain stable and within target for the month, with the number of early leavers with less than 2 years' service dropping slightly. Work continues to address the accuracy level against PDR compliance whilst the overall compliance has again increased slightly.

Previous	A
Current	A
Forecast	A

Summary Table	Target	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Engagement Score	>=70						75						
Engagement Actions Completed	>=90%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PDR Completion	>=90%	87%	90%	90%	90%	90%	80%	48%	74%	80%	83%	84%	85%
Annual Training Spend / Head	£275/Year	£228	£325	£352	£395	£518	-	-	£89	£103	£136	£158	TBC
12 Month Average Sickness Absence%	<=3%	2.7%	2.7%	2.3%	2.2%	2.0%	1.7%	1.6%	2.0%	1.9%	1.8%	1.8%	2.1%
Mandatory Training - All Staff (composite)	>=90%	#	45%	76%	89%	93%	93%	94%	93%	92%	92%	93%	92%
Mandatory Training - New Starters (composite)	>=90%	#	#	#	52%	50%	61%	66%	59%	65%	63%	58%	67%
Time to Hire - In post	>=70	62	69	69	72	78	56	51	53	60	63	48	49
Turnover	9% - 11%	8%	8%	8%	8%	8%	11%	11%	11%	11%	11%	11%	11%
Net Monthly Movement	TBC	43	12	28	-2	-13	-55	1	14	16	-1	-5	11



Engagement

- The 2016 staff survey will be issued once the new categorisations within the survey have been finalised. This will ensure the facilitation of meaningful results for professional groups to respond to.
- The 'pulse' survey will be run again in November to gauge how staff feel about our overall direction and working in NHS Digital. The results will be published with a comparison against the previous survey.
- Detailed work has been undertaken to develop a Workforce Communication Plan to better utilise a range of channels for key messages. Success is being measured through access/usage metrics.

Training and Development

Mandatory Training - Induction of New Starters

- Corporate Induction event 47% / Online Induction access 87% - those who have joined in the last 3 months
- An issue with the ICT new starter process has led to incomplete induction figures being produced this month. ICT are working to resolve the issue as soon as possible.

Mandatory Training - All Staff

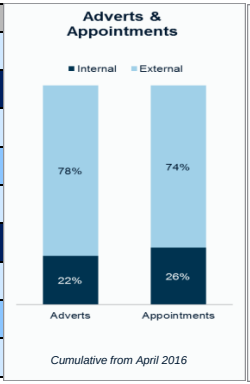
- Fire Safety compliance score: 86%
- Information Security compliance score: 94%
- Information Governance compliance score: 94%

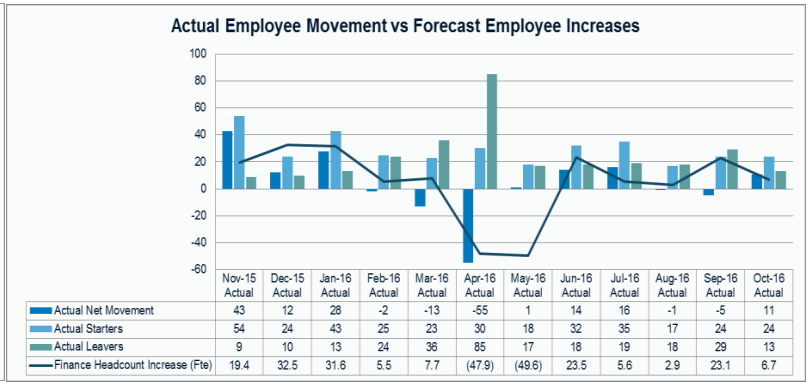
PDR Monitoring is now reported on a rolling 6 month basis

Sickness Absence

- The graph above shows the actual absence in month. Both the long-term absence and short-term absence have **increased slightly** 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 **increased slightly.**
- Absence cases continue to be reviewed on a fortnightly basis by HR. Concentration is on repetitive short term absences and more complex longer term cases.
- The most common reason for absence is anxiety / stress and mental health issues.

Growing Talent Summary	Final position, cumulative 15/16	Projected placements for 16/17	Appointments 16/17 to date	Live Campaigns	% Total Time	Working Days
Work Experience Unpaid work shadowing up to 2 weeks	6	8	10	**Advertising**	**Approval to advert**	
				31	2.1%	1.12
Apprenticeship Paid training role against framework/standard	7	63	5	**Selection**	**advert to outcome**	
				43	62.6%	33.33
Internship Paid 8 week placement	18	10	11	**Appointment**	**outcome to checks**	
				109	21.0%	11.20
Graduate Training Scheme Paid high potential training scheme	9	30	15		**checks to agreed start date**	
					14.2%	7.58





	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 Actual	Aug-16 Actual	Sep-16 Actual	Oct-16 Actual
Actual Net Movement	43	12	28	-2	-13	-55	1	14	16	-1	-5	11
Actual Starters	54	24	43	25	23	30	18	32	35	17	24	24
Actual Leavers	9	10	13	24	36	85	17	18	19	18	29	13
Finance Headcount Increase (Fte)	19.4	32.5	31.6	5.5	7.7	(47.9)	(49.6)	23.5	5.6	2.9	23.1	6.7

Attracting and Growing Talent

- An Apprenticeship proposal was considered by Workforce SMT in October which set out a provisional recruitment plan for the remainder of 2016/17. Our target for the year of 2.3% has been challenging to achieve due to the work involved in planning for such a significant shift in volume. As it is the first year of the target, we are expected to be mindful of it and focus on planning for future years. We are now working with the Business and Operational Delivery profession to confirm the recruitment plan to bring in a large cohort of Business Support apprentices (c.15-20) to provide administrative support across the organisation. We continue to work with other professions to recruit smaller numbers of apprentices with an aim of recruiting 30 apprentices over the financial year.
- We attended 3 **jobs fairs** in October which were the first ones we have attended under NHS Digital. We had over 300 registrations from individuals interested in hearing more about opportunities with us. We have followed up with everyone inviting CV applications and inviting Software Developers to complete a tech task.
- We are working with Heads of Professions to confirm our target for graduate trainees to start in September 2017. Learning from our experiences this year, we will begin advertising before the Christmas period and operate a much shorter end to end selection process.

Recruitment

- In response to the overall demand requirements across the organisation, recruitment activity is now at its highest level this year. Areas are responding to key business priorities, with examples of noticeable recruitment activity underway in PPD, Commercial and B&OD, together with targeted recruitment campaigns for Software Development and Solution Assurance professionals based in the Exeter office.
- There has been a marked increase in the number of posts which are now at the appointment stage of the process. The pipeline of new joiners will therefore increase in the remaining months of the year.
- Four suppliers for the new Applicant Tracking System have been invited to provide demonstrations as part of the current tender activity and a decision is anticipated on the preferred supplier in November.

Net Movement

- **Headcount** at the end of October was 2758.

Corporate Data Quality Assurance Quarterly KPI Dashboard

The dashboard is focussed entirely on the maturity of NHS Digital internal processes for managing data quality

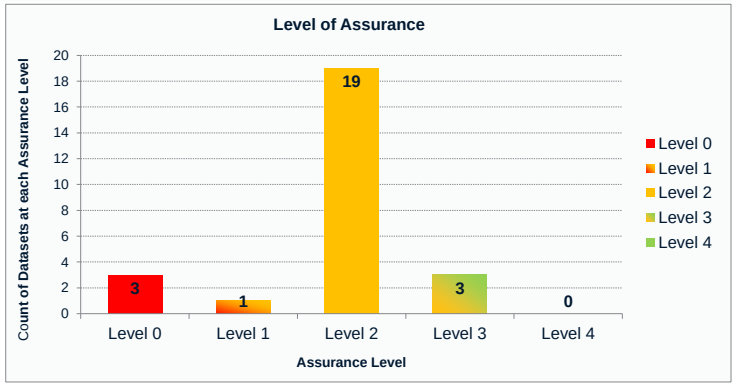
NHS Digital

KPI Performance Measure

Previous RAG	Current RAG	Forecast RAG
Amber	Amber	Amber

Explanatory Note:
3 assessments are incomplete and the majority of assessments require improvement.
There are no datasets with an exemplary assessment score.

Each dataset has a level of assurance based on their answers to an internal Data Quality Assurance Assessment. The graph shows the count of datasets at each level of



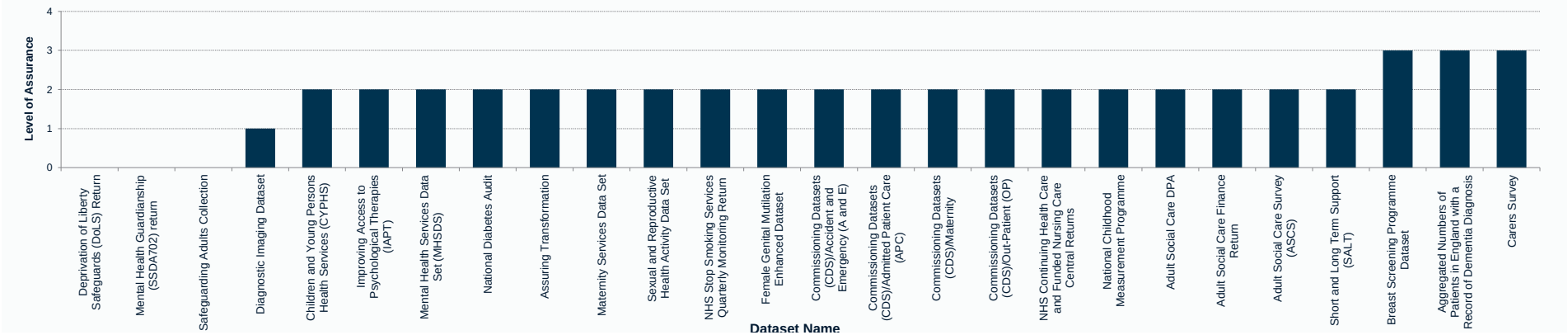
KPI Performance Measure Explained

Level 0	Level 1	Level 2	Level 3	Level 4
Assessment Incomplete	Requires Significant Improvement	Requires Some Improvement	Satisfactory	Exemplary

The level of assurance is determined by the answers to an internal Data Quality Assurance Assessment that is carried out for each of the datasets. The assessment is made up of the 20 questions below. Each question is weighted and the answers are averaged as per a defined methodology to equal the level of assurance.

Weight	Assurance item
A	A SCCI national information standard has been approved and is used in the assessment of data quality
A	Coverage is assessed and reported in line with HSCIC secondary uses DQA policy requirements
A	Validity assessed and reported in line with HSCIC secondary uses DQA policy requirements
A	Default values assessed and reported in line with HSCIC secondary uses DQA policy requirements
A	Completeness assessed and reported in line with HSCIC secondary uses DQA policy requirements
A	Timeliness assessed and reported in line with HSCIC secondary uses DQA policy requirements
A	Integrity assessed and reported in line with HSCIC secondary uses DQA policy requirements
A	Corporate reference data is used exclusively for validity and default data quality checks
A	A comprehensive list of expected data providers is clearly documented and maintained
A	Robust feedback mechanisms are in place for data providers
A	Robust feedback mechanisms are in place for data users
A	Data quality rules and supporting metadata are documented in plain English
A	Data quality assessment methods are documented in plain English
A	Data quality results reports are documented in plain English
B	Data quality rules, assessment methods and results reports are available on the HSCIC website via a fully completed HSCIC Data Quality Assessment and Reporting Methods template
B	Data quality results are available on the HSCIC website as Open Data
B	A named data quality contact at each provider is documented and maintained
B	A comprehensive list of known data users is documented and maintained
C	A data provider forum has been set up, meets regularly, and produces meeting notes and actions
C	A data user forum has been set up, meets regularly, and produces meeting notes and actions

Assurance Breakdown by Dataset



Corporate Data Quality Assurance Quarterly Management Information

This dashboard measures the quality of data we receive from external providers

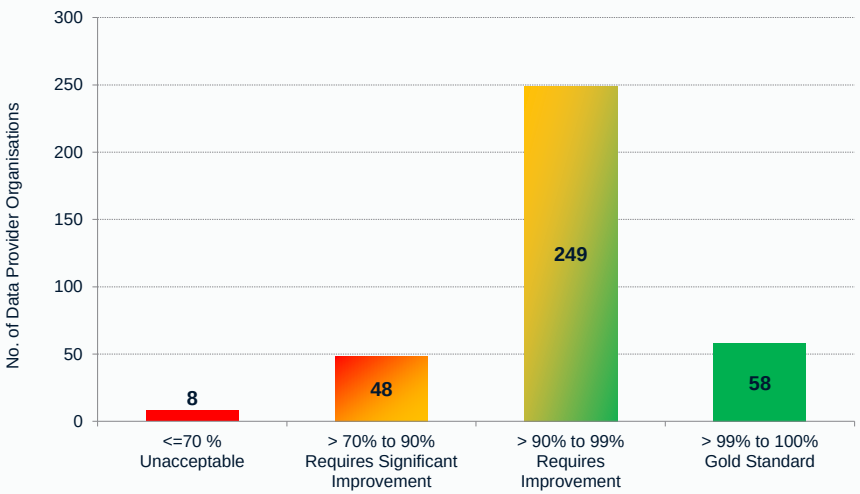
NHS Digital

Data Quality Maturity Index (DQMI)

The DQMI rates each provider organisation with a score of between 0 - 100% based on a number of data quality criteria (validity[1], completeness[2] and default values[3]) for the data they submit[4]. A higher score shows a higher level of maturity.

Investigation and action will be taken to support organisations in the lower score bandings.

Range of Provider DQMI Scores for April - June 2016



National Average of DQMI Score per Publication

The table below averages together all provider scores for each publication of the DQMI to show whether national data quality is improving over time. To ensure a fair comparison, the table reports on the same scope for each reporting period[5].

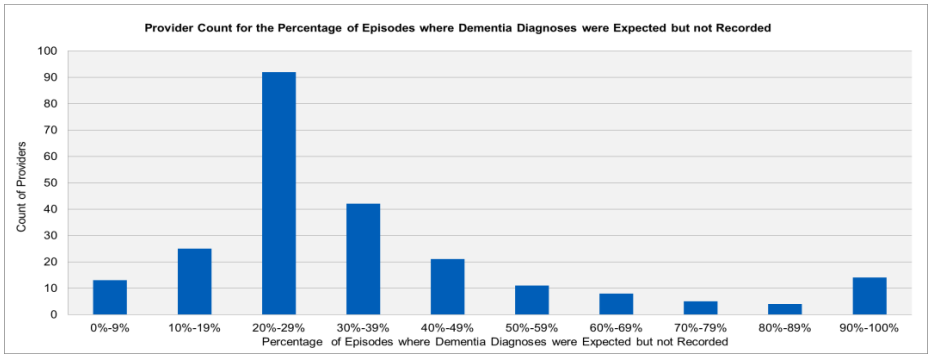
	Overall	A&E	APC	DIDS	IAPT	MSDS	MHSDS	OP
DQMI Score Jan-March 16 Data	96.4%	98.7%	96.6%	91.7%	96.4%	95.5%	94.3%	97.1%
DQMI Score April-June 16 Data	96.5%	98.9%	96.5%	92.2%	96.7%	95.7%	95.2%	97.2%

[1] Completeness is the degree to which an expected data item holds a value, e.g. an NHS Number field should be populated with data and not be left blank
[2] Validity is the degree to which data satisfy the set of standards and business rules that govern the permitted values and formats for each field in a dataset, e.g. are dates submitted in the expected format, does the hospital admission method contain one of the codes required by a national data standard.
[3] A default is a predesigned value when a value is not specified. E.g. "Not Known/Specified" or "No Fixed Abode".
[4] The DQMI is based upon data from 7 datasets. N.B. Not every provider submits all 7 dataset, the score for each provider is only based on the datasets they submit.
[5] The same scope represents validity and completeness. Defaults were not included in the previous publication.

Featured Management Information

Data Quality in Dementia Diagnosis

National Clinical Coding Standards deem the diagnosis of Dementia to be clinically relevant to every diagnosis for the patient. This analysis has highlighted a data integrity issue with the recording of dementia diagnoses.



- Out of a total of 277,425 episodes where a dementia diagnosis was expected because it was recorded in a previous diagnosis, 84,397 (30.42%) had no dementia diagnosis in subsequent episodes
- The baseline was comprised of all patients with an in-scope dementia diagnosis code between April 2013 and March 2016 and the reporting period is April - June 2016

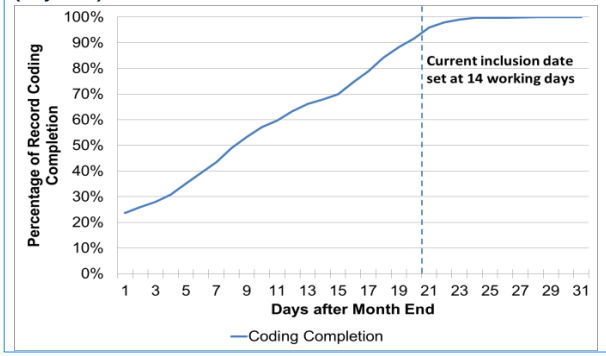
Caveats:

The results are reliant on the accurate diagnosis and recording of dementia by providers within the baseline period. If a patient is not diagnosed, or is incorrectly diagnosed, with dementia in the baseline then there is potential for data inconsistencies

This report is based upon patients who have attended hospital and were diagnosed with dementia within the baseline period.

Featured Management Information

Average proportion of completed clinical coding by number of days after the end of the month of treatment (May-2016)



The graph shows the level of clinical coding completeness over a 30 day period. Completeness is measured by the depth of coding at day 30. Working backwards on the graph shows that the earlier data is taken, the lower the level of coding completeness.

Notes and caveats

- This is an average across the reporting period
- The coding at each day is expressed a percentage of the total coding completed 30 days after the month end. In reality further coding may occur beyond this point
- The dotted line graph shows the average percentage of coding completion at current submission date (inclusion) to SUS

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

Previous RAG	R
Current RAG	R
Forecast RAG	R

	Budget (£m)	Forecast (£m)	Var (£m)
Income (GiA, ring-fenced & other)	(222.6)	(222.8)	0.2
Costs (incl. contingency)	222.6	236.6	(14.0)
(Surplus)/Deficit	**0.0**	**13.8**	(13.8)
Optimism adjustment:	(5.0)		(5.0)
P2020 income to cover staff		(16.0)	16.0
Staff costs/ recruitment of 100 FTEs		(2.8)	2.8
Release contingency		(3.4)	3.4
(Surplus)/Deficit - adjusted	**(5.0)**	**(8.4)**	3.4

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 M7, 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 M7 forecast has been adjusted by a high-level optimism adjustment of £22.2m which takes into account expected P2020 funding to fund staff costs, an estimated realistic recruitment profile for the remainder of the year (100 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 £8.4m 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. Current expectation is that will happen at M9. Given the expected volatility of the bottom line over the coming months, we are using 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.

2016/17 Financial Year Tracke	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	R	R	R					

KPI	Programme Achievement
KPI Owner	James Hawkins

Appendix 1 - P2020 Programme Delivery Dashboard

Paperless 2020 Dashboard - October 2016

Domain	P2020 No		Reporting Month:	Ex-ec 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		
					Aug	Sep	Oct	Nov	Dec	Jan	Aug	Sep	Oct	Jul	Aug	Sep	Aug	Sep	Oct	Aug	Sep	Oct
A	1	P0394	NHS Citizen Identity	HDS	A/R	A/R	R	R	R	R	A	A	A	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	A	A/G	A	A	A	G	G	G	G	G	G	N/A	N/A	N/A
A	3		Health Apps Assessment and Uptake	HDS	N/A	N/A	A	A	A	A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
A	4		Widening Digital Participation	HDS	A/G	A/G	A	A	A	A	A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
A	16		Personal Health Record	PSI	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
A	31		Wi-Fi	HDS	N/A	N/A	A	A	A	A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
B	5		Clinical Triage	HDS	R	R	A/R	A/R	A/R	A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
B	6		Patient Relationship Management	HDS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
B	7		Access to Service Information	HDS	A	A	A	A	A	G	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
B	8		Out of Hospital Care	HDS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
C	9		GP Payments Futures	HDS	N/A	N/A	A	A	A/G	G	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		P0422	SNOMED CT in Primary Care	HDS	N/A	N/A	A	A	A	A	N/A	N/A	A	N/A	N/A	A	N/A	N/A	G	N/A	N/A	G
		P0518	GP Connect	HDS	N/A	N/A	A	A	A	A/G	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
C	10		Adopting existing Tech in GPs	D&T	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
C	11		Technology for GP Transformation	HDS	A	A	A	A	A	A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
C	12		GP Data for Secondary Uses	HDS	A	A	A	A	A/G	A/G	A	A	A	A	A	G	N/A	A	A	N/A	N/A	N/A
D	13		Integration Projects	PSI	A	A/R	A/R	A/R	A	A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
D	14		Interoperability & Architecture	PSI	A	A	A	A	A	A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
D	15	P0341	Social Care	PSI	A	A	A	A	A	A	A	A	G	N/A	N/A	A	N/A	N/A	N/A	N/A	N/A	N/A
E	17		Digitising Community Pharmacy	HDS	A	A	A	A	A	A/G	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
E	18		Pharmacy Supply Chain & Secondary Uses	HDS	A	A	A	A	A	A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
E	19		Intergrating Pharmacy	HDS	A/R	A/R	A	A	A	A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
F	20	P0238	Digital Referrals & Consultations	HDS	A	A	A	A	A	A	G	A	A	A	G	G	G	G	G	A	A	A
G	21		Provider Digitisation	PSI	A/G	A/G	A/G	A/G	A/G	A/G	N/A	N/A	G	N/A	N/A	G	N/A	N/A	G	N/A	N/A	N/A
G	22		Digital Child Health	PSI	A/G	A/G	A	A	A	A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
G	23		Digital Diagnostics	PSI	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
G	24		Building a Digital Ready Workforce	PSI	A/G	A	A	A	A/G	A/G	N/A	A	N/A	N/A	N/A	N/A	N/A	G	N/A	N/A	N/A	N/A
H	25	P0453	National Data Services Development	I&A	A	A/R	A/R	A/R	A/R	A	A	A	A	G	A	A	N/A	N/A	N/A	A	A	A
H	26		Data Content	I&A	A/G	A	A	A	A	A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
H	27		Innovative uses of Data	I&A	N/A	A/R	A/R	A/R	A/R	A/R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
I	29	P0196	NHSmail 2	HDS	A	A	A	A	A	A	A	G	G	R-U	R-U	A	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	A	A	R-U	R-U	R-U	A	A	A	A	R	A
J	32	P0325	Cyber Security Programme	OAS	A/G	A/G	A	A	A/G	G	G	A	A	G	G	G	G	G	G	N/A	N/A	N/A
J	33		National Opt-Out Model	PSI	A	A	A	A	A	A	G	G	G	N/A	G	G	G	G	G	N/A	N/A	N/A

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

Delivery Confidence - Paperless 2020:	
October-2016	A 55.86%
January-2017	A/G 65.52%

Sourced from Highlight Reports and Initiation Reports — October-16

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

Non Completion Key	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 1 - P2020 Programme Delivery Dashboard

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			
				Aug	Sep	Oct		Aug	Sep	Oct		Aug	Sep	Oct		Aug	Sep	Oct		Aug	Sep	Oct		Aug	Sep	Oct	
A	1	P0394	NHS Citizen Identity	N/A	N/A	N/A	-	R	R	R	→	R	R	G	↑	N/A	N/A	N/A	-	A	A	A	→	A	A	A	→
A	2	P0425	NHS.UK	R	R	R	→	R	R	R	→	G	G	G	→	G	G	G	→	A	A	R	↓	A	A	A	→
A	3		Health Apps Assessment and Uptake	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
A	4		Widening Digital Participation	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
A	16		Personal Health Record	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
A	31		Wi-Fi	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
B	5		Clinical Triage	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
B	6		Patient Relationship Management	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
B	7		Access to Service Information	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
B	8		Out of Hospital Care	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
C	9		GP Payments Futures	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
0	0		SNOMED CT in Primary Care	N/A	N/A	A	-	N/A	N/A	G	-	N/A	N/A	G	-	N/A	N/A	N/A	-	N/A	N/A	A	-	N/A	N/A	A	-
0	0		GP Connect	N/A	N/A	N/A	-	N/A	N/A	G	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	A	-	N/A	N/A	G	-
C	10		Adopting existing Tech in GPs	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
C	11		Technology for GP Transformation	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
C	12	P0413	GP Data for Secondary Uses	N/A	N/A	N/A	-	N/A	N/A	A	-	A	A	A	↑	N/A	N/A	N/A	-	R	R	R	→	A	R	R	→
D	13		Integration Projects	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
D	14		Interoperability & Architecture	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
D	15	P0341	Social Care	G	G	G	→	G	G	G	→	G	G	G	→	G	G	G	→	A	A	A	→	G	G	G	→
E	17		Digitising Community Pharmacy	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
E	18		Pharmacy Supply Chain & Secondary Uses	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
E	19		Intergrating Pharmacy	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
F	20	P0238	Digital Referrals & Consultations	G	G	G	→	G	G	G	→	G	G	G	→	G	G	G	→	R	A	A	→	G	G	G	→
G	21		Provider Digitisation	N/A	N/A	G	-	N/A	N/A	G	-	N/A	N/A	G	-	N/A	N/A	N/A	-	N/A	N/A	G	-	N/A	N/A	G	-
G	22		Digital Child Health	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
G	23		Digital Diagnostics	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
G	24		Building a Digital Ready Workforce	N/A	A	N/A	-	N/A	A	N/A	-	N/A	G	N/A	-	N/A	N/A	N/A	-	N/A	A	N/A	-	N/A	A	N/A	-
H	25	P0453	National Data Services Development	G	G	G	→	G	G	G	→	A	R	R	→	A	R	R	→	A	A	A	→	G	G	A	↓
H	26		Data Content	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
H	27		Innovative uses of Data	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-	N/A	N/A	N/A	-
I	29	P0196	NHSmail 2	G	G	G	→	G	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	→	G	G	G	→	G	G	G	→	A	A	G	↑	G	A	A	→	R	A	A	→
J	32	P0325	Cyber Security Programme	G	G	G	→	G	G	G	→	G	G	G	→	G	N/A	A	-	A	A	A	→	A	A	A	→
J	33		National Opt-Out Model	G	G	G	→	G	G	G	→	A	G	G	→	G	G	G	→	A	A	A	→	G	G	G	→

Overall Delivery Confidence for Paperless 2020 (Calculated):	
October-2016	A 55.86%
January-2017	A/G 65.52%

Sourced from Highlight Reports and Initiation Reports — October-16

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

Appendix 2 - Programme Delivery Dashboard

Existing Portfolio Delivery - October 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		
			Aug	Sep	Oct	Nov	Dec	Jan	RPA	Aug	Sep	Oct	Jul	Aug	Sep	Aug	Sep	Oct	Aug	Sep	Oct
P0012	Electronic Transfer of Prescriptions	HDS	A/R	A/R	A/R	A/R	A/R	A/R	N/A	G	G	G	R-U	R-U	R-U	G	G	G	G	G	G
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/G	A/G	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	R	R	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	G	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/R	A/R	A/R	A/R	A/R	A/R	Med	R	R	R	R-U	R-U	R-U	G	G	G	G	G	G
P0301	FGMP	PSI	A	A	A	A	A	A	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	G	G	G	G	High	A	A	G	G	G	G	G	G	G	A	A	G
P0050	Spine 2	OAS	G	NR	G	G	G	G	High	G	NR	G	R-U	G	G	G	NR	G	G	NR	G
P0335	SUS Transition	OAS	G	NR	G	G	G	G	High	G	NR	G	G	G	G	G	NR	G	G	NR	G

Delivery Confidence - Existing Portfolio:	
October-2016	A/G 68.33%
January-2017	A/G 70.00%

- 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 Digital and Tech Spend Approval)
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Appendix 2 - Programme Delivery Dashboard

		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		
		Aug	Sep	Oct	Aug	Sep	Oct	Aug	Sep	Oct	Aug	Sep	Oct	Aug	Sep	Oct	Aug	Sep	Oct
P0012	Electronic Transfer of Prescriptions	G	G	G	G	G	G	A	A	A	G	G	G	A	A	A	A	A	A
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	R	R
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	G	A	R	G	A	A	A	G	G	G	A	A	G	A	A	G
P0050	Spine 2	A	NR	A	G	NR	G	G	NR	G	G	NR	G	G	NR	G	G	NR	G
P0335	SUS Transition	G	NR	G	G	NR	G	G	NR	G	G	NR	G	G	NR	G	G	NR	G

Delivery Confidence - Paperless 2020:	
October-2016	A/G 68.33%
January-2017	A/G 70.00%

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 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:	Transformation Update: Embedding the Operating Model
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 03 b
Paper presented by:	Rachael Allsop, Director of Workforce
Paper prepared by:	Rowena Herbert, Head of Workforce
Paper approved by: (Sponsor Director)	Rachael Allsop, Director of Workforce
Purpose of the paper:	To provide an update to the Board on the latest status of NHS Digital Transformation and progress in embedding the Operating Model.
Additional Documents and or Supporting Information:	None
Please specify the key risks and issues:	No significant risks or issues in relation to this update paper.
Patient/public interest:	No direct Patient/Public interest
Supplementary papers:	None
Actions required by the Board:	The Board is requested to note the progress of embedding the Operating Model and to be aware of the focus of activity to the end of the Financial Year.

NHS Digital

Embedding the Operating Model

Transformation update

Published 16 November 2016

Information and technology
for better health and care

Contents

Executive Summary

This paper provides an overview of the current status of embedding the new Operating Model, as implemented through the Transformation Programme for NHS Digital.

Background

The NHS Digital Transformation Programme was conceived in 2015 to enable the then HSCIC to be equipped to embrace the known present and future challenges.

Specifically, its vision was:

'To empower our people and our organisation to be more flexible and agile in order to deliver the right things for our customers with greater efficiency and provide better value for money in line with the urgent needs of the health and care system'.

The ambitious timescale set by the Board for the first phase resulted in a fairly narrow scope for a new Operating Model (known as the Minimum Viable Product or MVP) being delivered by 1 April 2016. In the last seven months, the further development of the MVP and embedding of the new Operating Model has been delivered through business as usual activity under the new structure and the Transformation Team has been substantially downsized.

Update on current status

Transformational change is long term, complex and multi-layered and the implementation of the MVP on the organisation has not been without its challenges. Feedback from staff has been that there have been some benefits already being realised, but there are also strong feeling of frustration relating to the impact of the MVP on operational activities and hence delivery.

A Transformation Review has been undertaken in the last few months to review the current status of Operating Model implementation and make recommendations on priority activities to support enhancement of the model and steps to support further embedding of the organisational change.

The Transformation Review looked at the 5 workstreams of the original Programme and the key recommendations are below:

Business Architecture:

- Development of a Corporate Information Systems Board to provide governance and priority of delivery projects ;
- Delivery of an agreed programme of tactical delivery projects;
- Development and implementation of training needs analysis for users of Project 2016;

Professions:

- Sponsoring Directors defined for Professions, followed by assessment of Professional Maturity in order to identify and address gaps in terms of the strategic maturity of their professions;

- Each profession to have a plan relating to the rolling out of talent assessment in line with the Talent Management strategy for profession staff.
- Engagement process to be defined and implemented cross organisation to ensure that Portfolio Owners/Managers engage with Workforce team in planning their delivery to ensure joint understanding of scope; and reach agreement on the types of resources required for each phase are accurate and affordable.

Resource Management:

- 100 day sprint improvement programme with focus on Organisational demand, Service Delivery, Management Information, Communications and Tool Development;
- Complete the 'Opportunities' pilot to open up visibility of assignments and implement more widely if agreed, based on feedback from the pilot

Portfolio, Finance and Governance:

- New Portfolio to be implemented following an agreed plan with full consideration of impact on systems and services across the organisation
- Re-confirmation of responsibilities for Portfolio Item management and Assignment Management;
- Definition and implementation of Prioritisation approach for Portfolio items;
- Consideration of Resource Management approach for Digital Delivery Centre(s) and future approach for Centre of Excellence for Agile Delivery;
- Define requirements, design, build and implement the NHS Digital 'Way we work' online handbook;
- Ongoing development of Management Information reporting to meet governance requirements;
- Co-ordinated plan of action across the organisation raise awareness, address training needs and consider monitoring and compliance to deliver significant improvements in data quality in order to improve quality of decision making.

People and Culture:

- Further work to structure a cultural change programme including operational, people, structural and communications elements;
- Benchmark NHS Digital Employee Engagement against other Digital bodies/organisations
- Measure Employee Engagement on a regular basis via staff pulse surveys – targeted at areas of concern and comparing levels against internal and external benchmarks
- Staff communication campaign to be developed/delivered reinforcing the importance of excellent customer focus and service, evidenced by examples of good NHS Digital practice.
- Implementation of Leadership Development Programme

In addition, the Workforce team, newly formed as part of the Operating Model, has also undertaken activity on Workforce Capability Planning. This has been made possible by the establishment of Professions and the visibility of staff capability and capacity by Profession which has enabled a greater maturity of understanding of staff supply than would have been possible before April 2017

Further to this, the NHS Digital Capability Review has been recently commissioned by the organisation to review people, processes, leadership, systems and culture to assure that NHS Digital have the appropriate capabilities to deliver its ongoing statutory commitments

and services, commitments to the Five Year Forward View and the technology and information portfolio.

The Transformation Review paper will be an input to the Capability Review. This will then, in turn, provide outputs in early 2017 to inform a further phase of organisation development/transformation.

Implications

Strategy Implications

There are no significant strategy implications in relation to this update paper.

Financial Implications

There are no significant financial implications in relation to this update paper.

Stakeholder Implications

There are no significant stakeholder implications in relation to this update paper.

Handling

There are no significant handling requirements in relation to this update paper.

Actions Required of the Board

The Board is requested to note the progress of embedding the Operation Model and to be aware of the focus of activity to the end of the Financial Year.

Board Meeting – Public Session

Title of paper:	Paperless 2020: Clinical Governance and Clinical Safety
Board meeting date:	Wednesday 30 November 2016
Agenda item no:	NHSD 16 04 04 a
Paper presented by:	Martin Severs, Medical Director and Caldicott Guardian
Paper prepared by:	Martin Severs, Medical Director and Caldicott Guardian
Paper approved by: (Sponsor Director)	Martin Severs, Medical Director and Caldicott Guardian
Purpose of the paper:	This paper explains how it is intended that clinical governance and patient safety are integrated into the Paperless 2020 portfolio of programmes at an operational level.
Additional Documents and or Supporting Information:	No additional or supporting documents.
Please specify the key risks and issues:	- Reputational risk of NHS Digital taking clinicians away from direct clinical work, given the staffing shortage in the NHS. -Managing perceptions of Programme Directors & SRO -Availability of the needed volume of clinicians with the appropriate skill set.
Patient/public interest:	Indirect
Supplementary papers:	No supplementary papers
Actions required by the Board:	The board are asked to: - Approve this paper - Assign a Non-Executive Director the responsibility of being sighted on Clinical Safety and Clinical Governance.

NHS Digital

Paperless 2020: Clinical Governance and Safety

Published 30 November 2016

Information and technology
for better health and care

Contents

Executive Summary

This paper explains how it is intended that clinical governance and patient safety are integrated into the Paperless 2020 portfolio of programmes. It demonstrates this integration from a structural and process perspective and describes the intended outcomes.

It is submitted to the Board for approval.

Background

Clinical Governance in the context of NHS Digital is:

"A framework through which NHS Digital is accountable for continuously improving the quality of its services, programmes and safeguarding high standards of care including 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.

This paper puts into operational practice the strategic papers previously shared with the Board and its Audit and Risk Committee, which were supported. The Board requested this specific operational paper to be presented to them for approval.

Recommendations

Structure

There will be a simple three level model as shown in the table below:

Level	Scope	Specific Responsibility and Accountability
C	NHS Digital	Corporately, the Medical Director will be responsible and accountable for clinical governance and safety across the Paperless 2020 portfolio. On a day to day basis: The Director of Clinical Governance will oversee, monitor and support all clinical governance activities and produce an annual review and improvement plan. The Director of Clinical Safety will oversee, monitor and support all patient safety activities including safety cases and incident management and produce an annual review and improvement plan. This role is clinically responsible for the clinical safety

Level	Scope	Specific Responsibility and Accountability
		Group activities.
B	Business Domain	Each business domain will usually have one clinician with a professional background and competencies relevant to its activity. This role is responsible and accountable for clinical governance and safety within the business domain including ensuring each programme has the proportionate and appropriate clinical input to meet its clinical governance and patient safety responsibilities.
A	Programme	Each programme will have one or more clinicians with professional background and competencies relevant to its activity. They are responsible and accountable for clinical governance and safety within the programme.

An assessment of all the business domains has taken place and there is a need for 6.6 WTE [11 people] to be recruited. The recruitment process is underway and adverts and appointment processes are expected in the next 30 days[1]

Programme appointments will commence throughout January and February 2017[2]. It is estimated that there will be a requirement for 16 WTE [up to 30-35] clinicians in the programmes. A number of existing clinical staff have been reassigned to work within domains and programmes. In some cases previous work has been incorporated into P2020.

Function

All staff in Paperless 2020 who are undertaking a clinical role, which includes clinical governance activities, must be registered with a professional regulator. This includes having a license to practice or equivalent revalidation. All clinical staff undergo organisational mandatory training plus clinical mandatory training which includes basic Cardio-Pulmonary Resuscitation and Clinical Safety Training [from January 1st 2017].

The Medical Director and Caldicott Guardian is the Executive Sponsor for the Clinical Informatics Professional Group so there is a professional and organisational alignment.

All new portfolio items proposed through the Investment Sub-Group have a clinical governance and safety assessment, by the Clinical Services Executive Portfolio team so that going forward, NHS Digital project and programme leads are been given appropriate clinical governance advice from the point of inception of a project or programme.

Role Profiles for Business Domain Clinical Leads have been completed APPENDIX 1 and a generic role profile for Programme Clinical Leads have been produced APPENDIX 2.

It is of paramount importance to understand that the clinical governance role is to put patients first, so that the service delivery functions or data collection systems, as a minimum maintain and ideally improve the quality of care patients receive. There may be managed tension which is creative and positive, but there should be no needless loss of pace as the role of the clinician is to be a problem solver, risk reducer and issue resolver. In situations where this proves impossible, there are clear and fast escalation routes to achieve the optimum for both patients and the relevant programme.

[1] Please note some interim appointments have been made to support early and required progress
[2] Please note some interim appointments have been made to support early and required progress

Outcome

The outcome of this clinical governance and patient safety approach to Paperless 2020 is as set out in the table.

Outcome Perspective	Assurance given by Clinical Governance and Safety approach
Patients	Can be assured the duty of care is taken very seriously by NHS Digital and a systematic & systemic approach is being implemented which focuses on the quality of care and patient safety.
NHS Digital Board	Can be assured the clinical governance and safety process is comprehensive, proportionate and risk based. It can better understand the cost and role of clinicians in digital transformation, both in terms of the programmes but also the services which will follow.
Clinical stakeholders	Will welcome the explicit and prominent way NHS Digital is approaching clinical governance and safety, fully aligned to mainstream practice. In addition the explicit focus on clinician benefit and patient safety signals the fact that the technology is being designed to support the primary business of health and social care.
Commissioners	Will understand in an explicit sense what clinical informaticians do and the value they bring to the enterprise of digital transformation. Equally the link to mainstream service improvement and business needs will be welcomed.

Implications

Strategy Implications

This proposal is aligned to the agreed organisational strategy and business plans. The former is explained in the table below and the latter is self-evident in that it relates to the Paperless 2020 portfolio, which is mission critical to the organisation over the next 3.3 years.

Strategic Objective	Implication
Ensure that every citizen's data is protected	Clinicians have both a duty to share relevant information as well as to maintain confidentiality. This proposal aims to reach a sound balance point to meet this objective.
Establish shared architecture and standards for the benefit of everyone	Continuity of care and the blending of technology and business including the adherence to standards is a major driver for clinicians.
Implement services to meet national and local needs	It is this NHS Digital objective that is likely to be enhanced to the greatest extent from good clinical governance and patient safety.

Strategic Objective	Implication
Support organisations to get the best from technology, data and information	Good clinical governance and patient safety both rely on and promote getting the best from technology, data and information. The focus of NHS Digital clinicians on patients means it is more likely that organisations will get the best from their investment in staff and technology.
Make better use of health and care information	The statement above equally applies to NHS Digital and its clinicians as it does to the broader health and social care system. We all have a duty to make better use of the assets that are available.

Financial Implications

The Paperless 2020 portfolio has been funded to include clinical input, at the current time there are no known shortfalls or concerns identified with regard to full clinical participation within the portfolio. The expected cost of clinicians including pensions will be:

Business level	£	951,000.00
Programme level	£	2,457,000.00

A full breakdown of these costs can be found in APPENDIX 3.

Stakeholder Implications

As stated in the outcomes section, clinical stakeholders and patient groups are likely to respond very positively. Additionally, previous large scale programmes have been criticised for not having explicit clinical involvement in a meaningful way. This proposal delivers a necessary and sufficient internal clinical component to Paperless 2020. It is complemented with an external involvement through the Strategic Clinical Reference Group [SCRG].

Handling

This proposal will be communicated internally within NHS Digital through the Clinical Informatics Professional Group. It will be communicated externally through the role profiles for all external appointments and will form the basis of any national and regional presentations by Clinical Services Portfolio directors.

Risks and Issues

Risk	Mitigation
Programme Directors and SRO's may feel that the clinician role is a challenge to their authority	The clinical role is complementary, ensuring the programme or group of programmes delivers benefits for patients and clinicians. If managed properly the role is one of creative tension aimed at the optimum benefit.
Programme Directors and SRO's may feel that the clinician role will reduce pace of the programme	The clinical governance and patient safety requirements can be incorporated into overall planning, so that challenges can be mitigated and built into time

Risk	Mitigation
	scales so that quality of the product or service is optimal without undue delay.
Clinicians currently not available and in future may not be available in the right numbers with the right skills	The approach being taken is one of blended teams so that a balance is taken with experience and expertise. This supports a growth and succession of clinicians coming into the programmes so that the clinical capacity within the system is grown and is not stagnated.
NHS Digital taking clinicians away from direct clinical work, given staffing shortage in the NHS	The services and products produced by NHS Digital impact on very large numbers of people e.g. a clinician can see 50-90 people per day but the triage system they build will support 30,000 people.

Corporate Governance and Compliance

Clinical governance and patient safety is a key part of NHS Digital's corporate governance approach and is an essential component of our duty of care. As this is a framework of improvement, compliance is necessary but not sufficient. An annual plan of improvement by the most senior operational directors is also a key component and forms the major platform for feedback to the Board.

In an outcomes based approach, clinical governance could be said to be working well if:

- There are almost no patient safety events when a programme goes live
- Any patient safety events are dealt with quickly and effectively and the duty of candour is fully met
- The clinical risk chart has considered and mitigated all eventualities when the programme goes live
- Clinicians and/or patients take up the offered service ahead of schedule
- Clinicians present and share the programme learning to all other colleagues in the Clinical Informatics Professional Group
- External Clinical conferences, courses, round tables and other events include NHS Digital clinicians as part of their offering
- All clinicians involved will have completed their externalisation contributions whether written, presented, taught or networked.

Management Responsibility

The executive director who will have accountability for the proposal is Martin Severs, Medical Director and Caldicott Guardian.

The staff member responsible for the clinical informatics professional group, its recruitment and its internal clinical professional development opportunities will be Sue Faulding.

The Director responsible for all clinical matters patient safety will be Manpreet Pujara.

The Director responsible for clinical governance matters will be Anne Cooper.

A Non-Executive Director should be assigned the responsibility of being sighted on Clinical Safety and Clinical Governance.

Actions Required of the Board

It is recommended the Board approve this proposal with or without conditions or amendments and they assign a Non-Executive Director the responsibility of being sighted on Clinical Safety and Clinical Governance.

APPENDIX 1

Role Profile for a Paperless 2020 Business Domain Clinician

The person filling this role will have seniority in terms of achievement within their profession, experience of working nationally, running clinical teams, significant informatics experience and a national profile. There will be a domain "fit" with their knowledge and skills. They will provide leadership and direction for other clinicians working across the programmes, and establish effective and collaborative stakeholder relationships both internally and externally.

They will be responsible for advising the Head of Profession on the appointment of suitably qualified clinicians in the right skill mix to manage clinical governance and safety in the related programmes. They will be given a career management role for clinicians in programmes attached to different Business Domains.

The Business Domain Clinician will oversee, monitor and support all clinical governance and safety activities within the programmes of the business domain. They will be responsible and accountable for their actions including those issues escalated to them and remedying gaps or shortfalls in programme clinical governance or safety.

The main clinical governance and safety activities within scope of a Business Domain Clinical Lead's programmes includes:

- Clinical Effectiveness assuring that best evidence of what works is built into each programme. As a minimum, a literature search should have been completed before or during the design and/or discovery phase which includes the planned digital transformation and the best ways of delivering it successfully.
- Clinical safety including the approved safety standards, this not only includes ensuring all clinicians are trained in clinical safety but also following the safety case approach to product release. There will be close working between the programme clinical leads and the domain clinical lead as well as the Clinical Safety Group. There will be an active explicit approach to significant event reporting, investigation, management and lessons learnt. These include but are not limited to failures or malfunction of the digital intervention, breaches of privacy, failures of record management, failure of sharing leading to harm or potential harm.
- Clinical risks and clinical impacts of non-clinical risks will be recorded using standard NHS Digital tools and mitigated with an agreed level of clinical risk.
- Patient and/or user satisfaction including access, continuity of care and co-ordination of care and performance of clinical team functions to deliver better and/or more efficient care with the same quality.
- Quality Improvement includes a range of activities a suitable suite of which will be used within each business domain. These include but are not limited to:
    - Case Review
    - Clinical audit
    - Morbidity and/or mortality meetings
    - Internal teaching
    - Research and innovation

  - Practice development
  - A complaints management system and learning from it.

- Externalisation which is the outward facing activities which enable clinician and clinical bodies to be aware of, understand and support the work being delivered. This involves external speaking, networking events, publication of articles in mainstream and grey literature and the use of social media.
- Clinician Benefit; it is crucial that the benefits to clinicians are described, realised and documented. Often this requires education and training not simply the provision of systems. The Business Domain Clinician will be the focal point of demonstrating clinician benefit from his or her set of programmes internally and externally.

APPENDIX 2

Role Profile for a Paperless 2020 Programme Clinician

The person filling this role may be early or late in their career, a passion for a career in informatics would be an advantage. There will be a domain "fit" with their knowledge and skills.

They may work alone or in a small team of clinicians, having a sound relationship with the Programme Lead and the Business Domain Lead is crucial. They will be responsible and accountable for their actions and should seek help from the Business Domain Clinician, when appropriate.

The main clinical governance and safety activities one would expect to be within scope of a Programme Clinician includes the following. It is likely these activities will be supported across the business domain and some e.g. quality improvement may be managed across the organisation:

- Clinical Effectiveness assuring that best evidence of what works is built into each programme. As a minimum a literature search should have been completed before or during the design phase which includes the planned digital transformation and the best ways of delivering it successfully.
- Clinical safety including the approved safety standards and following the safety case approach to product release. There will be close working between the programme clinical leads and the domain clinical lead as well as the Clinical Safety Group. There will be an active explicit approach to significant event reporting, investigation, management and lessons learnt. These include but are not limited to failures or malfunction of the digital intervention, breaches of privacy, failures of record management, failure of sharing leading to harm or potential harm.
- Clinical risks and clinical impacts of non-clinical risks will be recorded using standard NHS Digital tools and mitigated with an agreed level of clinical risk. And escalated to the Domain clinical lead as appropriate.
- Patient and/or user satisfaction including access, continuity of care and co-ordination of care and performance of clinical team functions to deliver better and/or more efficient care with the same quality.
- Quality Improvement includes a range of activities a suitable suite of which will be used within each business domain. These include but are not limited to:
    - Case Review
    - Clinical audit
    - Morbidity and/or mortality meetings
    - Internal teaching
    - Research and innovation
    - Practice development
    - A complaints management system and learning from it.

- Externalisation which is the outward facing activities which enable clinician and clinical bodies to be aware of, understand and support the work being delivered. This involves external speaking, networking events, publication of articles in mainstream and grey literature, and the use of social media.
- Clinician Benefit; it is crucial that the benefits to clinicians are described, realised and documented. Often this requires education and training not simply the provision of materials. The Programme Clinician will work with the Business Domain Clinician will be the focal point of demonstrating clinician benefit from his or her set of programmes internally and externally.

APPENDIX 3

Cost breakdown for Clinicians

	Medical Levels or AfC banding	Salary	Cost Recovery Amount (Salary & Pensions etc.) FTE	FTE	Part time Salary (Inclusive Pension)	Volume Required	Total
Medical Domain Leads	Medical Level 3 (top of)	£128,306.00	£163,241.00	0.6	£97,945.00	8	**£783,560.00**
Clinician Lead 8 D	Band 8D Top	£82,434.00	£104,479.00	0.8	£83,583.00	2	**£167,166.00**
						Business Level Sub-Total	**£950,726.00**
Medical Clinician	Medical Level 2 (middle)	£96,913.00	£123,026.00	0.5	£61,513.00	16	**£984,208.00**
Clinician - Non medic 8C	Band 8c Top	£68,484.00	£86,609.00	1	NA	17	**£1,472,353.00**
						Programme Level Sub-Total	**£2,456,561.00**
						Total	**£3,407,287.00**

Board Meeting – Public Session

Title of paper:	NHS Digital Data Strategy
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 04 b
Paper presented by:	David Hughes, Executive Director of Information and Analytics Matt Neligan, Director of Transformation (Information and Analytics) Daniel Ray, Director of Data Science
Paper prepared by:	Matt Neligan, Director of Transformation (Information and Analytics)
Paper approved by: (Sponsor Director)	David Hughes, Executive Director of Information and Analytics
Purpose of the paper:	To agree the final version of NHS Digital's data and information strategy
Additional Documents and or Supporting Information:	None
Please specify the key risks and issues:	• financial • security and protection of citizens' data • capacity and capability to deliver • impact on stakeholders (see paper for full details)
Patient/public interest:	Indirect – setting direction for an organisational approach to the data strategy that will ensure we are better able to conduct our business and to have an impact on decision making and delivery of services for patients and the public.
Supplementary papers:	Appendix A: NHS Digital data and information strategy
Actions required by the Board:	The Board is asked to note the revised articulation of strategic direction and positioning in response to the views expressed by the Board; and agree the data and information strategy

NHS Digital

Data and information strategy

Published 30 November 2016

Information and technology
for better health and care

Contents

Executive Summary

This paper presents the Board with a final draft strategy for data and information. This document sets out the future role that NHS Digital will take in driving forward the use of data and information in delivering the Five Year Forward View and government priorities.

The document recognises our role in the wider system and is explicitly positioned as a strategy for our role with data and information. The wider strategy for data for the system looking at new ways of working with data in health and care organisations, data standards, defining new data content and the way in which the health and care system aims to use data and information to transform care will be owned by the National Information Board. This data strategy aligns to the Paperless 2020 programme but looks at the role of NHS Digital in delivery.

This paper seeks the Board's input to the final strategy document that will then be used to engage with partners over how it needs to iterate and inform the wider system strategy for data.

Background

At the Board business meeting on 13 April 2016 the Board discussed the potential direction of travel and outline content for key areas within the developing data strategy for the organisation. Key messages from this discussion were confirmed in the public Board meeting in May around five specific areas, namely data acquisition; data quality; statistics; analytics and tools; and data science centre of excellence.

Further work since then has included:

- Implementation of key immediate priorities within the strategy as directed by the Board in April including:
    - Delivery of the Data Quality Maturity Index (DQMI) and initiation of actions to drive up data quality across the health and care system
    - Delivery of new data content in line with the NIB plans and priorities (tactical data sets)
    - Actions to engage with partners and ensure greater responsiveness including relentless focus on listening and driving action to deliver customer requirements; and
    - Rapid development of plans and actions to speed up data availability for core data sets (HES and SUS with others to follow).
- Informal engagement and socialising of messages with colleagues across national partner organisations to test headline content within the emerging strategy.
- A proposal to re-position the work in relation to the external system, partly in response to feedback from NHS England and other partners specifically including NIB engagement and ownership.
- Development of the strategy as a product with engagement through EMT and other key individuals across NHS Digital. In particular this has focused on building the strategic proposal around the following key areas:
    - Data acquisition: how we can radically change and improve the process
    - Analytical services: a new offer to the system that adds value while respecting our position relative to partners and the market
    - Analytical tools: making the publications and data that we produce available through business intelligence solutions that offer maximum value
    - Statistics: engaging with the UK Statistics Authority to examine and articulate our role in relation to other organisations producing health and care statistics.

The Board Development Day in October considered progress to date on implementation of the strategy and headline areas of interest for the Board for further clarification. A number of comments were raised that have been reflected as appropriate in the revised strategy that is included at Appendix A. Two fundamental areas of focus in this discussion were:

- **Clarifying our analytical service offer.** The Board considered the merits of the proposals to extend and improve our analytical service offering. The discussion picked up key areas in which we would look to offer analytical services to users and customers of data and information. This was broadly supportive of an enhanced offer and suggested specific areas in which we would provide analytical services in the future.
- **Engaging with the market of business intelligence providers over the impact of our strategy**. The Board explored the issues and impact of our proposals on the market of business intelligence and analytics providers. It was clear that our improved offer should not destroy or aim to damage the market; it should instead “raise the bar” for analytics. It should reflect the fact that the way in which available data and information should be presented in the modern age needs to utilise best available technology. This effectively means that we will continue to develop and enhance our “baseline” presentation of data, in a way that will incentivise and stimulate the market to occupy new, value-adding territory. We need to positively engage with this provider market to listen to views and to communicate our proposals.

The key focus for this paper is the final version of the Data and Information Strategy that is included at Appendix A for the Board to consider.

Recommendation

The data and information strategy has been developed to reflect the ambition expressed at the October Board Development Day. The full document is set out in Appendix A.

The approach recommended in the two fundamental areas of focus picked up by the board is as follows:

Analytical services offer

We draw the distinction between **analytical** services (interactive tools offered through data science and visualisation that will provide ready access to data and information) and **analysis** services (delivery of statistical work, publications and indicators to support the derivation of intelligence). Our analysis services will increasingly draw on (for internal use and production) and be offered through (for external presentation) analytical tools where the required analysis is simple enough and appropriate to do so.

We will develop a clear, baseline analytical service offer that adds value and raises the bar for analytics across the system. This will allow local organisations and other partners to build on our standard offering through 'buying greater value intelligence,' negating the need to buy the basic fundamental analytical building blocks which currently occurs. This means that these investments can be made into innovation in relevant areas in the market. The service will add value and will provide vital insight into health and care performance and outcomes.

We will develop an enhanced, interactive, web-based analytics service for the data we hold on behalf of the health and care system, which will be offered through tools as a standard way of presenting data. This will accelerate the ability of the system in its entirety to make better use of its analytical capabilities and will shift the focus more to the use of information to drive improvement in quality, efficiency and outcomes.

We will develop a service catalogue for the analysis services that we offer. These will be provided where:

- we are directed or commissioned by a customer specifically to provide these services;
- there is an economic case to provide these services once across a large population (e.g. for the whole country); or
- the analysis is an essential element of the production of an indicator or other NHS Digital statutory service

We will not provide analysis services that require local engagement, specific customisation and further intelligence innovation (unless they meet one of the criteria above).

Engaging with the market of business intelligence providers

Technology has moved on such that basic web based analytics are provided as a simple provision within standard technology installations, and web reports can be created by individuals with basic knowledge in very short timescales. We recognise that our analytical service offering can (and indeed should) have an impact on the market of business intelligence analytical providers. By making standard, baseline data analytics that are easily available and easy to be interpreted, we expect to shift the market into adding greater value and innovation for the health system and taxpayer. We recognise the value to the health system of a vibrant market of business intelligence analytics and are looking not to disrupt, but to develop, enhance and stimulate the market through occupying a different space to those providers.

We will therefore increase our engagement with, and outline to, the market of what we are and what we are not going to do in this space, and will signal this in a timely way that allows the market to respond and occupy a position that adds greater value. We will develop and deliver new underpinning data architecture and infrastructure that creates an innovation ecosystem for the market that is larger than that which currently exists.

The Board is asked to:

- **note** the revised articulation of strategic direction and positioning in response to the views expressed in the Board development day in October; and

- **agree** the data and information strategy

Implications

Strategy Implications

The data and information strategy is an important element of, and entirely complementary to, our organisational strategy for 2015-20 "*Information and technology for better care*." It will have an impact across our business and in particular will support delivery of the following organisational priorities:

- Ensure that every citizen's data is protected
- Make better use of health and care information

The data and information strategy describes how we will work as an organisation and sets a number of key objectives. It is an important refresh of our organisational ambition and is intended to take this to the next stage and reflect the ambitions that we have for the new organisation as NHS Digital.

Financial Implications

The strategy is wide ranging and has significant financial implications. The general theme is that this is about how we re-use the resource that we already have to deliver a better service for our customers. The strategy sets out a number of initiatives that will have cost implications of varying types, including:

- Existing initiatives with funding in place that are being refreshed or aligned to the strategy;
- New services that have an additional associated cost and that are funded through planned expenditure on baseline budgets, new NIB funding, or anticipated new charging models;
- New services that have an additional associated cost and that are unfunded; and
- Transformational initiatives that will reduce cost in the medium term that can be recycled to deliver new and unfunded initiatives.

A business case will be developed for all elements of the strategy that have a significant financial implication and the overall impact of the strategy will be considered through the business planning process for 2017-18 and beyond. Business cases for new services will be expected to explore internal efficiencies to the limit in particular the anticipated workforce efficiencies through transformation, before making the case for new resource.

Stakeholder Implications

Stakeholders and customer implications are significant. This strategy is largely about the way in which we can ensure we are more responsive to customer requirements and how we transform to become an organisation that can effectively deliver against their expectations. This has implications in a number of dimensions:

- **Placement of the strategy relative to the wider health and care system**. This is explicitly a strategy for NHS Digital's role with data and information. It therefore sets out how we will operate to carry out our essential role as a part of the health and care system. It needs to be both complementary to and supportive of wider, emerging strategy in the system. It anticipates some elements of that as we need to be ready to deliver.
- **Engagement over the content of the strategy**. The informal socialising of content to date will now be supplemented with further work across NHS Digital to engage in a structured way with customers and users of our data over the content of the strategy.
- **Delivering the engagement outlined in the strategy**. The engagement activity in the strategy is critical to the approach. This corporate approach to engagement further informs and iterates the content of the strategy which needs to be flexible enough to adapt to future changing requirements and emerging priorities.

Handling

A communications strategy is being developed in conjunction with the Communications team. This will incorporate engagement with stakeholders and staff to raise awareness, encourage feedback and input, and help to refine and position the strategy. As delivery of individual work streams gets underway, the communications strategy will be reviewed to consider the use of additional communications channels, including media.

Risks and Issues

Given the breadth of the data and information strategy the risks and issues associated with it relate to the major corporate risks for the organisation, in particular those that relate to how we use data. Consideration of risks and issues should therefore be viewed in that context.

Many of the elements of the strategy are a key mitigation against corporate risks, although it is acknowledged that the data strategy presents new or increased risk in the following areas:

- **financial** risks associated with the ability to deliver the strategy. *Mitigated through business case development and corporate governance (ISG and Operations Board oversight);*
- **security and protection of citizens' data** which is an existing risk but the presentation of risk alters as we change the way in which we handle and present data. *Mitigated through existing information governance arrangements*;
- **capacity and capability to deliver** against commitments when we are setting out ambition to introduce a significant number of new ways of working. *Mitigated through the corporate Capability Review, workforce plans set out in the strategy and transformation that provides efficiency and thereby additional capacity to deliver*;
- **impact on stakeholders** including other arms-length bodies (ALBs), NHS and social care organisations, the public, and private sector providers of data services, in particular ensuring that our plans for our role with data are well understood by others and fit with those of other national organisations. Our role with respect to the market for BI analytics is critical in this and the proposal outlined in the data strategy needs to be well understood. Similarly our position as the single authoritative source of data for the NHS and care system which needs to be placed in its appropriate context. *Mitigated through extensive and ongoing engagement as set out in the strategy.*

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Corporate Governance and Compliance

Ongoing monitoring of the strategy will take place periodically through corporate governance structures including the Operations Board and reporting to the Board meeting at an appropriate frequency.

A detailed implementation plan that sets out key milestones around each initiative in the strategy will be developed. This will aim to include KPIs and metrics to demonstrate progress against all of the aims and objectives that are outlined in the strategy.

Management Responsibility

David Hughes, Executive Director of Information and Analytics leads the development of the content of the data and information strategy.

Beverley Bryant, Director of Digital Delivery leads the process to further engage with the system on the strategy.

The wide-ranging nature of the data strategy means that responsibility for day-to-day delivery of the proposals sits across the entire organisation. The coordination point for delivery is Matt Neligan, Director of Transformation (Information and Analytics).

Actions Required of the Board

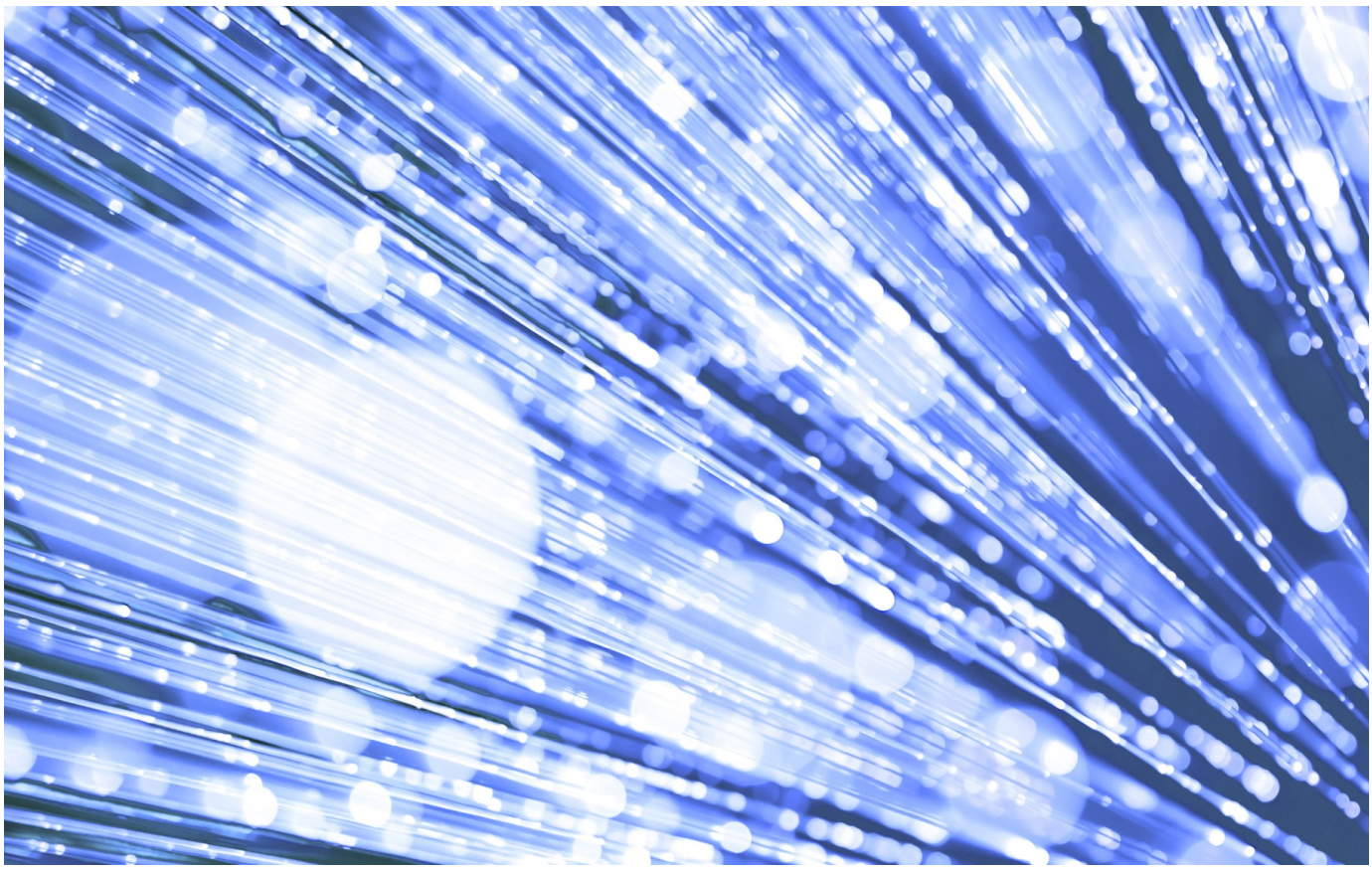
The Board is asked to:

- **note** the revised articulation of strategic direction and positioning in response to the views expressed in the Board development day in October; and
- **agree** the data and information strategy

NHS Digital

Data and information strategy

Draft v0.8 November 2016



Information and technology
for better health and care

Contents

Introduction

This data and information strategy sets out the future role that NHS Digital will take in driving forward the use of data and information in delivering the Five Year Forward View and government priorities. It aligns to the shared vision and plans for data and information across the health and care system that are owned by the National Information Board and the Paperless 2020 programme.

The role of NHS Digital

Our role is an integral part of the health and care system and we view it as essential support to the delivery of high quality, effective health and care and the achievement of improved health and wellbeing outcomes for citizens.

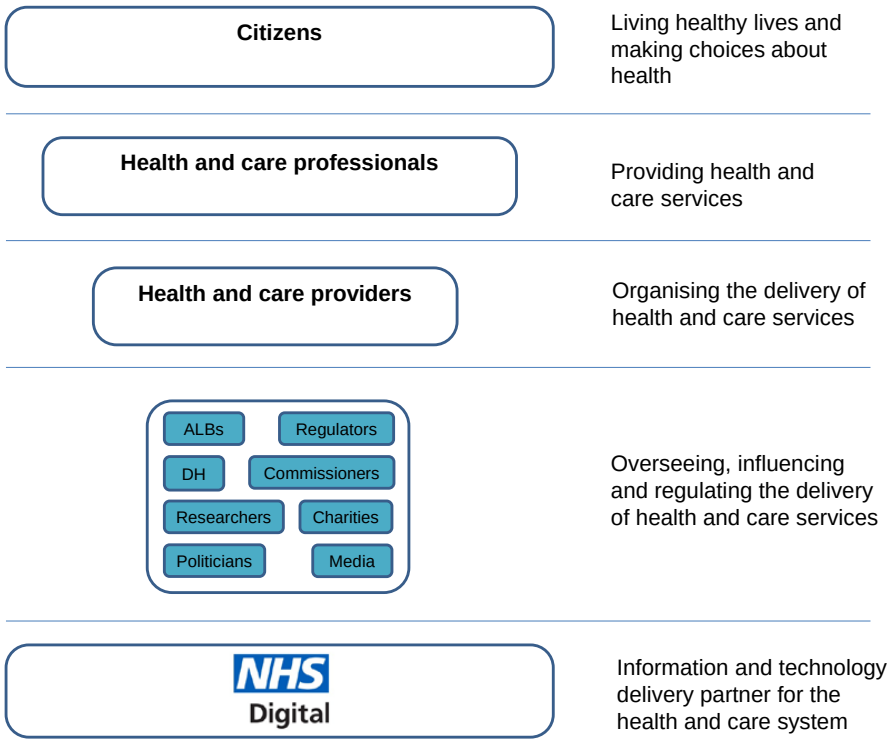


Fig. 1. The health and care system that NHS Digital supports

Our corporate position statement describes our role as follows:

*NHS Digital is the **information and technology delivery partner** for the health and social care system. Our team of information analysis, technology and project management experts create, deliver and manage the essential technology infrastructure, digital systems, services, products and standards upon which health and care professionals depend.*

*We **work in partnership** with the other national bodies and with those that use our data and services locally.*

*Our statutory duty is to ensure that the information we hold in trust for the public is always kept **safe, secure and private**.*

*Our responsibility is to **deliver** the high quality and reliable technology of today, while seeking to unlock the potential of the new, exciting and innovative technologies of our time.*

*What we do **enables health and care professionals** to care for people more safely and effectively. We gather and disseminate the information providers and commissioners rely upon to improve care quality, and we generate the data that researchers work with to find new ways to prevent and treat disease.*

Our role with data and information

NHS Digital offers three types of data and information services:

- **Data services**: making data available to customers on health and care services to enable research and analysis by individuals and organisations (including commissioners, providers, arms-length bodies, researchers, the intermediary market etc.).

- **Analytical services**: providing standard and bespoke analysis services to customers that either answer their question or that provide them with the tools to answer their question.

- **Statistical services**: developing and publishing national, official and other statistical publications that describe health and healthcare across the country.

In order to provide these services we carry out critical functions that extend through the lifecycle of data and that are underpinned by the legal framework set out principally in the Health and Social Care Act 2012. These include:

- Providing business-critical **technology services** which underpin local health and care organisations and that generate the data associated with delivering care;
- **Collecting, analysing and presenting** national health and social care data;
- Making data **available** for others to use under safe and secure governance;
- Publishing **guidelines and standards** that are important for shaping the way services are delivered locally;
- Working to create **professional standards** and regulatory frameworks for health informatics individuals;
- Designing, publishing and assuring **indicators** that can be used to measure the quality of health and care services;
- Helping health and care organisations improve the **quality of the data** that they submit;
- Reducing **administrative burden** on local health and care organisations associated with national data collections;
- Designing and assuring the implementation of **national standards** and **currencies** that ensure consistent capture and application of health and care data;
- Implementing approved **data standards** and maintaining national data standards

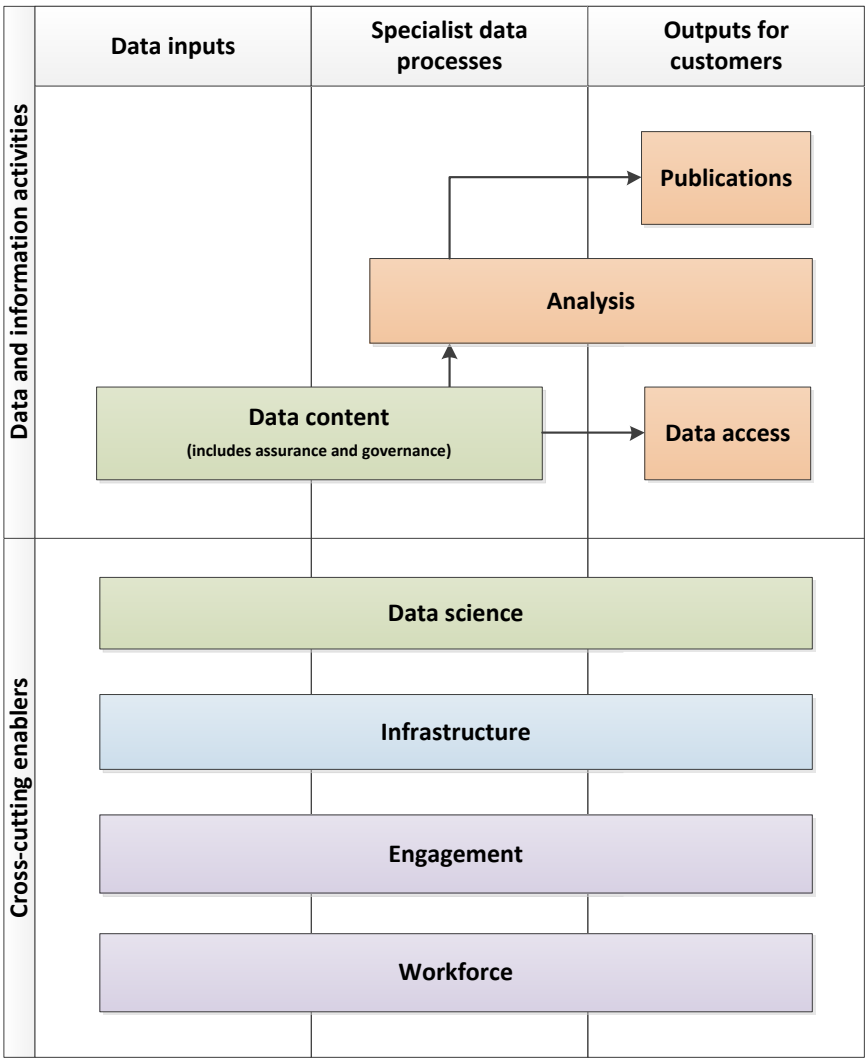


Fig. 2. The role that NHS Digital has with data and information

Data and information in the health and care system

In order to deliver our services effectively and to add real value to the health and care system, we must ensure that we work to release the potential of data and information in all our engagement with our partners. We support the achievement of better health and wellbeing in the population by enhancing the ability of citizens, providers, commissioners, national bodies and researchers to use data to make better decisions on how to improve health and healthcare. Data and information are vital to improving health and care services and allowing individual citizens to take control of their health and wellbeing.

Because we are the delivery partner for organisations throughout the health and care system, it is essential that our work appropriately reflects the priorities of those organisations and is targeted at the activities and services that will make the greatest difference to health

and healthcare. The National Information Board (NIB) is the principal means through which we ensure that the priorities of partner organisations are being addressed in our services. The role of the National Information Board is to put data and technology safely to work for patients, service users, citizens and the professionals who serve them. The NIB brings together national health and care organisations from the NHS, public health, clinical science, social care and local government, along with appointed independent representatives to develop the strategic priorities for data and technology.

It designs and develops the vision, strategy and direction for the health and care system through engagement with partners and stakeholders, including industry and ensures that priorities for investment and delivery are clear. This translates into annual commissioning priorities and an agreed delivery plan for NHS Digital.

The overarching strategy for NHS Digital for 2015-20 therefore recognises the challenges and priorities for the wider system – and in particular the unprecedented challenges that the health and social care system faces. Constraints on resources, coupled with rising expectations and an escalating demand for services, are placing the current models of health and social care under increasing strain. However, there is also considerable agreement on how we must respond to these challenges. A growing consensus says that we must do more to help citizens look after their own well-being. We need to join up health and social care services to better reflect the way these services are accessed and delivered. We must also give more support to unpaid carers and professional health and social care staff, so they can deliver safer services more efficiently. This strategic context informs the joint priorities of the National Information Board and is reflected in the way that we will put data and information to work through this strategy.

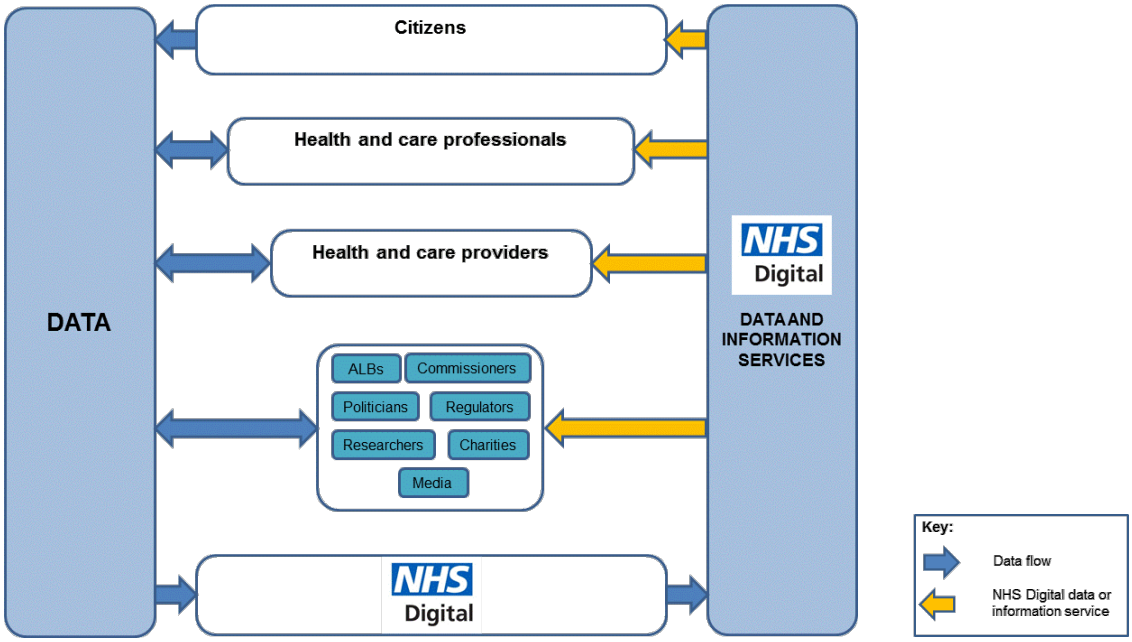


Fig. 3. The role of NHS Digital with data and information in the health and care system

Vision

Our vision for 2020 for data and information is for:

> *… a health and care system that has all the data and information that it needs, provided in an accessible and timely way, to enable it to provide the best possible services and to achieve world class health outcomes.*

This vision reflects the critical role that data and information play throughout the health and care system as we strive to deliver great care. It builds on the NHS Digital vision 'to harness the power of information and technology to make health and care better' by articulating a specific vision for our role with data and information.

As an organisation we aim by 2020 to have revolutionised the way technology, data and information are used to transform the delivery of England's health and social care services. Our vision is unapologetically bold, and we know we need to transform the way in which we work and our offering to the system in order to deliver this future.

The key corporate priority for NHS Digital that is set out in the corporate strategy[1] is "making better use of health and care information". This corporate strategy articulates where we want to be and where the system will be by 2020 and sets a framework for this strategy that articulates how we will carry out our role with data and information to support the wider ambitions of the health and care system. The elements of the vision within our strategy are:

- 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 services. It will also provide research organisations with the data they need.
- By 2020, all the citizens who want it will have access to national and local data and technology services that enable them to see and manage their own records; undertake a wide range of transactions with care providers; and increasingly manage their own health, care and well-being. By the same date, care professionals will have timely access to the information, data, analysis and decision-support systems that they need to deliver safe and effective care.
- By 2020, much more data will be available because of new initiatives such as genomics, data from personal devices and more standardised collections from care

[1] *Information and technology for better health and care:* NHS Digital Strategy 2015-20, *2015* https://digital.nhs.uk/article/249/Our-Strategy

providers. This data will be more accessible and the burden of collection will be reduced. Better data will help researchers, commissioners and national bodies gain better insight. Clinicians and care professionals will have access to more and better information to inform better care. The UK will be seen as one of the best places globally to conduct research and the collection and use of the nation's care data will have made a substantial contribution to the development of health and social care services.

Mission

The way in which we deliver this vision is by linking our work to the needs of customers and delivering services that are high impact and value-adding. Our mission for how we will deliver our vision is that:

> *… we will empower the health and care system to be intelligent in the way it uses data and information to drive improvements in health and care, by delivering world class data and analytics services through the highest level of skills, expertise, tools, techniques and technology.*

Our mission is fundamentally linked to the role that we play in the system and we must continually deliver and develop services that enable the wide range of data and information users to drive better health and care.

The Wachter Review[2] has concluded that in order for the NHS to continue to provide a high level of healthcare at an affordable cost, it must modernise and transform. This transformation will involve enormous changes in culture, structure, governance, workforce, and training. The review states that none of the changes are likely to be as sweeping, as important, or as challenging as creating a fully digitised NHS and it emphasises that the ultimate purpose of the transformation to radically improve the system's ability to provide crucial information when and where it is needed..

It is essential that our teams and our partners are clear about our role and the way in which we will work to achieve this mission. We will:

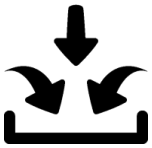
- **Engage with our customers** proactively to understand their challenges and the data and information landscape in which we operate
- **Be the single authoritative source of data** across the health and social care system
- Support a shift from data collections to **data harvesting**
- Utilise data to add value in all that we do and making **data accessible** by getting them into the hands of users in a timely way
- Provide **thought leadership** in the use and application of our data
- Present and **publish data and statistics in innovative ways** that add value for our customers and enable them to turn data into information
- Ensure that we use the most **up to date technological infrastructure** and applications to deliver our data services

[2] *Using information technology to improve the NHS*: Dept. of Health, *September 2016*
https://www.gov.uk/government/publications/using-information-technology-to-improve-the-nhs

Objectives

Our objectives are organised thematically. They represent the roadmap to improving the use of data and information in health and care by 2020 and achieving our mission.

Data content



1: **Reduce burden:** Collect core data sets in a way that minimises burden on providers

2: **New content:** Undertake new data collections that respond to customer needs and directions

3: **Right data:** Ensure that we collect data which add value for our core customers and that are based on reliable sources

4: **Data quality:** Ensure the quality of data is of a high standard throughout the system

Data access

5: **Easy access:** Ensure data are readily and easily accessible

6: **Transparency:** Have a clear and transparent process for accessing data

7: **Innovative access:** Develop new and innovative ways of accessing data

8: **Greater reach:** Increase the number of customers of the data so that more data is being used to improve health and care with an appropriate legal basis

Publications

9: **Relevant:** Add value and are relevant to our customers

10: **Creative presentation:** Presented in an accessible and flexible way

11: **Robust:** Ensure that we have satisfied our statutory obligations

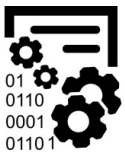
Analysis

12: **Value adding:** Production of a range of indicators, outcomes analysis, intelligence and statistics that add value for customers

13: **Rapid and robust:** Robust analysis that is able to respond rapidly and that is proactively presented

14: **Meaningful:** Data and information that are meaningful for customers and users

Data science



15: **Innovative:** We will present data in innovative and interactive ways

16: **Enhanced delivery:** Add value to data across the delivery chain

17: **Thought leadership:** Drive thought leadership

Customer engagement

18: **Responsive:** Highly responsive to customer needs

19: **Listening:** Engaged in understanding customers and how we will work with them

20: **Communicative:** Letting the world know about our data and our services

Workforce

21: **Delivery culture:** Agile, flexible and engaged workforce with a positive culture of delivery

22: **Highly skilled:** Trained and transformed with the right balance of skills and capacity to do the job well

Infrastructure

23: **Advanced techniques:** Ensure that we have the most technically advanced and appropriate ways of processing data

24: **Enabling transformation:** Establish new infrastructure to support transformation through handling key data management processes: data linkage, handling large datasets, enabling remote access

25: **Data security:** Ensure a high level of security and governance linked to legal basis for processing and analysis

Strategy

To deliver these objectives requires us to renew and revitalise our service offer to customers and to work differently to deliver those new services. The sections below set out the strategic initiatives that deliver against our eight objectives. We have taken a fresh look at our service offering and within the boundaries of our role we have identified initiatives that pursue three broad themes. These reflect the feedback that we have had from customers and the insight that we have into the ways in which we must work in line with our mission to deliver our objectives. The three themes are:

Collaborate

We will collaborate with the best in class to ensure that we are developing, procuring or using the most up to date technology as well as employing a collaborative approach with our customers to ensure we understand their needs and are responsive to their requirements.

Innovate

We will be innovative both in terms of technology and approaches but also through bringing original thinking that pushes the boundaries and that provides thought leadership in the use of data. Our agile approach will support the position we wish to take at the leading edge of innovation.

Stimulate

We will stimulate the health and care system to improve by providing core data presentation services that allow objective representation of data and accessible descriptive tools. We will stimulate the market for inferential analytics to raise the bar and add value.

There are four main types of activity that run through this strategy:

- **Making rapid, visible, tactical improvements** to services in those areas where customers have experience poor performance or where we know there are improvements that can be made to our service offer and way of working.
- **Engaging extensively** and creatively with partners, users and citizens to develop a service offer that adds greater value, leverages our role in the system with data and information and that recognisably reflects the ambitions of our customers.
- **Developing and delivering innovative services** that accelerate the ability of the health and care system, including citizens, to be intelligent in the way it uses data and information to drive improvements in health and care, in line with our mission.
- Taken together these represent a **transformation** in the services that we offer and the skills, expertise, tools, techniques and technology that we use.

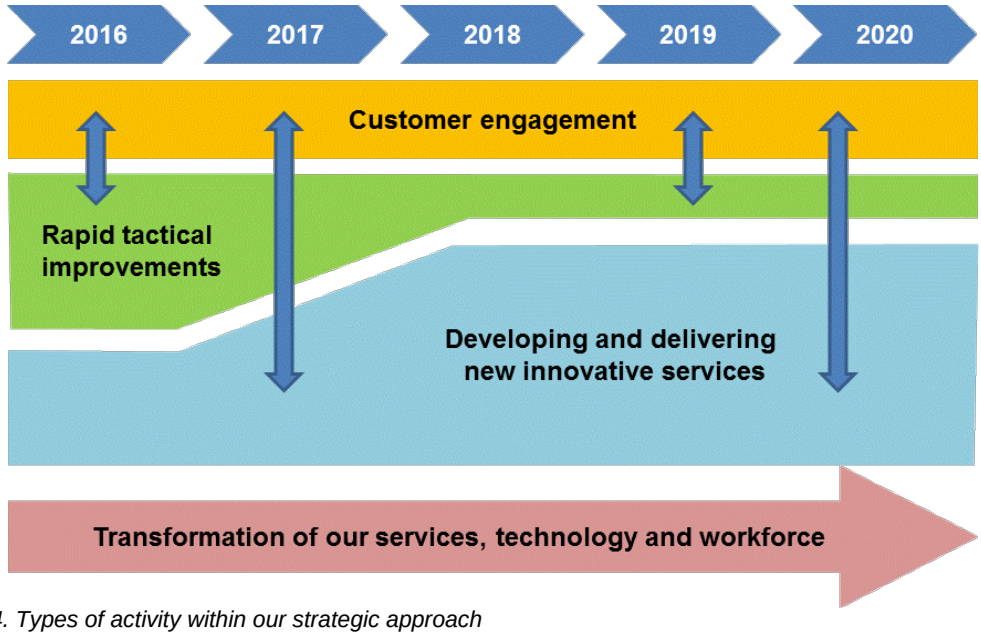
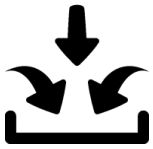


Fig. 4. Types of activity within our strategic approach

For each objective we have set out the activities that we will be carrying out in line with this strategic direction and that appropriately reflect our starting point. Where we know there are rapid improvements that need to be made to bring services up to the required standard we will address these early. Where we are creating a new or different way of delivering our services then we need to develop and refine our service offer in line with the expectations and ambitions of customers and partner organisations. In these areas the transformation will take longer.

Data content



1: **Reduce burden:** Collect core data sets in a way that minimises burden on providers

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4: **Data quality:** Ensure the quality of data is of a high standard throughout the system

Statement of need

The data that we have historically collected has been developed piecemeal, with new data collections driven by single policy initiatives or around individual services. There are 200 different data collections across the health and care system that are describing a much smaller number of service types.

There is good coverage for some services but in other areas the range of data collected does not support the intelligence the system needs. The delivery of the Paperless 2020 Data Content programme through the National Information Board will define the new data content that the system requires and that we need to be able to deliver. In this area, it is critical that we are responsive to the wider health and care system's requirements and ensure that our attention is on the data that the system needs. We will create a service offer as a place to come for advice on how to use the data rather than coming with a data requirement – we anticipate that customers should come with a question and we help them develop how they might answer it given our expertise and knowledge of data and analytical techniques.

Where data collections do not adhere to fundamental information standards, this increases the burden and the likelihood of duplicating effort by collecting the same information twice. We need to ensure that the system conforms to published data standards.

Providers of care currently put significant resource into deriving, assuring and submitting data files to NHS Digital and other national bodies. Data is gathered in a range of ways including collections, audits and surveys. We have a great opportunity to improve the way in which we collect data, gathering them in the most appropriate and efficient way according to the type and source of data. This will involve harvesting directly from existing systems at the point of care wherever possible, many of which we operate on behalf of providers in our technology programmes. The underlying principle will be to collect or harvest data once, direct data flows, and re-use within the bounds of the appropriate legal basis multiple times.

Strategic initiatives to deliver

Key: Rapid tactical improvements; Customer engagement; New innovative services; Transformation

Project	Description	Milestones	Deliverables
PLICS data	Establish a pilot PLICS data collection (2016 NIB priority).	Oct 2016	One off data bundle delivered to NHS Improvement
Community data	Establish community health services data collection. (2016 NIB priority).	Oct 2016	Discovery and start up completed
MCDS data	Delivery of the Maternity and Child Services dataset.	Oct 2016	Data Flowing for Mental Health, Maternity, Children and Young People's health
Data mapping	Establish map of current data including data collections and alternative data sources. Create a data library to validate new collections against.	Oct 2016 Dec 2016	Map completed reflecting NHS Digital collections and known ALB collections Define data collected by NHS Digital but not available to NHS Digital analysts and agree prioritised action plan to support data flow within NHS

Project	Description	Milestones	Deliverables
		Mar 2017	Digital. First draft data library available
Data standardisation	Review existing collections and establish adherence to fundamental standards.	Mar 2017	Published level of adherence by organisation and data standard.
Data quality	Tactical actions to use available system levers to drive improvements in data quality	Dec 2016	Initiatives in place with local organisations to drive up data quality.
Data capture review	Review current and future data sources and the mechanisms by which these are collected to make proposals to NIB on how the content and process for future data collections might operate.	Dec 2016	First summary and options available for Programme 26 programme board to consider.
Front Door Service for New Data Collections	Create a cohesive and marketable front door service for individuals and organisations seeking existing or new data collection.	Tbc	Agree structure and resourcing within NHS Digital to enable effective and marketable 'Front Door'. Set up and market 'one stop shop' for existing and new data collections. To support single contact for customer, with supporting infrastructure to enable Front Door liaison to provide information, quotations for work, information on processes and services associated.
Data rationalisation	Deliver work that is informed by the data capture review and scoped and prioritised by the NIB Data Domain (H) on how we might change the content and architecture of data sets to move to a "collect once, use multiple times" model.	Mar 2016	Agree scope of work and key deliverables with Programme Board Agree funding and resource for 2017/18 delivery
Data harvesting	Agreed strategic scope of ambition for Domain H Programme 26, with	Dec 2016	Strategic vision document agreed by board, Proposed approach to be scoped and high level plan with

Project	Description	Milestones	Deliverables
	timelines and key work streams signed off.		agreed work streams defined. Will include options for enhancement of current data collection through to complete data harvesting / extracts.

Data access

5: **Easy access:** Ensure data are readily and easily accessible

6: **Transparency:** Have a clear and transparent process for accessing data

7: **Innovative access:** Develop new and innovative ways of accessing data

8: **Greater reach:** Increase the number of customers of the data so that more data is being used to improve health and care with an appropriate legal basis

Statement of need

We know that some users have been frustrated with our processes for accessing data that they need and that our service has been perceived as poor in the past. We have made good progress on moving away from the paper application system with the establishment of our Data Access Request Service (DARS) online. We need to continue this journey, by enabling easier access and introducing processes that encourage greater usage of our data services to support the objectives outlined above. This will involve expansion of the range of data that is available through our single, consistent online process to cover all available data. By increasing the proportion of data accessed remotely rather than by transferring whole data sets, we will also have the opportunity to strengthen security and reduce compliance issues. We will review the charging model for data to ensure that we are appropriately recovering costs while improving access.

Strategic initiatives to deliver

Project	Description	Milestones	Deliverables
DARS Online	Continue implementation and expansion of the online service for data requests to cover all services.	Oct 2016 Mar 2017	Move to new supplier Delivery of current known priority improvements Customer access to summary of application at any point in the process. Improved method for customer to select products. Improved response to data requests
Unified set of registers	Integrate the workflow and data capture to	Oct 2016	Requirements gathering complete

Project	Description	Milestones	Deliverables
	create a single source of automatic register generation.	Dec 2016	Automatic creation of release register and DSA schedule Data release register for all NHS Digital disseminations published and maintained via an online process
Rapid data access	Improving data processing times across all datasets.	Q1 2017	Integrate electronic workflow across datasets Model office and continuous improvement across all teams
Customer engagement	Responding to customer feedback including delivery of training to make data access easy.	Date tbc	Deliverables tbc
Developing a charging model for data	Engaging with customers over our charging model and implementing the model.	Dates tbc	Review of 2016/7 charging model and compare to operational costs. Updated charging model for 2017/8
Remote data access	Establishing remote data access services under the highest standards of governance. PCD access managed within NHS Digital via an online tool with reporting capability.	Oct 2016 Nov 2016	Tool set up and used as part of BAU Tool fully managed by Data Steward Service as part of wider registers project Roll out of tool to the DSCRO team for use with CCG applications for data. Further remote access deliverables tbc (e.g. HDSI2)
Data Management Specialist Service	A structured model for environment management and database administration A transparent set of standards/ policies underpinning how we manage data.	Oct 2016 Nov 2016 Q1 2017 Q2/3 2017	Project structure established Audit of current activities across teams Pilot migration Phased full migration

Publications

9: Relevant: Add value and are relevant to our customers

10: Creative presentation: Presented in an accessible and flexible way

11: Robust: Ensure that we have satisfied our statutory obligations

Statement of need

Our statistical publications are widely disseminated and are vital to understanding health and care, with a number designated as National Statistics demonstrating quality and trustworthiness. However, we know from our customers that our information can be difficult to access and to navigate. The rationale for many of the publications and their associated data collections can be unclear. There is also often a lack of coherence and sometimes duplication with publications produced by other producers of English health statistics. We should use technology to produce increasingly flexible and interactive output and some of the resource involved in manual production of publications should be deployed in developing this, along with a more flexible approach to determining the level of commentary in publications based on impact and user need.

Strategic initiatives to deliver

Project	Description	Milestones	Deliverables
Publications consultation	Formal public consultation on rationalisation of existing statistical publications and to release resources from teams to provide more user-focused service.	Sep 2016 Mar 2017 Sep 2016 – 2017	Response to consultation published Implementation plans to be reviewed at team level and overall Phased implementation of actions to improve data provision, reduce internal burden, focus product content and enhance overall delivery
Publications and Indicator portal replacement	Replacing the publications portal to improve accessibility.	Dec 2016 Mar 2017 Apr 2017	Discovery phase started Alpha phase complete Submission of case for Beta phase and live implementation
Multi-organisation English Health Statistics	Merged publications, collaboration and joint publications across organisations, statistics that are coherent to the end user	Nov 2016 Dec 2016	System wide-publication advisory board established, working with UKSA Topic networks established Further deliverables tbc
Data engagement and visualisation	Development of new, creative means of presenting and visualising data and information for customers, and to raise the bar of expectations from data intermediaries.	Oct 2016	Leveraging of existing corporate licence for Power BI to identify opportunities in each analytical team Further deliverables tbc

Project	Description	Milestones	Deliverables
Future publications	Long term shift to new publication formats	2017	Linked to Publications Consultation and data engagement and visualisation. Deliverables tbc

Analysis

12: Value adding: Production of a range of indicators, outcomes analysis, intelligence and statistics that add value for customers

13: Rapid and robust: Robust analysis that is able to respond rapidly and that is proactively presented

14: Meaningful: Data and information that are meaningful for customers and users

Statement of need

We have a wealth of expertise in analysis but the service we offer to customers is unclear. We offer a variety of different products that do not present a consistent approach to users. As an organisation, we provide *ad hoc* responses to questions from external partners through teams who have a broad set of responsibilities across the data process. Our responsibility for providing analysis to other organisations is unclear and has hampered our ability to create the clear and consistent service offer that is needed. Local analysis tailored to the hundreds of organisations across the health and care system needs to be done by those organisations.

We draw the distinction between **analytical** services (interactive tools offered through data science and visualisation that will provide ready access to data and information) and **analysis** services (delivery of statistical work, publications and indicators to support the derivation of intelligence). Our analysis services will increasingly draw on (for internal use and production) and be offered through (for external presentation) analytical tools where the required analysis is simple enough and appropriate to do so.

We will develop a service catalogue for the analysis services that we offer. These will be provided where:

- we are directed or commissioned by a customer specifically to provide these services;
- there is an economic case to provide these services once across a large population (e.g. for the whole country); or
- the analysis is an essential element of the production of an indicator or other NHS Digital statutory service

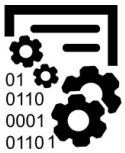
We will not provide analysis services that require local engagement, specific customisation and further intelligence innovation (unless they meet one of the criteria above).

Strategic initiatives to deliver

Project	Description	Milestones	Deliverables
Faster data programme	Enabling faster delivery of data to our customers via process redesign, and improving the timelines for official publications.	Dec 2016 Mar 2017	Faster delivery of SUS data Shorter HES publication schedule Engagement with customers around other key datasets e.g. MHSDS
Analytical toolset consolidation	Shift to reduced number of analytical tools to standardise and enhance.	Mar 2017	Mapping of current toolsets Proposed rationalisation Link to analytical tool upgrade
Customer engagement	Wide programme of engagement with customers and users of the data and information to inform our future service offer.	Oct 2016 Dates tbc	Workshops held with key customers Review of user groups Re-establishment of partnership agreements e.g. NICE Successful delivery of SoS commitments with partners
Knowledge sharing best analytical practice	Engagement with wider partners to enhance and refine our service offer on the basis of best international practice.	Tbc	Deliverables tbc
Move from ad-hoc to annual updates for key data sets	Previous ad-hoc dataset updates were difficult for NHS Digital and customers to manage effectively. Driven from extensive customer engagement and feedback.	Apr 2017	Mental Health Services Data Sets - MHSDS v2.0 delivery incorporating bed types and out of area treatments - MHMDS v3.0 (April 2018) incorporating IAPT dataset and move to xml
Rapid response analysis	Development of an enhanced service offer that can rapidly respond to analytical questions from key customers.	Oct 2016	Providing appropriate analytical information to populate dashboards for monitoring the implementation of a number of 5 year strategies, including mental health
National Library of Quality Assured Indicators	The national library of quality assured indicators will deliver a library, repository, directory and electronic workflow to form the central, authoritative source of indicator metadata and associated documentation for the health and care	Dec 2016 Mar 2017	Phase 1 Prototype for release A library of quality assured indicators A repository containing assurance documentation A directory of health and care indicators

Project	Description	Milestones	Deliverables
	system.		An integrated workflow functionality that will deliver service efficiencies
New and enhanced analytics and information	Each team will be identifying new products and services as well as responding to requests from customers.	Jan 2017 Apr/May 2017 Jan 2017	GP metrics, quarterly release OF 10 metrics Provision to PHE of data on number and type of health checks performed at practice level Provision of analytical data via an interactive reporting tool (iView+), first mental health cube

Data science



15: Innovative: We will present data in innovative and interactive ways

16: Enhanced delivery: Add value to data across the delivery chain

17: Thought leadership: Drive thought leadership

Statement of need

The tools and techniques that we currently use are driven by individual requirements and we do not have standard enterprise-wide approaches. We have the opportunity to harness new advanced analytical techniques and approaches to data that will allow us to add value and generate efficiencies. We have an opportunity to be a leader for the system on recognising and responding to the possibilities on what we might do with data.

Through our work in data science we will develop a clear, baseline analytical service offer that adds value and raises the bar for analytics across the system. This will allow local organisations and other partners to build on our standard offering through 'buying greater value intelligence,' negating the need to buy the basic fundamental analytical building blocks which currently occurs. This means that these investments can be made into innovation in relevant areas in the market. The service will add value and will provide vital insight into health and care performance and outcomes.

We will develop an enhanced, interactive, web-based analytics service for the data we hold on behalf of the health and care system, which will be offered through tools as a standard way of presenting data. This will accelerate the ability of the system in its entirety to make better use of its analytical capabilities and will shift the focus more to the use of information to drive improvement in quality, efficiency and outcomes.

Strategic initiatives to deliver

Project	Description	Milestones	Deliverables
Data management & warehousing	Implementation of new data management environment.	Q1 2017 tbc	Data Management Services uplift using existing tools and systems Data Services Platform (DSP) data management solution
Analytical tools upgrade	Rapid review of analytical tools and consolidation to future best practice tools.	Nov 2016 Dec 2016	Review of existing tools Rapid assessment of tools available in the market to identify the best value for money tool to uplift existing capability
Data Science Centre of Excellence	Development of a virtual data science Centre of Excellence across Arm's Length Bodies.	Oct 2016	ToR confirmed with ALBs, DH, DWP and Cabinet Office Further deliverables tbc
Innovative uses of data	Delivery of NIB programme 26 "Innovative uses of data" in line with agreed system ambitions.	tbc	Deliverables tbc

Customer engagement

18: Responsive: Highly responsive to customer needs

19: Listening: Engaged in understanding customers and how we will work with them

20: Communicative: Letting the world know about our data and our services

Statement of need

We have worked hard to engage with customers but we have received feedback from them that they have not received services in a timely way or that the data and information products they received did not meet their requirements. We have the opportunity to develop a consistent approach to customer engagement that reaches into their businesses, understands what it is that they require from data and information to carry out their role effectively and a service that meets or exceeds their expectations.

Technology has moved on such that basic web based analytics are provided as a simple provision within standard technology installations, and web reports can be created by individuals with basic knowledge in very short timescales. We recognise that our analytical service offering can (and indeed should) have an impact on the market of business

intelligence analytical providers. By making standard, baseline data analytics that are easily available and easy to be interpreted, we expect to shift the market into adding greater value and innovation for the health system and taxpayer. We recognise the value to the health system of a vibrant market of business intelligence analytics and are looking not to disrupt, but to develop, enhance and stimulate the market through occupying a different space to those providers.

We will therefore increase our engagement with, and outline to, the market of what we are and what we are not going to do in this space, and will signal this in a timely way that allows the market to respond and occupy a position that adds greater value. We will develop and deliver new underpinning data architecture and infrastructure that creates an innovation ecosystem for the market that is larger than that which currently exists.

Strategic initiatives to deliver

Project	Description	Milestones	Deliverables
Front door service (general)	Establishment of rapid access service to customers that signposts and coordinates delivery of data content and analytical services.	tbc	Corporate front door function that integrates effectively with data and information services
Customer engagement programme	Development and delivery of in-depth structured programme of engagement with customers and users of data services.	Jan 2017 Mar 2017	Engagement programme in place Feedback informing future service plans and future iterations of the data strategy
NIB data strategy	Supporting and driving the ambition of the system-wide strategy for data through the NIB.	Mar 2017	Strategy for data and information (system-wide) agreed and launched
Communication plan	Developing and delivering a robust communication plan to ensure that customers and partners are aware of the services that we offer.	Dec 2016 Mar 2017	Communication plan agreed and in place Service offer descriptors confirmed
Collaboration	Building a strategic approach to working with commercial partners on the delivery of our services.	tbc	tbc

Workforce

21: Delivery culture: Agile, flexible and engaged workforce with a positive culture of delivery

22: Highly skilled: Trained and transformed with the skills and capacity to do the job well

Statement of need

Our workforce is skilful, talented and has a deep understanding of the data and information that we use. However, the way in which teams operate is inconsistent. In the future, we will need to handle more data and use new tools and techniques that require a new mix of skills in our teams. Our capacity and capability will need to be fundamentally different. We need to drive a transformation through training, adjusting skill mix, new approaches in teams and the recruitment of new talent to ensure that we are fit for the future.

Strategic initiatives to deliver

Project	Description	Milestones	Deliverables
Tactical recruitment	Recruitment of data management specialists and data scientists to address short term needs.	Nov 2016 Apr 2017	Defined resource requirement (grade & job description) for recruitment campaign Staff in position
Centralisation of specialist data functions	Shift from large, generic analytical teams to specialisation in teams leading data processes.	Feb 2017 Apr – Sep 2017	Pilot target operating model, concentrating data management activities into DM service. Phased roll-out across all teams
External and internal staff rotation	Development and delivery of a programme to place team members in new environments to spread and adopt learning through professions.	Oct 2016 tbc	8c staff rotation Further rotations tbc
Skills mapping	Understanding current skills against an agreed reference.	tbc	Reference skill list for each profession Mapping of current staff skills against the reference, for each profession.
Capacity and capability review	Review of capacity and capability across NHS Digital.	Nov 2016	First draft report
Model Office	Implementing model for improved efficiency within teams.	Nov 2016 Feb 2017	Pilot implementation of improvements (Primary Care) Implementation into 2 – 3 further

Project	Description	Milestones	Deliverables
		Apr – Sep 2017	teams Rollout across remainder of teams
Target Operating Model	New, flexible, workforce structure. Concentration of skills into specialist teams. Investment in strategic skills and tools.	Dec 2016	(Data management functions covered above) Identification of strategic tools and skills (initial)
Skills and leadership training programme	Commissioning of training programme for teams in line with future business needs relative to starting point.	tbc	Tool and process strategy and target operating model Skills gap for best practice and tool optimisation Training plan, and funding confirmation, to meet skills gap
Strategic workforce plan	Developing future skills forecast requirements and implementing plans.	tbc	Work pipeline Skills requirement to meet pipeline

Infrastructure

23: Advanced techniques: Ensure that we have the most technically advanced and appropriate ways of processing data

24: Enabling transformation: Establish new infrastructure to support transformation through handling key data management processes: data linkage, handling large datasets, enabling remote access

25: Data security: Ensure a high level of security and governance linked to legal basis for processing and analysis

Statement of need

We are currently operating in multiple environments that duplicate effort and functions. We have standalone systems that have been set up to support to individual services. While reliability has improved we know that there is a need to build platforms and infrastructure that is able to handle future data needs. This will involve larger data sets and will require enhanced processing power to handle complex data processes across a wider range and combination of data. The development of the Data Services Platform as part of the National Data Services Development Programme is critical in this; as we develop and replace our data environments and tools this needs to be aligned to the future DSP model. We envisage that the DSP will be the single place where we land, process and manage data and that the managed incremental migration to this platform will include incorporation of existing data environments where applicable and the creation of new functionality and tools in line with the future service model outlined in this strategy.

Strategic initiatives to deliver

Project	Description	Milestones	Deliverables
Current Collection Toolset Consolidation	Consolidation of existing data collection tools	During 2016/7	A rationalisation of tools promoting SAS grid and associated tools plus SQL server management studio where applicable. Readiness for transition to DSP
NDSD: DSfC	Delivery of the Data Services for Commissioners programme within NDSD.	Sep 2016 Mar 2017	Data Landing Portal pilot created DSP delivery of de-id and re-id
SUS+, HES+	Delivery and alignment of SUS+ and HES+ services	Mar 2017 Apr 2017 Apr – Jun 2017	SUS+ implementation including linkage, MPI, de-id HES rebuild available for use Dual running SUS and SUS+
NDSD: NTS, SUS & HES	Delivery of NTS programme within NDSD	tbc	SUS+ and HES+ data feeds into DSP
NDSD: Transition	Transition from existing to new platform	tbc	One approach to data collection & management Integrated toolset for analytics One integrated electronic workflow Integrated toolset of publication, access and dissemination tools

Delivery

To achieve our objectives and deliver the strategy, we must:

Internal

- Establish a detailed **work programme** covering all of the elements of this strategy. Where existing plans are in place, these should be tested to ensure they align with the content and vision of this strategy.

- Ensure clear **leadership and ownership**. This is a data and information strategy for NHS Digital and therefore requires input and engagement from across the organisation. Work stream leads are identified for every initiative and will engage appropriately across the organisation to ensure we are aligned on delivery.

- Confirm that appropriate **funding** is in place to deliver the entirety of the change programme associated with the strategy. It is recognised that many of the initiatives are able to be delivered within existing resources and that in the medium term the transformation of the workforce will generate efficiencies that allow us to deliver more for less. Our new data services will have a clear business case attached to them that needs to explore internal efficiency to the limit before making the case for new resource.

- Ensure that we have the **capacity and capability** in place and the right teams and individuals focused on delivery of the strategy. There is a significant amount of new work associated with the implementation of the various work programmes. There is an expectation that the strategy will deliver significant efficiencies for our business and allow us to re-focus valuable time and resource on the new work.

- Establish appropriate **reporting arrangements** for all work streams. Each element of the work programme will establish appropriate steering and programme management arrangements to oversee delivery. Regular reporting on progress will take place through the Information and Analytics Portfolio Leadership Team, with corporate oversight and governance provided through the Operations Board and the Investment Sub-Group.

- Implement an internal **communications plan** to help individuals and teams understand the implications of the strategy for them and their role in delivery.

External

- **Engage with partner organisations** throughout the system to understand and influence the system strategy for data. The National Information Board will set direction on the future data content, the mechanism for how external organisations will access and submit data and how that data needs to be provided and presented.

- Ensure that we have consulted on and developed an appropriate **charging model** for our data and information services. This will reflect any future approach to Grant in Aid

funding and will ensure that we are able wherever possible to offer services that are free to users.

- Develop an external **communications plan** to give confidence to partner organisations that we are committed to improving our services to reflect their needs and requirements.

Board Meeting – Public Session

Title of paper:	**Business Analysis (Front Door) – Proposal for Approval**
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 04 c
Paper presented by:	Beverley Bryant (Director of Digital Transformation)
Paper prepared by:	Jeremy Thorp (Director of Business Architecture)
Paper approved by: (Sponsor Director)	Beverley Bryant (Director of Digital Transformation)
Purpose of the paper:	This paper proposes the establishment of a Business Analysis "front-door" service that co-ordinates NHS Digital's response to requirements and opportunities from customers. The main focus is to manage our engagement with policy leads across a range of national bodies, including the DH and NHS England. The aim is to ensure that NHS Digital is seen as credible, relevant, and in a position to proactively influence the shape of emerging policy proposals and their impact on informatics, and the health systems and services we deliver.
Additional Documents and or Supporting Information:	No additional documents for reference / supporting information.
Please specify the key risks and issues:	No key risks or issues for the board to be aware of.
Patient/public interest:	Indirect
Supplementary papers:	No supplementary papers
Actions required by the Board:	Support for the proposal (Approval)

NHS Digital

Business Analysis (Front Door)

Proposal for Approval

Published 30 November 2016

Information and technology for better health and care

Contents

Executive Summary

This paper proposes the establishment of a Business Analysis "front-door" service that co-ordinates NHS Digital's response to requirements and opportunities from customers. The main focus is to manage our engagement with policy leads across a range of national bodies, including the DH and NHS England. The aim is to ensure that NHS Digital is seen as credible, relevant, and in a position to proactively influence the shape of emerging policy proposals and their impact on informatics, and the health systems and services we deliver.

An effective 'Front Door' service will bridge the gap between new business requirements and technology delivery ensuring robust and inquisitive analysis is undertaken prior to new programmes being commissioned to maximise benefit, avoid duplication and deliver the intended business outcome.

The service will be led by Jeremy Thorp, and will work with NHS Digital account management representatives and our policy customers as appropriate to engage in discussions on emerging policy. The service will be resourced from and supported predominantly by a revised 'Business Benefits and Analysis' profession.

As part of this proposal, the current Business Analysis and Benefits Management professions will be adapted and merged to support both the professional and career development requirements of staff and the needs of the business and operating model under a new Head of Profession, Rachel Habergham.

Background

Earlier this year, the Executive Management Team discussed ways in which the process for potential new work could be developed to improve our responsive to customers, provide a coordinated response from across our organisation and focus on those opportunities where we could add the most value to the health and care system. The proposals in this paper build on the earlier work and adopt the same principles of applying formal governance processes (e.g. for new work). EMT considered and approved these proposals on 10th November 2016.

Proposal

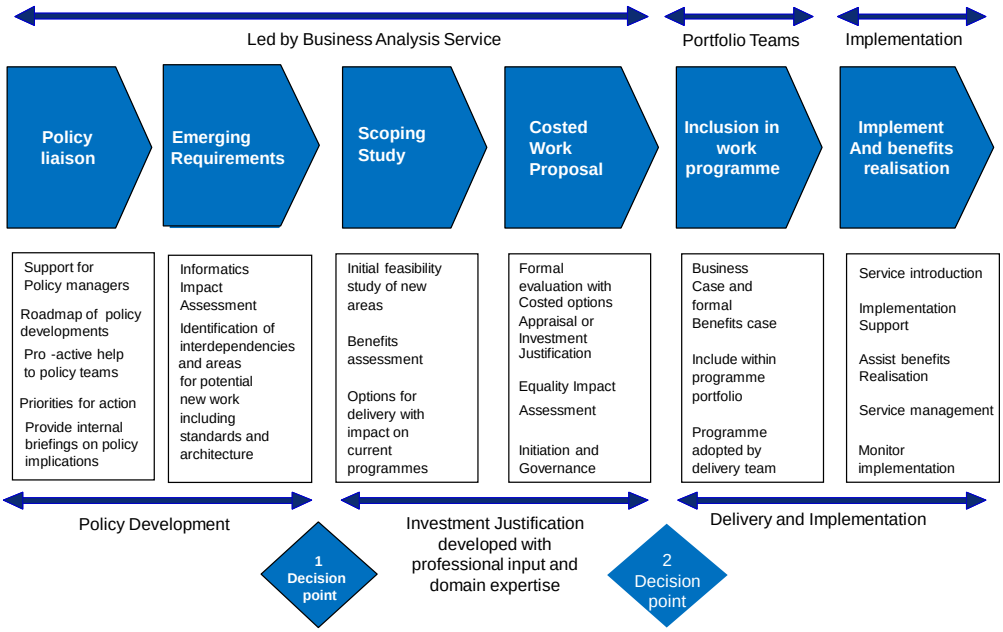
The primary objective of the Business Analysis service is to take a pro-active role in engagement on new and emerging policy areas where, often based on new and innovative approaches to operational delivery from the front line, a national system or intervention is required. The service will:

- Provide policymakers with an improved understanding of the capabilities, possibilities, benefits and constraints of informatics and technology options.
- Support policymakers in the formulation of requirements for policy initiatives and to undertake informatics impact assessment of such proposals.
- Appraise policymakers of policy amendments / requirements necessary to support the business changes we are delivering through the systems and services commissioned.
- Co-ordinate formal feasibility and option appraisal studies for proposed new initiatives, providing the opportunity for comparative assessments across the organisation.
- Work with the National Information Board and Digital Delivery Board to prioritise requirements and develop proposals (in the form of investment justifications or similar) to be formally considered by the relevant investment groups.

- Provide an appropriate resource library of policy requirements and responses for NHS Digital colleagues (such as account managers) to draw upon, to reduce the likelihood of repetition and / or conflicting dialogue with customers.

The process is illustrated below and demonstrates the steps by which, through appropriate decision gates, portfolios become involved in and take the lead on approved work items.

Business Analysis Process



The process is designed to ensure that we:

- manage expectations with DH, NHS England and other primary account relationships.
- develop a clear understanding of the case for change, business requirements and options for meeting the requirements.
- establish an understanding of how an initiative aligns to the strategic objectives of the organisation before formal work is commissioned, including assisting the customer with alternative delivery sources if necessary.
- have clarity around the availability of funding for new work (or the lack of it).
- co-ordinate involvement of appropriate professional and domain expertise to support each piece of work.
- co-ordinate connections with other relevant work, e.g. P2020 domains.

The specific steps are:

- **Policy liaison** across a range of national bodies, including DH / NHS England / NHS Improvement directorates, with 'horizon scanning' of policy and informatics agendas as appropriate**.** This will be done through a variety of methods in line with NHS Digital account management, and to be determined according to the business needs of each directorate. It is likely to include regular liaison meetings with individual members of

staff or groups. It will dovetail with the business planning cycle and other key strategic activities. This requires understanding of the strategic context and business objectives for health and care, linking to the enterprise architecture, together with an awareness of emerging trends / ideas and their implications. Outputs might include impact studies and briefings for internal and external colleagues on emerging trends and upcoming issues.

- Identification of **emerging requirements** requiring informatics input**.** Discussions could be initiated by the Front Door Team, the policy lead working on a particular area or via internal referral from a portfolio area. The purpose of this step is to understand business and user needs and business benefits to be realised. Whilst it is likely that this is best done at the earliest opportunity in the policy development process, it may be preferable to defer detailed work until a later stage, when more is known about the actual policy requirements. This requires a good understanding of current and planned services provided by NHS Digital and others to be able to identify opportunities for re-use, re-profiling and to gain from lessons learned. It will require a network of contacts throughout NHS Digital and wider stakeholders with whom to consult and engage.

  The Business Benefits and Analysis profession has an existing methodology (developed through Business Benefits and Analysis Community Of Practice (BBACOP). The methodology needs to be reviewed, developed, maintained and implemented in practice through the Business Benefits and Analysis professional assignments. One of the fundamental elements of this methodology is establishing the ownership of specific business needs and benefits in the user and stakeholder communities.

  The development of a requirements repository will enable the capture of good practice examples as well as traceability, including establishing the linkage between objectives, benefits and outcomes.

- **Decision Point One** gives an early opportunity to determine whether or not the activity should proceed to the next stage. A "no" might indicate the item is not needed, not in line with strategic objectives or is within the agreed scope of a current portfolio. A "yes" would signal the need to begin assembling a virtual team of relevant experts from across NHS Digital, candidate business owners and possibly other organisations, to work on the next level of detail. By way of example, Annex A describes the process being followed for digital diagnostics.

- **Scoping study**, including outline option appraisal**.** Depending on the nature of the requirements, it may be necessary to:
  - Identify the contributions required from colleagues;
  - Prepare procurement plans;
  - Undertake market soundings where significant investment is required;
  - Prepare proposals for formal sign off (e.g. PIDs, outline business case, etc.);
  - Prepare bids for funding.

- Formal **costed work proposal,** which might take the form of an options appraisal, investment justification or a project brief. Depending on scale, such a proposal may require formal approval**.** The service will ensure that all relevant stakeholders are involved in these activities. It should not be assumed at this stage that policy leads will undertake procurement activities, for instance. What is proposed is that the right expertise is engaged early enough to inform the planning, decision making, etc.

- **Decision Point Two** is the point at which an item might enter the formal work programme through the standard assessment process for new work, and would be the point at which the front-door service hands over leadership to the responsible portfolio area for i**nclusion in a work programme and for implementation and benefits realisation.**

Corporate Governance and Compliance

The proposal allows NHS Digital to exercise more control and consideration over the ideas and requests that come to us. It enables us to be more pro-active in our consideration and response to stakeholders and to be much less likely to appear parochial or uncooperative, and help prioritise initiatives with the most significant benefits to the system.

The process will be supported by a Review Group to consider candidate proposals and areas of work and to prioritise the work against a prioritisation model. Depending on the nature and volume of such developments, the group may meet virtually, convening specifically to prioritise if there is resource contention, to appraise complex cases or to review the overall process. Each portfolio area will be invited to attend, alongside Portfolio Office and the Business Analysis service; the nominated leads will need to be of sufficient seniority to contribute to the group agenda and to act as the point of contact for agreeing resource input (e.g. specialist clinical support) to individual work items.

Resources

The proposal for the service is based on a small core team which will engage with national-level policy managers in coordination with the appropriate NHS Digital account managers on a range of issues. As ideas progress, the service will involve subject matter experts from across relevant portfolio areas as necessary. The number, grade and professional mix of roles within the proposed core service has been based on an assessment, over the past six months, of the volume and complexity of items for consideration. Annex B lists some of the engagements to date used to inform this sizing. Of those listed, roughly one third have been resolved quickly and easily, one third have involved specific portfolio areas and been handed across, and the final third have either involved, or are likely to require, significant input. This resource proposal is based on three or four major topics being active at any one time. This structure also includes the role for the Head of Business Benefits and Analysis profession.

Funding

The first two steps in the process are proposed to be provided "free-of-charge" to national bodies, with the first decision point raising the question, as necessary, of charges for the scoping study and costed work proposal.

The current budget supporting this service proposal has been inherited in 2016/17, but will be fully reviewed as part of the development of the target operating model and onwards as part of business planning to ensure appropriate funding is available within the Digital Transformation administration budget for 2017/18 and beyond.

Implications

Our stakeholders will experience credible, considered responses to their requests. Initial customers are other Agencies and ALBs such as the Department of Health, NHS England, NHS Improvement, Public Health England and the Care Quality Commission but a full review

will be conducted in the development of the operating model, and in liaison with the emerging NHS Digital Account Management function.

Others such as Health Education England, NHS Health Research Authority, National Institute for Health Care Excellence, the Medicines and Healthcare Products Regulatory Agency and the NHS Business Services Authority will be engaged as and when necessary.

Handling

These proposals are largely about internal processes and do not require any extensive explanation to a wider audience. We will work with colleagues in DH, NHS England and other bodies to publicise the new arrangements.

Risks and Issues

The following risks have been identified:

Risk / Issue Description	Impact Score 1 = V Low 5 = V High	Likelihood Score 1 = Rare 6 = Issue	Mitigating Action Plan / Issue Resolution Plan
Business Analysis are unable to cope with the volume of work	4	2	Effective prioritisation model required. Additional resource could be allocated to right size the team, but only once prioritisation approach is agreed. Synthesis with the exisiting benefits management profession will provide additional resources and expertise.
Business Analysis may have insufficient skills to decide how to deal with some items	3	2	Appropriate professional input will be sought at the scoping study stage; if required, such input could be sought earlier, especially when informing policy managers of current and potential functionality and service. Funding will be made available within the budget to accommodate additional costs.
Lack of funding for additional development identified during the pilot stage.	3	2	Product outputs and subsequent go / no-go decision gates and requirements clear to customers.

Management Responsibility

The responsible director is Beverley Bryant, Director of Digital Transformation.

Actions Required of the Board

The Board is asked to approve the proposal.

Annex A: Example of Digital Diagnostics

The Digital Diagnostics Programme in Domain G of P2020 was subject to a "deep-dive" by a fledgling “Business Analysis” team to test out the new process and gain customer feedback and insight.

NHS Digital was asked to consider:

- The vision for the programme
- The urgent time-critical actions
- The key components of a future digital diagnostics programme

A core team, consisting of staff from NHS England and NHS Digital worked together through September to address the first two points, and presented to Sue Hill, Chief Scientist, and Beverley Bryant in late September. This resulted in agreement over the future vision and over a number of short-term actions required to ensure service continuity pending detailed programme development.

The NHS England publication “Improving Outcomes Through Personalised Medicine” (September 2016) described the aim as follows: “*to maximise the true value of the information available about our health, we need to bring together genomic, clinical and diagnostic, medicines, and lifestyle data. It is the integration and analysis of this information that forms the powerhouse for personalised medicine*.”

In October, the core team was expanded, to include further genomics input through NHS England, and technical and programme input through NHS Digital. Work is underway on describing the shape of the forward strategy and component project activities, ready for wider stakeholder consultation.

The work to date has demonstrated the value of joint teams working together to a common purpose, in so doing building trust and confidence. It will lead, by the end of the year, to an agreed, costed work programme for delivery through P2020 Domain G,

As an early exemplar of the front-door process, this assignment is helping to provide information on the level of effort (and costs) of those engaged in the work. This will help us to assess the scope and scale of input, both from members of the front-door team and the wider group. The activity is also helping to shape views on the ways of working between NHS England and NHS Digital in which each “owns” both the process and the output.

Annex B: Business Analysis Service work items 2016/17

Reference	Date Initiated	Contact organisation	Topic	Current State
101	27/06/2016	DH	Database of innovative treatments	Awaiting further discussion with DH
102	15/07/2016	NHS Digital	Citizen identity policy assistance	Brief provided to DH as input to policy discussions
103	15/07/2016	NHS England	Procurement / Cancer Wait Times	Response provided to NHS England
104	18/08/2016	NHS England	Diagnostics vision and strategy	Presentation in September to be followed by wider consultation around diagnostics, genomics and personalised medicine
105	12/09/2016	NHS England	Personal Health Budgets	Discussions around shape of requirement and potential procurement approach to be adopted
106	20/09/2016	NHS England	Modular data	Input to workshop discussions, including colleagues from information and analytics
107	20/09/2016	NHS Digital	MHRA and advice for IDMP	Request for advice on the implications of the emerging standards for pharmaceutical product identification – passed to domain specialist
108	23/09/2016	NHS England	Availability of primary care performance data / webtool	Discovery process for improved route for collecting primary care performance data; considering options through nhs.uk
109	20/09/2016	DH	Access to health records and death registration	Initial focus on access by medical examiners to death notifications – passed to information governance team for advice
110	29/09/2016	NHS Improvement	Development of patient safety information management system project	Investigation regarding proposed route for provision of facilities to enable capture of information relating to patient safety information

Board Meeting – Public Session

Title of paper:	The process for managing data requests, data releases and associated audits.
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 05 a
Paper presented by:	Martin Severs Medical Director of Caldicott Guardian
Paper prepared by:	Sonia Walters Senior Business and Operational Delivery Manager
Paper approved by: (Sponsor Director)	Martin Severs Medical Director of Caldicott Guardian
Purpose of the paper:	As requested by the Board, the attached table sets out the different stages of managing a request for data and the lead directors for each stage in the process. The table is provided for information
Additional Documents and or Supporting Information:	No additional documents or supporting information
Please specify the key risks and issues:	N/A
Patient/public interest:	Direct
Supplementary papers:	Flow diagram available upon request
Actions required by the Board:	Note contents of the paper

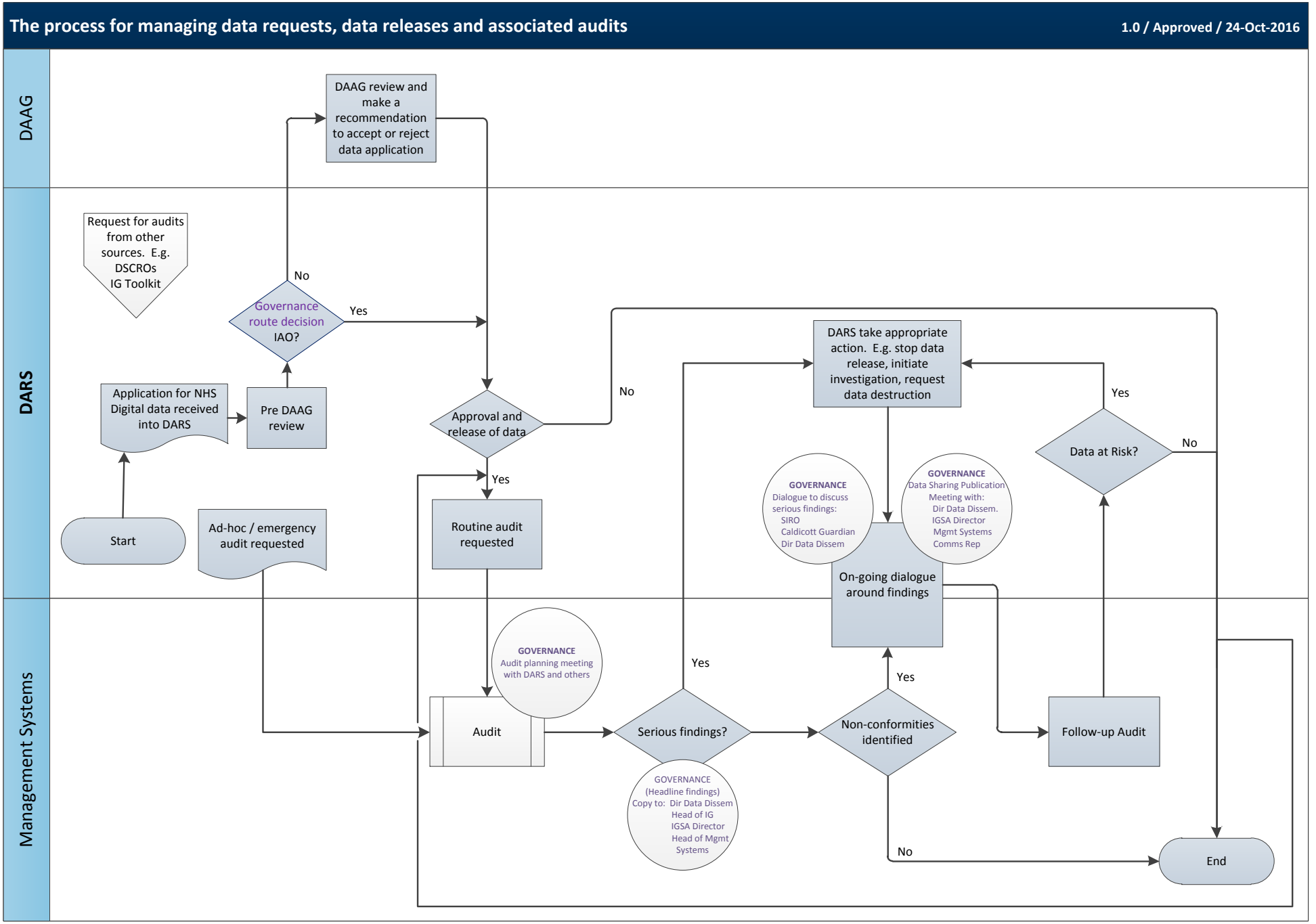
Action: NHS Digital Board is required to understand the data release audit outputs; who is responsible and how it will be managed.
(A RACI matrix is detailed below. An end-to-end process diagram of the data release audit outputs is available upon request)

RACI

Responsible, Accountable, Consulted and Informed

	DARS	Management Systems	DAAG	Output	Director Responsible for service	Director Accountable for output
Data Application	AR	—	CI	Data Sharing Agreement	David Hughes	Rob Shaw
Data Release	AR	—	—	Data	David Hughes	Rob Shaw
Audit	C	AR	I	Audit Report	Martin Severs	Martin Severs
Investigate	AR	I	I	Investigation Report	David Hughes	Rob Shaw
Follow-up Audit	C	AR	—	Follow-up Report	Martin Severs	Martin Severs
Data Destruction	AR	—	—	Data Destruction letter	David Hughes	Rob Shaw
Stop Data	AR	I	—	Form	David Hughes	Rob Shaw

Red = Activity by Management Systems
Black = Activity by DARS


The process for managing data requests, data releases and associated audits
1.0 / Approved / 24-Oct-2016
DAAG
DARS
Management Systems
DAAG review and make a recommendation to accept or reject data application
Request for audits from other sources. E.g. DSCROs IG Toolkit
No
Governance route decision IAO?
Yes
Application for NHS Digital data received into DARS
Pre DAAG review
Approval and release of data
No
DARS take appropriate action. E.g. stop data release, initiate investigation, request data destruction
Yes
Data at Risk?
No
Start
Ad-hoc / emergency audit requested
Yes
Routine audit requested
GOVERNANCE
Dialogue to discuss serious findings:
SIRO
Caldicott Guardian
Dir Data Dissem
GOVERNANCE
Data Sharing Publication Meeting with:
Dir Data Dissem.
IGSA Director
Mgmt Systems
Comms Rep
On-going dialogue around findings
GOVERNANCE
Audit planning meeting with DARS and others
Audit
Serious findings?
Yes
Non-conformities identified
Yes
Follow-up Audit
GOVERNANCE
(Headline findings)
Copy to: Dir Data Dissem
Head of IG
IGSA Director
Head of Mgmt Systems
No
End

Board Meeting – Public Session

Title of paper:	Clinical Registration and Revalidation Policy
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 05 b
Paper presented by:	Martin Severs Medical Director
Paper prepared by:	Ken Baker Head of Employment Policy and Practice
Paper approved by: (Sponsor Director)	Martin Severs Medical Director
Purpose of the paper:	To seek endorsement of the updated policy for clinical registration and revalidation
Additional Documents and or Supporting Information:	Registration and Revalidation Policy
Please specify the key risks and issues:	The updated policy addresses a risk that NHS Digital does not have adequate processes and controls in place to ensure that staff working in a clinical capacity meet statutory requirements for practice.
Patient/public interest:	Direct: Clinicians provide clinical advice and leadership on a number of key systems and products. It is in the interests of patients and the public to ensure that those clinicians are appropriately registered and licensed to practise.
Supplementary papers:	No supplementary papers
Actions required by the Board:	The Board is asked to endorse the updated policy

NHS Digital

Clinical Registration and Revalidation Policy

15 November 2016

Information and technology
for better health and care

Contents

Executive Summary

This paper seeks Board endorsement of an updated policy for the registration and revalidation of clinical staff at NHS Digital

Background

The Board has previously received a briefing on the obligations of NHS Digital in respect of the registration and revalidation of clinical staff. This focussed primarily on medical staff and the statutory requirements vested in the General Medical Council to ensure ongoing registration and fitness to practise.

Similar requirements exist across other clinical professions and the opportunity has been taken to widen the scope of the original policy to cover all roles that require professional registration. At the same time, the policy has been simplified and the original document has been repositioned as detailed guidance on the revalidation process for medical staff.

Recommendation

The Board is recommended to endorse the updated policy to maintain compliance with our statutory obligations in respect of clinical staff.

Implications

Strategy Implications

Virtually every aspect of the Paperless 2020 agenda and the NHS Digital Strategy requires some form of clinical governance, assurance and/or engagement for successful implementation. Ensuring that all clinicians who work with NHS Digital are fully competent and qualified to provide that governance, assurance and engagement is critical to our success and to patient and public confidence

Financial Implications

There are no financial implications arising directly from the policy

Stakeholder Implications

The draft policy has been shared with the NHS Digital Policy Council, Trades Union representatives and clinical leaders within the organisation. The policy seeks to provide a clear understanding of the requirements for registration and revalidation, the processes for maintaining compliance and the support available from the organisation. This will help to assure the highest quality of clinical advice to programmes and services engaged in the development and maintenance of clinical systems and services.

Handling

The policy will be published on the NHS Digital Intranet and will be included in the Policy Portal to ensure accessibility.

Risks and Issues

The updated policy addresses a risk that NHS Digital does not have adequate processes and controls in place to ensure that staff working in a clinical capacity meet statutory requirements for practice.

Corporate Governance and Compliance

The policy will support compliance with our duties in respect of professional registration. Registration status will be monitored via the Electronic Staff Record and Revalidation status will be tracked in a bespoke tool within the Clinical Informatics Professional Group. The Clinical Informatics Head of Profession and the Responsible Officer will prepare an annual report for the Workforce Board and the NHS Digital Board, setting out registration and revalidation activities throughout the year and providing assurance that the requirements have been met.

Management Responsibility

The NHS Digital Medical Director, will be accountable for the policy. The Clinical Informatics Head of Profession will have day-to-day responsibility for the operation of the policy.

Actions Required of the Board

That the Board endorse the NHS Digital Clinical Registration and Revalidation Policy

Clinical Registration and Revalidation Policy

Document Controls

Revision History

Version	Date	Summary of Changes
0.1	05/07/2016	First draft
0.2	28/07/2016	Clarification of roles and responsibilities following discussion with Clinical Professional Group representatives
0.3	07/10/2016	Updated following feedback from Policy Council and initial comments from the BMA
1.0	11/11/2016	Final version following further feedback from the BMA

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version
Martin Severs	Medical Director		1.0
Rachael Allsop	Director of Workforce		1.0
Sue Faulding	Head of Profession		1.0
Rowena Herbert	Head of Workforce		1.0
Raj Kumar	Responsible Officer		1.0
Ed Cheetham	BMA Representative		1.0

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Martin Severs				1.0
Rachael Allsop				1.0

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of the document are not controlled.

Related Documents

These documents will provide additional information.

Title	Version
Medical Staff Revalidation Process	
Appraisal and Performance Development Review Process	

Contents

Definitions

Acronym or Expression	Definition
Clinical Role	A role in which the post-holder is required to apply their specific medical, clinical or professional social care qualifications, knowledge, skills, experience and judgement.
Clinical Staff	All staff engaged in a clinical role and are registered with the appropriate professional or regulatory body
Medical Staff	Specifically, doctors who are registered with the GMC and hold a current licence to practise.
GMC	General Medical Council
NMC	Nursing and Midwifery Council
HCPC	Health and Care Professions Council
GPhC	General Pharmaceutical Council
Professional Registration	Requirement to be on a professional register maintained by the relevant registration authority, e.g. NMC, GMC, GPhC, HCPC
Fitness to Practise	Having the requisite knowledge, skills, experience and registration to work as an autonomous practitioner
Licence to Practise	Licence issued by the GMC to confirm fitness to practise
Revalidation	Process of assessing continuing fitness to practise
CPD	Continuing Professional Development
Appraisal	Standard NHS Digital process for assessing individual performance and professional development needs for all staff
Clinical Appraisal	Specific appraisal of clinical practice for staff in clinical roles
PDR	Performance Development Review

1. Introduction

1.1 NHS Digital is responsible for the management of major systems and services across the Health and Care System. We collect, analyse and disseminate the nation's health and care data and have a duty to safeguard that data. Health and Care professionals help us to meet these responsibilities by providing clinical assurance, advice, and governance, and by ensuring effective and collaborative clinical stakeholder relationships.

1.2 Health and care professional regulators work within a statutory framework to protect the users of health and care services and the public by setting strict standards of competence and conduct for their registrants. Requiring all NHS Digital clinical staff to maintain professional registration and to demonstrate their continuing fitness to practise is essential for effective governance and public confidence.

1.3 Professional Registration and Revalidation also addresses the key value of *Professional*, which requires that staff will apply the "*highest levels of expertise, conduct and personal responsibility*".

2. Policy Statement

In addition to the standard appraisal and performance management arrangements that apply to all staff, those in clinical roles are required at all times to comply with the statutory registration and revalidation requirements for their profession. Staff who do not comply with the requirements will not be permitted to work in a clinical role. NHS Digital will provide appropriate procedures, guidance and support but staff are personally responsible for meeting these requirements.

3. Purpose and Scope

3.1 This policy seeks to ensure that all staff who are required by NHS Digital to undertake professional roles or activities that are subject to a statutory requirement to be registered with a professional or regulatory body are fully aware of this requirement and are supported to maintain their registration and revalidation. This policy applies to all staff in clinical roles within NHS Digital, including directly employed staff, secondees, agency staff and contractors.

3.2 The underpinning guidance and processes for registration and revalidation are set out in the NHS Digital Revalidation Procedure, which should be considered as an integral part of this policy. The procedure is available on the Intranet.

4. Equality Impact Assessment and Privacy Impact Assessment

There is no provision, criterion or practice in this policy that is likely to have a disproportionate impact on staff with a protected characteristic. Information on staff registration and revalidation will be collected, monitored and reported. However, this information is freely available to the public via the relevant registration authorities.

5. Legal/Risk Mitigation

Professional registration and revalidation are legal requirements for clinical staff. Failure to maintain registration and evidence of fitness to practise creates a risk to clinical safety and assurance of our systems, services and data management. It also creates a risk of considerable reputational damage.

6. Principles

6.1 The requirement for professional registration and revalidation will be made clear in job descriptions for each applicable post and in advertisements for new appointments. No appointment will be made to posts requiring registration where the applicant is unable to provide proof of registration and fitness to practise.

6.2 Staff in clinical roles will have access to appropriate support to maintain their fitness to practise, including professional group activities and mentoring. However, staff are also expected to be proactive in identifying and accessing CPD opportunities that may not be available within their NHS Digital role.

6.3 Registration and revalidation requirements must be met in a timely manner. Failure to meet prescribed deadlines, which will not take account of any 'grace' period that may be allowed by the registration authority, without good cause will be deemed a performance issue and managed accordingly.

6.4 Staff will not be permitted to undertake a clinical role if they do not meet the requirements for registration and revalidation. Each case will be reviewed on its merits but options available to the Head of Profession will include:

- A period of paid or unpaid leave pending the requirements being met
- Reference to the performance management or disciplinary procedures, with or without suspension from duty
- Reassignment to a non-clinical role at the grade and pay rate applicable to that role

6.5 Training and support will be provided to clinical appraisers, career managers and others where necessary to support the implementation of this policy

7. Rights and Responsibilities

7.1 The **Chief Executive** has overall responsibility for the policy, on behalf of the Board, and has delegated this to the **Medical Director**.

7.2 The role of the **Responsible Officer** (RO) is governed by The Medical Profession (RO) Regulations 2010 and subsequent amendments. The RO is accountable to the NHS Chief Medical Officer and, via the NHS Digital Medical Director, to the NHS Digital Board and Chief Executive for implementing and managing the revalidation process for medical staff, including appraisal outcomes. The RO will receive, review, act appropriately upon and securely store all outputs from clinical appraisal.

The RO will also be responsible for preparing an annual report on medical staff revalidation for the Workforce Board and, thereby, the NHS Digital Board and for any actions arising from this. The RO will ensure that medical appraisers are trained and regularly assessed to carry out their role.

7.3 The Clinical Informatics **Head of Profession** is accountable to the Chief Executive and Medical Director for implementing and managing the revalidation process for clinical (non-medical) staff. This will include the appointment of non-medical clinical appraisers (e.g. the 'Confirmer' role for Nurses and Midwives). S/he also has day-to-day responsibility for the application of the policy, ensuring appropriate arrangements are in place to assure the registration and revalidation status of clinical staff, and maintaining an effective community of professional practice. The Head of Profession will lead on the management of clinical staff who, for any reason, fail to meet their professional registration or revalidation requirements.

7.4 **Career Managers** will ensure that all clinical staff undertake regular standard appraisals and Performance Development Reviews, and have access to appropriate professional development opportunities relevant to their role. The Career Manager will ensure that all clinical staff are aware of their obligations in respect of this policy and will report any breach to the Clinical Informatics Head of Profession.

7.4 **Assignment Managers** will report any concerns about clinical practice arising in the course of an assignment to the relevant career manager.

6.6 **Medical Appraisers** will be appointed by the Responsible Officer, who will be responsible for ensuring that appraisals are conducted to high standards in line with the revalidation procedure. They must devote adequate time for preparing, conducting and recording appraisal. In addition, appraisers must fully engage with quality assurance processes and appraisal training.

7.7 **All Clinical Staff** are responsible for:

- Maintaining their registration with the relevant regulatory body
- Meeting the CPD and Revalidation requirements of the regulatory body
- Working within the relevant professional code of conduct
- Reporting any breach of the registration or revalidation requirements, or other material facts that may affect their fitness to practise, to the Clinical Head of Profession and to their registration body, at the earliest opportunity
- Providing evidence of registration and revalidation in the course of pre-employment checks and when otherwise reasonably requested to do so

7.8 The **Human Resources** function and the **Clinical Informatics Professional Group** will provide timely and accurate information on current registration and revalidation status. HR will undertake appropriate pre-employment checks, including registration status. HR will also provide appropriate support and guidance on the interpretation and application of the policy, and in dealing with any breach of the policy.

7.9 The **Procurement** function will take appropriate steps to obtain assurance that any agency staff or contractors supplied to perform a clinical role comply with the requirements for registration and revalidation.

8. Governance

8.1 The Clinical Informatics Head of Profession and the RO will prepare an annual report for the Workforce Board and the NHS Digital Board, setting out registration and revalidation activities throughout the year and providing assurance that the requirements have been met. In the event that the requirements have not been met, the report will include an action plan to achieve compliance.

8.2 Monthly reports will be produced from ESR and the Medical Revalidation database identifying staff who are due to renew their registration or to undertake revalidation within the following three months (see figure 1). Reports will be shared with the Head of Profession for action where necessary.

8.3 The Head of Profession and the RO will maintain a list of clinical appraisers and will ensure that appropriate arrangements for training and quality assurance are in place and recorded.

8.4 The Head of Profession will ensure that accurate and up to date records of all clinical/medical appraisals and outcomes are maintained.

8.5 This policy will be reviewed at intervals of 3 years, or earlier if required by changes to legislation or the business needs of NHS Digital, in conjunction with relevant stakeholders.

Board Meeting – Public Session

Title of paper:	**NHS Digital Corporate Governance Manual 2017-18**
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 05 c
Paper presented by:	Carl Vincent Director of Finance and Corporate Services
Paper prepared by:	Annabelle McGuire Secretary to the Board
Paper approved by: (Sponsor Director)	Carl Vincent Director of Finance and Corporate Services
Purpose of the paper:	The Corporate Governance Manual 2017-18 has been reviewed and approved by the Assurance and Risk Committee at its meeting on 16 November 2016. The manual is being presented to the Board for approval. The three changes to this new version of the manual are as below: • The addition of section 2.2.4 - Ex-Officio Board Directors In this section it states the role of an ex-officio Board Director on NHS Digital's Board and specifies terms of office. • The addition of section 3.1.1 confidentiality responsibilities In this section it confirms that confidential information should be marked in accordance with the Cabinet Office Government Security Classifications Policy. 1. **OFFICIAL** - The majority of information that is created or processed by the public sector. This includes routine business operations and services, some of which could have damaging consequences if lost, stolen or published in the media, but are not subject to a heightened threat profile. A limited subset of official information could have more damaging consequences. In

	such cases where there is a clear and justifiable requirement to reinforce the 'need to know', assets should be conspicuously marked: 'OFFICIAL–SENSITIVE'. 2. **SECRET** - Very sensitive information that justifies heightened protective measures to defend against determined and highly capable threat actors. For example, where compromise could seriously damage military capabilities, international relations or the investigation of serious organised crime. 3. **TOP SECRET** – The Governments most sensitive information requiring the highest levels of protection from the most serious threats. For example, where compromise could cause widespread loss of life or else threaten the security or economic wellbeing of the country or friendly nations. • The overhaul of section 4.7 delegation of powers to named posts The table in this section now makes the distinction between signature authority, the power to sign a contract or take action that binds NHS Digital and approval authority, giving consent for decisions which have a financial implication. The CEO must sign NHS Digital legal documents, the CEO and Executive Management Team Directors can sign contracts. The Board is requested to note that proposals are currently being worked through in respect to NHS Digitals oversight of investment decisions. This will lead to further updates to the Corporate Governance Manual being required in due course.
Additional Documents and or Supporting Information:	Updated Corporate Governance Manual - all of the latest amendments have been highlighted for ease of reference.
Please specify the key risks and issues:	There is a risk that without a comprehensive and correct NHS Digital Corporate Governance Manual standards and best practice may not be adhered to organisationally.
Patient/public interest:	Organisational corporate governance best practice
Supplementary papers:	None
Actions required by the Board:	**Approve the Corporate Governance Manual 2017-18**

NHS Digital

Corporate Governance Manual 2017-18

Information and technology
for better health and care

Policy Title: NHS Digital Corporate Governance Manual 2016-17			
Status	DRAFT		
Document Record ID Key	Not Applicable		
Version	1.0	Version Date	02/11/2016
Director Responsible for this policy	Carl Vincent – Director of Finance and Corporate Services		
Person to contact about this policy	A McGuire		
Author	A McGuire		

Document Management

Revision History

Version	Date	Summary of Changes
1.0	2017/18 review	• Ex-Officio Board Membership paragraph added at section 2.2.4 • Confidentiality obligations paragraph added at section 3.1.1 • Delegation of Powers to Named Posts table updated at section 4.7

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version
Fraser Carlisle	Programme Head, Finance and Corporate Services		
Annabelle McGuire	Secretary to the Board and Head of Corporate Governance		

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Andy Williams		CEO		
Carl Vincent		Director of Finance and Corporate Services		

Document Status

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Glossary of Terms

Term / Abbreviation	What it stands for

Contents

1 Introduction

The Corporate Governance Manual sets out the corporate governance rules applying to the Health and Social Care Information Centre (NHS Digital). These rules are in line with its responsibilities as a public body and ensure that it operates in an open, transparent and proper manner.

1.1 The Statutory Framework

The Health and Social Care Information Centre (NHS Digital) was established on 1 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.

The headquarters of NHS Digital is 1 Trevelyan Square, Boar Lane, Leeds, LS1 6AE.

1.2 Governance Framework

The establishment and constitution of the Health and Social Care Information Centre (NHS Digital) is set out in Schedule 18 of the Health and Social Care Act 2012

NHS Digital is led by a 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.

The organisation is managed on a day to day basis by an executive team led by the Chief Executive who is the Accounting Officer and is accountable to the Secretary of State and to Parliament for the performance of all functions and for meeting statutory duties.

In operational terms, this accountability is to the Senior Departmental Sponsor in the Department of Health. The accountability arrangements are set out in the Accounting Officer memorandum sent to the Chief Executive of NHS Digital by the Department's Accounting Officer. These arrangements are also confirmed in the Framework Agreement (Annex C) which governs the relationship between NHS Digital and the Department of Health.

Board Members have corporate responsibility for ensuring that NHS Digital complies with all statutory and / or administrative requirements for the use of public funds.

Details of the conduct of Board business and the roles and responsibilities of the Chair, Board and Chief Executive are set out in the Standing Orders (Section 2) and Code of Conduct for Board Members (Section 3).

The Board meets at least 6 times a year in public. The Board may also resolve to meet in private session in order to transact commercial in confidence or other confidential business.

The Executive Management Team is responsible for NHS Digital's development and performance. It is accountable to NHS Digital Board for the delivery of NHS Digital business plan and for meeting NHS Digital's strategic objectives. This is measured against the delivery of the objectives contained in the business plan and against indicators and targets set out in the Performance Pack as agreed by the Board.

1.3 The Manual

The material in this manual fulfils the dual role of protecting NHS Digital's interests and protecting staff from any possible accusation that they have not acted properly. All executive and non-executive directors and all members of staff should be aware of the existence of this document and, where necessary, be familiar with the detailed provisions.

Failure to comply with requirements set out in this manual may potentially be a disciplinary offence which could result in dismissal in cases of gross misconduct.

A Definition of Key Terms can be found at Annex B.

Please note this document contains a number of links to appendices within the document, links to external documents and embedded documents.

2 Standing Orders

2.1 Board Membership and Conduct of Meetings

1. All business will be conducted in the name of NHS Digital[1].

2. Appointments of the Chair and non-executive Board Members, as laid out in Schedule 18 of the Health and Social Care Act 2012 are made by the Secretary of State, for periods of up to four years.

3. The powers of NHS Digital established under statute are exercised by the Board, meeting in public session, except as otherwise provided for in paragraph 16.

4. Certain decisions may only be exercised by NHS Digital in formal session. These are set out in the Scheme of Delegation (Section 4) and have effect as if incorporated into these Standing Orders.

5. 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 NHS Digital and are appointed by the non-executive members. One of the executive members must be appointed as the Chief Executive;
    - The first appointment to the position of CEO was made by the Secretary of State.

    Membership of the current Board and its terms of reference can be found at Annex D.

6. The Chair and non-executive members will be appointed and hold office as follows:

    - The Chair and non-executive members are appointed by the Secretary of State
    - Subject to Schedule 18 (termination of tenure of office) of the Health and Social Care Act 2012, the term of office of the Chair and non-executive members is such period, not exceeding four years, as the Secretary of State specifies on making the appointment and;
    - Subject to Schedule 18 (disqualification for appointment), the Chair and any non-executive member will, on the termination of their office, be eligible for re-appointment.

7. The Chair and members may appoint one of the non-executive members to be vice-Chair for such period, not exceeding the remainder of their term as a member, as they may specify on appointment.

8. Any member so appointed may at any time resign from the office of vice-Chair by giving notice in writing to the Chair.

[1] When acting on behalf of the Department of Health or other government body NHS Digital must adhere to the relevant legislation and follow procurement policy of the Department of Health or other government body.

9. Where the Chair is unable to perform their duties as Chair owing to illness, absence or any other cause, references to the Chair in the schedule to these regulations will, so long as there is no Chair available to perform their duties, be taken to include references to the vice-Chair.

10. The Chair and members may appoint one of the non-executive members to be the Senior Independent Director (SID) for such period, not exceeding the remainder of their term as a member, as they may specify on appointment (Section 4.5).

11. Any member so appointed may at any time resign from the office of Senior Independent Director (SID) by giving notice in writing to the Chair.

12. The Chair or a non-executive member may resign from the office at any time during the term of office by giving notice in writing to the Secretary of State.

13. Where the Secretary of State is of the opinion that it is not in the interests of, or conducive to the good management of, NHS Digital or of the health and social care service that the Chair or a non-executive member should continue to hold office, he may terminate their tenure of office immediately by giving them notice in writing to that effect. In such circumstances, the Secretary of State may appoint a non-executive member as the interim Chair to exercise the Chair's functions.

14. The Secretary of State may remove a person from office as the Chair or other non-executive member on any of the following grounds:

    - Incapacity
    - Misbehaviour, or
    - Failure to carry out their duties as a non-executive member.

15. Where a person has been appointed to be the Chair or a non-executive member, and:

    - Becomes disqualified for appointment under schedule 18, the Secretary of State shall notify that person in writing of such disqualification; or
    - It comes to the notice of the Secretary of State that at the time of appointment the person was so disqualified; he will declare that the person in question was not duly appointed and provide notification in writing to that effect and upon receipt of any such notification, their tenure of office, if any, will be terminated.

16. If it appears to the Secretary of State that the Chair or a non-executive member has failed to comply with the requirements set out in schedule 18 he may terminate that person's tenure of office by giving notice in writing to that effect.

2.2 Meetings of NHS Digital's Board

17. The public and representatives of the press may attend all formal meetings of NHS Digital Board but will be required to withdraw upon the Board 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)'.

18. Nothing in these Standing Orders requires the Board to allow members of the public or representatives of the press to make a video or audio recording of proceedings as they take place without the prior agreement of the Board.

19. Before each meeting of NHS Digital, a notice of the meeting which specifies the principal business proposed to be transacted together with accompanying papers will be issued to each member at least five working days before the day of the meeting. The proceedings of any meetings are not invalidated by a failure to deliver such notice to any member.

20. A member desiring a matter to be included on an agenda must make their request in writing to the Chair at least seven working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than seven days before a meeting may be included on the agenda at the discretion on the Chair.

21. The Board may determine that certain matters appear on every agenda for a meeting of NHS Digital and are addressed prior to any other business being conducted.

2.2.1 Motions

22. A member desiring to move or amend a motion must send a written notification of this at least ten working days before the meeting to the Chair, who will include it in the agenda for the meeting. This Standing Order does not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

23. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

24. Notice of motion to amend or rescind any resolution (or the general substance of any resolution) that has been passed within the preceding six calendar months, must bear the signature of the member who gives it and also the signature of four other members. When any such motion has been disposed of by NHS Digital no member, other than the Chair, may propose a motion to the same effect within six months. However the Chair may do so if they consider it appropriate.

25. When a motion is under discussion or immediately prior to discussion a member may move:

- An amendment to the motion
- The adjournment of the discussion or the meeting
- That the meeting proceed to the next business
- That the question be now put
- A motion under section 1(2) of the Public bodies (Admission to Meetings) Act 1960 resolving to exclude the public (including the press)

26. No amendment to the motion can be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

27. The decision of the Chair of the meeting on question of order, relevancy and regularity (including procedure on handling motions) and the Chair's interpretation of the Standing Orders is final.

2.2.2 Quorum

28. No business may be transacted at any meeting unless at least one-third of the membership (including at least two non-executives, one of whom must be the Chair or vice-Chair) is present.

29. The Chair, and at least two non-executive members, must be present at any meeting of NHS Digital which is convened for the purpose of appointing a person to act as the Chief Executive.

30. An officer in attendance for an officer member but without formal acting up status may not count towards the quorum.

31. If the Chair or a member has been disqualified from participating in the discussion on any matter, and/or from voting on any resolution by reason of the declaration of a conflict of interest, they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position will be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

2.2.3 Voting

32. The Chair and non-executive directors have a minimum of 6 votes and the executive members have 5 votes. Executive votes are allocated as follows:

- CEO – 1 vote
- Director of Finance and Corporate Services – 1 vote
- Chief Operating Officer – 1 vote
- Director of Workforce – 1 vote
- Director of Digital Transformation – 1 vote

33. All questions put to the vote are, at the discretion of the Chair of the meeting, determined by oral expression, or by a show of hands. A paper ballot may also be used if a majority of the members present so request.

34. If at least one-third of the members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each member present voted or abstained.

35. If a member so requests, their vote will be recorded by name.

36. Under no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

37. An officer, who has been appointed formally by the Board to act up for an officer member during a period of incapacity, or temporarily to fill an officer member vacancy, is entitled to exercise the voting rights of the officer member.

38. An officer who is attending the Board to represent an officer member during a period of incapacity or temporary absence, without formal acting up status, may not exercise the voting rights of the officer member. An officer's status when attending a meeting will be recorded in the minutes.

2.2.4 Ex-Officio Board Directors

39. The term "ex-officio" is a Latin phrase which when literally translated means "from the office." It is a status a person has, by virtue of their position, to serve on a board or committee.

40. The Director General for Community Care, DH and the NHS Chief Clinical Information Officer are Ex Officio Directors of NHS Digital's Board. These appointments will support closer system alignment on informatics matters.

41. Ex-officio Board Directors do not have voting rights on NHS Digital's Board; they are Board Members in a consultative and advisory capacity.

42. Ex officio Board Directors are not subject to term limits because the director position is tied to their office.

2.2.5 Minutes

43. The minutes of the proceedings of a meeting will be drawn up by the Secretary to the Board (or their representative) and submitted for ratification at the following Board meeting; once ratified they will be signed by the Chair.

44. Any amendment to the minutes must be agreed and recorded in the minutes of the Board meeting at which they are submitted for agreement.

45. The minutes of Board meetings, other than the minutes of the private session containing confidential information, will be available to the public.

2.2.6 Suspension of, and amendments to, Standing Orders

46. Except where this would contravene any statutory provision or any directions made by the Secretary of State, any one or more of the provisions of the Standing Orders may be suspended at any meeting, provided that:

- At least two-thirds of the Board Members are present, including one executive and two non-executive members, and that a majority of those present vote in favour of suspension
- The variation proposed does not contravene a statutory provision or direction made by the Secretary of State

47. A decision to suspend Standing Orders will be recorded in the minutes of the meeting.

48. A separate record of matters discussed during the suspension of Standing Orders must be made and made available to the Chair and members of the Board.

49. No formal business may be transacted while Standing Orders are suspended.

50. The Assurance and Risk Committee will review every decision to suspend Standing Orders.

51. The names of the members present at a meeting will be recorded in the minutes.

2.2.7 Arrangements for the exercise of functions by delegation

52. Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of NHS Digital, of any of its functions by a committee or sub-committee or by an officer of NHS Digital. In each case this will be subject to such restrictions and conditions as the Board thinks fit.

53. The powers which the Board has retained to itself may in emergency be exercised by the Chair, after having consulted at least two non-executive members. The exercise of such powers by the Chair must be reported to the next formal meeting of the Board for ratification.

54. The Board shall agree from time to time the delegation of executive powers to be exercised by committees or sub-committees which it has formally constituted. The constitution and terms of reference of these committees and sub-committees, and their specific executive powers, must be approved by the Board.

55. Those functions of NHS Digital which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee will be exercised on behalf of NHS Digital by the Chief Executive. The Chief Executive determines which functions he will perform personally and nominates officers to undertake the remaining functions for which he will still retain accountability to the Board.

56. The Chief Executive must prepare a Scheme of Delegation for consideration and approval by the Board, subject to any amendment agreed during discussion. The Chief Executive may periodically propose amendments to the Scheme of Delegation for consideration and approval by the Board.

57. Nothing in the Scheme of Delegation impairs the discharge of the direct accountability to the Board of the Director of Finance and Corporate Services and other executive directors to provide information and advise the Board in accordance with any statutory requirements. Outside these statutory requirements the roles of the Director of Finance and Corporate Services and any other executive director are accountable to the Chief Executive.

58. The arrangements made by the Board, as set out in the Scheme of Delegation, have effect as if incorporated in these Standing Orders.

2.2.8 Committees and Sub-Committees

59. Subject to such directions as may be given by the Secretary of State, NHS Digital may, and, if so directed by the Secretary of State, will appoint committees of NHS Digital, consisting wholly or partly of members of NHS Digital or wholly of persons who are not members of NHS Digital.

60. A committee appointed under paragraph 55 may, subject to such directions as may be given by the Secretary of State or NHS Digital, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they are members of NHS Digital) or wholly of persons who are not members of NHS Digital or the committee.

61. Paragraphs 55 and 56 apply to the appointment of members of committees and sub-committees appointed under this regulation as they apply to the appointment of members of NHS Digital

62. The Standing Orders of NHS Digital, as far as they are applicable, apply with appropriate alteration to meetings of any committees established by the Board.

63. Each such committee has terms of reference and powers and is subject to such conditions, as the Board decides. Such terms of reference have effect as if incorporated into the Standing Orders.

64. Where committees are authorised to establish sub-committees they may not delegate their executive powers to the sub-committee unless expressly authorised by the Board.

65. The Board approves appointments to each committee, which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, are appointed to a committee, the terms of such appointment will be within the powers of the Board as defined by the Secretary of State. The Board will define the powers of such appointments and shall agree the terms of their remuneration and/or reimbursement for loss of earnings and/or expenses.

66. The Chair of the Assurance and Risk Committee will be appointed by the Chair of the Board and will be a non-executive director; the Chair of the Board will not chair the committee.

67. The Chair of the Information Assurance and Cyber Security Committee will be appointed by the Chair of the Board and will be a non-executive director; the Chair of the Board will not chair the committee.

68. The Chair of the Board will chair the Remuneration Committee.

69. A member of a committee must not disclose a matter dealt with by, or brought before, the committee without its permission until the committee has reported to the Board or

otherwise has concluded on that matter except on those issues covered by the Public Interest Disclosures Act 1998.

70. A Director of NHS Digital or a member of a committee must not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee resolves that it is confidential.

71. Further details of powers delegated to sub-committees can be found in the Scheme of Delegation (Section 4).

2.3 Personal Liability of Board Members

72. Although there are circumstances when legal proceedings initiated by a third party could be brought against the Board, in exceptional cases proceedings (civil or, in certain cases, criminal) could also be brought against the Chair or individual Board Members.

73. The Government has indicated that where individual Board Members have acted honestly and in good faith they will not have to meet any personal civil liability which is incurred in the execution or purported execution of their Board Member functions, save where the person has been shown to have acted recklessly. NHS Digital will, within its legal powers, issue to Board Members a suitable indemnity consistent with this paragraph and Board Members who need further advice on this can consult NHS Digital's legal advisers.

3 Code of Conduct for Board Members

74. The Code of Business Conduct sets out the responsibilities and conduct expected from all members of staff, including Board Members and any independent members who sit on Board committees and sub-committees.

3.1 Responsibilities of Individual Board Members

75. Individual Members should note their wider responsibilities to the general public and must follow the principles of public life and service listed in Annex A. In addition, in carrying out their duties Board Members must act in good faith and in the best interests of NHS Digital.

3.1.1 Confidentiality Responsibilities

76. Confidential information should be marked in accordance with the Cabinet Office Government Security Classifications Policy. If information is not so marked but has been provided in circumstances where the discloser would have a reasonable expectation of confidence, and the Board member is not informed of any legal justification why such information can be shared, Board members should assume such information is also confidential.

77. In the course of their term on NHS Digital's Board:

- Board Members have a responsibility to ensure that any information gained will not be misused for personal advantage or political purpose e.g. releasing confidential information on social media, providing confidential information to the press, releasing procurement information ahead of procurement release dates to contacts.
- Board Members must not externally disclose any information which is confidential in nature, or which is provided in confidence, without permission or the owner or authority unless legally obliged to do so. This includes information received from other arms' length bodies (ALBs) which would be considered confidential by those ALB's.
- Board Members shall limit the disclosure of confidential information within the organisation (NHS Digital) to those having a need to know, and will not divulge confidential information further unless legally obliged to do so.
- Board Members have a duty to safeguard and keep secure copies of all confidential information, in whatever format it is issued to them, at all times in accordance with NHS Digital standards as set out in the IG Toolkit.

78. Board Members shall comply with NHS Digital's Confidentiality Policy.

79. Board members shall notify the Chair or Senior Independent Director of NHS Digital of any breach of their confidentiality obligations.

80. Upon leaving the Board, Board Members shall confirm they have deleted and/or destroyed any copies of confidential information held, in whatever format it was issued, and shall maintain such confidentiality unless and until such information is published by NHS Digital.

3.2 Board Declarations of Interest and Register of Interests

81. The Conflicts of Interest Policy requires that all Board Members must declare interests which are relevant and material to NHS Digital. Any Board Member appointed must do so on appointment.

82. It is the personal responsibility of all Board Members to declare any personal or business interests which may conflict with their responsibilities (see the Conflict of Interest Policy for further details).

83. If a Board Member has any doubt about the relevance of an interest, this should be discussed with the Chair or the Secretary to the Board.

84. At the time Board Members' interests are declared, they will be recorded in the Board minutes. Any changes in interests will be declared at the next Board meeting following the change occurring.

85. Board Members' directorships of companies likely or possibly seeking to do business with the health and care sector will be published in NHS Digital's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

86. During the course of a Board meeting, if a conflict of interest is established, the Board Member concerned should declare their interest, and at the Chair's discretion withdraw from the meeting and play no further part in the relevant discussion or decision. The declaration of interest shall be recorded in the minutes of the meeting.

87. The Secretary to the Board will maintain a register of the Interests declared by Board Members.

3.3 Media and Public Speaking Engagements

88. Board Members must ensure that they inform the Chair of the Board of any engagements to speak to the media, or in a public forum where there is a likelihood of media coverage, on any subject related to the work of NHS Digital. They must always make explicit those occasions when they are speaking as an official representative of NHS Digital and when they are expressing their own personal views.

89. The Chair of the Board is the official spokesperson for NHS Digital. Board Members must not commit to media interviews solely as representatives of NHS Digital without first consulting and gaining the approval of the Chair.

3.4 Standards of Business and Personal Conduct

90. The following provisions should be read in conjunction with the Code of Business Conduct

91. Canvassing of Board Members of NHS Digital, or of members of any committee directly or indirectly, for any appointment under NHS Digital will disqualify the candidate from such appointment. The contents of this paragraph must be included in application forms or otherwise brought to the attention of candidates.

92. A Board Member must not solicit for any person any appointment under NHS Digital or recommend any person for such appointment: but this paragraph does not preclude a Board Member from giving written testimonial of a candidate's ability, experience or character for submission to NHS Digital.

93. Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

94. Candidates for any staff appointment under NHS Digital must, when making an application, disclose in writing whether they are related to, or have a relationship with, any Board Member or the holder of any office under NHS Digital. Failure to disclose such a relationship will disqualify a candidate and, if appointed, render them liable to instant dismissal.

95. The Chair and every Board Member and officer member of NHS Digital must disclose in writing to NHS Digital any relationship between themselves and a candidate of whose candidature that member or officer is aware. It is the duty of the Chief Executive to report to the Board any such disclosure made.

96. On appointment, Board Members (and prior to acceptance of an appointment in the case of officer members) must disclose to NHS Digital whether they are related to any other member or holder of any office under NHS Digital.

97. Board Members must adhere to NHS Digital's Hospitality Policy for staff in respect of the offer or acceptance or rejection of any gifts or hospitality and notify the Secretary to the Board in writing of the offer or acceptance or rejection of gifts in accordance with the Policy.

98. NHS Digital Secretary to the Board will ensure registers are established to record formally declarations of interests in contracts, employment or relationships, gifts and hospitality by Directors. The registers will be available for inspection by any Board Member.

99. The Conflict of Interest, Hospitality and Confidentiality Policies, including the declaration forms, can be found by clicking on the link.

3.5 Entering into Contracts

100. Legislation and government policy jointly convey the principle that contract opportunities should be openly competed to ensure that Value for Money is achieved. Competitive tenders should be undertaken in line with NHS Digital's Commercial Policy as this implements NHS Digital's legislative and policy obligations.

101. The policies and procedures for:

- Entering into contracts on behalf of NHS Digital;
- Entering into contract on behalf of the Department of Health or one of the department's Arm's length Bodies;
- Making use of existing contract and frameworks wherever appropriate;
- Managing the resulting contracts;
- Raising purchase orders;
- Confirming receipt of goods or services;

- Dealing with invoices for goods and services; are mandatory and ensure compliance with the principles of this manual.

102. Cabinet Office policy determines that, where a central contract or framework meets a requirement, this should be utilised. Where a central contract or framework exists, any order or contract must follow the procedures and guidance set out for that contract or framework.

103. When taking part in competitive tender exercises, staff should be aware of their responsibilities under NHS Digital's Commercial Policy.

3.5.1 Single Tenders

104. Competitive tendering procedures may only be waived by those with suitable delegated authority. The principles of the Public Contract Regulations 2015 (as amended) will be taken into account when considering 'single tenders', in particular;
    - Regulation 32 – 'Use of the negotiated procedure without prior publication' For requirements over the threshold at which the regulations apply in full, this regulation specifies the limited circumstances in which contract can be awarded without competition.
    - Chapter 8 – 'Below-Threshold Procurements'

105. Single tenders cannot be used an alternative to the robust planning of procurement activity.

3.5.2 Extending Existing Contracts

106. Contracts may only be extended, in duration or value, if the original competition and the contract itself allow for this or this is allowable under specific provisions within Regulation 32 – 'Use of the negotiated procedure without prior publication'. Advice should be sought from commercial specialists to establish the potential for this action.

3.6 Private Finance

107. When NHS Digital proposes, or is required, to use finance provided by the private sector:

    - The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;
    - Where the sum exceeds limits delegated by the Department of Health, a business case must be referred to the Department of Health for approval or treated as per current guidelines;
    - The proposal must be specially agreed by the Board;
    - The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

3.7 Miscellaneous

Signature and Sealing of Documents

108. Where the signature of any document will be a necessary step in legal proceedings involving NHS Digital it shall be signed by the Chief Executive or in their absence, the Director of Finance and Corporate Services, unless any enactment otherwise requires or authorises a variation, or the Board has given the necessary authority to some other person for the purpose of such proceedings.

109. The Chief Executive or nominated officers will be authorised by resolution of the Board, to sign on behalf of NHS Digital any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board, committee or sub-committee thereof, to which the Board has delegated their powers on its behalf.

110. The Director of Finance and Corporate Services must sign all finance and operating lease agreements for the supply of goods and/or services by NHS Digital which it is proposed that NHS Digital enters into, irrespective of their financial value.

111. The common seal of NHS Digital will be kept by the Chief Executive or their nominated manager in a secure place.

112. Where it is necessary that a document is sealed, the seal will be affixed in the presence of two senior managers duly authorised by the Chief Executive, one of which will not be from the originating department, and will be attested by them.

113. The Chief Executive will keep a register in which they, or another manager of NHS Digital they authorise, will enter a record of the sealing of every document.

114. Where any document is a necessary step in legal proceedings on behalf of NHS Digital, it will, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any executive director.

115. It is the duty of the Chief Executive to ensure that existing members and officers and all new appointees are notified of, and understand, their responsibilities set out within the Corporate Governance Manual, and specifically the Standing Orders, SFIs and Code of Conduct. Updated copies of these documents will be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of the Standing Orders.

116. The SFIs and the Scheme of Delegation have effect as if incorporated into Standing Orders.

117. Standing Orders are reviewed annually by NHS Digital Board, on the advice of the Assurance and Risk Committee. The requirement for review extends to all documents having effect as if incorporated in Standing Orders.

118. The annual review of these documents will also reflect any updates to any financial directions issued since the last annual review.

4 Scheme of Delegation

4.1 Introduction

119. The Scheme of Delegation sets out those matters on which decisions are reserved to the Board and those which are delegated to budget holders, other directors, operational managers or employees.

120. The fundamental objective of the Scheme of Delegation is to ensure that the work of NHS Digital is managed efficiently within the policies laid down by NHS Digital. It is therefore necessary for the Accounting Officer to delegate to others certain powers, in order to incur expenditure within approved budgets, to appoint staff within financial establishments and resource ceilings, and for sundry other matters as may be decided by the Board.

121. The Chief Executive remains accountable for all the functions of the organisation - even those delegated to other directors or employees. The Chief Executive retains an over-riding right to take any decision or to call for any information in respect of any decision taken by an individual under this delegated authority.

122. The arrangements outlined herein are to be read in conjunction with, and subject to, the Standing Orders and SFIs adopted by NHS Digital and Government Accounting rules published by HM Treasury. For the avoidance of doubt, Government Accounting rules will always take precedence over the Scheme of Delegation.

4.2 Role of the Chair

123. The responsibilities of the Chair are to:

- Ensure that NHS Digital's affairs are conducted with probity, and that the Board's policies and actions support NHS Digital in the efficient discharge of its statutory functions and duties.
- Set, by example, the standards of integrity and ethical leadership expected for the organisation.
- Chair the Board and its meetings; plan the agenda and determine the quality, quantity and timeliness of information from management; develop the organisation's priorities and create an environment for constructive debate on key issues.
- Ensure effective corporate governance arrangements are in place and processes agreed in order to discharge NHS Digital's accountability requirements to the Department of Health and Parliament.
- Conduct annual evaluation, objective setting and performance appraisal of the Chief Executive and objective setting and performance appraisal of non-executive directors.

4.3 Role of the Chief Executive

124. All powers of NHS Digital, which have not been retained as reserved by NHS Digital or delegated to an executive committee or sub-committee, will be exercised on behalf of NHS Digital by the Chief Executive. Responsibility for day-to-day management of NHS Digital is delegated to the Chief Executive, within a framework of strategic control described within this Scheme of Delegation.

125. These arrangements are based on the principle that the Chief Executive, and at the Chief Executive's discretion other designated individuals, be given, subject to certain constraints, the authority to discharge those responsibilities which NHS Digital has delegated. The arrangements also reflect the responsibilities of the Chief Executive in the role as the Accounting Officer for NHS Digital.

126. As Accounting Officer, the Chief Executive is accountable to the Principal Accounting Officer of the Department of Health for the funds entrusted to NHS Digital. The Chief Executive also has a direct line of accountability to Parliament

127. The identification of responsible officers and managers throughout this document does not, unless stated, limit their discretion to allocate the task to subordinates. The individual held accountable for performance will, however, remain as denoted in the column headed "responsible individual".

128. In the absence of an individual to whom powers have been delegated, those powers shall be exercised by that individual's superior unless:

- Alternative arrangements have been approved by NHS Digital;
- The responsible individual has formally delegated authority.

129. If the Chief Executive is absent for any length of time, delegated powers may be exercised by an Executive Director nominated by the Chief Executive, subject to the Chair's approval.

130. Powers are delegated to individuals on the understanding that they would not exercise delegated powers in a matter which, in their judgement, was likely to be a cause for public concern.

4.4 Role of the Board

131. The powers retained by and the responsibilities of the Board include:

- Agreeing the vision and values, culture and strategy of NHS Digital within the policy and resources framework agreed with the DH sponsor
- Agreeing appropriate governance and internal assurance controls
- Approving business strategy, business plans, key financial and performance targets and the annual accounts
- Ensuring sound financial management and good value for money
- Ensuring controls are in place to manage financial and performance risks, including ensuring that NHS Digital has the capability to deliver its strategic objectives
- Using information appropriately to drive improvements

- Supporting the Executive Management Team and holding it to account
- Ensuring the Board is able to account to Parliament and the public for how it discharges its functions
- Ensuring that NHS Digital complies with any duties imposed on public bodies by statute, including without limitation obligations under health and safety legislation, the Human Rights Act 1998, the Data Protection Act 1998, the Freedom of Information Action 2000, the Equality Act 2010, the Public Bodies Health and Social Care Act 2011, the Health and Social Care Act 2012 and by secondary legislation made under relevant Acts.
- Ensuring that NHS Digital has specific responsibility for sustainable development and operates within the framework of the Department of Health's environmental policies.
- Approving recommendations of Board committees
- Approving income and expenditure as defined in NHS Digital Levels of Delegated Authority document

4.4.1 Accountability for Public Funds

132. Board Members have a duty to ensure the safeguarding of public funds - which for this purpose must be taken to include all forms of receipts from fees, charges and other sources - and the proper custody of assets which have been publicly funded. They must take appropriate measures to ensure that NHS Digital at all times conducts its operations as economically, efficiently and effectively as possible, with full regard to the relevant statutory provisions and to relevant guidance in Managing Public Money.

133. Board Members are responsible for ensuring that NHS Digital does not exceed its powers or functions, whether defined in statute or otherwise, or through any limitations on its authority to incur expenditure. They are normally advised on these matters by the Chief Executive and NHS Digital's legal advisers.

4.4.2 Annual Report and Accounts

134. As part of its responsibilities for the stewardship of public funds, the Board must ensure that NHS Digital includes a full statement of the use of its resources in its Annual Report and Accounts. Such accounts must be prepared in accordance with the Accounts Direction issued by the responsible Minister and such other guidance as may be issued, from time to time, by the Department of Health and the Treasury, including *Executive Non-Departmental Public Bodies: Annual Reports and Accounts Guidance*.

135. Subject to any existing statutory requirements, NHS Digital must produce an Annual Report and Accounts as a single document.

136. The Annual Report and Accounts must provide a full description of NHS Digital's activities; state the extent to which key strategic objectives and agreed financial and other performance targets have been met; list the names of the current Board Members and senior staff; and provide details of remuneration of Board Members and senior staff in accordance with Treasury guidance. The Annual Report must contain information on access to the Registers of Interests as set out in the Standing Orders.

4.4.3 Failure to Comply

137. Failure to observe these requirements set out in the Code of Conduct for Board Members would be a breach of the Board Standing Orders and could in the event of allegations of fraud and/or corruption, leave the Board Member involved open to criminal proceedings under the Prevention of Corruption Acts, as well as other civil and criminal penalties.

138. Any questions about the Code of Conduct for Board Members or the Board Standing Orders should be directed to the Secretary to the Board in the first instance.

139. This Code will be reviewed periodically by the Board.

4.5 Role of the Senior Independent Director (SID)

140. The SID is a non-executive director appointed by the Chair and members of the Board and may be, but does not have to be, the vice-Chair of the Board. The vice-Chair is eligible, except while acting as Chair when the latter position is vacant. In addition to the duties described here the SID has the same duties as the other non-executive directors.

141. The responsibilities of the Senior Independent Director are to:

- Support the Chair in leading the Board and act as a sounding board and source of advice for the Chair.
- Be available where there are concerns that contact through the usual channels of Chair, Chief Executive, Finance Director and Secretary to the Board has failed to resolve an issue or where it would be inappropriate to use such channels.
- Meet with the other members of the Board as and when deemed appropriate and act as an alternative point of contact for Executive Directors, if required, in addition to the normal channels of the Chair and Chief Executive.
- Hold a meeting with the other non-executive directors in the absence of the Chair at least annually as part of the appraisal process.
- Act on the results of any performance evaluation of the Chair.
    - There may be other circumstances where such meetings are appropriate. Examples might include informing the re-appointment process for the Chair, where there are expressions of concern regarding the Chair or where the Board is experiencing a period of stress.
- Assist in resolving issues of concern in circumstances where the Board is undergoing a period of stress.
- Intervene where there is a disagreement or dispute between the Chair and the Chief Executive and where deemed appropriate, to identify issues that have caused the rift and try to mediate and build a consensus.
- Provide a link to stakeholders where the relationship between the Chair and Chief Executive is particularly close, and they do not communicate fully with stakeholders.
- Work with the Chair, and other Directors to resolve significant issues in the circumstances outlined above.

142. The Board should have a clear understanding of when the SID might intervene.

143. Other duties can be added to the role if required provided they are in keeping with the principle of independence and review.

144. The SID will undertake that they will have sufficient time to meet the rigours of the role and the additional responsibilities. Their other significant commitments will be disclosed before appointment, with a broad indication of the time involved.

4.6 Delegation to Board Committees

4.6.1 Assurance and Risk Committee

145. In accordance with the Standing Orders, the Board shall formally establish an Assurance and Risk Committee, with clearly defined terms of reference. The Assurance and Risk Committee shall be responsible to the Board for ensuring that there are arrangements in place to measure, evaluate and report on the effectiveness of internal control and efficient use of resources.

146. The Terms of Reference of this committee are set out in Annex E. These should be reviewed on an annual basis.

147. The Assurance and Risk Committee shall report annually to the Board on the extent of audit cover achieved, providing a summary of audit activity during the report period, and detailing the degree of achievement of the approved plan.

148. Where the Assurance and Risk Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the Chair of the Assurance and Risk Committee shall raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health.

149. The Chief Executive shall ensure that NHS Digital has a programme of risk management, which will be approved and monitored by the Board. Such responsibility shall also be enshrined in the Assurance and Risk Committee.

150. The programme of risk management shall incorporate all elements of risk to NHS Digital, not just financial, and should provide adequate assurance on the overall risk profile of NHS Digital. The programme should include:

- A process for identifying and quantifying risks and potential liabilities
- Engendering among all levels of staff a positive attitude towards the control of risk and establishing a culture to embed risk management at all levels of the organisation
- Management processes to ensure all significant risks and potential liabilities are regularly reviewed and addressed including effective systems of internal control and decisions on the acceptable level of retained risk
- Contingency plans to offset the impact of adverse events
- Audit arrangements including internal audit and a health and safety review
- Arrangements to review the risk management programme.

151. The Assurance and Risk Committee will review the adequacy of and make recommendations to the Board as appropriate on:

- The operational effectiveness of policies and procedures
- The policies and procedures for all work related to fraud, corruption and whistleblowing, including the appointment of a Local Counter Fraud Specialist and to enable the Local Counter Fraud Specialist to attend Assurance and Risk Committee meetings when required.

152. The Assurance and Risk Committee will ensure that there is an effective internal audit function established by management that meets mandatory internal audit standards and provides appropriate independent assurance to the Chief Executive and Board.

153. The Assurance and Risk Committee will review the work and findings of the External Auditor and take account of the implications and management responses of their work.

154. The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal control. The statement of the effectiveness of internal control covers all controls within NHS Digital, not just financial controls.

155. 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 to the Committee
- Changes in, and compliance with, accounting policies and practices
- Major judgemental areas
- Significant adjustments resulting from audit.

156. The effectiveness of the Assurance and Risk Committee should be formally reviewed on an annual basis, in line with best practice procedures.

4.6.2 Information Assurance and Cyber Security Committee

157. In accordance with Standing Orders, the Board shall formally establish an Information Assurance and Cyber Security Committee, with clearly defined terms of reference. The Information Assurance and Cyber Security Committee shall be responsible to the Board for ensuring that there are arrangements in place to measure, evaluate and report on the effectiveness of internal control and efficient use of resources.

158. The Terms of Reference of this committee are set out in Annex F. These should be reviewed on an annual basis.

159. The Information Assurance and Cyber Security Committee shall report annually to the Board, providing a summary of activity during the reporting period, and detailing the degree of achievement of all approved plans.

160. 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 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 NHS Digital's expense, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
- To ensure that there is an effective Information Assurance function that meets recognised industry and Government standards and provides appropriate independent assurance to the Chief Executive and Board.
- To review the work and findings of the Cyber Security Programme and take account of the implications and management responses to their work.
- To 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.

161. The effectiveness of the Information Assurance and Cyber Security Committee should be formally reviewed on an annual basis, in line with best practice procedures.

4.6.3 Remuneration Committee

162. In accordance with the Standing Orders, the Board shall formally establish a Remuneration Committee, with clearly defined terms of reference. The Remuneration Committee is chaired by the Chair of the Board, supported by the Director of Workforce.

163. The Board has delegated full responsibility to the Remuneration Committee to determine appropriate arrangements for senior staff pay and matters relating to redundancy and the terms and conditions of staff that are not on Very Senior Managers (VSM) or Agenda for Change terms. In discharging these responsibilities the Committee will, where necessary, make recommendations to the Department of Health (DH) Remuneration Committee for approval.

164. Terms of reference for the Remuneration Committee are attached at Annex G.

165. The effectiveness of Remuneration Committee should be formally reviewed on an annual basis, in line with best practice procedures.

4.7 Delegation of Powers to Named Posts

167. The delegation of powers and responsibilities to named posts is shown in the following table. These need to be read in conjunction with the Standing Orders and Standing Financial Instructions.

Powers Delegated	**Responsible Individual or Group**
Governance	
Final authority on the interpretation of the Standing Orders	Chair
To adopt an organisation structure	Chief Executive
Receive and respond to official reports from statutory and regulatory bodies	Chief Executive
Undertaking of powers conferred on the Chief Executive Officer in their absence	Executive Director nominated by Chief Executive
Strategic oversight and operational delivery of NHS Digital portfolio	Chief Operating Officer
Management and oversight of the organisations information assets	Senior Information Risk Owner (SIRO)
Responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing	Caldicott Guardian
Preparing and signing of the Annual Report	Chief Executive
Signature authority - the power to sign a contract or take action that binds NHS Digital	Chief Executive and Executive Management Team Directors
Finance and Commercial	
Approval authority – give consent for decisions which have a financial implication	See the Levels of Delegated Financial Authorities in appendix H
Waiving of Standing Financial Instructions	Chief Executive
Final authority on the interpretation of Standing Financial Instructions	Assurance and Risk Committee
Authorisation of losses and special payments and reporting to DH / Board as appropriate	Director of Finance and Corporate Services
Ensuring there is an adequate and appropriate system of financial control	Director of Finance and Corporate Services
Responsibility for the collection of amounts due and authorise the write off of bad debts	Director of Finance and Corporate Services
Delegating cost centre accountability	Director of Finance and Corporate Services
Delegating expenditure authorisation	Director of Finance and Corporate Services
Human Resources	
Disciplining Chief Executive and Non-Executive Directors	Chair
Disciplining Executive Directors	Chief Executive
Appointment of all staff and issuing contracts of employment	Director of Workforce
Dismissal of an employee	Chief Executive, Director of Workforce or their deputies
Delegation of the management of staff resources	Director of Workforce

4.7.1 The Director of Workforce is responsible for:

- The Director of Workforce is an executive director who sits on NHS Digital Board, and shares corporate responsibility for strategic planning, corporate policy-making and the delivery of NHS Digital's objectives.
- The Director of Workforce ensures that NHS Digital has an appropriate, well-motivated, highly skilled and high-performing workforce.
- Is responsible for the provision of professional leadership, vision and direction for the human resources and transformation function and provides high quality, innovative and consistent operational services to meet the needs of NHS Digital.
- Provides advice and support to the Chair, Chief Executive and other Executive Directors as required on specific senior employee relations or other workforce issues.
- Provides confidential, professional advice and support to the Remuneration Committee.

4.7.2 The Chief Operating Officer (COO) is responsible for:

- The COO is an executive director who sits on NHS Digital Board, and shares corporate responsibility for strategic planning, corporate policy-making and the delivery of NHS Digital's objectives.
- As an executive director the COO oversees ongoing business operations with management responsibility for NHS Digital portfolio.
- The COO is accountable for service and programme delivery, ensuring processes and systems are performance managed so as to meet delivery requirements.

4.7.3 The Senior Information Risk Owner (SIRO) is responsible for:

- The SIRO is a director who is familiar with and takes ownership of the organisation's information risk policy, and acts as the advocate for information risk and serious untoward incidents on the Board.
- The SIRO reports to the Board and provides advice and guidance in respect to information risk and incident management.
- Provides information risk advice and support to the Assurance and Risk Committee.
- Provides information security advice and support to the Information Assurance and Cyber Security Committee.

4.7.4 The Caldicott Guardian is responsible for:

- The Caldicott Guardian is a senior person within the organisation, and is responsible for ensuring that patient data is kept secure.
- Is responsible for protecting the confidentiality of patient and service-user information and for enabling appropriate information-sharing.
- Provides impartial professional advice and support to the Board and the Board sub-committees on data sharing and data security issues.

4.7.5 The Medical Director is responsible for:

- The Medical Director is a director who sits on NHS Digital Board, and shares corporate responsibility for strategic planning, corporate policy-making and the delivery of NHS Digital's objectives.
- The Medical Director is responsible for ensuring a sound system of clinical governance is in place across the organisation, which meets the standards expected by the clinical professions and their regulators.
- Provides impartial professional advice and support to the Board and the Board sub-committees on clinical issues and associated matters.

5 Standing Financial Instructions (SFIs)

5.1 General

168. These SFIs are issued in accordance with the Financial Directions issued by the Secretary of State under the provisions of the NHS Act 2006 as amended by the Health and Social Care Act 2012 and by secondary legislation made under this Act. .

169. Within the SFIs it is acknowledged that the Chief Executive and the Director of Finance and Corporate Services will have responsibility for ensuring that NHS Digital performs its functions within the financial resources made available to it.

170. The Chief Executive has overall executive responsibility for NHS Digital's activities and is ultimately responsible as Accounting Officer for ensuring that NHS Digital stays within its available resources.

171. The SFIs may only be changed as directed by the Standing Orders. This includes an annual review which will incorporate all updates to any financial directions issued since the last annual review.

172. The Chief Executive, as Accounting Officer, shall exercise financial supervision and control by:

- Requiring the submission and approval of revenue budgets within the projected income, and of capital budgets within the approved allocation
- Defining and approving essential features of financial arrangements in respect of important procedures and financial systems, including the need to obtain value for money and
- Defining specific responsibilities placed on budget holders and/or expenditure authorisers.

173. Wherever the title Chief Executive, Director of Finance and Corporate Services, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

174. Wherever the term "employee" is used, and where the context permits, it shall be deemed to include employees of third parties contracted to NHS Digital when acting on behalf of NHS Digital.

5.2 Responsibilities and Delegation

175. The Board exercises financial supervision and control by:

- Formulating the financial strategy
- Requiring the submission and approval of budgets within approved allocations/overall income
- Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money)
- Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation and

- In-year monitoring of NHS Digital's income and expenditure against approved budgets.

176. The Board is responsible for ensuring that its obligation to perform its functions within the available financial resources and that its financial targets are met. The Chief Executive is responsible as Accounting Officer as set out and defined by HM Treasury.

177. The Chief Executive will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation adopted by NHS Digital.

178. The Chief Executive has overall responsibility for NHS Digital's system of internal control.

179. The Chief Executive will, as far as possible, delegate detailed responsibilities, but will remain accountable for financial control.

180. It is a duty of the Chief Executive to ensure that existing directors, employees and all new appointees, are notified of and understand their responsibilities within these instructions.

181. The Director of Finance and Corporate Services is responsible, on behalf of the Chief Executive, for:

- Implementing NHS Digital's financial policies and for co-ordinating any corrective action necessary to further these policies
- Maintaining an effective system of internal financial control, including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions
- Ensuring that sufficient records are maintained to show and explain NHS Digital's transactions, in order to disclose, with reasonable accuracy, the financial position of NHS Digital at any time; and, without prejudice to any other functions of NHS Digital and employees of NHS Digital
- The provision of financial advice to NHS Digital and its directors and employees
- The design, implementation and supervision of systems of internal financial control and
- The preparation and maintenance of such accounts, certificates, estimates, records and reports as NHS Digital may require for the purpose of carrying out its statutory duties.

182. All directors and employees of NHS Digital are severally and collectively responsible for:

- The security of the property of NHS Digital
- Avoiding loss
- Exercising economy and efficiency in the use of resources
- Conforming to the requirements of Standing Orders, Standing Financial Instructions, and the Scheme of Delegation.

183. Any contractor or employee of a contractor who is empowered by NHS Digital to commit NHS Digital to expenditure, or who is authorised to obtain income, shall be covered by these instructions.

5.3 Financial Systems

184. NHS Digital's principal financial ledgers and systems are managed by NHS Shared Business Services (SBS). The payroll is processed through the NHS wide Electronic Staff Record (ESR) system and managed by SBS.

185. The Director of Finance and Corporate Services shall be responsible for the accuracy and security of the computerised financial data of NHS Digital.

186. The Director of Finance and Corporate Services shall devise and implement any necessary procedures to ensure adequate reasonable protection of NHS Digital's financial data, software and systems from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard to the Data Protection Act 1998 and other NHS Digital information governance policies.

187. The Director of Finance and Corporate Services shall ensure that:

- Adequate, reasonable controls exist over financial data entry processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system
- An adequate management audit trail exists through all computerised systems
- New systems and amendments to current systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by an external service provider (including SBS), assurances of adequacy shall be obtained from them prior to implementation
- Contracts for computer services for financial applications with an external service provider shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract shall also ensure rights of access for audit purposes
- Adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent over transmission networks including the appropriate use of encryption software and passwords, especially over sensitive personal record data
- Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management audit trail exists
- That all finance staff understand and follow the systems, processes and controls agreed with the external service providers except where variations have been agreed
- The annual audit report of the service provider is obtained and reviewed, with any identified weaknesses or issues highlighted discussed with the service provider
- On-going performance of the service provider is reviewed on a regular basis through meetings with the account manager

188. The Director of Finance and Corporate Services shall ensure that all financial data and files held on NHS Digital's internal systems have adequate controls over security and access

189. The Director of Finance and Corporate Services may request computer audit reviews as necessary and arrange that the agreed recommendations are actioned.

190. Advice should be sought where required for relevant information governance and security issues from the Chief Operating Officer.

5.4 Fraud and Corruption

191. In line with their responsibilities, the Chief Executive and Director of Finance and Corporate Services shall monitor and ensure compliance with Secretary of State's directions on fraud and corruption. NHS Digital shall take all necessary steps to counter fraud and bribery affecting publically funded services in accordance with the Fraud Act 2006 and the Bribery Act 2010. The Chief Executive and Director of Finance shall monitor and ensure compliance with the relevant legislation.

192. The Board shall appoint, either internally or externally, a suitable person to carry out the duties of the Counter Fraud Specialist as specified by the NHS fraud and corruption manual and guidance.

193. The Counter Fraud Specialist shall report to NHS Digital Director of Finance and Corporate Services and work with staff in the Department of Health Directorate of Counter Fraud Services and the Counter Fraud Operational Services Anti-Fraud Unit (DHAFU) in accordance with the NHS Fraud and Corruption Manual and in accordance with Department of Health Fraud Policy Statement and Annex 4.9 of HM Treasury Managing Public Money.

194. In the event of an allegation of fraud, bribery and corruption against the CEO and/or Executive Management Team the Counter Fraud Specialist shall reserve the right to report directly to the Chair of the Assurance and Risk Committee and DHAFU without prejudice.

195. The Counter Fraud Specialist shall ensure that robust checks are in place on financial flows to guard against money laundering.

196. The Counter Fraud Specialist shall have the right of attendance at the Assurance and Risk Committee and shall present relevant reports to this committee.

197. NHS Digital will have in place a policy and process whereby employees or other persons may provide details of a suspected fraud or other irregular event to the appointed Counter Fraud Specialist anonymously.

198. The Director of Finance and Corporate Services will issue a management statement on NHS Digital's stance against corruption and fraud.

199. The Counter Fraud Specialist will ensure that NHS Digital has in place a Fraud Policy Statement, a Fraud Risk Strategy and a Fraud Response Plan as highlighted in Annex 4.9.6 Responding to Fraud Risk of Managing Public Money.

5.5 Income and Expenditure - Budgets, Control and Reporting

200. NHS Digital has a responsibility to prepare financial budgets in accordance with resource, capital and cash limits allocated by the Department of Health. It shall perform its functions within the total of funds available. All financial approvals and control systems shall be designed to meet this obligation and shall include the requirement for regular review in the light of variations from the financial budget.

5.5.1 Income and Expenditure

201. The Chief Executive, in conjunction with the Director of Finance and Corporate Services, shall be responsible for ensuring that, where relevant, all costs incurred are recovered through income and recharges due under service agreements, contracts for the provision of goods and services to customers and other agreements.

202. The Director of Finance and Corporate Services shall ensure that the financial details contained within service agreements or contracts entered into by NHS Digital are consistent with the requirement to balance income and expenditure; and shall ensure that adequate financial systems are in place to monitor and control all such contracts and to facilitate the compilation of estimates, forecasts and investigations as may be required from time to time.

203. NHS Digital Board has the delegated responsibility to approve expenditure as set out in NHS Digital levels of Delegated Authority (Annex H).

5.5.2 Budgets

204. The Director of Finance and Corporate Services shall submit capital and revenue budgets consistent with the policies of NHS Digital for approval by the Board prior to the commencement of each financial year. The budgets shall show clearly how proposed expenditure is to be funded from income due under contracts, service agreements and other sources of funding and shall be reconciled to the budget and savings targets notified to NHS Digital by the Department of Health. The budget shall be accompanied with a statement summarising any key issues or risks associated with its achievement. In so doing:

- The Director of Finance and Corporate Services shall review the basis and assumptions used to prepare the budget and ensure that they are sensible and realistic
- The Director of Finance and Corporate Services shall have right of access to all budget holders on budgetary related matters and ensure that all budgets submitted by budget holders are consistent with theses bases and assumptions
- Such budgets shall relate to income and expenditure in that year and shall have supporting statements in order to explain any matter material to the understanding of those budgets

205. The budgets approved by the Board could be subsequently amended due to external influences not under the control of NHS Digital. The Director of Finance and Corporate Services shall report to the Board any such amendments.

206. The Chief Executive may, within budgetary limits approved by the Board, delegate responsibility for a budget or a part of a budget to operational managers to permit the performance of defined activities. Such delegation shall be included in the Scheme of Delegation and its terms shall include a clear definition of individual and group responsibilities for control of expenditure, achievement of planned levels of service and the provision of regular reports upon the discharge of these delegated functions to the Chief Executive.

207. In carrying out their duties:

- The Chief Executive shall not exceed the budgetary limits set by the Board
- Budget Holders and expenditure authorisers shall not exceed the budgetary limits set for them by the Chief Executive
- The Chief Executive may vary the budgetary limit of an officer within the Chief Executive's own budgetary limits.

208. Except where otherwise approved by the Chief Executive, taking account of advice of the Director of Finance and Corporate Services, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purposes shall revert to the immediate control of the Chief Executive.

209. Expenditure for which no provision has been made in an approved budget shall be incurred only after authorisation by the Chief Executive or the Director of Finance and Corporate Services as appropriate.

5.5.3 Control

210. The Director of Finance and Corporate Services shall be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable NHS Digital to fulfil its statutory responsibility to meet its budget and savings targets issued by the Department of Health.

211. The Director of Finance and Corporate Services shall devise and maintain systems of budgetary control and all managers whom the Board may empower to engage staff or otherwise incur expenditure, collect or generate income, shall comply with the requirements of those systems. The systems of budgetary control shall incorporate the reporting of, and investigation into, financial, workload, or manpower variances from budget. The Director of Finance and Corporate Services shall be responsible for providing information and advice to enable the Chief Executive and other operational managers to carry out their budgetary responsibilities and for issuing to all relevant staff, rules and procedures governing the operation of budgets and control of expenditure.

212. The Chief Executive shall devise and maintain adequate systems to ensure that NHS Digital can identify, implement and monitor opportunities for cost improvements and income generation.

5.5.4 Reporting

213. The Director of Finance and Corporate Services shall prepare as required a report showing:

- The income and expenditure of NHS Digital during the previous month and for the financial year to date, in comparison with the corresponding proportions of the approved budget to date
- A forecast of NHS Digital's expected position at the following 31 March.

214. The Director of Finance and Corporate Services shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards, and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

5.5.5 Capital Expenditure

215. Capital expenditure and investments should be incurred and executed in line with the accounting policies set out in the annual financial accounts and those required by the Department of Health and HM Treasury.

216. The Board shall approve the proposed capital expenditure budget at the beginning of the financial year. Delegated levels of authority can be found in the Levels of Delegated Authority at Annex H.

217. The Director of Finance and Corporate Services shall report regularly to the Board the actual expenditure against authorisation of capital expenditure and budget and report on any impairments or material changes in the valuation of assets.

218. The Director of Finance and Corporate Services shall ensure that controls are in place to ensure that capital funds are used only for the purpose for which they were approved and all requests for capital expenditure are properly authorised prior to acquisition.

5.5.6 Cash and Resource Limit Control

219. For all expenditure subject to cash limits the Director of Finance and Corporate Services must ensure that before each financial year, an income and expenditure budget and a cash flow is drawn up, setting out the financial resources proposed for carrying out NHS Digital's functions for that year approved by the Board.

220. The Director of Finance and Corporate Services must ensure that money drawn from the Department of Health against the Cash Limit is within the approved limits and is drawn down with the agreement of the Department of Health.

221. The Director of Finance and Corporate Services shall take the necessary action to prevent NHS Digital's cash limit being exceeded.

5.5.7 Reporting and the Annual Accounts

222. The Director of Finance and Corporate Services shall keep sufficient records to show and explain NHS Digital's transactions, and they shall be such as to disclose with reasonable accuracy, at any time, the financial position of NHS Digital.

223. The Director of Finance and Corporate Services shall prepare and submit such financial returns as may be required by the Board, the Department of Health or any other statutory requirements.

224. The Director of Finance and Corporate Services shall

- Prepare the annual accounts and year end consolidation returns in accordance with the requirements of the Financial Reporting Manual (FReM) and other current guidelines and standards and present them to the external auditors within the agreed timescale for review
- Provide the external auditors with all explanations and assistance that they require to fulfil their statutory duties
- Present them to the Assurance and Risk Committee for review and subsequent approval by the Board.

225. The Chief Executive (as Accounting Officer) on behalf of NHS Digital, shall submit annual accounts to the Comptroller and Auditor General to certify in respect of each financial year in such a form as the Secretary of State may, with the approval of the Treasury, direct (Schedule 18 s.14, Health and Social Care Act 2012).

5.5.8 Banking Arrangements

226. NHS Digital, being an ENDPB body of the Department of Health, is obliged to use the Government Banking Service (GBS) for its normal banking arrangements. However, commercial banks may be used for specific purposes, for instance where a credit card terminal is required.

227. The Director of Finance and Corporate Services shall advise the Board upon the provision of banking services. This advice shall take into account guidance and requirements issued, from time to time, by the Secretary of State or HM Treasury.

228. The Board shall approve the banking arrangements when for any reason an account other than a GBS account is used.

229. If banking arrangements other than via the Paymaster General are required then the Director of Finance and Corporate Services shall:

- Review the banking needs of NHS Digital at regular intervals
- Ensure that they reflect current business patterns and represent best value for money
- Undertake competitive offer exercises for banking services when demanded by changed circumstances, or at intervals not exceeding five years from a previous such exercise
- Advise bankers in writing, including a copy of the Board's resolution, of the conditions under which each account shall operate. All funds shall be held in accounts in the name of NHS Digital. No director or employee other than the Director of Finance and Corporate Services shall open any bank account in the name of NHS Digital.

230. In the operation of all GBS and bank accounts, the Director of Finance and Corporate Services shall ensure:

- That payments authorised to be made from such accounts do not exceed the amount credited to the account
- That payments made out of any accounts are authorised by no less than two authorised signatories and
- The Board shall approve a panel of directors or employees, which shall include the Director of Finance and Corporate Services, who are authorised signatories for payments from such accounts.

231. All payment instruments shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

232. The Director of Finance and Corporate Services may enter into a formal agreement with the Director of Finance of another organisation for payments to be made on behalf of NHS Digital to pay legitimate NHS Digital expenses, from bank accounts maintained in the name of that other organisation or by electronic funds transfer (i.e. BACS).

5.5.9 Security of Cash, Negotiable Instruments and 'Controlled Stationery'

233. The Director of Finance and Corporate Services is responsible for:

- Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable
- Ordering and securely controlling such stationery
- The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys etc.
- Prescribing systems and procedures for handling cash and negotiable securities on behalf of NHS Digital.

5.5.10 Pricing and Income

234. Within the following paragraphs, the Director of Finance and Corporate Services is identified as being responsible for ensuring that appropriate systems exist for the collection and management of income.

235. In respect of pricing NHS Digital goods or services, margins will be determined according to national guidelines (including HMT fees and Charge Guide) approved by the Chief Executive on the advice of the Director of Finance and Corporate Services.

236. In respect of income generation, NHS Digital must act in accordance with its statutory powers and framework document. Any variation should be approved by the Department of Health or Secretary of State, where appropriate.

237. The Director of Finance and Corporate Services shall be responsible for designing and maintaining systems for the proper recording, invoicing and collection of all monies due, including the creation of a register for regular income, which shall incorporate the principles of internal checks and separation of duties.

238. The Director of Finance and Corporate Services shall be responsible for ensuring that all invoices to purchasers of services are sent out in accordance with the terms of the relevant service agreement or contract, or otherwise in accordance with guidance from the Director of Finance and Corporate Services.

5.5.11 Approval of Invoices

239. All invoices received by NHS Digital shall be matched against the relevant purchase order and receipt of goods and providing it agrees within agreed tolerances, shall be approved electronically. Otherwise, invoices will be forwarded and approved manually by officers of NHS Digital in line with the Schedule of Delegations and approved by the Board.

5.5.12 Payment of Accounts

240. The overall responsibility for safe and efficient payment arrangements rests with the Director of Finance and Corporate Services who shall approve specific arrangements. Where the management of payment of accounts has been contracted to a third party then the Director of Finance and Corporate Services must be satisfied that the system is being operated within the principles detailed below. The principles are general in nature and will need to be tailored to meet the requirements of the particular payment systems in operation.

241. The Director of Finance and Corporate Services shall ensure that payment for goods and services is made only after the goods and services are received, or where a prepayment is considered appropriate, (e.g., rent, rates, purchase of licences) processes are in place to ensure NHS Digital receive the goods or services paid for.

242. The Director of Finance and Corporate Services shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with the agreed contract terms.

243. The Director of Finance and Corporate Services shall be responsible for approving systems for the verification, recording and payment of all accounts payable whether internal or through an out source supplier.

5.5.13 Payment of Staff

244. The Director of Finance and Corporate Services is responsible for the provision of a payroll service whether provided in-house or contracted out. NHS Digital currently use the Electronic Staff Record (ESR), a system developed for the use of the whole NHS. Consequently the payroll process has timetables, processes, and calculations etc. which are undertaken on a standard basis applicable to all NHS users. ESR shall be monitored so that the arrangements established for the payment of staff are in accordance with normally accepted principles. The Director of Finance and Corporate Services is responsible for ensuring that all such arrangements are compatible with NHS Digital's methods of working.

245. Staff are appointed and retained using the NHS Agenda for Change system wherever possible recognising that some staff are transferred to NHS Digital from other organisations and certain terms and conditions have to be applied. The guidelines and

process of the DH Pay and Performance Oversight Committee and the DH Remuneration Committee are followed in relation to staff termination payments.

246. No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

- Unless that individual has the necessary delegated authority and
- It is within the limit of their approved budget

247. The Director of Workforce will ensure that there is a system of control and approval of all new starters to ensure that the post is approved and that sufficient funds are available.

248. The Director of Workforce is responsible for ensuring that NHS Digital ESR records are maintained to a high standard.

249. The Director of Finance and Corporate Services is responsible for ensuring that:

- There is a proper procedure for updating and maintaining payroll records
- The calculated payroll is reviewed for accuracy on a monthly basis and significant variances are explained
- All employee deductions including taxes and pension contributions are paid on time to the correct body
- There is adequate security and confidentiality of payroll information

250. Appropriately nominated managers have delegated responsibilities for submitting:

- Time records and other notifications in accordance with an agreed form and within the predetermined timetable
- Termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, Human Resources must be informed immediately

251. The Director of Finance and Corporate Services will receive on a regular basis as directed from the Head of Finance or the Head of Human Resources a summary of all significant payroll movements and statistics as deemed necessary.

5.6 Security and Register of Assets

252. Each employee has a responsibility to exercise a duty of care over the property of NHS Digital and it shall be the responsibility of all staff in all disciplines to apply appropriate routine security practices in relation to NHS Digital property. Persistent or substantial breach of agreed security practices shall be reported to the Chief Executive.

253. Any damage to NHS Digital's property shall be reported by staff in accordance with the agreed procedure for reporting losses.

254. The Chief Executive shall ensure that a system is in place for the register and control of assets and, wherever practicable, items of equipment shall be marked as NHS Digital property.

255. The form of record and method of updating shall be as required by the Chief Executive as advised by the Director of Finance and Corporate Services, and shall make provision for:

- Recording managerial responsibility for each asset
- Identification of additions and disposals
- Identification of all repairs and maintenance expenses
- Physical security of assets
- Periodic verification of the existence of, condition of and title to assets recorded
- Identification and reporting of all costs associated with the retention of an asset
- Identification separately of equipment on loan from suppliers.

256. Additions to the fixed asset register must be clearly identified to an appropriate Budget Holder and be validated by reference to:

- Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties
- Wages records for own labour including appropriate overheads
- Lease agreements in respect of assets held under a finance lease and capitalised, signed by the relevant officer.

257. The up to date maintenance of the asset register and annual checking of asset records shall be the responsibility of the Head of Finance.

258. On the closure of any facility owned, occupied or used by NHS Digital, an asset check shall be carried out and a designated officer shall certify a list of items held showing eventual disposal.

259. Where capital assets are sold, scrapped, lost or otherwise disposed of, the appropriate adjustments shall be made in the accounting records and each disposal shall be validated by reference to authorisation documents and invoices (where appropriate).

260. The Director of Finance and Corporate Services shall approve procedures for reconciling balances on fixed asset accounts in ledgers against balances on fixed asset registers.

261. The value of each asset shall be indexed to current values in accordance with methods specified in the Capital Accounting Manual issued by the NHS.

262. The value of each asset shall be depreciated using methods and rates as agreed with the external auditors having considered best practice.

5.6.1 Losses, Condemnations and Special Payments

263. The Treasury retains specific controls over certain write-offs and payments known collectively as 'losses and special payments':

- 'Losses' cover any case where full value has not been obtained for money spent or committed, including for example cash losses, losses due to errors by staff, and
- 'Special payments' cover any compensation payments, extra-contractual or ex-gratia payments, and any payment made without specific identifiable legal power for the Department/ALB to make the payment.

264. Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service and thus requires special control reporting to Parliament. This has been delegated to the Department of Health. All losses must be reported via an agreed procedure with the Arm's Length Body unit.

265. NHS Digital has no delegated authority to make special payments and must refer all such cases to the Department of Health for approval.

266. The Director of Finance and Corporate Services must prepare procedural instructions on the recording of and accounting for condemnations, losses and approved special payments. The Director of Finance and Corporate Services must also prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

267. Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance and Corporate Services, or the Counter Fraud Specialist. The Local Counter Fraud Specialist will then inform the Director of Finance and Corporate Services and/or Chief Executive. The Director of Finance and Corporate Services should immediately inform the police if theft or arson is involved.

268. For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance and Corporate Services must immediately notify the Board, and the External Auditors.

5.6.2 Losses

269. Losses fall into four categories:

- Category 1 - losses of cash
- Category 2 - fruitless payments (including abandoned capital schemes)
- Category 3 - bad debts and claims abandoned
- Category 4 - damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use.

270. The Director of Finance and Corporate Services will investigate and review appropriate procedures arising from all such losses.

271. Special payments fall into four categories as follows

- Category 5 - compensation payments made under legal obligation
- Category 6 - extra contractual payments to contractors
- Category 7 - ex-gratia payments
- Category 8 - extra statutory and extra regulatory payments.

272. The Director of Finance and Corporate Services shall report regularly to the Assurance and Risk Committee full details of proposed ex-gratia payments to staff or, special payments prior to reference to the Department of Health for approval, and full details of write-offs made.

5.6.3 Condemnations

273. All unserviceable articles shall be condemned or otherwise disposed of by an officer authorised for that purpose by the Chief Executive. A record in a form approved by the Director of Finance and Corporate Services shall be kept of all articles submitted for condemnation and the condemning officer shall indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the counter-signature of a second officer authorised for the purpose by the Chief Executive.

274. The condemning officer shall decide whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Executive who shall take appropriate action. Where there are reasonable grounds to suspect that a criminal offence has been committed, action shall proceed as in paragraph 274 and in accordance with HSC1999/062.

5.6.4 Approval

275. The Board shall approve the writing-off of losses within the limits delegated to it from time to time by the Department of Health. The Chief Executive has responsibility to approve write-off and endorse special payments within delegated limits which should be reported to the Board on a timely basis.

276. All novel, contentious or repercussive cases shall be referred in advance of payment to the Department of Health for notification to and approval by HM Treasury. This includes all ex-gratia payments to staff in accordance with DAO (Gen) 11/05. The Director of Finance and Corporate Services shall inform the Board of any such referrals.

5.6.5 Register and Safeguards

277. The Director of Finance and Corporate Services shall maintain a losses and special payments register in which details of all losses and special payments shall be recorded as they are notified or approved. Write-off action approved by the Chief Executive and the Board and special payments approved by the Department of Health shall be recorded against entries in the register.

278. The Director of Finance and Corporate Services shall be authorised to take any necessary steps to safeguard NHS Digital's interest in bankruptcies and company liquidations.

5.7 Internal and External Audit

5.7.1 Internal Audit

279. The Director of Finance and Corporate Services is responsible, with the approval of the Assurance and Risk Committee, for appointing an effective Internal Audit service in a manner which encompasses the Department of Health assurance process. The objectives of an Internal Audit service are to review, appraise and report to the Assurance and Risk Committee upon:

- The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures
- The adequacy and application of financial and other related management controls
- The suitability of financial and other related management data
- The extent to which NHS Digital's assets and interests are accounted for and safeguarded from loss of any kind, arising from; fraud and other offences, waste, extravagance, inefficient administration, poor value for money or other causes.

280. Management's responsibility is to establish systems of internal control for operations for which it is responsible to ensure that these are properly run. The principal aim for Internal Audit, therefore, is to assist the various levels of management in discharging their duties and responsibilities by carrying out appraisals and making the necessary appropriate recommendations to the Assurance and Risk Committee.

281. Internal Audit shall be entitled, without necessarily giving prior notice, to require and receive:

- Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature
- Access at all reasonable times to any land, premises or employees of NHS Digital
- The production or identification by any employee of any of NHS Digital cash, stock and other property under the employee's control
- Explanations concerning any matter under investigation or review.

282. Where a matter arises which involves, or is thought to involve, irregularities concerning cash, stock or other property of NHS Digital or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance and Corporate Services shall be notified immediately.

283. The Director of Finance and Corporate Services, using the Local Counter Fraud Specialist where appropriate, shall investigate cases of suspected fraud, misappropriation or other irregularities in conjunction, where necessary, with the relevant director and in consultation with the police where appropriate in accordance with NHS Digital's fraud policy and response plan.

284. The Internal Audit function shall report direct to the Director of Finance and Corporate Services. Internal audit reports shall be referred for action to the responsible director as appropriate. Failure to take remedial action within a reasonable period shall be

reported to the Chief Executive or Assurance and Risk Committee as appropriate. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation on the objectivity of the audit, Internal Audit shall have access to report direct to the Chair or any non-executive member of the Board.

5.7.2 External Audit

285. The Comptroller and Auditor General is the statutory External Auditor of NHS Digital under schedule 18 s.14 (3) and s.15 (3) of the Health and Social Care Act 2012. NHS Digital will pay a cash fee for the annual audit, as agreed with the National Audit Office (NAO) on behalf of the Comptroller and Auditor General.

286. External Auditors acting on behalf of the National Audit Office (NAO) shall be entitled, without necessarily giving prior notice, to require and receive:

- Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature
- Access at all reasonable times to any land, premises or employees of NHS Digital
- The production or identification by any employee of any of NHS Digital cash, stock and other property under the employee's control
- Explanations concerning any matter under investigation or review.

287. The Assurance and Risk Committee will review the effectiveness of the external audit service, including considering whether the service offers value for money and any areas for improvement.

288. The Assurance and Risk Committee will receive the Annual Audit Strategy and reports on the audit.

289. The External Auditors shall have direct access to the Chair of the Assurance and Risk Committee as required, and at least once a year will meet with the non-Executive Directors of the Assurance and Risk Committee without the Executives.

5.8 Retention of Documents

290. The documents held in archives, including the archive known as 'The Safe Haven' within Information Governance shall be capable of retrieval by authorised persons.

291. Retained documents shall be destroyed in line with the Documents and Records Management Policy. Records shall be maintained of documents so destroyed.

6 Annexes

6.1 Annex A - The Seven Principles of Public Life

Nolan Committee's First Report, 'Standards in Public Life', Published in May 1995

6.1.1 Selflessness

Holders of public office will take decisions solely in terms of the public interest. They will not do so in order to gain financial or other material benefits for themselves, their family or their friends.

6.1.2 Integrity

Holders of public office will not place themselves under any financial or other obligation to outside individuals or organisation that might influence them in the performance of their official duties.

6.1.3 Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office will make choices on merit.

6.1.4 Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

6.1.5 Openness

Holders of public office will be as open as possible about all the decisions and actions that they take. They will give reasons for their decisions and restrict information only when the wider public interest clearly demands.

6.1.6 Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interests.

6.1.7 Leadership

Holders of public office will promote and support these principles by leadership and example.

6.2 Annex B – Definition of Key Terms

6.2.1 Interpretation

Save as permitted by law at any meeting the Chair of NHS Digital is the final authority on the interpretation of Standing Orders.

These Standing Orders are made pursuant to the Health and Social Care Act 2012. Any expression to which a meaning is given in the Health and Social Care Act or in regulations made under it has the same meaning in these Standing Orders, unless the context requires otherwise. In addition:

'Accounting Officer' means the Officer responsible and accountable for funds entrusted to NHS Digital. They are responsible for ensuring the proper stewardship of public funds and assets. This is the Chief Executive for NHS Digital.

'Board' means the Chair and non-executive Directors, appointed by the Secretary of State and the Executive Directors appointed by the Board of NHS Digital.

'Budget' means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of NHS Digital.

'Budget Holder' means the officer, as duly authorised, with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.

'Caldicott Guardian' means senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

'Chair' is the person appointed by the Secretary of State to lead the Board and to ensure that it successfully discharges its overall responsibility for NHS Digital as a whole. The expression 'the Chair of NHS Digital' is deemed to include the vice-Chair of NHS Digital if the Chair is absent from the meeting or is otherwise unavailable.

'Chief Executive' means the Chief Officer of NHS Digital; the first Chief Executive was appointed by the Secretary of State.

'Committee' means a committee appointed by the Board.

'Committee Members' are persons formally appointed by the Board to sit on or chair specific committees.

'Contracting and Procuring' means the system for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for the disposal of surplus and obsolete assets.

'Director' means a member of the Board. Executive Director means an officer member and non-executive Director means a non-executive member.

'Director of Finance and Corporate Services' means the Chief Finance Officer of NHS Digital.

'Expenditure Authoriser' means the officer, as duly authorised, with delegated authority to authorise the commitment of expenditure for a specific area of the organisation.

'Legal Adviser' means the properly qualified person appointed by NHS Digital to provide legal advice.

'Member' means non-executive and/or officer member of the Board

'Motion' means a formal proposition to be discussed and voted on during the course of a meeting.

'NHS Digital' means the executive non-departmental public body (ENDPB) known as the Health and Social Care Information Centre established under the Health and Social Care Act 2012.

'Nominated Officer' means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

'Officer' means an employee of NHS Digital and any secondee or contractor acting for NHS Digital.

'Operational Manager' means an employee of NHS Digital and any secondee or contractor acting for NHS Digital with authority to incur expenditure for a specific area of the organisation or for a specific portfolio item.

References to 'he/him/his' equally mean 'she/her'

'Schedule 18' is schedule 18 of the Health and Social Care Act 2012

'Scheme of Delegation' sets out those matters on which decisions are reserved to the Board and those which are delegated to the budget holders, directors or employees.

'Secretary of State' means the Secretary of State for Health.

'Secretary to the Board' means a person appointed by NHS Digital to ensure NHS Digital compliance with principles of best practice in delivering corporate governance standards and relevant public sector guidance.

'Senior Independent Director (SID)' means a person appointed by the Chair and NHS Digital Board to support the Chair in leading the Board.

'Senior Information Risk Owner (SIRO)' means an Executive or Senior Manager on the Board who is familiar with information risks and the organisation's response to risk.

'SFIs' means Standing Financial Instructions.

'Sub-committee' means a sub-committee appointed by NHS Digital Board.

'Sub-committee members' means persons formally appointed by NHS Digital Board to sit on or to chair specific sub-committees.

'Vice-Chair' means the non-executive member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

6.3 Annex C – Framework Agreement between the Department of Health and NHS Digital

Link below:

Annex C - Framework Agreement between the DH and NHS Digital

Framework Agreement

6.4 Annex D – NHS Digital Board Terms of Reference

Follow the link below for the:

NHS Digital Board Terms of Reference 2016-17

NHS Digital Board Terms of Reference

6.5 Annex E – Assurance and Risk Committee Terms of Reference

Link below:

Assurance and Risk Committee Terms of Reference 2016-17

NHS Digital ARC Terms of Reference 2

6.6 Annex F – Information Assurance and Cyber Security Committee Terms of Reference

Link below:

Information Assurance and Cyber Security Committee Terms of Reference 2016-17

IACSC Terms of Reference

6.7 Annex G – Remuneration Committee Terms of Reference

Link below:

Remuneration Committee Terms of Reference 2016-17

Remuneration Committee Terms of F

6.8 Annex H – NHS Digital Levels of Delegated Financial Authority

Link below:

Levels of Delegated Authority

Levels of Delegated Authority 2016-17

Board Meeting – Public Session

Title of paper:	Directions: Community Services Data Set Pilot
Board meeting date:	30 November 2016
Agenda item no:	NHSD16 04 05 d i
Paper presented by:	Prof. David Hughes (Executive Director of Information and Analytics at NHS Digital)
Paper prepared by:	Adrian Smith (Senior Project Manager, Community Services Data Set Project)
Paper approved by: (Sponsor Director)	Prof. David Hughes (Executive Director of Information and Analytics at NHS Digital)
Purpose of the paper:	Directions request from NHS England to enable the flow of data from Providers
Additional Documents and or Supporting Information:	Annex A – CSDS Pilot Directions NHS Digital Draft V 0 3 Annex B – Community services data set v1.0 requirements specification v Annex C – Community information data set (CIDS) technical output specification
Please specify the key risks and issues:	There is no risk directly associated with the acceptance of the Directions.
Patient/public interest:	There are no significant patient or public interest issues, there will be a reduction in burden as local collection will no longer be required.
Supplementary papers:	No supplementary Papers
Actions required by the Board:	The paper is being submitted for the acceptance of the Directions to enable data collection to be undertaken as part of the development of the Community Services Health Dataset.

NHS Digital

Directions: Community Services Data Set Pilot

Published 03 November 2016

Information and technology for better health and care

Contents

Executive Summary

The paper is a request for the agreement to the attached Directions to enable the voluntary collection of data from a number of pilot NHS service providers to support the delivery timeline for the new national Community Services Data Set Pilot (CSDS).

These providers have agreed to submit data to enable NHS Digital to determine the changes required to be made to the Children and Young Persons Health Services Dataset (CYPHS) to enable adult data to flow. Undertaking this work early will reduce the risk in terms of managing the change to an existing dataset.

Background

The flow of a national community services dataset has been prioritised by NIB and has a ministerial focus. A number of discussion have taken place with ministers and the Department of Health, with the DG for Community Care, Tamara Finkelstein, taking a personal interest in the timeline for the data to flow.

Agreement has been reached with NHS England to amend the existing 'Children and Young Persons Health Services Dataset' (CYPHS) to enable the collection of data for the whole community by removing the age restriction presently enforced when collecting data. In order to determine the level of change required to CYPHS a number of service providers have agreed to flow pilot data supporting both financial estimation and the SCCI process.

Directions have been raised by NHS England in support of the 'pilot'.

Recommendation

The Directions have been produced to cover the use of the pilot data for testing but will not be used to direct the collection of data from all providers. Directions for the mandated collection of community data will not be raised until the CSDS dataset standard has been approved by SCCI and an ISN issued, presently forecast for April 2017.

The Directions have been put in place, to ensure we have a clear legal basis for collection of the data from the providers who have volunteered to provide data for testing, on the advice of Information Governance. For the purposes of the pilot, providers will be asked to flow the same data to NHS Digital as they currently do for the CYPHS data set, but include all patients (not just those aged 0-18). In practice, we believe that a number of providers already produce an extract from their systems which includes all patients, and then strip out any patients over 18 when creating their submission file for the CYPHS data set. The providers will simply be asked to include all patients in their submission

It is proposed that EMT accept the attached Directions to enable the development of the CSDS on the understanding that they are will only being used to enable test data to be collected.

Implications

Strategy Implications

The project is aligned with the strategic objective of centralising major data collections to reduce local collection requirements and develop agreed information standards. It also supports both the NIB Paperless 2020 Agenda, being an explicit objective of Domain H, Programme 26, and the NHS England 5 Year Forward Plan.

Financial Implications

The funding for the start-up phase of the programme has been agreed through a new Work Commission and Investment Justification which this testing forms part of. The funding for phase 1, making the changes to the existing CYPHS system, is subject to separate investment justification which is presently being completed. The project is one of the prioritised projects under the NIB Programme and will be supported under Domain H's Data Content Programme.

Stakeholder Implications

There is clear focus and drive at the senior stakeholder level for a national flow of community services data, with an expected timeline for delivery of autumn 2017.

There are no major stakeholder implications, at present, as the existing CYPHS dataset will continue to operate until the Community Health Services Dataset is operational. The CSDS will effectively be a new dataset providing centralised community information and be welcomed by stakeholders.

Phase 2 of the programme will look at adapting the existing dataset to meet the new models of care being adopted and an Advisory Group is being set up to ensure we have comprehensive input into the development of future requirements.

Handling

There are no handling issues directly associated with accepting the Directions.

Risks and Issues

The request for the acceptance at this early stage is to ensure we reduce the overall risk on the development of the Community Services Dataset by gaining a detailed understanding of the changes required at the earliest opportunity. There is no risk directly associated with the acceptance of the Directions.

Corporate Governance and Compliance

There are corporate governance issues for this activity as the Directions are only being used for the pilot and before all providers are required to flow data a revised set of Directions and an Information standards Notice will have been issued. In terms of general governance the project has its own project board with an NHS England SRO, Suzanne Rastrick and reports to the Domain H Board via the Datacontent Programme Board.

Management Responsibility

Jill Sharples, Programme Manager, Data Content Programme has responsibility for the delivery of the Community Services Health Dataset.

Professor David Hughes, Executive Director, Information and Analysis Portfolio will deal with the Directions on a day to day basis.

Actions Required of the Board

The paper is being submitted for the acceptance of the Directions to enable data collection to be undertaken as part of the development of the Community Services Health Dataset.

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: Community Services Data Set 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: Community Services Data Set 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];
"CSDS"	means Community Services Data Set;
"Information Standard"	means a document containing standards in relation to the processing of information as provided for in section 250(2) of the 2012 Act. References to the number and title of an Information Standard are to the number and title given to a particular Information Standard within the Information

[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.

	Standards Notice;
"HSCIC"	means the Health and Social Care Information Centre[3];
"Relevant Organisation"	means an organisation listed in the Schedule to these directions;
"Specification"	means the Community Services Data Set v1.0 Requirements Specification draft version 0.2.1 dated 24/10/2016 (Document ID: SCCI1069 Pilot Data Set) and annexed to these Directions at Annex B;
"Technical Output Specification"	means the Community Information Data Set (CIDS) Technical Output Specification version 2.7.5 dated 26/01/2016 and annexed to these Directions at Annex C.

Establishing and Operating the CSDS 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 CSDS 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 in part 1 of the Specification and generally in such a way as to enable and facilitate compliance with the 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 testing of the draft revised Information Standard SCCI1069.

Fees and Accounts

[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

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 CSDS Information System.

Signed by authority of the NHS Commissioning Board

Sir Bruce Keogh
Caldicott Guardian

[INSERT DATE]

Schedule

Relevant Organisations

Trust	**ODS Code**
South Essex Partnership University NHS Foundation Trust	RWN
Liverpool Community Health NHS Trust	RY1
Norfolk Community Health and Care NHS Trust	RY3
Oxford Health NHS Foundation Trust	RNU
Berkshire Healthcare NHS Foundation Trust	RWX
Walsall Healthcare NHS Trust	RBK
The Whittington Hospital NHS Trust	RKE

Annex B – Community Services Data Set v1.0 Requirements Specification draft version 0.2.1 Pilot Data Set

Provided as a separate document

Annex C – Community Information Data Set (CIDS) Technical Output Specification version 2.7.5

Provided as a separate document

Document filename:	**SCCI1069_CSDS_v1.0_Requirements_Specification.pdf**		
Project / Programme	**Information and Analytics**	Project	**Community Services Data Set**
Document Reference	**SCCI1069 Pilot Data Set**		
Sponsor	**Ronan O'Connor, NHS England**	Status	**Draft**
Developer	**Tom Latham, NHS Digital**	Version	**0.2.1**
Author	**Tom Latham/Gavin Harrison, NHS Digital**	Version issue date	**24/10/2016**

Community Services Data Set v1.0 Requirements Specification – Pilot Data Set

Document management

Revision History

Version	Date	Summary of Changes
0.1	23/09/2016	First draft for comment
0.2	13/10/2016	Further amendments made; baseline version to be updated to support CSDS pilot
0.2.1	24/10/2016	Updated version of document; version for use in supporting CSDS pilot only

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.

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version
Tom Latham	Developer		0.2

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Tony Childs	Tony Childs	Information Analysis Lead Manager		0.1
Nicholas Richman	Nicholas Richman	Senior Business and Operational Delivery Manager		0.1

Glossary of Terms

Term / Abbreviation	What it stands for
Acute Trust	An NHS organisation responsible for providing a group of healthcare services. An acute Trust provides hospital services (but not mental health hospital services which are provided by a Mental Health Trust).
Aggregate data set	A set of data items (i.e. a data set) that captures data in aggregate form. Each record within the data set pertains to a specific form of grouping.
AHP	Allied Health Professionals work across a wide range of locations and sectors within acute, primary and community care. They are made up of the following staff groups: • Art, Drama, Music Therapists • Chiropodists/Podiatrists

	• Occupational Therapists • Orthoptists • Physiotherapists • Prosthetists and Orthotists • Radiographers Diagnostic and Therapeutic • Speech and Language Therapists • Dietitians
Anonymisation	A method applied to patient identifiable data items to protect the identity of individuals. Under anonymisation, the relevant data items are either randomly encrypted and no keys retained, or completely removed. Anonymised data cannot be linked with other data sets for the same individual, nor can it be reversed to expose the identity of an individual. Anonymisation is different from Pseudonymisation.
AQP	Any Qualified Provider - a means of commissioning certain NHS services in England. Clinical Commissioning Groups (CCGs) will determine the services to be commissioned as AQP; the intention is to increase patient choice. All providers must meet the qualification criteria set for a particular service and once qualified their service will appear on choose and book for patients to select. The Any Qualified Provider (AQP) scheme means that, for some conditions, patients will be able to choose from a range of approved providers, such as hospitals or high street service providers.
BAAS	The Burden Assessment and Advice Service (BAAS) process makes sure that information demands on the NHS are minimised, fit with current national health policies and are carried out in the most efficient way without duplication. It covers the Department of Health and its Arm's Length Bodies (ALBs).
Care Pathway	Care pathways describe the route that a patient will take from their first contact with a healthcare provider to the completion of their treatment.
CDW	Central Data Warehouse - a repository of data relating specifically to the CSDS.
CSDS	The Community Services Data Set is an information standard, approved by the governing standards body, which defines a patient-level data set for all patients in receipt of NHS-funded Community Services. CSDS is an 'output data set'; therefore it sets out to describe "what should be extracted" from local IT systems and periodically be submitted to the central data warehouse. CSDS is not an input standard or 'clinical data set'; therefore, this data set does not define "what should be captured or collected" from local IT systems.
CYPHS Data Set	The Children and Young People's Health Services Data Set is an information standard, approved by the governing standards body, which defines a patient-level data set for all patients, aged 0-18 inclusive, in receipt of NHS-funded Community Services. The CYPHS data set is an 'output data set'; therefore it sets out to describe "what should be extracted" from local IT systems and periodically be submitted to the central data warehouse. The CYPHS data set is not an input standard or 'clinical data set'; therefore, this data set does not define "what should be captured or collected" from local IT systems.
Collection Date	The date when services within the scope of this standard should start data collection in their electronic systems.
Commissioned Currencies	The payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. The two fundamental features being nationally determined currencies and tariffs. Currencies are the unit of healthcare for which a payment is made, and can take a number of forms

	covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long term condition. Tariffs are the set prices paid for each currency.
CIDS	The Community Information Data Set is an information standard, approved by the governing standards body, which defines a patient-level data set. CIDS is an 'output data set'; therefore it sets out to describe "what should be extracted" from local IT systems. CIDS is not an input standard or 'clinical data set'; therefore, CIDS does not define "what should be captured or collected" from local IT systems. CIDS is approved for local collection only and will be retired as part of this release, eliminating the need for a separate local data flow.
Conformance Date	The date when services and IT systems must conform to standards and meet the specification as set out in the mandate and guidance. This can be read as when the first submission window closes for the MHSDS and care providers must therefore be fully conformant.
Data Controller	A person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any personal data are, or are to be, processed. A data controller must be a "person" recognised in law, that is to say: • individuals; • organisations; and • other corporate and unincorporated bodies of persons. Data controllers will usually be organisations, but can be individuals, for example self-employed consultants. Even if an individual is given responsibility for data protection in an organisation, they will be acting on behalf of the organisation, which will be the data controller.
Data Group	A collection of data items that describe a distinct event or episode. This can also be referred to as a table of data.
Data Item	A single component of a data group that holds one piece of information relating to an event or episode.
Data Set	The full collection of data groups. See 'Technical Output Specification'.
Data Submission File	One file related to a data set that data providers submit to the central data warehouse. A data submission consists of an Intermediate Database (IDB) file containing the data for one or two consecutive reporting periods in the format defined by the HSCIC. When submitting two reporting periods in a single file, this would be the primary submission for month one and the refresh submission for month two.
Derived	A data item populated at the central data warehouse as part of post-deadline processing. The derived data item is based on the manipulation of the 'source' data items using mathematical, logical or other types of transformation process, or by using source data to derive further data from national look-up tables.
HSCIC	Health and Social Care Information Centre -a data, information and technology resource for the health and care system which plays a fundamental role in driving better care, better services and better outcomes for patients in England. Also known as NHS Digital.
Information Standard	An Information Standard as specified within the Health and Social Care Act 2012 is 'a document containing standards in relation to the processing and use of information'. An Information Standard specifies rules for the processing, management and sharing of information and specifies what process is needed, the 'quality' required in the form of conformance criteria and how it can be implemented.
ISN	Information Standards Notices (ISNs) are issued by the Standardisation Committee for Care Information (SCCI) to give notice of changes to information requirements and information standards used by the NHS and Social Care Services.

Last Good File	The most recent collection of valid records submitted by a data provider for a reporting period.
NHS Digital	The new name for the HSCIC.
N3	The NHS national broadband network linking hospitals, medical centres and General Medical Practices in England and Scotland. http://www.n3.nhs.uk/
Null	A data item with no value (i.e. blank) which therefore has no meaning. This is different from a value of 0, since 0 is an actual value.
ODS	Organisation Data Service (ODS) codes facilitate a patient's treatment by providing unique identification codes for organisational entities of interest to the NHS, for example NHS Trusts or CCGs, organisation sites such as hospitals, or GP Practices. The codes are distributed to the wider NHS and uploaded on to IT systems, thus providing a set of organisational data and organisation types, names, addresses etc that are consistent across the board.
Output Data Set	A set of standardised data items defining "what should be extracted" from local clinical IT systems. NHS trusts have the flexibility of adopting any local data collection process and system they see fit, so long as the system can extract data as per the Technical Output Specification (TOS). An output data set is not usually used for direct patient care and is only for secondary uses purposes e.g. national reporting.
Patient Level	Relating to a single data subject (e.g. person or patient), as opposed to an aggregate data set.
Post-deadline Processing	The processing undertaken at the close of a submission window by the central data warehouse.
Pre-deadline Processing	The processing carried out immediately on a submitted file to validate the file as a whole, extract the records that are (or may be) for the particular reporting period, and validate those records.
Pseudonymisation	A method applied to identifiable data items to protect the identity of individuals. Under pseudonymisation, a standard encryption key is used to encode patient identifiable data items so that data linkages within and outside the data set, for the same individual, are feasible. Because the encryption key is retained by a single "Data Controller", there is also the potential to reverse the process (de-code) and expose the identity of the individual. The encryption key is only decoded for specific purposes (e.g.: migration of data into another platform or enable linkages to other data sets). Pseudonymisation is different from Anonymisation.
Reference Data Set	A data set containing data groups and data items which are outside the scope of the Community Information Data Set, providing a comprehensive secondary uses data set for community care. The Reference Data Set has not been approved as a national data standard by the Information Standards Board nor does the Central Data Warehouse provide any storage capability for its data items.
RTT	Referral To Treatment refers to the length of waiting time for a patient's treatment, focusing on the entire patient journey from the initial receipt of a referral to the first definitive treatment.
Reporting Period	The period (usually a calendar month) for which a particular data upload refers.
SCCI	Standardisation Committee for Care Information - a committee with membership drawn from a range of health and social care organisations with responsibility for overseeing the development, assurance and approval of information standards, data collections, and data extractions used within the health and social care system.
Screening	A public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a

	disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications.
Secondary Uses	Re-using clinical and operational information for purposes other than direct patient care. For example, national reporting.
Submission Cycle	The data submission frequency and timescales to which Information Management Services must be able to compile electronic files and make periodical electronic submissions in accordance to the standard.
Submission Period or Submission Window	The time period (usually approximately one calendar month) during which a data provider may submit data uploads for a given reporting period.
Systemic Capability	The ability to record information (clinical, administrative or for any other purposes) in an electronic form. This applies to commercial IT solutions, bespoke IT systems or modular electronic services which have the functional capability of extracting the required data to meet the standards of a specific output specification.
TOS	Technical Output Specification – a specification that fully defines the data items within the output data set. The Technical Output Specification splits the data set into a number of data groups (tables), each containing related data items and values.
TCS	The Transforming Community Services programme provides essential care to many people, families and communities, from health promotion to end of life care. This care is provided in many settings, at critical points in people's lives, and often to those in vulnerable situations.

Contents

1 Overview

This product precisely defines the patient level Community Services Data Set (CSDS) standard, 'what it is' and 'how it should be implemented'. The purpose of this draft version (0.2.1) is to facilitate or enable the testing of the draft revised Information Standard SCCI1069.

When published, it will become the formal definition of the standard.

1.1 Background

Standard	
Standard Number	SCCI1069 (draft Specification - version 0.2.1)
Standard Title	Community Services Data Set
Description	**Background** The Community Services Data Set (CSDS) is an update to the Children and Young People's Health Services (CYPHS) data set standard (ref: SCCI 1069) so that it can collect data for people of all ages in receipt of NHS-funded Community Services. This document is in support of a pilot exercise to facilitate or enable the testing of the draft revised Information Standard SCCI1069. The CYPHS data set collected data for all patients aged 0 up until their nineteenth birthday, but this age barrier has been removed to mandate the national flow of community data for people of all ages. The CSDS is a patient level, output based, secondary uses data set which will deliver robust, comprehensive, nationally consistent and comparable person-based information for people who are in contact with NHS-funded Community Services. As a secondary uses data set it intends to re-use clinical and operational data for purposes other than direct patient care. It defines the data items, definitions and associated value sets to be extracted or derived from local systems. The CYPHS element of the CSDS forms part of an overall data set for Maternity and Children's Health Services, called the Maternity and Children's Data Set (MCDS). The MCDS has been developed as a key driver to achieving better outcomes of care for mothers, babies, children and younger people and consists of the following sub-data sets: • Maternity Services Data Set (MSDS). • Children's and Young People's Health Services (CYPHS) data set (now part of this standard). • Child and Adolescent Mental Health Services (CAMHS) data set (now part of the Mental Health Services Data Set, ref: SCCI0011). **In Scope** This will include all activity previously covered by the NHS Standard Contract for Community Services, including variations to this to support transition of services into new organisational forms as a result of

	Transforming Community Services. For the purpose of this scope, all services defined in 'Service Type Referred To' within the CSDS Technical Output Specification that are delivered by Healthcare Professionals within the scope of providing Community Services. Community Services that are funded and/or provided by the NHS are required to include their clinical activity in the CSDS. The definition of 'Community' is historically unclear and hard to define. However, some examples of Community Service activity within the scope of the CSDS are outlined below: • Health Promotion drop in sessions. • Home visits by District Nursing or Allied Health Professionals. • Residential care home visits. • School Nursing activities. • Community Dentistry. • Community Paediatrician sessions in a clinic. Please refer to the CSDS Technical Output Specification for a complete list of the Community Services currently covered within the scope of CSDS. These activities may take place in locations including health centres, Sure Start centres, day care facilities, schools or community centres, mobile facilities or the patient's own home (including care homes). **Out of Scope** The data set scope excludes all care settings (as defined below) outside of national contracting but may be re-addressed in line with any changes in service model provision: • Ambulance Care • Services covered by primary care contracts (General Medical Services (GMS) Personal Medical Services (PMS), Alternative Provider Medical Services (APMS) and Specialist Medical Provider Services (SPMS) • Other Primary Care Services that are not considered Community Services including General Dental Services, General Ophthalmology Services and Pharmacy Services • Social Care and specialist community services where separate data flows exist, e.g. community mental health • Admitted Patient Care (including Community Hospitals, General Acute or Mental Health) • Maternity Services - depending on local processes, information on Newborn Hearing Screening and Blood Spot Card Investigation Results can be captured by Maternity or Child Health Services (Health Visitors). The remit of this information standard covers results captured within Child Health (as opposed to Maternity) Services. • Out Patient Care which was previously provided under General Acute or Mental Health contracts.

- Non-NHS funded activity, e.g. Speech and Language Therapy activity which is funded directly by schools.
- Activity reported through the National Drug Treatment Monitoring System (NDTMS) Data Set, Sexual and Reproductive Health Activity Data Set (SRHAD) or Genitourinary Medicine Clinic Activity Dataset (GUMCAD).
- Activity funded through Acute Payment Currencies (formally Payment by Results or PbR), i.e. included in Health Resource Groups (HRGs).
- Prison or secure facility-based health services (however, community-based services visiting a prison or secure facility to deliver healthcare are in scope).

Please note that data items marked 'optional' may be captured at the discretion of the Community Services provider. Community systems must however enable the capture and reporting or derivation of such items.

Paper Capture

The standard does not provide financial cover for local procurement to support the transcription of paper records or purchase of IT systems to sustain the data submission. Therefore, where data requirements are predominantly recorded on paper and not transcribed to any electronic form, services are not required to make submissions of those data groups in the first instance. However, organisations are encouraged to make provision for IT solutions and should, at their own cost, progress the procurement/enhancement of electronic systems that meet this specification as early as possible.

Impact on Existing Data Flows

The following CSDS activity will continue to flow via the existing Commissioning Data Sets (CDS):

- Outpatient activity under the responsibility of Consultants or Nurses (and, optionally, Allied Health Professionals), including such activity taking place as part of a Consultant-Led Referral To Treatment (RTT) Pathway.
- Interface service activity which starts a Consultant Led RTT pathway (e.g. musculoskeletal services).
- Admitted Patient Care (APC) activity taking place within a Community Hospital.

In certain circumstances there may be a requirement to flow activity within multiple datasets, e.g. Interface Service activity which starts a Consultant Led RTT pathway should also flow in the Commissioning Data Set (CDS).

The CSDS does not change the existing mandated CDS flows for Admitted Patient Care, Outpatients or A&E. It does not alter the RTT

	flows covered by ISB 0092 Amd 7/2013 'Allied Health Professional (AHP) Referral To Treatment (RTT)'. http://www.isb.nhs.uk/documents/isb-0092/amd-7-2013/index_html
Applies to	**Organisation Types** The standard includes all activity previously covered by the NHS Standard Contract for Community Services, including variations to this which support services that have been impacted by the Transforming Community Services policy. This includes all organisational forms resulting from Transforming Community Services (TCS) and may include the following organisation types (both Foundation Trust and Non-Foundation Trusts): • Acute Trusts. • Mental Health Trusts. • Community Healthcare Trusts. • Care Trusts. • Social Enterprises. • Integrated Care Organisations. • Any Qualified Providers (AQPs). • Independent Sector Providers (including Third Sector). The standard also applies to IT systems used by Community Services. **Departments** The standard must be read and used by all Heads of Community Services, and related clinical and support services that have an active involvement in delivering the community care pathway or the support thereof. **Professionals** The standard applies to all community care professions working in or supporting Community Services, such as: • Nursing, Health Visitors and Midwifery staff; for example Specialist Nurses. • Allied Health Professionals; for example Physiotherapists and Dietitians. • Other Care Professionals; for example, Counsellors or Play Therapists. **IT Systems** The standard predominantly, but not exclusively, relates to Community Systems, Patient Administration Systems (PAS) and Electronic Patient Records (EPR).
Release	
Release Number	TBC

Release Title	Community Services Data Set (CSDS) Version 1.0
Description	Changes to existing standard are: • Removal of age limit restricting the data set to patients aged 0 up until their nineteenth birthday, so that the CSDS can collect data for people of all ages in receipt of NHS-funded Community Services.
Implementation Completion Date	**System Suppliers** From 1st November 2017, CSDS systems ***MUST*** be fully conformant with this standard. **Care Providers** From 1st November 2017, providers of NHS-funded CSDS ***MUST*** be able to collect information locally, and from 1st December 2017 ***MUST*** begin submitting CSDS submissions in accordance with this standard.
Full Conformance Date	1st December 2017

1.2 Supporting Documents

This document should be in conjunction with the following:

Ref #	Title
1	CSDS Change Request
2	CSDS Technical Output Specification
3	CSDS Data Model
4	CSDS Submission
5	CSDS System Conformance Checklist
6	CSDS – Implementation and Communications Plan
7	CSDS Implementation Guidance
8	CSDS User Guidance
9	CSDS Technical Guidance
10	CSDS Data Set Risk Register – Issues Log
11	CSDS XML Schema
12	CSDS Maintenance Plan

Please see section 2.2 of the *Implementation Guidance* for a full list and descriptions of each related document.

1.3 Related Standards

Ref #	Reference	Title
1	ISB 1513 Amd 45/2012	Maternity Services Data Set
2	ISB 1510	Community Information Data Set
3	ISB 1072 Amd 30/2012	Child and Adolescent Mental Health Services Data Set
4	ISB 0149-02	NHS Number for Secondary Care
5	ISB 0149-01	NHS Number for General Practice
6	ISB 1555	NHS Number for Babies (NN4B)
7	ISB 0092 Amd 16/2010	Commissioning Data Sets (CDS) version 6.2
8	ISB 0034	SNOMED CT
9	ISB 1609	Child Protection Information Sharing (CP-IS)
10	ISB 0090	Organisation Data Service (ODS)

2 Health and Care Organisations

2.1 Requirements

Requirement [1]	
The following section describes the care provider requirements to conform to this standard. Conformance of provider organisations is assessed through the mandated completion of a state of readiness questionnaire and latterly through analysis of the submitted data, once it is received by NHS Digital.	
Timeframe	
(1.1)	From 1st November 2017, providers of Community Services as defined in this Information Standard ***MUST*** be able to collect the information as defined in the Technical Output Specification for local use.
(1.2)	From 1st December 2017, providers of Community Services as defined in this Information Standard ***MUST*** begin submitting the monthly CSDS submissions as per the instructions in the CSDS Technical Guidance. The providers ***MUST*** allow time to review and implement corrections to their submission files within the designated window.
Scoping	
(2.1)	With immediate effect, providers ***MUST*** review the 'In scope' and 'Out of scope' sections of this Specification to establish whether the standard applies to the services they offer.
(2.2)	Providers ***SHOULD*** review all related documentation to fully understand the background, objectives and scope to this information standard.
Feasibility Assessment	
(3.1)	With immediate effect, providers of Community Services ***MUST*** review the CSDS Technical Output Specification (TOS) and CSDS User Guidance to understand the scope and definition of each data item.
(3.2)	As an Output Data Set, the CSDS is intended to only define "what should be extracted" from local IT systems, not "what should be captured". A clinical data set will need data items beyond what the CSDS specifies; consequently, providers of Community Services ***SHOULD NOT*** use this data set to support their clinical and operational data capture. The whole ethos around the CSDS is to only re-use clinical data and not specify standards for capturing clinical data.
(3.3)	Providers of Community Services ***SHOULD*** familiarise themselves with the CSDS XML schema and conversion tool to understand how data items are grouped for the Data Submission File.
(3.4)	Providers of Community Services ***SHOULD*** carry out a 'data mapping exercise' to understand how well their existing electronic systems align to the CSDS TOS and take appropriate action to ensure that the standard is fully met. The self-assessment 'System Conformance Checklist' tool is available on the NHS Digital website to support this mapping exercise. The mapping exercise is likely to need the involvement of experienced CSDS leads, the organisation's Information Management Service and the appropriate IT system suppliers.
(3.5)	Providers of Community Services ***MUST*** make submissions only for those data items defined in the TOS and no additional data items should be included.

[1] The key words MUST, SHOULD and MAY are defined in RFC-2119.

Information Governance

(4.1) The CSDS Implementation Guidance explains the Information Governance issues surrounding the data set. Caldicott Guardians and the Heads of Community Services ***MUST*** review the Information Governance Guidelines within the CSDS Implementation Guidance to understand:

- How data submission, storage and reporting processes handle identifiable and sensitive data items.
- How consent issues should be best managed.

(4.2) Providers of Community Services ***MUST*** make available information and guidance to patients stating that their clinical care data may be re-used for the purpose of data analysis and reporting.

(4.3) With immediate effect, providers of Community Services ***SHOULD*** read the 'NHS Confidentiality Code of Practice', 'Caldicott Report' and subsequent 'Information: To share or not to share?' Information Governance Review (second Caldicott review) for guidance and technical support related to data and information sharing at both operational and secondary use levels.

(4.4) Providers of Community Services ***SHOULD*** also consult and adhere to the good practice advice and guidance set out in the NHS Digital's 'A Guide to Confidentiality in Health and Social Care'.

(4.5) To prevent breaches of confidentiality, it ***MUST*** be the sole responsibility of the Providers of Community Services' Caldicott Guardian to ensure the subject information is withheld where appropriate.

(4.6) Any immediate concerns ***SHOULD*** be addressed to the Implementation Team at NHS Digital or the Health Research Authority (HRA) Confidentiality Advisory Group (CAG).

(4.7) Providers of Community Services ***SHOULD*** ensure that local data warehouses comply to appropriate data security controls.

Clinical Governance

Clinical governance is defined by Department of Health as 'the system 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 clinical excellence will flourish'.

(5.1) As an Information Standard that approves a national patient-level CSDS:

- Governing and audit bodies ***MAY*** use the data set to monitor whether providers of Community Services are making year on year improvements.
- Providers of Community Services ***MAY*** use the data set to compare and contrast performance to drive service improvements.

It is therefore clear that the data set can be used for clinical governance purposes.

Clinical Risks

(6.1) Providers of Community Services ***SHOULD*** always seek to understand the context of published national reports and be aware that the information presented depends greatly upon the quality of information submitted.

(6.2) Ongoing efforts ***SHOULD*** be made to ensure that data quality is of the highest standard before forming judgements about reports and introducing changes.

(6.3) Where there is a system change in order to meet this standard (e.g. the procurement of a new clinical system from a different supplier), providers of Community Services ***SHOULD*** ensure that supplier organisations are compliant with the safety standards SCCI0129 and SCCI0160.

Central Data Submission

(7.1) Providers of Community Services ***MUST*** create a monthly data submission as set out in the CSDS Technical Guidance. Therefore, Providers of Community Services ***MUST*** be

able to:
- Collate and extract data from local IT systems as per the CSDS TOS.
- Structure the data and create a data submission file as per the CSDS Technical Guidance.
- Apply the basic validation rules and ensure that the submission file conforms to these.
- Ensure the data submission file only contains data for a single month and relates to one provider organisation.
- Submit the data submission file as per the data submission protocol highlighted in the Technical Guidance.

(7.2) Providers of Community Services ***MUST*** submit data monthly to the Central Data Warehouse, based on a schedule that will be published in advance of the Conformance Date.

(7.3) The schedule outlines the timeframe (Submission Window) during which data relating to a monthly period (Reporting Period) ***MUST*** be submitted in.

(7.4) Providers of Community Services ***MUST*** check for error reports, correct errors and make re-submissions at the earliest opportunity. Further details on error correction and re-submissions are explained within the Technical Guidance.

Constructing a Data Submission File

The CSDS Technical Guidance document provides information on how to create a monthly submission file. Providers of Community Services ***MUST*** review this document; however, noted below are key requirements of the technical submission architecture.

(8.1) A submission ***MUST*** only:
- Contain data for a single provider organisation.
- Contain data relating to activities occurring in a single month.

Meet the conditions and validation rules explained in the CSDS TOS.

(8.2) Each Data Submission File ***MUST*** consist of a:
- Header group.
- One or more data groups, including CYP001 and CYP002 entries for every record.

(8.3) Each group consists of one or more data items. The groupings of data items for each table ***MUST*** be as per the layout specified in the CSDS TOS.

(8.4) Providers of Community Services ***MUST*** include in their submission all data groups they can generate from local electronic systems.

(8.5) The first data submission ***MUST*** include all data relating to referrals that were open on 1st November 2017 and all subsequent new referrals.

(8.6) The Information Standard does not stipulate how data should be collected in local electronic systems, so the groups ***MAY*** generate data from one or more data sources. It ***MAY*** be that providers of Community Services adopt a local data warehouse to aggregate data from all relevant sources and use this to generate the Data Submission File. A conversion tool has also been provided which ***MAY*** be used to collate data from multiple systems and produce a submission file in the correct XML format.

Validation Rules

(9.1) With immediate effect, providers of Community Services ***MUST*** review the CSDS TOS to understand the data quality rules that will be applied to each data group on arrival at the Central Data Warehouse. Data quality issues will be highlighted in a data quality report made available to the providers of Community Services for them to take further action before the submission window closes.

(9.2) Providers of Community Services ***SHOULD*** make every effort to resolve inherent systemic errors and address recurring data quality issues as once the submission window closes for a particular reporting period there will not be a further opportunity to resubmit the data.

Data Quality Feedback

(10.1) With immediate effect, providers of Community Services ***MUST*** review the CSDS TOS to understand the data quality rules that will be applied to each data group on arrival at the Central Data Warehouse. Data quality issues will be highlighted in a data quality report made available to the CSDS providers for them to take further action before the submission window closes.

(10.2) Providers of Community Services ***SHOULD*** make every effort to resolve inherent systemic errors and address recurring data quality issues as once the submission window closes for a particular reporting period there will not be a further opportunity to resubmit the data.

Monthly Submission

(11.1) A submission ***MUST*** be loaded onto the portal on a monthly basis and as per instructions laid out in the CSDS Technical Guidance.

Issues and Maintenance

(12.1) To support the implementation of this information standard, providers of Community Services ***SHOULD*** highlight any persistent issues. Feedback will be used by the standards developers to improve the implementation and data-collection processes for future consideration towards a data set change or, indeed, further implementation phases.

Requirements of Key Personnel Involved in the Delivery of this Data Set

(13.1) **Heads of Community Services** are responsible for capturing the information as part of the on-going care of patients. They ***MUST***:

- Familiarise themselves with the CSDS TOS to understand what data items are mandated by this Information Standard.
- Assist their organisation's IT or Information Management service in completing the CSDS System Conformance Checklist to assess what proportion of the CSDS TOS data items are available from the their organisation's local IT systems.
- Ensure they understand and implement the Information Governance approach adopted for this data set, which can be found in the Information Governance section of the Implementation Guidance.
- Explain to operational and clinical staff the importance of capturing data for the CSDS.

(13.2) **Clinical staff *MUST***:

- Capture the CSDS TOS data items in an accurate and timely manner.
- Understand the deployed IG approach, especially in relation to the handling of sensitive data.

(13.3) **Informatics staff** are responsible for producing extracts that conform to the XML schema and TOS. They ***MUST***:

- Familiarise themselves with the CSDS TOS and XML schema to understand what data items are mandated by this Information Standard.
- Configure electronic patient record systems to allow compliance with the standard.
- Submit the data to the Central Data Warehouse within the prescribed reporting periods and deadlines.
- Review and work with clinicians to resolve data quality issues identified in the output reports.
- Ensure they understand and implement the Information Governance approach adopted for this data set, which can be found in the Information Governance section of the Implementation Guidance.

Informatics staff ***MAY*** also be responsible for the collation of information from a range of disparate systems into the CSDS. This will include ensuring completeness and data quality of the information within the data set.

Working Practices

How providers of Community Services should cascade the Information Standard requirements to operational staff

(14.1) With immediate effect, all clinicians and operational staff involved in community care need to be made aware of this Information Standard. Providers of Community Services' Chief Executives ***MUST*** be held accountable to comply with the dates instructed by the mandate. The mandate and an appropriate Project Brief ***SHOULD***, therefore, be cascaded to the commissioned Community Services for the attention of the Community Service leads and other relevant staff.

(14.2) Instructions ***MUST*** also be communicated to the organisation's information leads to initiate collaborative work with informatics services and Community Services as early as possible.

System upgrades

(15.1) This Standard looks to re-use clinical and operational data for national analysis and reporting. Providers of Community Services ***SHOULD*** conduct a mapping exercise to determine how well local systems map to the CSDS TOS (using the CSDS System Conformance Checklist).

(15.2) For data items that align to the data set TOS, providers of Community Services ***MUST*** make all efforts to collate the data locally on a monthly basis.

(15.3) Where the mapping exercise identifies gaps, providers of Community Services ***SHOULD*** plan to undertake development efforts with their IT system suppliers to upgrade existing IT systems.

(15.4) Providers of Community Services ***SHOULD*** consider the provision of adequate resources to make plans for any transcription requirements of paper records to electronic forms which ultimately meet the entire mandated data standard for central returns.

How CSDS providers should look to capture data

(16.1) This Standard defines the data items that that should be extracted from local electronic systems. Providers of Community Services ***SHOULD*** continue to develop their electronic systems to support the clinical data capture which best supports their working practices and business plans.

(16.2) However, when planning to improve systems and services, consideration ***MUST*** be made to this Information Standard during the development and implementation stages.

The TOS and User Guidance provide further information on the data items which need to be captured.

How to achieve timely data capture and file submission

(17.1) The data set has been deliberately split into a number of data groups. The data groups are intended to support the business processes of Community Service providers. Providers of Community Services ***MUST*** make every effort to record clinical information in real time or as a minimum, transcribe information to an electronic form at the earliest opportunity to support clinical interventions and decisions. This procedure will also support seamless data extraction from electronic systems for the required monthly central return.

How to manage data submissions if data is captured across several systems

(18.1) Due to the number of services considered Community Services, each of which ***MAY*** use its own dedicated IT system, the CSDS spans several services and systems (e.g. Health Visiting and Child Health). The Information Standard makes it very clear that a submission file can only include data pertaining to one organisation and for reporting periods that are open. Therefore, providers of Community Services ***MAY*** wish to

consider developing a local data warehouse to generate the monthly data submission files.

2.2 Conformance Criteria

This section describes the tests that can be measured to indicate that the information standard is being used correctly by a provider organisation (conformance criteria).

Conformance Criteria
From 1st November 2017, providers of NHS-funded Community Services ***MUST*** be able to collect the information, as defined in the Technical Output Specification, for local use.
From 1st December 2017, providers of NHS-funded Community Services ***MUST*** begin submitting the monthly CSDS submissions as per the instructions in the CSDS Technical Guidance.
From 1st December 2017, providers of NHS-funded Community Services ***MUST*** review and act on the validation and data quality reports provided by NHS Digital after each submission.
From 1st December 2017, when the Central Data Warehouse rejects a complete or part submission, providers of NHS-funded Community Services ***MUST*** allow time to review and implement corrections to their submission files within the designated window. Providers ***SHOULD*** document lessons learned from validation errors to avoid repetitive mistakes.
During October 2017 a state of readiness questionnaire will be circulated to assess conformance with this standard. This ***MUST*** be completed by providers of Community Services and returned to NHS Digital within the specified deadline.

3 IT Systems

3.1 Requirements

Requirement [2]	
The following section describes the care provider requirements to ensure that their IT systems conform to this standard. Conformance of provider organisations is assessed through the mandated completion of a state of readiness questionnaire and latterly through analysis of the submitted data, once it is received by NHS Digital.	
Timeframe	
(1.1)	From 1st November 2017 Community systems ***MUST*** be able to capture and/or derive the data items defined within this standard. This includes mapping of local codes to national codes, and the ability to extract this information as envisaged within this standard, e.g. without interim workarounds.
(1.2)	Suppliers ***MUST*** ensure that the increase on burden for providers for capturing and extracting the information defined in the CSDS TOS is proportionate.
(1.3)	When considering potential developments, minimising the burden on providers and supporting good data quality ***MUST*** be prioritised.
Scoping	
(2.1)	IT Systems Suppliers ***SHOULD*** review all related documentation to fully understand the background, objectives and scope of this information standard.
Feasibility Assessment	
(3.1)	With immediate effect, IT Systems Suppliers ***SHOULD*** review the CSDS Technical Output Specification (TOS) and CSDS User Guidance to understand the scope and definition of each data item.
(3.2)	As an Output Data Set, the CSDS is intended to only define “what should be extracted” from local IT systems, not “what should be captured”. A clinical data set will need data items beyond what the CSDS specifies.
(3.3)	While IT Systems Suppliers ***SHOULD*** use this data set to support their system development, they ***SHOULD NOT*** use the data set exclusively and ***SHOULD*** also consider the full requirements of the care setting where it is used. The whole ethos around the CSDS is to only re-use clinical data, not specify standards for capturing clinical data.
(3.4)	IT Systems Suppliers ***SHOULD*** familiarise themselves with the CSDS XML schema and conversion tool to understand how data items are grouped for the Data Submission File.
(3.5)	IT Systems Suppliers ***SHOULD*** provide tools to enable a ‘data mapping exercise’ to be carried out and where possible complete the mappings to the national codes on behalf of the CSDS providers. A self-assessment ‘System Conformance Checklist’ is a tool available on the NHS Digital website to support this mapping exercise.
Information Governance	
The CSDS Implementation Guidance explains the Information Governance issues surrounding the data set.	

[2] The key words MUST, SHOULD and MAY are defined in RFC-2119.

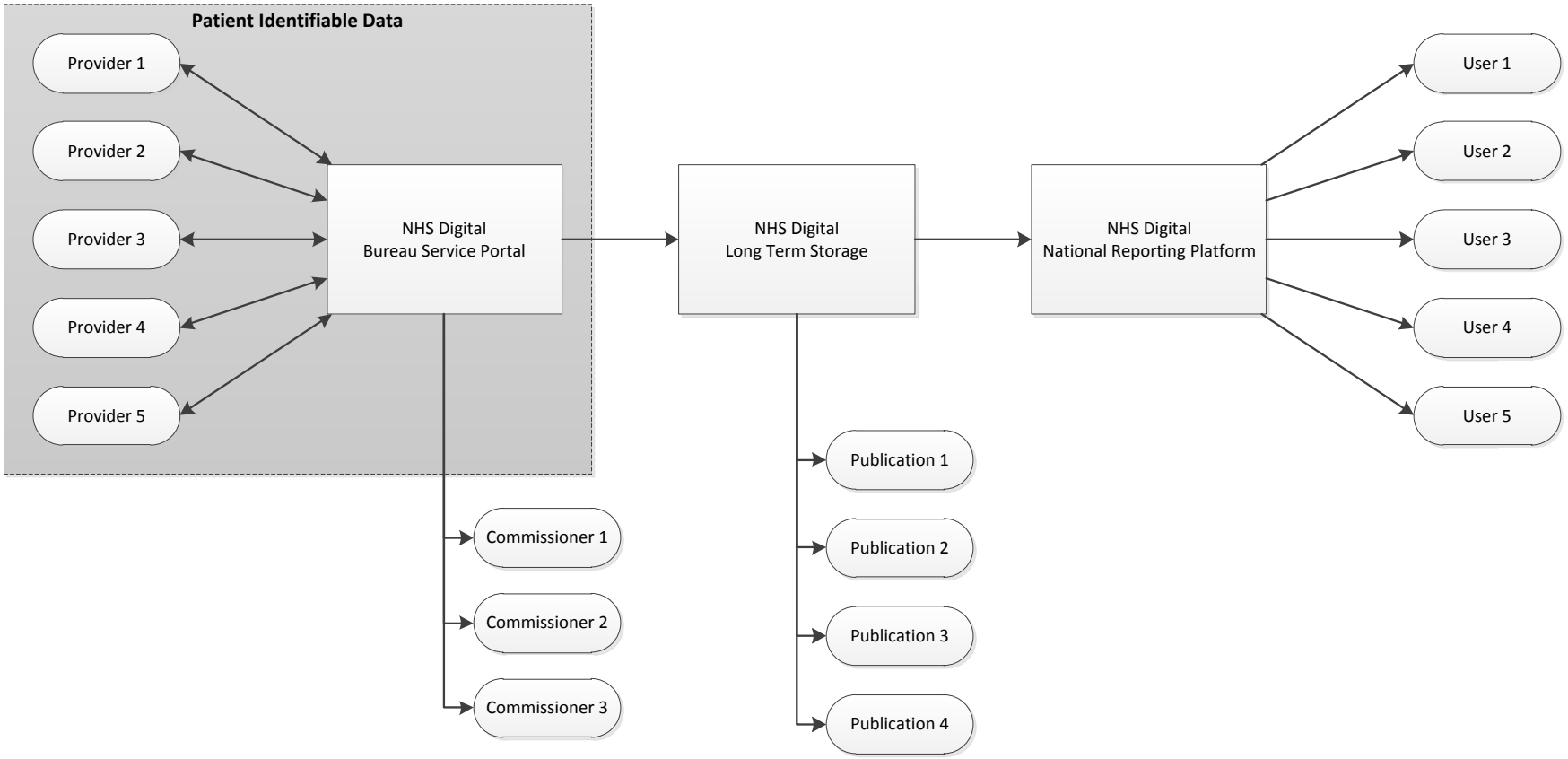
(4.1)	IT Systems ***MUST*** provide a mechanism to allow providers to identify records where patients have objected to the use of their data for secondary purposes or where there is a legal requirement to restrict the flow of identifiable information for a patient.
Clinical Risks	
(5.1)	IT System suppliers ***SHOULD*** always ensure that any changes resulting from the implementation of the CSDS are compliant with the safety standards ISB 0129 and ISB 0160.
Constructing a data submission file	
(6.1)	The CSDS Technical Guidance document provides information on how to create a monthly submission file. IT Systems Suppliers ***SHOULD*** review this document and the steps outlined in Section 2.1 (Health and Care Organisations - Requirements) above.
(6.2)	
Validation rules	
(7.1)	IT Systems Suppliers ***SHOULD*** review the CSDS Technical Guidance and TOS to understand the data validation rules that will be applied at the central data warehouse to all incoming Data Submission Files. Any validation rules not adhered to will result in appropriate groups or the entire Data Submission File being rejected, depending on the particular validation rule.
Data quality feedback	
(8.1)	With immediate effect, IT Systems Suppliers ***SHOULD*** review the CSDS TOS to understand the data quality rules that will be applied to each data group at arrival to the Central Data Warehouse.

3.2 Conformance Criteria

This section describes the tests that can be measured to indicate that the information standard is being used correctly by an IT system supplier.

Conformance Criteria
From 1st November 2017, all Community systems ***MUST*** be able to capture and/or derive the data items defined within this standard, which includes functionality to map local codes/values to national codes/values. Suppliers can assess this against the System Conformance Checklist which can be found on the NHS Digital website.
From 1st November 2017, all Community systems ***MUST*** be able to extract data for the CSDS with minimal additional burden to providers in a format which is compatible with the XML schema, e.g. without interim workarounds.
From 1st December 2017, all Community systems ***MUST*** have the ability to produce data quality reports to support providers in producing their submission files in line with the CSDS TOS.
During October 2017 a questionnaire will be circulated to assess conformance with this standard. This ***MUST*** be completed by all suppliers of Community systems and returned to NHS Digital within the specified deadline.

Appendix A – CSDS Data Flow Diagram



Board Meeting – Public Session

Title of paper:	Mandatory request from the National Institute for Health and Care Excellence for 'Quality and Outcomes Framework (QOF) Pilot 11' data extraction
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 05 d ii
Paper presented by:	Prof. David Hughes (Executive Director of Information and Analytics at NHS Digital)
Paper prepared by:	Dave Roberts (Head of Business and Operational Delivery, Primary Care Domain, NHS Digital)
Paper approved by: (Sponsor Director)	Prof. David Hughes (Executive Director of Information and Analytics at NHS Digital)
Purpose of the paper:	Provide the NHS Digital Board with the information necessary to consider the mandatory request that is required to support the Quality and Outcomes Framework (QOF) Pilot 11 data extraction and approve its acceptance.
Additional Documents and or Supporting Information:	Not applicable.
Please specify the key risks and issues:	NICE require these data to be disseminated to colleagues from the Institute of Applied Health Research at the University of Birmingham before the end of 2016. The NHS Digital Board accepting the mandatory request on 30 November 2016 will allow this to take place, whereas waiting until the next NHS Digital Board meeting on 1 February 2017 would result in this being delayed.
Patient/public interest:	Indirect.
Supplementary papers:	Annex A - QOF Pilot 11 Mandatory Request Annex B - QOF Pilot 11 Indicators
Actions required by the Board:	**The NHS Digital Board is asked to accept the mandatory request from NICE for the QOF Pilot 11 data extraction at the NHS Digital Board meeting on 30 November 2016.**

NHS Digital

Mandatory request from the National Institute for Health and Care Excellence for 'Quality and Outcomes Framework (QOF) Pilot 11' data extraction

Published 30 November 2016

Information and technology
for better health and care

Contents

Executive Summary

On behalf of the Department of Health (DH) and now NHS England, the National Institute for Health and Care Excellence (NICE) has requested NHS Digital to support the Quality and Outcomes (QOF) Pilot 11 data extraction; that is: the 11th edition of the QOF pilot. This paper provides the NHS Digital Board with the information necessary to consider the mandatory request that is required to support this work (see Annex A - QOF Pilot 11 Mandatory Request) and approve its acceptance.

Background

The purpose of QOF piloting is to try and understand how potential indicators work in general practice and whether or not these indicators have any unintended or adverse consequences. QOF piloting is used to assess the effectiveness of indicators that are being piloted as these pilot indicators may go on to be included in future iterations of QOF.

QOF Pilot 11 will involve aggregated level data (that is: counts of patients broken down by general practice) being extracted for a number of indicators from different clinical areas (see Annex B - QOF Pilot 11 Indicators). Approximately 26 general practices in England will be included in the data extraction and there will be three extractions in total: 1) Baseline, 2) Mid-term and 3) Final.

Apollo Medical Software Solutions (referred hereafter to as Apollo) will extract the data before it is returned to NHS Digital where any appropriate analysis will be performed. NHS Digital will then share the aggregated level data with colleagues from the Institute of Applied Health Research at the University of Birmingham (that is: the data processor working on behalf of NICE).

A mandatory request, issued under section 255 of the Health and Social Care Act 2012 from NICE to NHS Digital is required to ensure the legal extraction of the data. As only aggregated level data are being extracted, Type 1 objections and Type 2 objections do not apply.

Recommendation

The recommendation is for NHS Digital Board to accept the mandatory request from NICE for the QOF Pilot 11 data extraction at the NHS Digital Board meeting on 30 November 2016.

Implications

Strategy Implications

One of the objectives of QOF piloting is to replicate the process of data extraction for 'live' QOF as closely as possible (within the piloting context). NHS Digital's General Practice Extraction Service (GPES) extracts data from all participating general practices in England for 'live' QOF. NICE works with an independent Indicator Advisory Committee to determine which piloted indicators should go forward to the NICE menu of indicators and be considered

for inclusion in live QOF during annual General Practitioner (GP) contract negotiations between NHS Employers (on behalf of NHS England) and the British Medical Association General Practitioners Committee.

In line with the NHS Digital data and information strategy (currently in draft), the QOF Pilot 11 data extraction supports two of the 'data content' objectives and one of the 'analysis' objectives:

- New content: Undertake new data collections that respond to customer needs and directions.
- Right data: Ensuring that we collect data which add value for our core customers and that are based on reliable sources.
- Value adding: Production of a range of indicators and statistics that add value and are aligned to customer needs.

Financial Implications

There is £75,000 allocated for the extraction of the QOF Pilot 11 data within the allocation of resources for the Primary Care Domain; this will cover the costs from Apollo and may also cover staff costs from the General Practice Extraction Service (GPES). Staff costs from the Primary Care Domain will be covered by the Grant in Aid funding that NHS Digital receives. Colleagues in the NHS Digital Investment Sub-Group (ISG) have agreed that there is no requirement for the QOF Pilot 11 costs to formally go through the ISG process.

Stakeholder Implications

QOF and the QOF pilots are long established pieces of work and therefore we do not envisage the need for there to be a targeted consultation with Joint General Practitioners Committee (GPC) and Royal College of General Practitioners (RCGP) IT subcommittee for the QOF Pilot 11 data extraction. We propose to inform the Joint GPC and RCGP IT Subcommittee that this data extraction is taking place as opposed to carrying out a full targeted consultation.

Handling

Following the NHS Digital Board acceptance of the mandatory request, a Data Provision Notice will be issued to the general practices that are participating in this data extraction. This will inform the general practices of the key information of this extraction, including the form, manner and period. The general practices will have already been made aware of this information through the Institute of Applied Health Research at the University of Birmingham, who are in frequent contact with the general practices participating in this data extraction. Apollo will not run the first data extract until after the Data Provision Notice has been issued to the general practices.

NHS Digital will not to wait the 'standard' six weeks between issuing the Data Provision Notice and the data being extracted; this is because the general practices have already agreed to participate in this data extraction and are aware of what will be involved. NHS Digital sent a letter to all of the participating general practices informing them of this data

extraction. This letter was sent on 29 September 2016; the first data extraction will take place more than six weeks after this date.

Risks and Issues

As NICE is issuing a mandatory request to NHS Digital to establish the QOF Pilot 11 data extraction, a Data Provision Notice needs to be issued to the general practices that are participating in this data extraction. A Data Provision Notice can only be issued following SCCI assurance of the extraction and the mandatory request being accepted by the NHS Digital Board.

NICE require these data to be disseminated to colleagues from the Institute of Applied Health Research at the University of Birmingham before the end of 2016. The NHS Digital Board accepting the mandatory request on 30 November 2016 will allow this to take place, whereas waiting until the next NHS Digital Board meeting on 1 February 2017 would result in this being delayed.

Corporate Governance and Compliance

The QOF Pilot 11 data extraction will be considered by SCCI on 30 November 2016. The SCCI process includes a detailed burden assessment from the Burden Advice and Assessment Service (BAAS). This will consider the burden placed on general practices in the data being extracted from their clinical systems.

Approval from the Data Access Advisory Group (DAAG) / Independent Group Advising on the Release of Data (IGARD) will be required before any data are disseminated to colleagues from the Institute of Applied Health Research at the University of Birmingham. DAAG / IGARD approval is scheduled for early December 2016 ahead of the data being extracted from general practices.

Management Responsibility

- Executive Director: Prof. David Hughes (Executive Director of Information and Analytics at NHS Digital)
- Information Asset Owner: Dave Roberts (Head of Business and Operational Delivery, Primary Care Domain, NHS Digital)
- Project Manager: Rory McKnight (Project Manager, General Practice Extraction Service, NHS Digital)

Actions Required of the Board

The NHS Digital Board is asked to accept the mandatory request from NICE for the QOF Pilot 11 data extraction at the NHS Digital Board meeting on 30 November 2016.

NHS Digital

Mandatory request for Quality and Outcomes Framework (QOF) Pilot 11: Annex A

List of indicators included in the extraction

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List of indicators included Quality and Outcomes Framework (QOF) Pilot 11 data extraction

The data will be extracted via a third party supplier as opposed to via the General Practice Extraction Service (GPES); the procurement process has recently been completed and Apollo Medical Software Solutions (referred hereafter to as Apollo) has been chosen as the third party supplier to extract the data.

In order for Apollo to extract the aggregated level data, they will be utilising their GP Systems of Choice (GPSoC) accredited software which will be populated with all patient data available from the Interface Mechanism provided by the appropriate Clinical System Provider. As the Apollo software and the clinical data will both be installed and held at the practice, there is no risk associated with any patient level data leaving the practice or the domain of the Data Controller. The Apollo software will collate aggregated data at the practice and this will be the only data returned to NHS Digital. No patient level data will be returned to NHS Digital, nor will Apollo hold any patient level data as this will all be held within the general practice's domain (i.e. no patient level data will leave the general practice). The Apollo software will also allow the practice to view the reports locally and view what data has been sent.

QOF Pilot 11 includes the following 16 indicators (covering eight clinical areas):

Clinical area	Indicator ID	Indicator title
Post-natal Mental Health	PNMHP1101	The percentage of women who have given birth in the preceding 12 months* who have had a post-natal enquiry about their mental health using the Whooley 2 depression questions and the GAD-2 between 4-10 weeks post partum *please note the indicator is worded as it would be if it went forward as a QOF indicator. However for the purposes of the pilot for the baseline extract the indicator is looking back 12 months but for the mid-term it should look back 6 months and for the final look back 5 months where stated
	PNMHMIP1102 (management information count only)	Count of the number of patients who have given birth in the last 12 months* who have an unresolved diagnosis of depression and/or anxiety *for the purposes of the pilot for the baseline extract the indicator is looking back 12 months and for the final look back 5 months where stated. No mid-term extract is required
Atrial Fibrillation	AFIBP1101	The percentage of patients with atrial fibrillation, currently treated with an anticoagulant, who have had a review in the preceding 12 months* which included:

		a. Assessment of stroke/ VTE risk b. Assessment of bleeding risk c. Assessment of renal function, creatinine clearance, FBC and LFTs d. Any adverse effects related to anticoagulation e. Assessment of compliance f. Choice of anticoagulant. *please note the indicator is worded as it would be if it went forward as a QOF indicator. However for the purposes of the pilot for the baseline extract the indicator is looking back 12 months but for the mid-term it should look back 6 months and for the final look back 5 months where stated
Pulse Monitoring	PMP1101	The percentage of patients registered at the practice aged 65 years and over who have been diagnosed with one or more of the following conditions: hypertension, diabetes, CKD, PAD, stroke/TIA, COPD or RA who have had a pulse rhythm assessment in the preceding 12 months* *please note the indicator is worded as it would be if it went forward as a QOF indicator. However for the purposes of the pilot for the baseline extract the indicator is looking back 12 months but for the mid-term it should look back 6 months and for the final look back 5 months where stated
Diabetes Prevention	NDHP1101	The contractor establishes and maintains a register of patients with a diagnosis of non-diabetic hyperglycaemia
	NDHP1102	The percentage of patients newly diagnosed with non-diabetic hyperglycaemia in the preceding 12 months* who have been referred to a Healthier You: NHS Diabetes Prevention Programme for intensive lifestyle advice *please note the indicator is worded as it would be if it went forward as a QOF indicator. However for the purposes of the pilot for the baseline extract the indicator is looking back 12 months but for the mid-term it should look back 6 months and for the final look back 5 months where stated
	NDHP1103	The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c in the preceding 12 months*

		*please note the indicator is worded as it would be if it went forward as a QOF indicator. However for the purposes of the pilot for the baseline extract the indicator is looking back 12 months but for the mid-term it should look back 6 months and for the final look back 5 months where stated
Gestational Diabetes	GDMP1101	The percentage of women who have had gestational diabetes, diagnosed more than 12 months ago, who have had an HbA1c test in the preceding 12 months* *please note the indicator is worded as it would be if it went forward as a QOF indicator. However for the purposes of the pilot for the baseline extract the indicator is looking back 12 months but for the mid-term it should look back 6 months and for the final look back 5 months where stated
Autistic Spectrum	ASP1101	The contractor establishes and maintains a register of patients on the autistic spectrum.
Multimorbidity	MM001	The number of patients on 2 or more QOF registers at the end of the reporting period
	MM002	The number of patients on 3 or more QOF registers at the end of the reporting period
	MM003	The number of patients on 4 or more QOF registers at the end of the reporting period
Acute Kidney Injury (AKI)	AKIP1101	The contractor establishes and maintains a register of patients aged 18 years and over with an episode of AKI in the preceding 12 months
	AKIP1102	The percentage of patients aged 18 years and over with an episode of AKI in the preceding 12 months* who have had a medication review within 1 month of the record of diagnosis *please note the indicator is worded as it would be if it went forward as a QOF indicator. However for the purposes of the pilot for the baseline extract the indicator is looking back 12 months but for the mid-term it should look back 6 months and for the final look back 5 months where stated (this is captured within the Qualifying Criteria of the Clinical Data Extraction Criteria in the case of this indicator)
	AKIP1103	The percentage of patients aged 18 and over with an episode of AKI in the preceding 12 months* who have had a serum creatinine, eGFR and either an ACR or PCR recorded within 3 months of

		diagnosis *please note the indicator is worded as it would be if it went forward as a QOF indicator. However for the purposes of the pilot for the baseline extract the indicator is looking back 12 months but for the mid-term it should look back 6 months and for the final look back 5 months where stated (this is captured within the Qualifying Criteria of the Clinical Data Extraction Criteria in the case of this indicator)
	AKIP1104	The percentage of patients aged 18 and over with an episode of AKI in the preceding 12 months* who have been given written information about AKI within 1 month of diagnosis *please note the indicator is worded as it would be if it went forward as a QOF indicator. However for the purposes of the pilot for the baseline extract the indicator is looking back 12 months but for the mid-term it should look back 6 months and for the final look back 5 months where stated (this is captured within the Qualifying Criteria of the Clinical Data Extraction Criteria in the case of this indicator)

Dear Andy Williams,

Mandatory Request for QOF Pilot 11

I am writing to NHS Digital to formally request, under section 255(1) of the Health and Social Care Act 2012 (the Act), that NHS Digital establishes and operates a system for the collection and analysis of information relating to Quality Outcome Framework (QOF) Pilot 11.

NICE is a principal body, as listed in section 255(9) of the Act and as such this is a mandatory request. In accordance with section 257(4) of the Act, NICE has consulted with NHS Digital before making this request.

NICE considers that the information obtained by complying with this request is necessary or expedient for us to have in relation to the discharge of our duty to develop general practice indicators suitable for inclusion in the QOF. The dissemination of the information will be in connection with the provision of health services or adult social care in England, specially the powers conferred under s261(1) ('Other dissemination of Information') of the Health and Social Care Act 2012.

Background

NHS Digital has been required by the Department of Health and NHS England to support the development of new QOF indicators by providing NICE with QOF pilot data extractions since 2009. The purpose of this piloting is to try and understand how potential indicators work in general practice and whether or not these indicators have any unintended or adverse consequences. QOF piloting is used to assess the effectiveness of indicators that are being piloted as these pilot indicators may go on to be included in future iterations of QOF and this is dependent on the outcome of the pilot and further negotiations.

NHS Digital is requested to collect and analyse the QOF Pilot 11 data as listed below. NHS Digital is then requested to send the data to the National Collaborating Centre for Indicator Development, which is made up of staff from the University of Birmingham and the York Health Economics Consortium (YHEC). NICE has commissioned staff at the National Collaborating Centre for Indicator Development to develop and review clinical indicators for QOF Pilot 11.

The data to be collected

Aggregated level data (i.e. counts of patients broken down by general practice) will be extracted for a number of indicators from different clinical areas (note that the indicators included in the two pilots are different). 26 general practices in England will be included in the data extraction and there will be three extractions in total: 1) Baseline, 2) Mid-term and 3) Final.

For QOF Pilot 11, the data to be collected comprise 16 indicators covering the following 8 clinical areas:

1. Post-natal Mental Health

2. Atrial Fibrillation
3. Pulse Monitoring
4. Diabetes Prevention
5. Gestational Diabetes
6. Autism
7. Multimorbidity
8. Acute Kidney Injury (AKI)

Please see Annex A for details of the indicators.

In line with patient rights contained within the NHS Constitution and the Directions from the Secretary of State to NHS Digital concerning patient objections, NHS Digital 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. Type 1 opt-outs will be upheld when extracting the primary care data. Type 2 opt-outs do not apply as only aggregated non-confidential data will be collected by NHS Digital.

Please accept this as a request under section 255(1) of the Act.

Yours……

Board Meeting – Public Session

Title of paper:	Direction from Department of Health for 'NHS Health Check for adults aged 40 – 74 years' data extraction
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 05 d iii
Paper presented by:	Prof. David Hughes (Executive Director of Information and Analytics at NHS Digital)
Paper prepared by:	Dave Roberts (Head of Business and Operational Delivery, Primary Care Domain, NHS Digital)
Paper approved by: (Sponsor Director)	Prof. David Hughes (Executive Director of Information and Analytics at NHS Digital)
Purpose of the paper:	Provide the NHS Digital Board with the information necessary to consider the Direction that is required to support the NHS Health Check for adults aged 40 – 74 years data extraction and approve its acceptance.
Additional Documents and or Supporting Information:	Not applicable.
Please specify the key risks and issues:	PHE require these data before the end of the 2016-17 financial year. Following the acceptance of the Direction, there needs to be 1) at least six weeks between the Data Provision Notice being issued and the first data extract taking place and 2) sufficient time for any processing and analysis of these data. The NHS Digital Board accepting the Direction at the NHS Digital Board meeting on 30 November 2016 will allow sufficient time for this processing and analysis ahead of these data to be disseminated to PHE before 31 March 2017. Waiting until the next NHS Digital Board meeting on 1 February 2017 for the NHS Digital Board to accept the Direction would result in a delay in disseminating the data to PHE as there would not be sufficient time for the processing and analysis between the first data extract taking place and 31 March 2017.
Patient/public interest:	Indirect.
Supplementary papers:	Annex A - NHS Health Check Direction Annex B - NHS Health Check Data Items (to support the Direction)

Actions required by the Board:	**The NHS Digital Board is asked to accept the Direction from DH for the NHS Health Check for adults aged 40 – 74 years data extraction at the NHS Digital Board meeting on 30 November 2016.**

NHS Digital

Direction from Department of Health for 'NHS Health Check for adults aged 40 – 74 years' data extraction

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Contents

Executive Summary

The Department of Health (DH), on behalf of Public Health England (PHE), wish to Direct NHS Digital to establish and operate a system for the collection and analysis of data on the NHS Health Check programme. This will concern data on the 'NHS Health Check for adults aged 40 – 74 years' (referred hereafter to as the 'NHS Health Check'). This paper provides the NHS Digital Board with the information necessary to consider the Direction that is required to support this work (see Annex A - NHS Health Check Direction) and approve its acceptance.

Background

PHE wish to use the General Practice Extraction Service (GPES) to extract general practice data on the NHS Health Check programme in order to evaluate this programme and inform better decisions on its delivery. This will involve GPES extracting identifiable patient / record level data (see Annex B - NHS Health Check Data Items), which will be held within NHS Digital's Data Management Environment (DME).

PHE require this extract on an annual basis. The first extract is scheduled to take place before the end of the 2016-17 financial year. Pseudonymised patient / record data will be disseminated to PHE. PHE also wish to link these data to other relevant clinical data, including, but not limited to, secondary care Hospital Episode Statistics (HES) data and Office for National Statistics (ONS) mortality data. This is why identifiable patient / record data need to be extracted (that is: for linkage purposes). Linking the general practice data to HES data and mortality data will allow PHE to track patient outcomes following their interaction with the NHS Health Check programme. Analysis of these data is expected to better understand the long term health impacts of the NHS Health Check programme and provide a robust evidence base for this.

A Direction, issued under section 254 of the Health and Social Care Act 2012, from the DH, on behalf of PHE, to NHS Digital is required to ensure the legal extraction of the general practice data. Type 1 objections will be upheld in extracting the general practice data and NHS Digital will have regard to and comply with the Type 2 Objections Direction to NHS Digital as appropriate in the dissemination of these data to PHE.

Recommendation

The recommendation is for NHS Digital Board to accept the Direction from DH for the NHS Health Check for adults aged 40 – 74 years data extraction at the NHS Digital Board meeting on 30 November 2016.

Implications

Strategy Implications

NHS Digital extracting data on the NHS Health Check programme will support PHE in their evaluation of this programme. It is anticipated that the outcomes of the analysis will support policymakers and facilitate future commissioning.

In line with the NHS Digital data and information strategy (currently in draft), the NHS Health Check data extraction supports two of the 'data content' objectives:

- New content: Undertake new data collections that respond to customer needs and directions.
- Right data: Ensuring that we collect data which add value for our core customers and that are based on reliable sources.

Financial Implications

NHS Digital and PHE have agreed a Work Package for the NHS Health Check data extraction. This covers the general practice system supplier costs as well as the GPES development and running costs. The general practice system supplier costs are due to be confirmed in late November 2016; once received, this information will be added to the Work Package, which will be sent to NHS Digital's Investment Sub-Group (ISG). A Project Brief will be submitted to ISG six to eight weeks after this initial ISG meeting. Following ISG, the Work Package will require agreement / sign off from Carl Vincent (Executive Director of Director of Finance and Corporate Services) and the appropriate representative at PHE. The funding detailed in the Work Package covers the costs for NHS Digital performing one data extraction. Further funding will be required to support any future data extractions.

Staff costs from other work areas that sit outside of this Work Package will be covered by NHS Digital Grant in Aid funding.

Stakeholder Implications

PHE are currently seeking the support of the General Practitioner (GP) profession for the NHS Health Check data extraction through engaging with the Joint General Practitioners Committee (GPC) and Royal College of General Practitioners (RCGP) IT subcommittee. This engagement is seeking to gain support for the overall policy and purpose of this extract.

As part of the Standardisation Committee for Care Information (SCCI) process, there will be a targeted consultation with the Joint GPC and RCGP IT subcommittee for the NHS Health Check data extraction. This will cover the technical aspects of this data extraction and will provide professional assurance ahead of this being considered by SCCI at the meeting on 30 November 2016.

Handling

Following SCCI assurance of the extraction and the NHS Digital Board acceptance of the Direction, a Data Provision Notice will be issued to all general practices in England at least six weeks prior to the data extraction taking place. This will inform general practices of the key information of this extraction, including the form, manner and period. The extraction will be offered out to all general practices in England via the Calculating Quality Reporting Service (CQRS). This offer must be accepted by all general practices in England.

As the extraction will require extracting identifiable patient level data, fair processing principles will apply. It is anticipated that a national fair processing notice will be produced, which general practices will be able to reference. General practices will be made aware of their responsibilities as 'Data Controllers' in the Data Provision Notice.

As this is a new data extraction, it may attract media / social media interest. We will work with the media team to produce a separate media handling plan including strong lines to take and will ensure that this is completed before the Data Provision Notice is issued.

Risks and Issues

As DH is Directing NHS Digital to establish the NHS Health Check data extraction, 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 SCCI assurance of the extraction and the Direction being accepted by the NHS Digital Board.

PHE require these data before the end of the 2016-17 financial year but, following the extraction of these data, there needs to be sufficient time for processing and analysis of these data. This will take place prior to the data being disseminated to PHE.

The NHS Digital Board accepting the Direction at the NHS Digital Board meeting on 30 November 2016 will allow sufficient time for this processing and analysis ahead of these data to be disseminated to PHE before 31 March 2017. Waiting until the next NHS Digital Board meeting on 1 February 2017 for the NHS Digital Board to accept the Direction would result in a delay in disseminating the data to PHE as there would not be sufficient time for the processing and analysis between the first data extract taking place and 31 March 2017.

Corporate Governance and Compliance

The NHS Health Check data extraction will be considered by SCCI on 30 November 2016. The SCCI process includes a detailed burden assessment from the Burden Advice and Assessment Service (BAAS). This will consider the burden placed on general practices in the data being extracted from their clinical systems.

Approval from the Data Access Advisory Group (DAAG) / Independent Group Advising on the Release of Data (IGARD) will be required before any data are disseminated to PHE. DAAG / IGARD approval is scheduled for early 2017 ahead of the data being extracted from general practices.

The data that will be disseminated to PHE will contain a number of potential identifiers, which, either treated on their own on together, may cause risk of identification. It is anticipated that a separate legal basis will be required to disseminate the data. Options for this legal basis include Section 251 Support through the Confidentiality Advisory Group (CAG), or incorporating the NHS Health Check data extraction into either the Memorandum of Understanding (MoU) that is currently in place between NHS Digital and PHE, or The Health Service (Control of Patient Information) Regulations 2002. DH, NHS Digital and PHE Information Governance colleagues are currently discussing these options. This should not affect the Direction from progressing.

Management Responsibility

- Executive Director: Prof. David Hughes (Executive Director of Information and Analytics at NHS Digital)

- Information Asset Owner: Dave Roberts (Head of Business and Operational Delivery, Primary Care Domain, NHS Digital)
- Project Manager: Simon Faulkner (Project Manager, General Practice Extraction Service, NHS Digital)
- Senior Responsible Owner: Jamie Waterall (National Lead for Cardiovascular Disease Prevention, Associate Deputy Chief Nurse, Public Health England)
- Sponsor: Prof. John Newton (Chief Knowledge Officer, Public Health England)

Actions Required of the Board

The NHS Digital Board is asked to accept the Direction from DH for the NHS Health Check for adults aged 40 – 74 years data extraction at the NHS Digital Board meeting on 30 November 2016.

Department of Health

Andy Williams
Chief Executive,
NHS Digital
1 Trevelyan Square,
Boar Lane
Leeds
LS1 6AE

[#] DRAFT

Dear Andy,

I am writing to provide a Direction to NHS Digital to establish and operate a system for the collection and analysis of data on the NHS Health Check programme; specifically, this will concern data on the 'NHS Health Check for adults aged 40 – 74 years' (referred hereafter to as the 'NHS Health Check').

The NHS Health Check is a check of an individual's heart health and aimed at adults in England aged 40 to 74 years, who are invited to attend at 5 yearly intervals. The NHS Health Check is intended to check vascular and circulatory health, and is used to calculate a person's risk of developing certain preventable illnesses.

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 (the Act)[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].

In accordance with section 254(2)(a) of the Act, the Secretary of State considers that the information obtained by complying with this Direction is necessary in connection with the provision of health services in England.

This Direction is to be known as the Direction for the NHS Health Check for adults aged 40 – 74 years data extraction, and comes into force on [insert date].

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

- Collect data (see Annex A for the list of data items to be collected) from General Practices in England about the following four cohorts of patients:
    1. Those who were invited to an NHS Health Check only.
    2. Those who either commenced, completed (by a GP or third party), did not attend or declined a NHS Health Check.

[1] 2012 c.7

[2] S.I. 2013/259

3. Those who are recorded as inappropriate for an NHS Health Check and who have not commenced, completed (by a GP or third party), did not attend or declined a NHS Health Check
4. Those with the four appropriate risk factors recorded within a six month period when they are continuously eligible for an NHS Health Check.

- Link the data collected from General Practices with relevant clinical datasets held by NHS Digital, including but not limited to the national audit collection and Hospital Episode Statistics (HES).
- Disseminate data collected under this direction in an anonymised form with Public Health England.

Please accept this letter as a direction given under subsection (1) of section 254 of the 2012 Act to NHS Digital to establish and operate a system for the collection and analysis of information about NHS Health Checks for adults aged 40 – 74 years.

NHS Digital will have regard to and comply with the Directions to NHS Digital to process Type 2 objections.

In accordance with section 254(5) the NHS Digital has been consulted before this Direction has been given.

Yours sincerely

Director name

Director title

..Ends

NHS Digital

Direction for NHS Health Check for adults aged 40 – 74 years: Annex A

List of data items included in the extraction

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List of data items included in the NHS Health Check for adults aged 40 – 74 years data extraction

The extract will include patients aged 18 years or over and there will be four patient cohorts in total:

- **Cohort 1:** patients invited to an NHS Health Check only
- **Cohort 2:** patients who either commenced, completed (by a GP or third party), did not attend or declined a NHS Health Check
- **Cohort 3:** patients who are recorded as inappropriate for an NHS Health Check and who have not commenced, completed (by a GP or third party), did not attend or declined a NHS Health Check
- **Cohort 4:** patients with the four appropriate risk factors recorded within a six month period when they are continuously eligible for an NHS Health Check

A patient will be included in the appropriate cohort due to the Read code(s) that are recorded in their medical record. This means that cohort 2 will be able to be broken down as required (for example: only looking at patients who have completed an NHS Health Check).

The table below lists the data items that will be extracted for patients who are captured in any of the four cohorts listed above. For every data item taken from the Journals Table, the following fields will be returned (where applicable):

- Date
- Code
- Value Condition 1
- Value Condition 2
- Value Prescription 1
- Value Prescription 2
- HCP - Professional Group of the Health Care Professional

Item number	Table name	Data item	Description
1	Patients Table	ACTIVE_STATUS	Patient's active status at the point of QESD.
2	Patients Table	PatientTable.Date of Birth	Patient's date of birth.
3	Patients Table	PatientTable.NHS Number	Patient's NHS number.
4	Patients Table	PatientTable.Postcode	Postcode of patient's CURRENT address only.
5	Patients Table	PatientTable.Practice	The NACS practice code of the GP practice where the patient is registered or deceased at the point where they are present in the cohort.
6	Patients Table	REG_DAT	The date the patient registered with the practice.
7	Patients Table	DECD_DAT	Patient's date of death.
8	Patients Table	PatientTable.Gender	Patient's gender.
9	Patients Table	PatientTable.Ethnicity	Ethnicity of the patient.
10	Patients Table	PatientTable.First Language	First language of the patient.
11	Journals Table	ETHNICITY_DAT	The most recently recorded ethnicity up to the achievement date.
12	Journals Table	LANGUAGE_DAT	The most recently recorded first language up to the achievement date.
13	Journals Table	{NHSHCINVITE_DAT}	All dates of NHS health check invitations leading up to the achievement date.
14	Journals Table	{NHSHCEVENT_DAT}	All dates of NHS health check events (completed, commenced, declined or not attended) leading up to the achievement date.
15	Journals Table	{NHSHCINAPP_DAT}	All instances (dates) of the patient being identified as inappropriate for a NHS health check leading up to the achievement date.
16	Journals Table	CARERLAT_DAT	The most recent carer status recorded before the first NHS health check activity.
17	Journals Table	{CARER_DAT}	ALL carer statuses recorded between the first and last records of NHS health check activity.
18	Journals Table	{ASMOK_DAT}	All smoking statuses recorded from 2 years before the first NHS health check activity, up to the achievement date.
19	Journals Table	{ABP_DAT}	All recorded blood pressures from 2 years before the first NHS health check activity, up to the achievement date.
20	Journals Table	{BPEX_DAT}	All blood pressure exceptions from 2 years before the first NHS health check activity, up to the achievement date.
21	Journals Table	{WEIGHT_DAT}	All recorded weights of the patient and the associated date from 2 years before the first NHS health check activity, up to the achievement date.

Item number	Table name	Data item	Description
22	Journals Table	{HEIGHT_DAT}	All recorded heights of the patient and the associated date from 2 years before the first NHS health check activity, up to the achievement date.
23	Journals Table	{ABMI_DAT}	All recorded BMIs of the patient and the associated date from 2 years before the first NHS health check activity, up to the achievement date.
24	Journals Table	{WAIST_DAT}	All recorded waist circumferences of the patient and the associated date from 2 years before the first NHS health check activity, up to the achievement date.
25	Journals Table	{GPPAQ_DAT}	All coded GPPAQ results from 2 years before the first NHS health check activity, up to the achievement date.
26	Journals Table	{GPPAQEXC_DAT}	All declined GPPAQ activity from 2 years before the first NHS health check activity, up to the achievement date.
27	Journals Table	{FAST_DAT}	All FAST alcohol screening tests delivered from two years before the first NHS health check activity up to the achievement date.
28	Journals Table	{AUDITC_DAT}	All AUDIT-C alcohol questionnaires delivered from two years before the first NHS health check activity up to the achievement date.
29	Journals Table	{AUDIT_DAT}	All AUDIT alcohol questionnaires delivered from two years before the first NHS health check activity up to the achievement date.
30	Journals Table	{ALCSCRNDEC_DAT}	All FAST alcohol screening, AUDIT-C alcohol questionnaire or AUDIT questionnaire declined or unsuitable from two years before the first NHS health check activity up to the achievement date.
31	Journals Table	{HISTCVD_DAT}	All codes indicating a family history of CVD anywhere in the patient's record leading up to the achievement date.
32	Journals Table	{STAT_DAT}	All statin prescriptions from two years before the first NHS health check activity up to one year after the last NHS health check activity.
33	Journals Table	{XSTAT_DAT}	All statin contraindications from two years before the first NHS health check activity up to one year after the last NHS health check activity.
34	Journals Table	{STATDEC_DAT}	All statin declined codes from two years before the first NHS health check activity up to one year after the last NHS health check activity.
35	Journals Table	{ANTIHYP_DAT}	All anti-hypertensive medication prescribed two years before the first NHS health check activity up to one year after the last NHS health check activity.
36	Journals Table	{ANTICOAG_DAT}	All oral anticoagulant drugs prescribed two years before the first NHS health check activity up to one year after the last NHS health check activity.
37	Journals Table	{XANTICOAG_DAT}	All persisting oral anticoagulant contraindications from two years before the first NHS health check

Item number	Table name	Data item	Description
			activity up to one year after the last NHS health check activity.
38	Journals Table	{TXANTICOAG_DAT}	All expiring oral anticoagulant contraindications from two years before the first NHS health check activity up to one year after the last NHS health check activity.
39	Journals Table	{DIABDRUG_DAT}	All records of diabetes related medication being prescribed from two years before the first NHS health check activity up to one year after the last NHS health check activity.
40	Journals Table	{PALCARE_DAT}	All records of palliative care from one year before the first NHS health check activity and up to their most recent NHS health check activity.
41	Journals Table	{PALCARENI_DAT}	All palliative care no longer indicated codes from one year before the first NHS health check activity and up to their most recent NHS health check activity.
42	Journals Table	{PULRHYTH_DAT}	All recorded pulse rhythms of the patient from two years before the first NHS health check activity up to the achievement date.
43	Journals Table	{CVDRISK_DAT}	All records that a CVD assessment was undertaken from two years before the first NHS health check activity up to the achievement date.
44	Journals Table	{CVDRISKEXC_DAT}	All records that a CVD assessment was unsuitable or declined from two years before the first NHS health check activity up to the achievement date.
45	Journals Table	DIETADVLAT_DAT	The most recent advice, signposting, information or brief intervention on diet provided to the patient prior to the first NHS health check activity.
46	Journals Table	{DIETADV_DAT}	All records that advice, signposting, information or brief intervention regarding diet was provided to the patient from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
47	Journals Table	PHYSADVLAT_DAT	The most recent advice, signposting, information and any brief intervention given regarding physical activity provided to the patient before their first NHS health check related activity.
48	Journals Table	{PHYSADV_DAT}	All records of advice, signposting, information and any brief intervention given regarding physical activity provided to the patient from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
49	Journals Table	WTADVLAT_DAT	The most recent advice, signposting, information or brief intervention given regarding weight management provided to the patient before their first NHS health check related activity.
50	Journals Table	{WTADV_DAT}	All records of advice, signposting, information or brief intervention given regarding weight management provided to the patient from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
51	Journals Table	SMOKADVLAT_DAT	The most recent a advice, signposting, information or brief intervention given regarding smoking or

Item number	Table name	Data item	Description
			smoking cessation provided to the patient before their first NHS health check related activity.
52	Journals Table	{SMOKADV_DAT}	All records of advice, signposting, information or brief intervention given regarding smoking or smoking cessation provided to the patient from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
53	Journals Table	ALCADVLAT_DAT	The most recent information, advice, signposting or brief intervention given regarding alcohol usage provided to the patient before their first NHS health check related activity.
54	Journals Table	{ALCADV_DAT}	All records of information, advice, signposting or brief intervention given regarding alcohol usage provided to the patient from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
55	Journals Table	DEMINFOLAT_DAT	The most recent dementia awareness information provided to the patient before their first NHS health check related activity.
56	Journals Table	{DEMINFO_DAT}	All records of dementia awareness information provided to the patient from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
57	Journals Table	LIFESTYLLAT_DAT	The most recent advice, signposting, information or brief intervention on lifestyle provided to the patient before their first NHS health check activity.
58	Journals Table	{LIFESTYL_DAT}	All records of advice, signposting, information or brief intervention on lifestyle provided to the patient from the date of their first NHS health check activity up to one year after their last record of NHS health check related activity.
59	Journals Table	DIETREFLAT_DAT	The most recent referral regarding diet before their first NHS health check activity.
60	Journals Table	{DIETREF_DAT}	All records of referral regarding diet from the date of the first NHS health check related activity up to one year after the last record of NHS health check related activity.
61	Journals Table	DIETREFDECLAT_DAT	The most recent record of the patient declining a referral regarding their diet before their first NHS health check activity.
62	Journals Table	{DIETREFDEC_DAT}	All records of the patient declining a referral regarding their diet from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
63	Journals Table	PHYSREFLAT_DAT	The most recent referral regarding physical activity before the first NHS health check activity.
64	Journals Table	{PHYSREF_DAT}	All records of referral regarding physical activity from the date of the first NHS health check related activity up to one year after the last record of NHS health check related activity.
65	Journals Table	PHYSREFDECLAT_DAT	The most recent record of the patient declining a referral regarding their physical activity before their first NHS health check activity.
66	Journals Table	{PHYSREFDEC_DAT}	All records of the patient declining a referral regarding their physical activity from the date of their first

Item number	Table name	Data item	Description
			NHS health check related activity up to one year after their last record of NHS health check related activity.
67	Journals Table	WTMGMTLAT_DAT	The most recent referral regarding weight management before the first NHS health check activity.
68	Journals Table	{WTMGMT_DAT}	All records of referral regarding weight management from the date of the first NHS health check related activity up to one year after the last record of NHS health check related activity.
69	Journals Table	WTMGMTDECLAT_DAT	The most recent record of the patient declining a referral regarding their weight management before their first NHS health check activity.
70	Journals Table	{WTMGMTDEC_DAT}	All records of the patient declining a referral regarding their weight management from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
71	Journals Table	SMOKREFLAT_DAT	The most recent referral regarding smoking habits before the first NHS health check activity.
72	Journals Table	{SMOKREF_DAT}	All records of referral regarding smoking habits from the date of the first NHS health check related activity up to one year after the last record of NHS health check related activity.
73	Journals Table	SMOKREFDECLAT_DAT	The most recent record of the patient declining a referral regarding their smoking habits before their first NHS health check activity.
74	Journals Table	{SMOKREFDEC_DAT}	All records of the patient declining a referral regarding their smoking habits from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
75	Journals Table	ALCREFLAT_DAT	The most recent referral regarding alcohol usage before the first NHS health check activity.
76	Journals Table	{ALCREF_DAT}	All records of referral regarding alcohol usage from the date of the first NHS health check related activity up to one year after the last record of NHS health check related activity.
77	Journals Table	ALCREFDECLAT_DAT	The most recent record of the patient declining a referral regarding their alcohol usage before their first NHS health check activity.
78	Journals Table	{ALCREFDEC_DAT}	All records of the patient declining a referral regarding their alcohol usage from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
79	Journals Table	LIFECNSLREFLAT_DAT	The most recent referral for lifestyle counselling before the first NHS health check activity.
80	Journals Table	{LIFECNSLREF_DAT}	All records of referral for lifestyle counselling from the date of the first NHS health check related activity up to one year after the last record of NHS health check related activity.
81	Journals Table	DPPREFLAT_DAT	The most recent referral to a diabetes prevention programme before the first NHS health check activity.

Item number	Table name	Data item	Description
82	Journals Table	{DPPREF_DAT}	All records of referral to a diabetes prevention programme from the date of the first NHS health check related activity up to one year after the last record of NHS health check related activity.
83	Journals Table	DPPDECLAT_DAT	The most recent record of the patient declining a referral to a diabetes prevention programme before the first NHS health check activity.
84	Journals Table	{DPPDEC_DAT}	All records of the patient declining a referral to a diabetes prevention programme from the date of the first NHS health check related activity up to one year after the last record of NHS health check related activity.
85	Journals Table	DPPACPTLAT_DAT	The most recent record that the patient has started, completed or not completed the diabetes prevention programme before the first NHS health check activity.
86	Journals Table	{DPPACPT_DAT}	All records that the patient has started, completed or not completed the diabetes prevention programme from the date of the first NHS health check related activity up to one year after the last record of NHS health check related activity.
87	Journals Table	DMASSREFLAT_DAT	The most recent record that the patient has been referred for an assessment of their diabetes before their first NHS health check activity.
88	Journals Table	{DMASSREF_DAT}	All records that the patient has been referred for an assessment of diabetes from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
89	Journals Table	IGTIFGREFLAT_DAT	The most recent record of referral for the assessment of IGT and/or IFG before the first NHS health check activity.
90	Journals Table	{IGTIFGREF_DAT}	All records that a patient has been referred for assessment of IGT and/or IFG from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
91	Journals Table	ECGREFLAT_DAT	The most recent record of referral for ECG before the first NHS health check activity.
92	Journals Table	{ECGREF_DAT}	All records that the patient has been referred for ECG from the date of their first NHS health check related activity up to one year after their last record of NHS health check related activity.
93	Journals Table	CVDRISKRVWLAT_DAT	The most recent CVD high risk review code before the first NHS health check activity.
94	Journals Table	{CVDRISKRVW_DAT}	All CVD high risk reviews from the date of the first NHS health check related activity up to one year after the last record of NHS health check related activity.
95	Journals Table	CVDRISKRVWDECLAT_DAT	The most recent record of the patient declining or being unsuitable for a CVD high risk review before their first NHS health check activity.
96	Journals Table	{CVDRISKRVWDEC_DAT}	All records of the patient declining or being unsuitable for a CVD high risk review from the date of

Item number	Table name	Data item	Description
			their first NHS health check related activity up to one year after their last record of NHS health check related activity.
97	Journals Table	{CHOLTEST_DAT}	All cholesterol recordings from 2 years before the first NHS health check related activity up to the achievement date.
98	Journals Table	{CHOLEXC_DAT}	All records of the patient declining a cholesterol test from 2 years before the first NHS health check related activity up to the achievement date.
99	Journals Table	{HDLTEST_DAT}	All HDL cholesterol tests from 2 years before the first NHS health check related activity up to the achievement date.
100	Journals Table	{CHEXC_DAT}	All records of the patient being unsuitable for a cholesterol test (with a persisting exception) from 2 years before the first NHS health check related activity up to the achievement date.
101	Journals Table	{TCHEXC_DAT}	All records of the patient being unsuitable for a cholesterol test (with an expiring exception) from 2 years before the first NHS health check related activity up to the achievement date.
102	Journals Table	{FASPLASGLUC_DAT}	All fasting plasma glucose tests from 2 years before the first NHS health check related activity up to the achievement date.
103	Journals Table	{IMGLUCTOLT_DAT}	All impaired glucose tolerance tests from 2 years before the first NHS health check related activity up to the achievement date.
104	Journals Table	{HBA1C_DAT}	All HbA1c tests from 2 years before the first NHS health check related activity up to the achievement date.
105	Journals Table	{FRUCTEST_DAT}	All fructosamine tests from 2 years before the first NHS health check related activity up to the achievement date.
106	Journals Table	{GLUCTESTEXC_DAT}	All records of the patient declining blood glucose tests from 2 years before the first NHS health check related activity up to the achievement date.
107	Journals Table	{EGFR_DAT}	All eGFR tests from 2 years before the first NHS health check related activity up to the achievement date.
108	Journals Table	{ACR_DAT}	All ACR tests from 2 years before the first NHS health check related activity up to the achievement date.
109	Journals Table	{DMASS_DAT}	All assessments for diabetes from 2 years before the first NHS health check related activity up to the achievement date.
110	Journals Table	{CHD_DAT}	All CHD diagnoses anywhere in the patient's record leading up to the achievement date.
111	Journals Table	{DEM_DAT}	All diagnoses of dementia leading up to the achievement date.

Item number	Table name	Data item	Description
112	Journals Table	{CKD_DAT}	All CKD stage 3-5 diagnoses anywhere in the patient's record leading up to the achievement date.
113	Journals Table	{CKD1AND2_DAT}	All CKD stage 1-2 diagnoses anywhere in the patient's record leading up to the achievement date.
114	Journals Table	{CKRES_DAT}	All CKD resolved codes anywhere in the patient's record leading up to the achievement date.
115	Journals Table	{DM_DAT}	All diabetes (type I or type II) diagnoses anywhere in the patient's record leading up to the achievement date.
116	Journals Table	{DMRES_DAT}	All diabetes resolved codes anywhere in the patient's record leading up to the achievement date.
117	Journals Table	{STRK_DAT}	All stroke diagnoses anywhere in the patient's record leading up to the achievement date.
118	Journals Table	{TIA_DAT}	All TIA diagnoses anywhere in the patient's record leading up to the achievement date.
119	Journals Table	{AFIB_DAT}	All atrial fibrillation diagnoses anywhere in the patient's record leading up to the achievement date.
120	Journals Table	{AFIBRES_DAT}	All atrial fibrillation resolved codes anywhere in the patient's record leading up to the achievement date.
121	Journals Table	{RARTH_DAT}	All diagnoses of rheumatoid arthritis leading up to the achievement date.
122	Journals Table	{IMPGLUCREG_DAT}	All diagnoses of impaired glucose regulation leading up to the achievement date.
123	Journals Table	{IMGLUCTOLDIAG_DAT}	All diagnoses of impaired glucose tolerance leading up to the achievement date.
124	Journals Table	{IMFASTGLY_DAT}	All diagnoses of impaired fasting glycaemia leading up to the achievement date.
125	Journals Table	{HF_DAT}	All heart failure diagnoses anywhere in the patient's record leading up to the achievement date.
126	Journals Table	{HYP_DAT}	All hypertension diagnoses anywhere in the patient's record leading up to the achievement date.
127	Journals Table	{HYPRES_DAT}	All hypertension resolved codes anywhere in the patient's record leading up to the achievement date.
128	Journals Table	{FNFHYP_DAT}	All diagnoses of familial and non-familial hypercholesterolemia leading up to the achievement date.
129	Journals Table	{PAD_DAT}	All PAD diagnoses anywhere in the patient's record leading up to the achievement date.
130	Journals Table	{NDHYP_DAT}	All non-diabetic hyperglycaemia diagnoses leading up to the achievement date.
131	Journals Table	{LD_DAT}	The earliest learning disability diagnoses from the date of their first NHS health check related activity up to one month (31 days) after their last record of NHS health check related activity.
132	Journals Table	{SERIOUSMH_DAT}	All diagnoses of serious mental illness up to one month (31 days) after their latest record of NHS health check activity.
133	Journals Table	{BLIND_DAT}	The earliest registered blind diagnoses up to one month (31 days) after their last record of NHS health check related activity.

Item number	Table name	Data item	Description
134	Journals Table	{SEVDEAF_DAT}	The earliest severely deaf diagnoses up to one month (31 days) after their last record of NHS health check related activity.
135	Journals Table	{SXOTRANS_DAT}	All sexual orientation or transgender statuses.
136	Journals Table	{ALC_DAT}	All records of the patient's alcohol usage from 2 years before the first NHS health check related activity up to the achievement date.
137	Journals Table	EMPLOYMENTLAT_DAT	The most recent employment status before the first NHS health check related activity.
138	Journals Table	{EMPLOYMENT_DAT}	All records regarding the patient’s employment status from the date of their first NHS health check related activity up to one month (31 days) after their last record of NHS health check related activity.
139	Journals Table	INTERPRETLAT_DAT	The most recent code regarding whether an interpreter is needed before the first NHS health check related activity.
140	Journals Table	{INTERPRETER_DAT}	All records regarding whether an interpreter is needed from the date of the first NHS health check related activity up to one month (31 days) after the last record of NHS health check related activity.
141	Journals Table	BIRTHCNTRY_DAT	The most recently recorded country of birth up to the achievement date.

Board Meeting – Public Session

Title of paper:	Direction from Department of Health for Emergency Care Data Set pilot
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 05 d iv
Paper presented by:	Prof. David Hughes (Executive Director of Information and Analytics at NHS Digital)
Paper prepared by:	Jackie Shears, Director of New Collections
Paper approved by: (Sponsor Director)	Professor David Hughes, Director of Information and Analytics
Purpose of the paper:	For the board to review and accept the direction from the Department of Health to collect data from the Emergency Care Data Set pilot
Additional Documents and or Supporting Information:	None
Please specify the key risks and issues:	There are no anticipated risks associated with doing this work appropriately and within the legal and governance frameworks within NHS Digital. There are potential risks associated with delay: • If the Direction is not accepted NHS Digital cannot legally collect data from the ECDS pilot; • Key project deliverables will not be met, causing damage to the reputation of NHS Digital amongst key stakeholders; • SCCI will not be able to issue the Information Standard Notice (ISN) and collection of A&E data will continue under CDS 010.
Patient/public interest:	Indirect
Supplementary papers:	ECDS Direction
Actions required by the Board:	The Board are asked to review and accept The Direction, to enable the collection of the pilot data

Direction from Department of Health for Emergency Care Data Set pilot

30 November 2016

Information and technology
for better health and care

Contents

Executive Summary

Section 254 of The Health and Social Care Act (2012) provides for

"(1) The Secretary of State or the Board may direct the Information Centre to establish and operate a system for the collection or analysis of information of a description specified in the direction."

And,

"(6) A function conferred by a direction given by the Secretary of State or the Board under subsection (1) is subject to directions given by the Secretary of State or (as the case may be) the Board about the Information Centre's exercise of the function."

The accompanying draft Direction is set to be received from the Department of Health as part of the Emergency Care Data Set impact assessment work commissioned by the Department of Health. The work is assessing the impact of implementing the new Emergency Care Data Set (ECDS). The new dataset is intended to facilitate better and timelier access to data on Emergency Department activity.

The **Direction covers only the transmission of ECDS pilot data to NHS Digital**, to facilitate analysis for the production and assurance of the associated information standard.

The board is asked to consider the draft Direction and to accept it.

A further Direction for the live flow of the data set will be required if full implementation of the ECDS goes ahead.

Background

Commissioning Data Set (CDS) type 010 was developed in the late 1970s. At that time the work of A&E was largely minor injuries and occasional major trauma and CDS Type 010 was appropriate for measuring this work at that time. In the last 40 years there has been a rapid and sustained increase in volume, scope and complexity Emergency Care. The main factors driving the change in provision and delivery of Emergency Care include:

- The changing health needs of the population such as an ageing population and multiple comorbidities;
- Changes in access to alternative healthcare services;
- Changes in the way that the population choses to access services and their expectations of the care that they receive.

CDS 010 has not evolved to keep pace with these changes and this has resulted in an 'information gap' in the data collected from A&E.

NHS Digital was commissioned to carry out a work package to assess the impact of implementing the proposed new Emergency Care Data Set (ECDS) by the ECDS project board, chaired by Professor Jonathan Benger, National Director of Urgent and Emergency Care, NHS England. This work package included limited piloting activity as part of the impact assessment.

The ECDS work package has, to date:

- facilitated the widespread agreement of the data set changes required, defining the data items to be collected in partnership with the Royal College of Emergency Medicine (RCEM) and other bodies;
- proposed updating the currently mandated Accident and Emergency data flow within CDS 010;

- assessed the impact of these changes on clinicians and trusts, NHS Digital (central processing) and with internal and external consumers of A&E data;
- conducted a live pilot of the data items being captured in a major acute (Leeds Teaching Hospitals NHS Trust) to ensure appropriateness in the context of patient consultations in a busy emergency department.

The full impact assessment report has been completed and accepted by the ECDS Project Board as part of the work package.

The piloting has not yet included transmission of that data to NHS Digital. This will form part of the next stage of the ECDS work package under the Direction attached.

A meeting with key stakeholders chaired by DH (David Williams) on 21st October 2016 confirmed support for the implementation of ECDS and has asked that NHS Digital prepare an Investment Justification aligned with Paperless 2020 Domain H. This approach has the support of NHS Digital Information and Analytics senior management and Domain H SRO – Tim Donohoe.

A further Direction for the live flow of the data set will be required if full implementation of the ECDS goes ahead.

Recommendation

It is the recommendation of the project team and EMT that The Board accept The Direction. The Direction requires NHS Digital to proceed to the next stage of the process and carry out formal piloting of the data flow into NHS Digital, with two data collections from the pilot trust which will be collected and anonymised in line with ICO code of practice. The Direction paperwork has been reviewed and approved by Catherine Nicholson (IG, NHS Digital) and Sean Kirwan (DH).

Implications

Strategy Implications

The ECDS aligns with Paperless 2020 domain H: 'Data Outcomes for Research and Oversight' and also the work of the Urgent and Emergency Care Review within NHS England. The SRO for Domain H has indicated this is a priority workstream, and this view is shared by the NHS England CCIO, and DH Urgent and Emergency Care Policy Lead.

Unplanned care is one of the top priorities for the health and care system. The scope of unplanned care includes all unplanned care across the NHS including Ambulance, NHS111 and type 1,2,3,4 emergency care settings. The piloting of the ECDS and the changes to the data set for emergency care will inform a key part of this work.

Financial Implications

The ECDS project has approved funding of £537,000 from the Department of Health for the impact assessment work - which includes flowing and analysing the pilot data to NHS Digital. The impact assessment work is tracking to budget and no additional costs (overspend) are anticipated.

Further funding will be sought due to the request to accelerate the implementation phase of the project – it is proposed to seek funding aligned with Paperless 2020 – Strategic Data Content (Domain H). An Investment Justification is being prepared with approval anticipated by December 2016.

Stakeholder Implications

Key stakeholders include NHS England, the Department of Health and the Royal College of Emergency Medicine as initiators of the project. NHS Digital is acting in the capacity of a delivery partner.

There is strong support for the new data set from Emergency Care clinicians across the service, and care has been taken to ensure good engagement at trust level. The Royal College of Emergency Medicine has played a major part in this.

If the Direction is delayed then there will be an impact on the ECDS project's key deliverables, including subsequent work and the ability to issue a new SCCI standard.

Handling

The potential changes to CDS 010 are being communicated through stakeholder engagement by the Royal College of Emergency Medicine, NHS Digital and SCCI. Previous versions of the ECDS have been widely consulted on, and the RCEM are proactively engaging with internal and external parties that may be affected by this change. There is no anticipated media or public engagement beyond normal legal obligations.

Risks and Issues

There are no anticipated risks associated with doing this work appropriately and within the legal and governance frameworks within NHS Digital. There are potential risks associated with delay:

- If the Direction is not accepted NHS Digital cannot legally collect data from the ECDS pilot;
- Key project deliverables will not be met, causing damage to the reputation of NHS Digital amongst key stakeholders;
- SCCI will not be able to issue the Information Standard Notice (ISN) and collection of A&E data will continue under CDS 010.

Corporate Governance and Compliance

This proposal carries no new or additional corporate governance implications. Existing compliance and corporate governance policies, processes and procedures will be followed at all times. The collections related to this Direction are small, one-off and not too dissimilar to the current A&E data collection (CDS010). Therefore the board will be informed via its secretariat once the collections have been successfully carried out.

Management Responsibility

Peter Sherratt is the Programme Manager with day to day responsibility for the ECDS work package. Jago Taylor is the Programme Head responsible for ECDS with Jackie Shears providing director level oversight. David Hughes is the EMT Director with accountability for this work.

Actions Required of the Board

The Board are asked to review and accept The Direction, to enable the collection of the pilot data.

Department of Health

Andy Williams
Chief Executive,
NHS Digital
1 Trevelyan Square, Boar Lane
Leeds
LS1 6AE

[#] November 2016

Dear Andy

I am writing to provide a Direction to NHS Digital, formerly known as the Health and Social Care Information Centre (HSCIC) and hereafter referred to as NHS Digital, to establish and operate an informatics system for the collection of emergency care 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 (the Act)[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].

In accordance with section 254(2)(b) of the Act, the Secretary of State considers that it is in the interests of the health service in England for this Direction to be given.

This Direction is to be known as the Emergency Care Dataset (Pilot) Direction, and comes into force on [insert date]. The Direction will cover two collections of data from the type 1 Emergency Departments at The Leeds Teaching Hospitals NHS Trust to support the pilot delivery phase of a proposed new data set for emergency care.

A type 1 Emergency Department is defined in the NHS Data Dictionary as being a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

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

- Collect data relating to Leeds Teaching Hospitals NHS Trust emergency department attendances during the pilot period. The collection includes demographic information, episode demographic information, clinical information such as diagnosis, information relating to attendances which are a direct result of injury and also discharge information. (See Annex 1 for full list of data items to be collected.)

There will be two data collections for the pilot:

- A first data collection for the pilot, which will relate to all emergency department attendances between 26th July and 31st October 2016.

[1] 2012 c.7

[2] S.I. 2013/259

- A second data collection for the pilot, which will relate to all emergency department attendances between 1st November 2016 and 31st January 2017. This collection is required for the purposes of further pilot analysis for the winter 2016/17 period.

Please accept this letter as a direction given under subsection (1) of section 254 of the 2012 Act to the NHS Digital to exercise the functions in relation to the informatics system for the collection of data from the Leeds Teaching Hospitals NHS Trust type 1 Emergency Departments to support the delivery of a pilot of a proposed new data set for emergency care. The purpose of the data collection is to demonstrate that new proposed dataset will not negatively impact on the purposes reliant on the current Commissioning Dataset for emergency care and to produce aggregate statistics to demonstrate the benefits of the new data items. These aggregate statistics may be shared outside of the NHS Digital, as part of project documentation including reports and briefings and to support the development of a new information standard.

NHS Digital will have regard to and comply with the Directions to NHS Digital to process Type 2 objections.

In accordance with section 254(5) of the Act, NHS Digital has been consulted before this Direction has been given.

Yours sincerely

Director name

Director title

..Ends

Annex 1

ECDS Pilot - Data Items to be Collected

ECDS Field Name

Person_Stated_Gender

Person_Age_At_Attendance

Person_NHS_Number_Status_Indicator

Person_Usual_Address_Postcode

Person_Residence_Org_Code

Person_Usual_Residence_Type

Person_GP_Practice_Code

Person_Comm_Lang

Person_Interpreter_Rqd

Person_Interpreter_Lang

Person_Ethnic_Category

Person_Visitor_Status

Commissioner_Unique_ID

Commissioner_Service_Line_ID

Commissioner_Provider_Ref_Number

Commissioner_Ref_Number

Commissioner_Org_Code

Provider_Org_Code

Provider_Org_Code_LocPatID

Provider_Site_Code

Provider_Site_Type

EmCare_Arrive_Transport_Mode

EmCare_Ambulance_ Org_Code

EmCare_Ambulance_ Incident_Number

EmCare_Arrive_DateTime

EmCare_Attendance_Type

EmCare_Referral_Source

EmCare_Arrive_Transfer_Source

EmCare_Assess_DateTime

EmCare_Clinicians_Type

EmCare_Clinicians_Tier

EmCare_Clinicians_Date/TimeStamp

EmCare_Clinicians_Discharge

EmCare_Referred_Service

EmCare_Referred_Service_DateTime

EmCare_DTA_DateTime

EmCare_Complete_DateTime

EmCare_Depart_DateTime

EmCare_Admit_Specialty

EmCare_Assessment_Type

EmCare_Assessment_Score

EmCare_ChiefComplaint

EmCare_Clinical_Narrative

EmCare_Diagnosis_Number

EmCare_Diagnosis

EmCare_Diagnosis_Moderator

EmCare_Investigations

EmCare_Investigations_Time/Date

EmCare_Treatments

EmCare_Treatments_Time/Date

EmCare_Inj_DateTime

EmCare_Inj_Intent

EmCare_Inj_Place_Type

EmCare_Inj_Activity_Status

EmCare_Inj_Activity_Type

EmCare_Inj_Mechanism

EmCare_Inj_Drug_Alcohol

EmCare_Discharge_Status

EmCare_Discharge_FollowUp

EmCare_Discharge_Information_Given

EmCare_Discharge_Safeguarding

EmCare_Transfer_Destination

Board Meeting – Public Session

Title of paper:	**Board Terms of Reference 2016-17**
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 05 f
Paper presented by:	Chair
Paper prepared by:	Annabelle McGuire Secretary to the Board and Head of Corporate Governance
Paper approved by: (Sponsor Director)	Carl Vincent Director of Finance and Corporate Services
Purpose of the paper:	Minor, non-material revisions made to the Board's Terms of Reference at the request of the Chair
Additional Documents and or Supporting Information:	None
Please specify the key risks and issues:	There are no risks and issues associated with the minor revisions
Patient/public interest:	Organisational adherence to corporate governance standards and best practice
Supplementary papers:	None
Actions required by the Board:	**For Board approval**

NHS Digital Board Terms of Reference and Code of Conduct

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 (appendix 7.1.1).
- 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 (appendix 7.1.2).

Further details including the conduct of meetings and the roles and responsibilities of the Chair, Vice-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

At the Chair's discretion Statutory Board meetings may be attended by other members of the Executive Management Team (appendix 7.1.4) in addition to Board members. They will not have voting rights. All Executive Director's will be invited to attend the Board Development Days.

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 statutory public meetings of the 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)'

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.

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 three working days before the meeting date. Queries about the public session can be raised by notifying the Secretary to the Board (execofficeteam@nhs.net) 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.

6 Frequency

The Board will meet in public at least six times a year.

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
- Dr Sarah Blackburn
- Sir John Chisholm
- Professor Maria Goddard

7.1.2 The Executive Members of the Board:

- CEO
- Director of Workforce
- Director of Digital Transformation
- Chief Operating Officer
- Director of Finance and Corporate Services

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

Board Meeting – Public Session

Title of paper:	**NHS Digital Board Forward Business Schedule**
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 05 g
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	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	Corporate Governance Manual 2017/18 Directions: NHS Health Checks DH Directions: Emergency Care Dataset DH Directions: Troubled Families Mandatory Request: QOF Pilot 11' DH Direction: Community Services Data Set	Scheme of Delegated Financial Authorities 2016-17 (update) Arrangements for the Annual Review of Board Effectiveness 2016-17 DH Direction: Troubled Families Direction: Sexual Reproductive Health Attendance Data Stop Smoking Services Collection – DH Direction	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 National Back Office Tracing Service Review * Mid-year review of Corporate Business Plan 2016-17	Board Performance Pack Staff Survey Results 2016-17 Data Release Audit Status Report Diversity and Inclusion Update * 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 - Final Paperless 2020: Finalised list of Programme SROs and Delivery Leads Business Strategy and Analysis Portfolio Proposal	Implementing the Capability Review The Digital Academy Implementation and Business Change Portfolio Proposal	Workforce Strategy Conclusions Innovation and Partnerships Portfolio Proposal
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 • 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 • Assurance and Risk Committee – 5 December 2016 • 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:	Breast and Cosmetic Implant Registry
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 07 a
Paper presented by:	Professor David Hughes Director of Information and Analytics
Paper prepared by:	Alyson Whitmarsh
Paper approved by: (Sponsor Director)	Professor David Hughes
Purpose of the paper:	The Department of Health (DH) is directing NHS Digital (formerly Health and Social Care Information Centre) to establish a Breast and Cosmetic Implant Registry (BCIR), under section 254 of the Health and Social Care Act 2012. The Board have previously accepted the Directions, but an issue related to the recall process was highlighted and needed to be resolved and addressed in the Directions before sign-off. During the development of the registry and the recall process, it was identified that where patients had undergone a procedure for a breast implant by a provider in the independent sector, that had subsequently ceased trading, a process and organisation had to be identified to contact those patients in the event of an implant failure and recall. Following discussions with the Department of Health and legal advice, it has been agreed that NHS Digital will contact these patients in writing and inform them that they should seek advice from an alternative provider. The wording of the letter is yet to be agreed between NHS Digital and DH. As a result of these discussions the Directions have been amended and upgraded to allow NHS Digital to undertake this task. This amendment does not raise any business or Information Governance objections. The registry will be populated with records where patient consent has been received. In accordance with the

	Directions to NHS Digital, a Type 2 objection will not apply as the patient has explicitly consented to that disclosure. As a result of this newly identified duty the financial arrangements are being confirmed.
Additional Documents and or Supporting Information:	Breast and Cosmetic Implant Registry Directions from Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/558997/Breast_and_Cosmetic_Implant_Registry.pdf
Please specify the key risks and issues:	Funding for the registry from Department of Health will finish 31/03/2017. Ongoing discussions and approaches to sustainable funding are being developed. The administrative role of the Clinical Audit and Registries Team in the recall process as part of the "Last resort process"
Patient/public interest:	The registry will improve the safety of care for patients and will provide a process to facilitate a recall in the event of product failure
In the event of a product recall	No supplementary papers
Actions required by the Board:	Presented for information as amendments to original directions have been made

Department of Health

Carolyn Heaney
Room 2N16
Quarry House,
LS2 7UB
Leeds

06 October 2016

Andy Williams
Chief Executive,
NHS Digital
1 Trevelyan Square, Boar Lane
Leeds LS1 6AE

Dear Andy

RE: Breast and Cosmetic Implant Registry

I am writing to direct the Health and Social Care Information Centre, now known as NHS Digital and thereafter referred to by this name, to establish and operate the Breast and Cosmetic Implant Registry (BCIR). This service will support the implementation of Recommendation 21 of the Keogh Review of the Regulation of Cosmetic Interventions

> *"A National Breast and Cosmetic Implant Registry should be established and operational within 12 months. All cosmetic surgery providers need to keep a minimum data set that should be defined by the RCS Inter-specialty Group. This should include details of the implant, the surgeon, the hospital and appropriate outcomes, and these data need to be held in electronic format until the registry is operational. These data should be easily accessible in the case of a product recall".*

The provision of the BCIR would also include the function of informing people who have an implant of any safety risks if the provider of their implant is no longer in business (known as "the Last Resort Purpose").

The priority is to develop and maintain a breast implant registry. However, the long term vision is to expand the registry to other types of implant, for example, buttock and calf implants.

The Health and Social Care Act 2012 makes provisions for Secretary of State to direct NHS Digital to exercise functions on the basis that Secretary of State considers it to be in the interests of the health service in England.

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

- host a Breast and Cosmetic Implant Registry to support the collection and storage of appropriately consented participant information;
- trace NHS numbers, where not available, and where possible to trace for those patients whose NHS number was not initially supplied to allow unique identification within the registry;
- track latest known patient address in the event of a product failure;
- monitor the outcomes achieved by 'brand' of prosthesis, hospital and surgeon, and highlight where these fall below an expected performance in order to allow prompt investigation and to support follow-up action.

NHS Digital will undertake the Last Resort Purpose to write to patients to inform them of a product failure in the event of their cosmetic surgery provider no longer being in business, to support the provision of health care, and promotion of health.

Please accept this letter as a direction given under subsection (1) of section 254 of the 2012 Act to NHS Digital to establish and operate the Breast and Cosmetic Implant Registry, details of which are set out in the attached schedule.

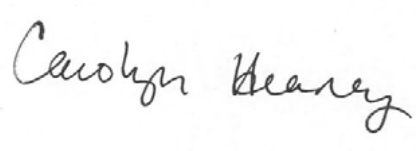
The Department of Health acknowledges that the Last Resort Purpose has been planned on the basis of, and is scoped for, those patients that have given their active consent as set out below, however nothing in this direction restricts the NHS Digital's power to process and disseminate information as set out in sections 261(1)(a)(b),(2)(c) and section 270 of the Act.

NHS Digital is directed to publish and disseminate data in line with its responsibilities under relevant legislation and guidance following consultation with DH.

The Breast and Cosmetic Implant Registry shall be established for England. NHS Digital should work with the devolved administrations to enable those administrations to request that NHS Digital collect data on their behalf.

Implementation
Data can be submitted to the Breast and Cosmetic Implant Registry for implants, including implants received prior to its launch date where patient consent is received and will follow a schema agreed between NHS Digital and the Department of Health. The initial dataset schema is attached in the schedule below.

Yours sincerely



Carolyn Heaney
Deputy Director, Portfolio Management
Public & International Health Directorate
..Ends

Schedule to Direction
Breast and Cosmetic Implant Registry

System Scope

1. The Service will enable NHS Digital to collect patient identifiable data with the appropriate patient consent on implant devices e.g. breast implants which have been inserted into the body for cosmetic or reconstructive surgery.

2. The data shall be securely stored and managed by NHS Digital acting as an agent for the Department of Health. No one outside NHS Digital will have access to the registry. The Breast and Cosmetic Implant Registry will track and trace patients where the Medicines and Healthcare Products Regulatory Agency considers the risk to be high and referral back to a surgeon advisable.

3. The priority is to develop and maintain a breast implant registry. However, the long term vision is to expand the registry to other types of implant, for example, buttock and calf implants.

4. NHS Digital will become the Data Controller for data that is submitted to the registry. The key NHS Digital deliverables are as follows;

    - Develop an appropriate dataset for the Breast and Cosmetic Implant Registry. This will include mapping to existing clinical terminologies and classifications as appropriate.
    - Data will be collected from:
        - Private cosmetic surgery clinics, providing breast augmentation services.
        - NHS Providers of reconstructive and plastic surgery.
    - Trace NHS numbers, where not available, and where possible to trace for those patients whose NHS number was not initially supplied to allow unique identification within the registry.
    - Track latest known patient address in the event of a product failure.
    - Monitor the outcomes achieved by ‘brand’ of prosthesis, hospital and surgeon, and highlight where these fall below an expected performance in order to allow prompt investigation and to support follow-up action.
    - Publish data in line with its responsibilities under the Statistics and Registration Services Act 2007 (SRSA) and relevant professional guidance including the UK Statistics Authority Code of Practice for Official Statistics. NHS Digital may also publish in other forms, manner and times that it considers appropriate following consultation with DH
    - Disseminate data in line with its responsibilities under relevant legislation and guidance following consultation with DH.
    - Write to patients to inform them of a product failure in the event of their cosmetic surgery provider no longer being in business. It is recognised that the provision of

a steering group will be essential to the approval of content of the letter(s) and thus a joint responsibility of the parties

The detailed schema detailing how the breast and cosmetic implant registry will work has been developed and agreed separately.

Board Meeting – Public Session

Title of paper:	Forthcoming Statistical Publications
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 03 07 b
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)	Prof. David Hughes Executive Director of Information and Analytics.
Purpose of the paper:	This paper describes NHS Digital Official (and National) Statistics publications published in October 2016 and planned for November – December 2016, and media and web coverage for publications released between August and October 2016.
Additional Documents and or Supporting Information:	N/A
Please specify the key risks and issues:	N/A
Patient/public interest:	Overview of NHS Digital Statistical Publications
Supplementary papers:	N/A
Actions required by the Board:	For information

NHS Digital Statistical Publications

Author Chris Roebuck

Published 30 November 2016

Information and technology
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Contents

Executive Summary

This paper describes:

- NHS Digital Official (and National) Statistics publications released during October 2016 and planned for November – December 2016;
- Media coverage for press released Official Statistics publications during August – October 2016;
- Web activity for publications released during August – October 2016.

Background

As at 01 November 2016, NHS Digital is responsible for 95 active (currently published or planned for future release) series of Official Statistics of which 32 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 launched a consultation on changes to them:

http://digital.nhs.uk/article/7041/Consultation-on-changes-to-HSCIC-Statistics-201617---201819-Now-Closed

It was a public consultation lasting 12 weeks, and covered NHS Digital statistical publications over the next three years. Any subsequent changes are expected to be implemented between 2016/17 and 2018/19. An initial response to the findings was published on the 30th of September 2016, and can be found here:

http://content.digital.nhs.uk/media/22446/Our-response-to-the-consultation/doc/our_response_to_the_consultation.docx

Forthcoming and recently released publications

Official and National statistics

October 2016

New releases: None in October 2016.

Biennial

19 October 2016	Dental Working Hours - 2014/15 and 2015/16 Additional Analysis

Annual

05 October 2016	Measures from the Adult Social Care Outcomes Framework, England - 2015-16
05 October 2016	Safeguarding Adults - 2015-16, Experimental statistics
05 October 2016	Community Care Statistics: Social Services Activity, England - 2015-16 Report
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	Sexual and Reproductive Health Services, England - 2015/16 [NS]
19 October 2016	Dental Earnings and Expenses - 2014/15 Additional Analysis
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 in October 2016.

Quarterly

18 October 2016	Numbers of Patients Registered at a GP Practice - October 2016
26 October 2016	Seven-day Services - England, April 2015 - March 2016, Experimental statistics
27 October 2016	Statistics on NHS Stop Smoking Services in England - April 2016 to June 2016

Monthly

06 October 2016	Maternity Services Monthly Statistics - May 2016, Experimental statistics
06 October 2016	HES-DID Data Linkage Report - Provisional Summary Statistics, April to 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 2016 to May 2016
13 October 2016	Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2015 to March 2016 - October 2016 Release
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 Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - August 2016
20 October 2016	Provisional Accident and Emergency Quality Indicators for England - July 2016, by provider
25 October 2016	Improving Access to Psychological Therapies Report - July 2016 Final, August 2016 Primary and Quarter 1 2016-17
25 October 2016	NHS Workforce Statistics - July 2016, Provisional Statistics
25 October 2016	NHS Sickness Absence Rates - April 2016 to June 2016
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

November 2016

New releases

None planned for November 2016

Biennial

None planned for November 2016

Annual

03 November 2016	National Child Measurement Programme, England - 2015/16 school year [NS]
09 November 2016	Hospital Maternity Activity - 2015-16
09 November 2016	Hospital Admitted Patient Care Activity - 2015-16 [NS]
15 November 2016	Cervical screening programme - 2015-16 [NS]
16 November 2016	General Pharmaceutical Services - 2006/7 - 2015/16 [NS]
22 November 2016	Prescribing Costs in Hospitals and the Community - England, 2015-16
30 November 2016	Mental Health Bulletin - 2015-16, Annual report
30 November 2016	Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to Supervised Community Treatment - 2015/16, Annual figures

Biannual

None planned for November 2016

Quarterly

10 November 2016	Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England - April 2016 to June 2016
10 November 2016	Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England - April 2015 to March 2016 - November 2016 Release
17 November 2016	NHS Outcomes Framework indicators - November 2016 release [NS]
24 November 2016	NHS Dental Statistics for England - Quarter 1, 2016-17

Monthly

02 November 2016	Children and Young People's Health Services Monthly Statistics - October 2015 to March 2016
02 November 2016	Maternity Services Monthly Statistics - June 2016, Experimental statistics

09 November 2016	NHS Safety Thermometer Report - England October2015 - October 2016
11 November 2016	Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - October 2016
15 November 2016	Care Information Choices, England - November, 2016
22 November 2016	Mental Health Services Monthly Statistics - Final August, Provisional September 2016
22 November 2016	Improving Access to Psychological Therapies Report - August 2016 Final, September 2016 Primary and most recent quarterly data (Quarter 1 2016-17)
23 November 2016	NHS Sickness Absence Rates - July 2016, Provisional Statistics
23 November 2016	NHS Workforce Statistics - August 2016, Provisional Statistics
25 November 2016	Provisional Accident and Emergency Quality Indicators for England - August 2016, by provider
25 November 2016	Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - September 2016
29 November 2016	Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), October 2016, Experimental Statistics
Other	None planned for November 2016

December 2016

New releases

02 December 2016	Out of Area Placements in Mental Health Services - October 2016
09 December 2016	Health and Care of People with Learning Disabilities - Experimental Statistics, 2014/15

Biennial

08 December 2016	Dental Working Hours - 2014/15 and 2015/16 Motivation Analysis: Experimental Statistics

Annual

01 December 2016	Hospital Outpatient Activity - 2015-16 [NS]
14 December 2016	Health Survey for England: Trend Tables - Health Survey for England: Trend tables 2015 [NS]
14 December 2016	Health Survey for England - Health Survey for England 2015 [NS]
Biannual	None planned for December 2016

Quarterly

02 December 2016	CCG Prescribing Data - July to September 2016
06 December 2016	Female Genital Mutilation - July-September 2016, Experimental Statistics, Enhanced Dataset
07 December 2016	Statistics on Women's Smoking Status at Time of Delivery: England - Quarter 2, July 2016 to September 2016
15 December 2016	Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, July 2015 - June 2016 [NS]
15 December 2016	CCG Outcomes Indicator Set - December 2016 release

20 December 2016	NHS Staff Earnings Estimates - August 2016, Provisional Statistics

Monthly

06 December 2016	Children and Young People's Health Services Monthly Statistics - April to June 2016
07 December 2016	Maternity Services Monthly Statistics - July 2016, Experimental statistics
08 December 2016	Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2016 to July 2016
08 December 2016	Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2015 to March 2016 - December 2016 Release
09 December 2016	Care Information Choices, England - December, 2016
09 December 2016	NHS Safety Thermometer Report - England November 2015 - November 2016
16 December 2016	Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - November 2016
20 December 2016	NHS Workforce Statistics - September 2016, Provisional Statistics
20 December 2016	NHS Sickness Absence Rates - July 2016, Provisional Statistics
21 December 2016	Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - October 2016
21 December 2016	Provisional Accident and Emergency Quality Indicators for England - September 2016, by provider
21 December 2016	Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), November 2016, Experimental Statistics
22 December 2016	Mental Health Services Monthly Statistics - Final September, Provisional October 2016
22 December 2016	Improving Access to Psychological Therapies Report - September 2016 Final, October 2016 Primary and most recent quarterly data (Quarter 1 2016-17)

Other

13 December 2016	GP Contract Services - GP practices in England, 2015/16

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.

October 2016

14 October 2016	National Bowel Cancer Audit - Organisational Survey
21 October 2016	National Pregnancy in Diabetes Audit - National Pregnancy in Diabetes Audit 2015

November 2016

18 November 2016	National Diabetes Audit - National Diabetes Audit 2015-16 Participation

December 2016

16 December 2016	National Bowel Cancer Audit - The National Bowel Cancer Audit 2016 Annual Report

User and Media activity

The following tables show web and media coverage figures for Official (and National) Statistics released by NHS Digital between August and October 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.

August 2016

Publication	Date	Unique page views	Media units
Maternity Services Monthly Statistics, England – March 2016, Experimental statistics	03 August 2016	58	
Prescribing for Diabetes, England - 2005/06 to 2015/16	03 August 2016	216	35
Guardianship under the Mental Health Act 1983, England 2015-16, National Statistics [NS]	03 August 2016	14	
HES-DID Data Linkage Report - Provisional Summary Statistics, April 2015-March 2016 (Experimental Statistics	04 August 2016	5	
NHS Safety Thermometer Report - England July 2015 - July 2016	10 August 2016	31	
Patient-Led Assessments of the Care Environment - PLACE England 2016	10 August 2016	841	10
Finalised Patient Reported Outcome Measures (PROMs) in England - April 2014 to March 201	11 August 2016	629	
Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England - April 2015 to March 2016, August 2016 release	11 August 2016	18	
GP Contract Services - GP Practices in England, 2014/15	12 August 2016	210	
Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - July 2016	12 August 2016	348	
Care Information Choices, England - August, 2016	17 August 2016	171	
Provisional Accident and Emergency Quality Indicators - England, by provider for May 2016	17 August 2016	114	
Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency Data - April 2016 to June 2016	17 August 2016	83	
NHS Outcomes Framework indicators - August 2016 release	18 August 2016	294	
Statistics on NHS Stop Smoking Services in England - April 2015 to March 2016	18 August 2016	709	8
Learning Disability Services Monthly Statistics - England Commissioner Census (Assuring Transformation) - July 2016, Experimental Statistic	19 August 2016	20	
Improving Access to Psychological Therapies Report - May 2016 Final, June 2016 Primary and	23 August 2016	14	
Mental Health Services Monthly Statistics: Final May, Provisional June 2016	23 August 2016	70	
NHS Sickness Absence Rates - April 2016, Provisional Statistics	24 August 2016	134	
NHS Workforce Statistics - May 2016, Provisional statistics	24 August 2016	13	
NHS Vacancy Statistics England - 2015-2016, Provisional Experimental Statistics	25 August 2016	19	

September 2016

Publication	Date	Unique page views	Media units
Commissioning Group Prescribing Data - April to June 2016	06 September 2016	341	
Female Genital Mutilation - April-June 2016, Experimental Statistics, Enhanced Dataset	06 September 2016	237	26
HES-DID Data Linkage Report - Provisional Summary Statistics, April 2016 (Experimental Statistics)	07 September 2016	68	
Maternity Services Monthly Statistics - April 2016, Experimental statistics	07 September 2016	250	
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2015 to March 2016 - September 2016 Release	08 September 2016	177	
Statistics on Women's Smoking Status at Time of Delivery, England - Quarter 1, 2016-17	08 September 2016	282	
Care Information Choices, England - September, 2016	09 September 2016	217	
NHS Safety Thermometer Report - England August 2015 - August 2016	09 September 2016	224	
Dental Earnings and Expenses	14 September 2016	420	11
Dental Working Hours - 2014/15 and 2015/16 Initial Analysis	14 September 2016	225	
GP Earnings and Expenses - 2014/15	14 September 2016	835	30
Data on written complaints in the NHS - 2015-16	15 September 2016	424	
Personal Social Services Adult Social Care Survey, England - 2015-16	15 September 2016	613	
Data on written complaints in the NHS - 2016/17 Quarter 1, Experimental	15 September 2016	97	16
NHS Continuing Healthcare Activity Statistics for England, Quarter 1 2016-17 Report, Experimental Statistics	16 September 2016	155	
Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses, August 2016	16 September 2016	245	3
Learning Disability Services Monthly Statistics - England Commissioner Census (Assuring Transformation) - August 2016, Experimental Statistics	20 September 2016	137	
Improving Access to Psychological Therapies Report - June 2016 Final, July 2016 Primary and most recent quarterly data (Quarter 4 2015-16)	21 September 2016	425	
Investment in General Practice - 2011-12 to 2015-16, England, Wales, Northern Ireland and Scotland	21 September 2016	152	
NHS Payments to General Practice - England, 2015/16	21 September 2016	431	8
CCG Outcomes Indicator Set - September 2016	22 September 2016	260	
NHS Immunisation Statistics, England - 2015-16	22 September 2016	694	19
Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, April 2015 - March 2016	22 September 2016	194	

September 2016 – continued

NHS Dental Statistics for England - 2015-16, Annual Report	23 September 2016	848	25
General and Personal Medical Services, England September 2015 - March 2016, Provisional Experimental statistics	27 September 2016	683	
Healthcare Workforce Statistics - March 2016, Experimental	27 September 2016	126	36
NHS Sickness Absence Rates May 2016	27 September 2016	96	
NHS Staff Earnings Estimates - to June 2016, Provisional statistics	27 September 2016	123	
Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England), Annual Report 2015-16	28 September 2016	1370	17
Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014	29 September 2016	4118	63
Children and Young People's Health Services Monthly Statistics, England – September 2015, Experimental statistics	30 September 2016	462	3
Provisional Accident and Emergency Quality Indicators for England - June 2016, by provider	30 September 2016	129	
Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - July 2016	30 September 2016	157	

October 2016

Publication	Date	Unique page views	Media units
Community Care Statistics: Social Services Activity, England - 2015-16 Report	05 October 2016	677	1
Measures from the Adult Social Care Outcomes Framework, England - 2015-16	05 October 2016	737	9
Safeguarding Adults, Annual Report, England 2015-16, Experimental Statistics	05 October 2016	779	12
HES-DID Data Linkage Report - Provisional Summary Statistics, April to May 2016 (Experimental Statistics)	06 October 2016	40	
Maternity Services Monthly Statistics, England – May 2016, Experimental statistics	06 October 2016	113	
Care Information Choices, October 2016	11 October 2016	48	
Estates Returns Information Collection (ERIC) - England, 2015-16	11 October 2016	466	62
NHS Safety Thermometer Report - September 2015 to September 2016	12 October 2016	94	
NICE Technology Appraisals in the NHS in England (Innovation Scorecard): to March 2016	12 October 2016	224	
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2015 to March 2016 - October 2016 Release	13 October 2016	196	
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2016 to May 2016	13 October 2016	232	
GP Contract Services 2015-16	14 October 2016	253	
Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses, September 2016	14 October 2016	274	
Numbers of Patients Registered at a GP Practice - October 2016	18 October 2016	216	
Psychological Therapies, Annual report on the use of IAPT services - 2015/16	18 October 2016	763	6
Dental Earnings and Expenses - 2014-15 Additional Analysis	19 October 2016	215	
Dental Working Hours, 2014/15 and 2015/16	19 October 2016	83	
Sexual and Reproductive Health Services, England - 2015-16 [NS]	19 October 2016	533	7
Mental Health Services Monthly Statistics: Final July, Provisional August 2016	20 October 2016	456	
Provisional Accident and Emergency Quality Indicators for England - July 2016, by provider	20 October 2016	65	
Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency Data - April 2016 to August 2016	20 October 2016	86	

October 2016 - continued

Improving Access to Psychological Therapies Report, July 2016 Final, August 2016 Primary + Quarter 1 2016/17	25 October 2016	429	
NHS Sickness Absence Rates April 2016 to June 2016	25 October 2016	111	
NHS Workforce Statistics - July 2016, Provisional statistics	25 October 2016	135	
Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), September 2016, Experimental Statistics	26 October 2016	84	
Personal Social Services: Expenditure and Unit Costs, England - 2015-16 [NS]	26 October 2016	773	14
Seven-day Services - England, April 2015 - March 2016, Experimental statistics	26 October 2016	1333	41
Quality and Outcomes Framework (QOF) - 2015-16	27 October 2016	3101	7
Statistics on NHS Stop Smoking Services: England, April 2016 to June 2016	27 October 2016	272	

Recommendation

None – for information only.

Implications

Strategy Implications

These publications and their associated media and web coverage results form part of objective five of our strategy, “Making better use of health and care information” whereby we “are part of the Government’s Statistical Service and adhere to the UK Statistics Authority’s Code of Practice for national statistics. We publish data and statistics in formats that cannot be used to identify individual patients, service users or citizens.”

Financial Implications

There are no financial implications of this resolution/proposal.

Stakeholder Implications

This is for information purposes only, for stakeholders to review forthcoming publications and the media and web attention of those previously published..

Handling

There are no handling implications of this resolution/proposal

Risks and Issues

There are no associated risks and issues as this is for information only.

Corporate Governance and Compliance

All Official and National statistics publications adhere to the UK Statistics Authority's Code of Practice for Official Statistics which fulfil our obligations as a producer of Official and National statistics.

Management Responsibility

Professor David Hughes, Executive Director of Information and Analytics is the sponsor director accountable for these publications. The senior manager with overall responsibility is Chris Roebuck, Director of Publications and Head of Profession for Statistics.

Actions Required of the Board

None – for information only.

Board Meeting – Public Session

Title of paper:	Programme Definitions
Board meeting date:	30 November 2016
Agenda item no:	NHSD 16 04 07 c
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 provide the Board with a summary of each programme listed on the programme dashboards.
Additional Documents and or Supporting Information:	Descriptive project and programme definitions, including P2020 initiatives, will be developed as part of a portfolio restructure exercise, which is currently underway.
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 the HSCIC 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:	*no supplementary papers*
Actions required by the Board:	For Reference Only

Portfolio Code	Portfolio item name	Portfolio Item Description
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	Digital Referrals and Consultations	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.
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.
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 Programme	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.
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.

Descriptive project and programme definitions, including P2020 initiatives, will be developed as part of a portfolio restructure exercise, which is currently underway.