

Health and Social Care Information Centre Board

Agenda: Part 1 (Public Session)

23 September 2015 – 10:15 to 12:30

Venue: Comfort Zone, 8th floor Bridgewater Place, Water Lane, Leeds, LS11 5BZ

<u>Ref No</u>	<u>Agenda Item</u>	<u>Time</u>	<u>Presented By</u>
HSCIC 15 04 01	Chair's Introduction and Apologies (oral)	10:15 – 10:20	Chair
HSCIC 15 04 02	Declaration of Interests and minutes	10:20 – 10:30	
	(a) Register of Interests (paper) – for information		Chair
	(b) Minutes of Board Meeting on 15 July 2015 (paper) – to ratify		
	(c) Progress on Action Points (paper) – for information		
HSCIC 15 04 03	Business and Performance Reporting	10:30 – 11:00	
	(a) Board Performance Pack (paper) – for information		CEO
	i. Data Quality Key Performance Indicator Plan (paper) – for approval		Interim Director of Information and Analytics and Lead Clinician
	ii. Data Quality Strategy on a Page (paper) – for approval		
	iii. Data Quality Policy (paper) – for approval		
	iv. Data Quality next steps (paper) – for approval		
	(b) Transformation Programme Mid-Year Report 2015-16 – for information		Director of Human Resources and Transformation
	(c) Board Overview and Pipeline of Investment Decisions – for comment		Director of Finance and Corporate Services
HSCIC 15 04 04	Supporting the Health and Social Care System	11:00 – 11:45	
	(a) Type 2 Objections Direction – for acceptance		Interim Director of Information and Analytics and Lead Clinician (x 2 items)
	(b) Assuring Transformation Direction Update – for acceptance		
	(c) E-med 3 Direction: Fit Note Aggregated Data – for acceptance		Director of Programmes (x 2 items)
	(d) Female Genital Mutilation (FGM) Risk Information System (RIS) Direction - for acceptance		
	(e) HSCIC Information Governance Strategy – for approval		Director of Operations and Assurance Services
	(f) Streamlining the Independent Information Governance Advice to HSCIC – for information		Interim Director of Information and Analytics and Lead Clinician

HSCIC 15 04 05	Transparency and Governance	11:45 – 12:25	
	(a) Committee Reports:		
	i. Assurance and Risk Committee: 16 September 2015 (oral)		Committee Chair
	ii. Assurance and Risk Committee Terms of Reference - for approval		
	iii. Information Assurance and Cyber Security Committee: 15 September 2015 (oral)		Committee Chair
	iv. Remuneration Committee: 07 August 2015 (oral)		Chair
	v. Remuneration Committee Terms of Reference 2015-16 (paper) – for approval		
	vi. Board Terms of Reference - for approval		Chair
	(b) Board Forward Business Schedule 2015-16 (paper) – for information		Chair
HSCIC 15 04 06	Any other Business (subject to prior agreement with Chair)	12:25 – 12:30	Chair
HSCIC 15 04 07	Background Paper(s) (for information)		
	(a) Forthcoming Statistical Publications (paper) – for information		
	(b) Programme Definitions (paper) – for reference		
	(c) Correspondence from the UK Statistics Authority – for information		
	(d) Office for National Statistics Direction – for information		
	(e) Request from NHS Scotland under section 255 Health and Social Care Act 2012 – for information		
	(f) Data Disseminations (paper) – for information		

Date of next meeting 25 November 2015 - London

Board meeting – Public session

Title of paper:	HSCIC Board members Register of Interests 2015-16
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 02 (a)
Paper presented by:	Chair
Paper prepared by:	Annabelle McGuire, Secretary to the Board
Paper approved by: (Sponsor Director)	N/A
Purpose of the paper:	<p>The HSCIC is required by its Standing Orders to maintain a publically available Register of Members' Interests.</p> <p>The Register contains, as they become available, the Declarations of Interest made by Board members.</p>
Key risks and issues:	N/A
Patient/public interest:	Transparency and Openness
Actions required by the board:	For information

HSCIC Board Register of Interests 2015-16

Name	Declared Interest
Non-Executive Directors	
Kingsley Manning - Chair	<ul style="list-style-type: none"> • Director – Newchurch Limited (non-trading since 01 June 2013) • Director – Hennig UK Limited • Trustee and Board member - Royal Philharmonic Society • Director of Spectrum (General Partner) Limited, the investment advisory board for the Rainbow Seed Fund, which is an investment fund, funded by a number of the research councils.
Sir Ian Andrews - Non-Executive Director	<ul style="list-style-type: none"> • Director of IMA Partners Ltd (formerly known as Abis Partnership Ltd) provision of legal and management consultancy services to government, academia (KCL¹) and Transparency International UK • Consultancy advice to DH on aspects of governance of NHS Transformation, renegotiation of Connecting for Health contracts with CSC², and oversight of Fujitsu Arbitration process <p>Other Offices:</p> <ul style="list-style-type: none"> • Conservator of Wimbledon and Putney Commons • Trustee Chatham Historic Dockyard • Member of UK Defence Academy Academic Advisory Board
Sir John Chisholm - Non-Executive Director	<ul style="list-style-type: none"> • Executive Chair – Genomics England Ltd. • Chair – Nesta (the charity) • Director – Historic Grand Prix Cars Association Ltd.
Professor Maria Goddard - Non-Executive Director	<ul style="list-style-type: none"> • 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

¹ King's College London

² Computer Sciences Corporation

Name	Declared Interest
Sir Nick Partridge - Non-Executive Director	<p>Other Offices:</p> <ul style="list-style-type: none"> • Chair - Clinical Priorities Advisory Group, NHS England • Deputy Chair - UK Clinical Research Collaboration • Deputy Chair, Sexual Health Forum, DH
Dr Sarah Blackburn – Non-Executive Director	<ul style="list-style-type: none"> • Director - The Wayside Network Limited • Director - IIA³ Inc • Independent member of the Management Board, RICS⁴ • Non-Executive Partner, The Green Practice, Bristol <p>Employment (other than with the HSCIC): The Wayside Network Limited</p> <p>Other Offices:</p> <ul style="list-style-type: none"> • Audit Committee member, RAC Pension Fund Trustee <p>Contracts held in last 2 years: The Wayside Network Limited has:</p> <ul style="list-style-type: none"> • 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 <p>Shareholdings:</p> <ul style="list-style-type: none"> • 50% of The Wayside Network Limited
Executive Directors	
Andy Williams – CEO	<ul style="list-style-type: none"> • None
Rachael Allsop - Executive Director of Human Resources	<ul style="list-style-type: none"> • None
Rob Shaw - Executive Director of Operations and Assurance Services	<ul style="list-style-type: none"> • None
Carl Vincent - Executive Director of Finance and Corporate Services	<ul style="list-style-type: none"> • None

³ The Institute of Internal Auditors

⁴ Royal Institution of Chartered Surveyors

Name	Declared Interest
Directors	
Peter Counter - CTO ⁵	<ul style="list-style-type: none"> • Director at Canary Wharf College Limited
Tom Denwood - National Provider Support Director	<ul style="list-style-type: none"> • 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
James Hawkins - Director of Programme Delivery	<ul style="list-style-type: none"> • Parent Governor at St Peters Church of England Primary School, Harrogate
Isabel Hunt - Director of Customer Relations	<ul style="list-style-type: none"> • Trustee, Thackray Medical Museum (Leeds) • Council Member, Leeds Minster • Director - Barry Wades Estates Ltd
Professor Martin Severs – Interim Director of Information and Analytics, Caldicott Guardian and Lead Clinician	<ul style="list-style-type: none"> • Trustee of Dunhill Medical Trust, a research charity • Consultant Geriatrician with Portsmouth Hospitals NHS Trust • Professor of Health Care for Older People with University of Portsmouth <p>Other Offices:</p> <ul style="list-style-type: none"> • Member of SoS⁶ Independent Information Governance Oversight Panel <p>Other relevant interests:</p> <ul style="list-style-type: none"> • Medical consultant and member of the Royal College of Physicians, British Geriatrics Society and the Faculty of Public Health Medicine
Director of Information and Analytics	<ul style="list-style-type: none"> • Vacancy
Director of Strategy	<ul style="list-style-type: none"> • Vacancy

⁵ Chief Technical Officer

⁶ Secretary of State

Health and Social Care Information Centre

Minutes of Board Meeting – Wednesday 15 July 2015

Part 1 - Public Session

Present:

Chair	Kingsley Manning
Non-Executive Director	Sir Ian Andrews
Non-Executive Director	Sir John Chisholm
Non-Executive Director	Prof. Maria Goddard
Non-Executive Director (Vice Chair)	Sir Nick Partridge
Chief Executive Officer	Andy Williams
Director of Operations and Assurance Services	Rob Shaw

In attendance:

Chief Technology Officer	Peter Counter
National Provider Support Director	Tom Denwood
Director of Programmes	James Hawkins
Director of Customer Relations	Isabel Hunt
Interim Director of Information and Analytics and Lead Clinician (Caldicott Guardian)	Prof. Martin Severs
Assistant Director for Strategy and Policy Secretary to the Board	Linda Whalley Annabelle McGuire

1. **Chair's Introduction and Apologies** (HSCIC 15 03 01)
 - 1.1 The Chair convened a meeting of the HSCIC Board. He welcomed the observers attending the Board meeting. He expressed the Board's thanks to the HSCIC staff in Redditch for welcoming the Board, and the Board's thanks to those who had undertaken the organisation and administration of the Board.
 - 1.2 The Director of Human Resources and Transformation Rachael Allsop, The Director of Finance and Corporate Services Carl Vincent and Non-Executive Director Dr Sarah Blackburn had registered their apologies.
2. **Declaration of Interests and Minutes** (HSCIC 15 03 02)
 - 2.1 (a) Register of Interests (paper): HSCIC 15 03 02 (a)
The Board agreed the Register of Interests was correct.
 - 2.2 (b) Minutes of Board meeting on 10 June 2015 (paper): HSCIC 15 03 02 (b)
The Board ratified the minutes of the meeting on 10 June 2015 as correct.
 - 2.3 (c) Progress on action points (paper): HSCIC 15 03 02 (c)
The Board noted the progress on action points resulting from the previous meeting.
 - 2.4 (d) Matters Arising: HSCIC 15 03 02 (d):
 - The Board noted that the HSCIC Annual Report and Accounts 2014- 15 would be laid before Parliament on Thursday 16 July. Subsequently the HSCIC Annual Report and Accounts would be published on the HSCIC web site and hard copies would be made available.
 - The CEO informed the Board of the resignation of Andrew MacLaren, Director of Information and Analytics.
 - The CEO informed the Board of the interim arrangements. Prof. Martin Severs had been asked and had agreed to take up the role of interim Director of Information and Analytics and Lead Clinician (Caldicott Guardian). This was a temporary arrangement, which had been announced internally. Where any conflict of interests existed in respect to his role as Caldicott Guardian, Dr Alan Hassey would act as the interim Caldicott Guardian. As interim Caldicott Guardian Dr Hassey would have direct access to the Chair and CEO as required.
 - The CEO briefed the Board on a number of changes to the components of directorates. The details of the changes were being elaborated.
3. **Transparency and Governance** (HSCIC 15 03 03)
 - 3.1 (a) Committee Reports: HSCIC 15 03 03 (a)
 - i. Assurance and Risk Committee (ARC) (oral): HSCIC 15 03 03 (a)
Non-Executive Director Sir Ian Andrews, representing the Chair of the Assurance and Risk Committee, reported that the Committee had convened via teleconference with the National Audit Office (NAO) on 29 June to discuss the final draft of the HSCIC Annual Report and Accounts 2014-15, which the Board had considered at its last meeting. The Committee had agreed with the treatment of the unadjusted changes and recommended that the CEO sign the HSCIC Annual Report and Accounts. No other business had been discussed.
 - ii. Information Assurance and Cyber Security Committee (IACSC) 01 July 2015 (oral): HSCIC 15 03 03 (a) ii
The Chair of the IACSC, Non-Executive Director Sir Ian Andrews, reported that the Committee had met on 01 July with Department of Health (DH) representatives and colleagues from other government departments. The Committee received a report on the first meeting on 1 July of the DH Information Security Risk Board (ISRB) chaired by Will Cavendish, DH SIRO and Director General of Innovation, Growth and Technology and went on to discuss various current issues concerning Information Security. He informed the Board that a briefing for DH Non-Executive Directors on cyber and information security had taken place on 14 July. This had been well received and was likely to be repeated. There was recognition of the role that NEDs had to play in

holding executives to account and promoting the appropriate culture and behaviours.

iii. Information Assurance and Cyber Security Committee (IACSC) Terms of Reference (paper): HSCIC 15 03 03 (a) iii

The Chair of the IACSC, Non-Executive Director Sir Ian Andrews, presented the revised terms of reference for the committee. Further amendments were likely to clarify the respective roles of the IACSC and the Assurance and Risk Committee and the Board approved the terms of reference subject to these reconsiderations.

Action: Director of Operations and Assurance Services

3.2 (b) Board Forward Business Schedule 2015-16 (paper): HSCIC 15 03 03 (b)

The Board noted the forward business schedule. The Board considered that it would be of potential benefit to take this item later on the agenda.

3.3 (c) Board Oversight of Investment Decisions: HSCIC 15 03 03 (c)

The CEO presented this item. The purpose was to set out proposals for Board oversight of investment decisions. This was in response to interest expressed previously by the Board. The Board considered that the inclusion of a pipeline of Directions would be of benefit, for incorporation in the same report. In addition, long-term continuing programmes should also be included. These would be those above a sensible level of overall cost. The full report would come to the Board for information.

Action: Director of Finance and Corporate Services

The Board agreed it would be helpful to highlight the areas the executive needed to bring to their attention. The Board noted the report.

4. **Business and Performance Reporting (HSCIC 15 03 04)**

4.1 (a) Board Performance Pack (paper): HSCIC 15 03 04 (a)

The CEO presented this item. The purpose was to provide the Board with a summary of performance in May. The reputation and data quality key performance indicators were still be refined. The Board requested highlighting in the narrative where there was an incident or issue that occurred after the reporting period, the executive directors noted this request. The Board received and noted the Board Performance Pack.

4.2 (b) Data Release Review: Audit Status Report (paper): HSCIC 15 03 04 (b)

The Director of Operations and Assurance Services presented this item. The purpose was to brief the Board on the status of the data sharing audits. He summarised the position, and stated there had been no concerns to date. If any arose the IACSC would consider identified concerns. The Board noted and received the update.

4.3 (c) HSCIC Personal Development Review Report (paper): HSCIC 15 03 04 (c)

The CEO presented this item. The purpose was to report on the levels of performance and development activity by each HSCIC directorate at the start of the financial year. The Board discussed and endorsed organisational talent management. The Board agreed that in future, where a directorate did not achieve 92.5% completion rate they would like to be informed. The Board noted and received the update.

4.4 (d) National Audit Office (NAO) GP Extraction Service (GPES) Report (paper): HSCIC 15 03 04 (d)

The Director of Programmes presented this item. The purpose was to update the Board on the background to the NAO investigation, the findings from the investigation and future plans for GPES. He summarised the background, status and future plans. He confirmed the identification of significant lessons, and the completion of an internal report detailing the insights. The Board acknowledged that this was an inherited issue from a precursor organisation. The Board noted and received the update. The Board agreed the addition of primary care systems to the list of programmes.

Action: Director of Programmes

4.5 (e) Electronic Referral Service Go-Live (paper): HSCIC 15 03 04 (e)

The Director of Programmes presented this item. The purpose was to update the Board on the NHS E-Referral Service go live and early life. He briefed the Board on some of the challenges

post go-live. He stated that the end of July 2015 was the target date to fully stabilise the service and fix the majority of outstanding issues. The Board discussed the need to upgrade of internet browsers across the health and social care sector. The Board requested that the IACSC look at the associated risks.

Action: Director of Operations and Assurance Services

The Board noted and received the update. The Director of Programmes said he would present the lessons identified report at the 23 September Board.

Action: Director of Programmes

5 **Supporting the Health and Social Care System (HSCIC 15 03 05)**

5.1 (a) i. Care.data Programme Update (Board Approvals and Budget Position): HSCIC 15 03 05 (a) i ii. Care.data revised NHS England Direction (paper): HSCIC 15 03 05 (a) ii

The Interim Director of Information and Analytics and Lead Clinician presented this item. The purpose was to provide the rationale behind the Directions to facilitate the collection, analysis and dissemination of data from pathfinder practices, and background information on the investment to deliver requirements. The Board noted these Directions were a draft. The Board noted a letter from med-Confidential, along with a briefing on it from Eve Roodhouse, Programme Director care.data, and the letter of response from Sir Malcolm Grant (Chair NHS England), none of which constituted part of the Board pack. During Board discussion five main points emerged:

- The HSCIC Programme Team and the HSCIC Information Governance team should have seen the Privacy Impact Assessment and endorsed it, as the HSCIC is joint data controller with NHS England.
- The Direction should explicitly state the HSCIC data controller role or provide the Board with an agreed alternative mechanism for the organisations role to be explicitly stated.
- The Direction to be revised as stated, with the inclusion of participating GPs and data set specification.
- The Direction should explicitly reflect the publically stated position on data dissemination referencing the listed organisations, the use or not of a secure data facility and explicit reference on whether the listed public bodies e.g. Public Health England (PHE) can disseminate the data onward or provide the Board with an agreed alternative mechanism for this to be made explicit.
- The Direction should have an end date or review date given it is only applicable to the Pathfinder Stage.

The Interim Director of Information and Analytics and Lead Clinician was asked to make NHS England aware of these decisions.

Action: The Interim Director of Information and Analytics and Lead Clinician

5.2 (b) UK Genetic Infrastructure Direction (paper): HSCIC 15 03 05 (b)

The Interim Director of Information and Analytics and Lead Clinician presented this item. The purpose of the data collection is to gain information on the access and provision to genetic testing provided by the UK Genetic Testing Network (UKGTN). Non-Executive Director Sir John Chisholm said he would like to speak to the Interim Director of Information and Analytics and Lead Clinician outside the Board meeting. The Board considered that the following two factors should be considered during the consultation:

- Seek specific views on whether the NHS number should be routinely collected for all patients in England.
- Seek specific views from the DH policy team who deal with genetics.

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

5.3 (c) Data Service for Commissioners Direction (paper): HSCIC 15 03 05 (c)

The Interim Director of Information and Analytics and Lead Clinician presented this item. The revised Directions provided clarification that represents the most up to date legal advice and as such, there was very little risk in agreeing to accept the changes, which were to ensure alignment to policy.

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

- 5.4 (d) Dementia Prevalence Direction (paper): HSCIC 15 03 05 (d)
The Interim Director of Information and Analytics and Lead Clinician presented this item. The Board noted the executive management team had reviewed the Directions.

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

- 5.5 (e) NHS England Direction National Cancer Waiting Times Monitoring (paper): HSCIC 15 03 05 (e)

The Director of Operations and Assurance Services presented this item. The Direction provides a legal basis to continue to collect the relevant data through an existing service provided to NHS England. The Board being satisfied with the assurances provided approved the Direction.

The Interim Director of Information and Analytics and Lead Clinician agreed to establish if the HSCIC published a Register of Directions.

Action: Interim Director of Information and Analytics and Lead Clinician

6 **Any other Business (HSCIC 15 03 06)**

- The Director of Programmes informed the Board that the GPES Independent Advisory Group (IAG) had ceased to exist on the 30 June 2015. The Standardisation Committee for Care Information (SCCI) process and the Independent Group Advising on the Release of Data (IGARD) had replaced the GPES IAG. He thanked the members of the GPES IAG for their work since 2012.

7. **Background Papers (HSCIC 15 03 07)**

- 7.1 (a) HSCIC Social Care Work Update (paper): HSCIC 15 03 07 (a)
The Board noted this paper for information.

- 7.2 (b) Forthcoming Statistical Publications (paper): HSCIC 15 03 07 (b)
The Board noted this paper for information.

- 7.3 (c) Programme Definitions (paper): HSCIC 15 03 07 (c)
The Board noted this paper for information.

8.

- 8.1 The arranged date of the next public Board meeting was for 23 September 2015.

Table of Actions:

Action	Action Owner
The Chair of the IACSC, Non-Executive Director Sir Ian Andrews, presented the revised terms of reference for the committee. Further amendments were likely to clarify the respective roles of the IACSC and the Assurance and Risk Committee and the Board approved the terms of reference subject to these reconsiderations.	Director of Operations and Assurance Services
The purpose was to set out proposals for Board oversight of investment decisions. This was in response to interest expressed previously by the Board. The Board considered that the inclusion of a pipeline of Directions would be of benefit, for incorporation in the same report. In addition, long-term continuing programmes should also be included. These would be those above a sensible level of overall cost. The full report would come to the Board for information.	Director of Finance and Corporate Services
The Board agreed the addition of primary care systems to the list of programmes.	Director of Programmes
The Board discussed the upgrade of internet browsers across the health and social care sector. The Board requested that the IACSC look at the associated risks.	Director of Operations and Assurance Services
Electronic Referral Service: The Director of Programmes said he would present the lessons identified report at the 23 September Board.	Director of Programmes
<p>During Board discussion five main points emerged:</p> <ul style="list-style-type: none"> • The HSCIC Programme Team and the HSCIC Information Governance team should have seen the Privacy Impact Assessment and endorsed it, as the HSCIC is joint data controller with NHS England. • The Direction should explicitly state the HSCIC data controller role or provide the Board with an agreed alternative mechanism for the organisations role to be explicitly stated. • The Direction to be revised as stated, with the inclusion of participating GPs and data set specification. • The Direction should explicitly reflect the publically stated position on data dissemination referencing the listed organisations, the use or not of a secure data facility and explicit reference on whether the listed public bodies e.g. Public Health England (PHE) can disseminate the data onward or provide the Board with an agreed alternative mechanism for this to be made explicit. • The Direction should have an end date or review date given it is only applicable to the Pathfinder Stage. <p>The Interim Director of Information and Analytics and Lead Clinician was asked to make NHS England aware of these decisions.</p>	The Interim Director of Information and Analytics and Lead Clinician
The Interim Director of Information and Analytics and Lead Clinician agreed to establish if the HSCIC published a Register of Directions.	The Interim Director of Information and Analytics and Lead Clinician

Board meeting – Public session

Title of paper:	Update on action points for the previous meeting
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 02 (c)
Paper presented by:	Chair
Paper prepared by:	Annabelle McGuire, Secretary to the Board
Paper approved by: (Sponsor Director)	Action Updates as submitted by the relevant Executive Management Team director.
Purpose of the paper:	To share an update on action points from the previous meeting for information.
Key risks and issues:	As stated in the action and commentary
Patient/public interest:	Corporate Governance
Actions required by the board:	To note for information

Summary of progress against Board meeting actions

✓ = completed
c/f = on-going

Status	Summary of Action	Commentary	Responsible Director	For Information Only
✓	The Chair of the IACSC, Non-Executive Director Sir Ian Andrews, presented the revised terms of reference for the committee. Further amendments were likely to clarify the respective roles of the IACSC and the Assurance and Risk Committee and the Board approved the terms of reference subject to these reconsiderations.	One minor amendment has been made to the document, and is being kept under advisement.	Director of Operations and Assurance Services	Yes
✓	The purpose was to set out proposals for Board oversight of investment decisions. This was in response to interest expressed previously by the Board. The Board considered that the inclusion of a pipeline of Directions would be of benefit, for incorporation in the same report. In addition, long-term continuing programmes should also be included. These would be those above a sensible level of overall cost. The full report would come to the Board for information.	These updates are included in a refreshed report presented to the Board.	Director of Finance and Corporate Services	Yes
✓	The Board agreed the addition of primary care systems to the list of programmes.	These updates are included in a refreshed report presented to the Board.	Director of Programmes	Yes
c/f	The Board discussed the upgrade of internet browsers across the health and social care sector. The Board requested that the IACSC look at the associated risks.	To be tabled at a future Information Assurance and Cyber Security Committee meeting.	Director of Operations and Assurance Services	Yes
c/f	Electronic Referral Service: The Director of Programmes said he would present the lessons identified report at the 23 September Board.	Oral update provided to the 2 September Board Business Meeting, with the agreement of the Chair the final report will come to the 25 November Board meeting.	Director of Programmes	Yes

Status	Summary of Action	Commentary	Responsible Director	For Information Only
✓	<p>During Board discussion five main points emerged:</p> <ul style="list-style-type: none"> •The HSCIC Programme Team and the HSCIC Information Governance team should have seen the Privacy Impact Assessment and endorsed it, as the HSCIC is joint data controller with NHS England. •The Direction should explicitly state the HSCIC data controller role or provide the Board with an agreed alternative mechanism for the organisations role to be explicitly stated. •The Direction to be revised as stated, with the inclusion of participating GPs and data set specification. •The Direction should explicitly reflect the publically stated position on data dissemination referencing the listed organisations, the use or not of a secure data facility and explicit reference on whether the listed public bodies e.g. Public Health England (PHE) can disseminate the data onward or provide the Board with an agreed alternative mechanism for this to be made explicit. •The Direction should have an end date or review date given it is only applicable to the Pathfinder Stage. <p>The Interim Director of Information and Analytics and Lead Clinician was asked to make NHS England aware of these decisions.</p>	Action completed.	The Interim Director of Information and Analytics and Lead Clinician	Yes

Status	Summary of Action	Commentary	Responsible Director	For Information Only
c/f	The Interim Director of Information and Analytics and Lead Clinician agreed to establish if the HSCIC published a Register of Directions.	There is already a process in place for publishing directions though it is an interim arrangement. Karen Davison to update the Executive Office with a more comprehensive update in due course.	The Interim Director of Information and Analytics and Lead Clinician	Yes

Board meeting – Public session

Title of paper:	EMT Performance Pack
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 03 (a)
Paper presented by:	Carl Vincent, Director of Finance and Corporate Services
Paper prepared by:	John Willshire, Portfolio Director
Paper approved by: (Sponsor Director)	Carl Vincent, Director of Finance and Corporate Services
Purpose of the paper:	To provide the Board with a summary of financial data relating to programme spend, information governance incidents and risk management.
Justification for inclusion in private board:	The information on Programme spend is commercially sensitive.
Key risks and issues:	The corporate performance framework monitors HSCIC performance including risk management, information governance and security.
Patient/public interest:	The public interest is in ensuring the HSCIC manages its business in an effective way.
Actions required by the board:	To note

Board Performance Pack

August 2015 Data



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Contents

HSCIC Performance Summary	3
Programme Achievement KPI Report	4
IT Service Performance KPI Report	5
Organisational Health KPI Report	6
Data Quality KPI Report	7
Financial Management (HSCIC) KPI Report	8
Appendix 1 - Management Accounts	9 - 12
Appendix 2 - Programme Delivery Dashboard	13 - 16

HSCIC Performance Summary

Programme Achievement is reported as AMBER/GREEN for the sixth consecutive month, although overall programme delivery confidence fell (from 68.4% to 66.7%). The gap between actual and forecast delivery confidence widened and is now more than eight percentage points. Across the portfolio only one programme is rated as RED for overall delivery confidence (Health and Social Care Network).

IT Service Performance is reported as AMBER. This rating is mainly driven by the fact that 3 services (out of 66) did not achieve their availability target (the performance thresholds for this KPI are high). The AMBER status also reflects some of the performance issues relating to eRS (see below). There were 17 high severity service incidents, 8 fewer than last month. All of these (100%) were resolved within the target fix time. 88% of services (22 out of 25) achieved their response time target.

During the period June-August there have been a number of performance issues relating to the **Electronic Referral Service (e-RS)**. These incidents are not yet included in the routine service performance data because **e-RS** is still in its Deployment Verification Period and not treated as a fully-fledged live service. When **e-RS** exits the Deployment Verification Period it will be included in the performance data reported for the IT Service Performance KPI.

Organisational Health is reported as AMBER. Time taken to recruit is still above target, but has continued to reduce for both internal and external appointment and is now within 5 days of the target. Overall sickness absence and turnover remain below target and reasonably stable. PDR completion is at its highest level, and following the PDR-generated Training Needs Assessments the training spend per head has continued to rise. Engagement actions plans continue to be progressed above target, with 99% of actions now completed on time. Professional group membership has increased however this requires further improvement.

Data Quality is reported as GREEN as all of the datasets currently in scope meet the planned requirements in terms of data quality methodologies and assessments. New data quality KPIs are planned. A paper describing those plans, and requesting Board approval for them, is included in today's set of data quality Board papers.

HSCIC Financial Management is reported as GREEN: the year-to-date outturn at M5 shows an underspend of £3.6m (5.5%) against budgeted spend of £65.7m. The full-year position is forecasting an underspend of £2m (£158.6m against a budget of £160.6m)

Performance This Period

Performance Indicator	Owner	Current Period	Current Forecast	Previous Forecast
Programme Achievement	James Hawkins	A/G	A/G	A/G
IT Service Performance	Rob Shaw	A	G	G
Organisational Health	Rachael Allsop	A	G	G
Data Quality	Martin Severs	G	G	G
Financial Management: HSCIC	Carl Vincent	G	G	G

Performance Tracker: Rolling 12 months

	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Programme Achievement	A	A	A	A	A	A	A/G	A/G	A/G	A/G	A/G	A/G
IT Service Performance	G	G	A	A	G	A	G	G	G	G	G	A
Organisational Health	G	G	G	G	G	A	A	A	A	A	A	A
Data Quality	G	G	G	G	G	A	A	G	G	G	G	G
Financial Management: HSCIC	A	R	R	G	G	G	R		G	G	G	G

KPI Programme Achievement
 KPI Owner James Hawkins

Previous RAG 68.4% A/G
 Current RAG 66.7% A/G
 Forecast RAG 73.3% A/G

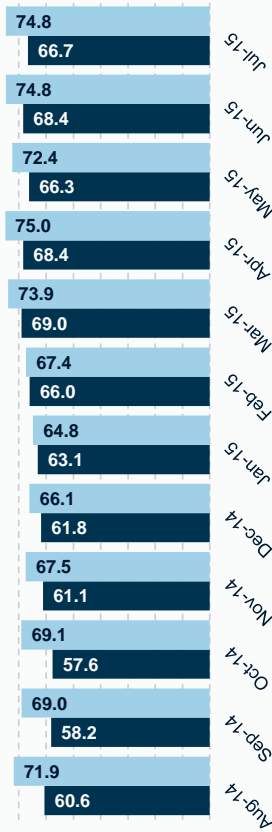
Overall Delivery Confidence

Overall Delivery Confidence across the portfolio is 66.7%, a fall from 68.4% last month. The overall RAG rating remains AMBER / GREEN.

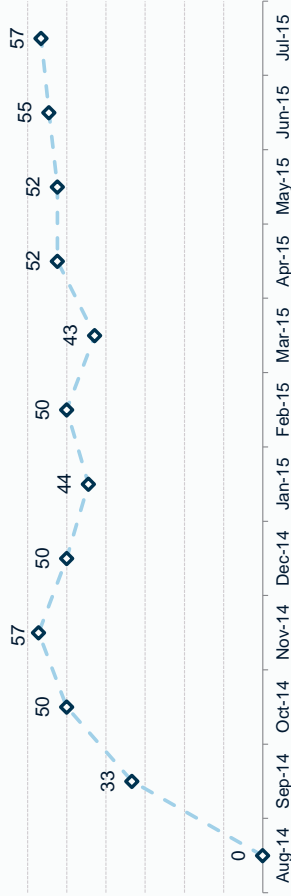
The forecast Delivery Confidence for July was 74.8%, 8.1 percentage points above the actual. This suggests an element of optimism bias in programme forecasting. Twelve programmes and projects failed to meet their forecast delivery confidence, an increase from ten last month.

Programme Achievement: Delivery Confidence (%)

Actual (this month) Forecast (three months ago)



Percentage of Gateways receiving AMBER or better



Gateway Reviews

One Gateway review took place in July: **SUS Transition**. This received a GREEN Gateway score. In the last 12 months there have been 23 gateway reviews, of which 13 achieved an outcome of AMBER or better (57%).

Submitted Prioritisation (Top 10)

Portfolio	Portfolio item name	RPA Score	Total score - External Delivery submitted	Confidence	Last Gate Date	Next Gate Date
P0050/00	Spine 2	High	18.5	Green	11/02/2015	30/09/2015
P0238/00	NHS e-Referral Service Programme	High	18.2	Amber\Green	24/04/2015	15/12/2015
P0335/00	SUS Transition	Medium	18	Green	16/07/2015	
P0208/00	GPSoc Replacement	High	17.7	Amber\Green	22/04/2015	31/05/2016
P0406/00	Data Service for Commissioners	Medium	17.5			
P0325/00	Cyber Security Programme (CSP)	High	17.5			
P0190/00	Health & Social Care Network (HSCN)	High	17.1	Red	28/01/2015	08/10/2015
P0031/00	CSC LSP Delivery Programme	High	17	Red	02/04/2015	30/09/2015
P0196/00	NHSmail 2	Medium	16.5	Amber\Green	25/02/2015	30/09/2015
P0022/00	BT LSP (London & South)	High	16	Amber\Red	27/03/2015	

Overall Delivery Confidence: Programmes Rated as RED

One Programme is rated as RED: **Health and Social Care Network (HSCN)**

Resourcing: Ministerial approval received for interim resourcing solution but the Programme delivery confidence is in RED until resources are boarded. Programme Director left the Programme on 30th June, causing additional resource issues.

Outline Business Case Development: OBC production has commenced. The draft OBC will be completed by July 2015. As this date is a delay from the date in the conditions attached to the PBC approval, the Programme has advised Cabinet Office and IPMB of this slippage. HM Treasury and Cabinet Office approvals for the OBC are due in October 2015.

Note: A number of external factors influence programme achievement performance (e.g. approvals). Through the new system-wide governance arrangements HSCIC will seek to exert stronger control over external factors.

Availability

July saw the average Availability Target achieved for the majority of services, with 63 out of 66 (95%) services achieving the availability target.

The Care Identity Service (CIS) experienced two hardware failures that impacted the service availability for Public Key Infrastructure (PKI) at a non-critical level. A number of mitigating actions have been identified and implemented to prevent further recurrence, including configuration changes and updates to network drivers and the session manager code. Further mitigating actions are planned for completion in October which is an update to the integrated lights out driver (iLO) which will require a site failover to implement.

The aggregate availability target for CSC NME's ECS / Ambulance service was breached in July, due to the Yorkshire Ambulance Service instance failing at a non-critical level. The root cause of this is still under investigation.

The Electronic Referral Service (e-RS) experienced a total of 7 hours and 25 minutes of service unavailability throughout July, following the service being made available to the NHS on Monday 15th June. These periods are summarised below and include the date, duration of service unavailability and brief description of the issue. It should be noted that e-RS is currently in the Deployment Verification Period (DVP) which means that this performance will not be included in the Service Performance RAG status until e-RS exits DVP.

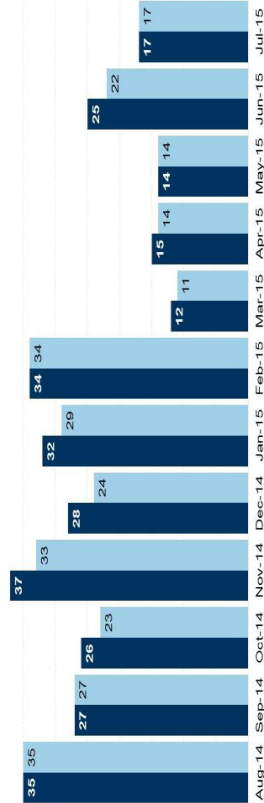
Monday 6 July - 13:25 - 13:45 - Service unavailable for multiple users following reports of severe performance issues resolved with a database restart.

Tuesday 7 July - 13:25 - 14:25 - Service unavailable for multiple users experiencing log in errors and slow performance resolved by a configuration change to the database.

Thursday 9 July - 10:55 - 17:00 - Service unavailable for multiple users following reports of severely degraded performance resolved by some database configuration changes.

Higher Severity Service Incidents: Achieving Fix Times Target

■ Number of HSSIs Raised ■ Number of HSSIs Achieving Fix Times Target



Performance Indicators

Month	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
No. of Services achieving Availability target	68	61	68	63	60	66	68	66	65	67	74	63
No. of Services breaching Availability target, but not to a critical level	1	0	0	4	1	0	0	0	0	0	1	3
No. of Services breaching Availability target at a critical level	0	0	0	0	0	0	0	0	0	0	0	0
Total No. of Services measured for Availability Performance >>>>	69	61	68	67	61	66	68	66	65	67	75	66
No. of Services achieving Response Times target	0	2	1	1	1	1	1	1	1	1	1	1
No. of Services breaching Response Times target, but not to a critical level	24	22	27	26	22	27	27	26	25	25	27	25
No. of Services breaching Response Times target at a critical level	35	27	37	37	26	37	34	12	15	14	25	17
Total number of Higher Severity Service Incidents (HSSIs)	35	27	35	33	23	24	24	11	14	14	22	17
% HSSIs achieving Fix Times target	100%	100%	100%	86%	86%	91%	100%	92%	93%	100%	88%	100%

Response Times

Performance was good for the majority of services in July, with 22 out of 25 (88%) services reported against having achieved or exceeded their Response Times target. The three services not meeting their target were:

1. **The Calculating Quality Reporting Service (CQRS)** experienced repeat failures at a critical level on Message Types 2 and 7 and a further critical level failure on Type 6. GDIT have proposed a number of amendments to the web components that are measured as part of the Message Type 2 metric, the majority of which have been accepted in principle and GDIT have submitted further information for the outstanding items. Message Type 7 failures on CQRS are attributed to the receipt of data that does not, at the point of receipt, require a calculation. GDIT are still investigating options to address this issue, however these options are still not fully elaborated. GDIT continue to implement monitoring around the retry queue size and take action to address this when required.

A remediation plan has been requested and HSCIC and GDIT are working to determine content and timescales of this plan. Weekly checkpoint meetings are being held to progress the production of this plan. The areas of focus have been identified and GDIT are investigating options in these areas. In addition, a review of service levels has been completed and revisions are being trialled for a three month period.

2. **CSC NME Lorenzo** Response Times experienced a repeat failure at a critical level in July against Type 5 on the LORS02 instance. CSC have identified that following the Lorenzo 2.6 and 2.7 upgrades there should have been changes to the transaction types that are being measured.

3. Response Times for **BT London Health RIO** failed at a non-critical level in July, due to a number of breaches across the different stack groups and Trusts. The failures have been attributed to usage of a particular search which is known to be resource heavy and significant levels of exit activity.

e-RS experienced a number of Response Time failures with widespread performance issues being reported by the user community. These have not been included in the RAG status due to eRS currently being in the Deployment Verification Period.

Fix Times: High Severity Service Incidents (HSSIs)

There were 17 HSSIs in July, a fall of 8 from the previous month. All HSSIs were fixed within the target time, an excellent achievement and the 5th time in the last 12 months when 100% of HSSIs have been fixed within target.

3 Security Incidents were logged to the Service Bridge as HSSIs and 5 Clinical Safety Incidents were raised as HSSIs. 1 HSSI had both Security and Clinical Safety implications.

e-RS experienced a number of HSSIs that were related to the periods of service unavailability detailed in the Availability section and the periods of poor performance referred to in the Response Times section. These have not been included in the RAG status due to eRS currently being in the Deployment Verification Period.

Incidents of note outside the reporting period

Since the reporting period of July and the generation of this commentary (7 September) the following HSSIs have been reported which are worthy of note:
05/08/2015 - GDIT - CQRS failed to generate payment a file resulting in no payments being generated
11/08/2015 - CSC - Lorenzo 1.9 unavailable for all users in multiple trusts
18/08/2015 - NHS Choices - All users receiving an error page when trying to access NHS Choices

In addition, e-RS experienced a total of 6 Severity 2 HSSIs during this period.

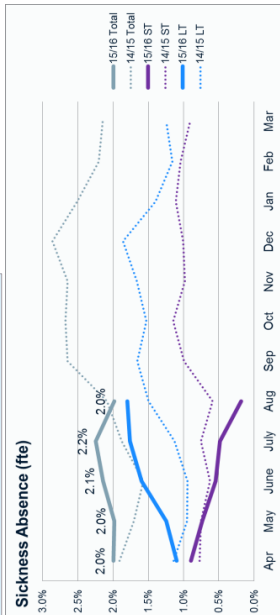
Forecast: It is forecast that a GREEN RAG status will be achieved in August.

KPI: Organisation Health
Owner: Rachael Allsop

Overall Position: AMBER rated, although there has again been positive progress with several indicators. Overall sickness absence and turnover remain below target and reasonably stable. PDR completion continues at its highest level, and following the PDR-generated Training Needs Assessments the training spend per head has continued to rise and is now over halfway towards its annual target. Engagement actions plans continue to be progressed above target, with 99% of actions now completed on time. Professional group membership has increased however this requires further improvement, with work in progress to formalise and automate group allocation. Recruitment development continues with the launch of multi-channel campaigns and targeted approaches to potential candidates, and positive feedback has been received from the current interns. Whilst the time taken to recruit is still above target, it has continued to reduce for both internal and external appointment and is now within 5 days of the target.

Previous RAG: A
Current RAG: A
Forecast RAG: G

Summary Table	Target	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Engagement Score	>=70	72	72	72	73	73	73	73	73	73	73	73	73
Engagement Actions Completed	>=90%	93%	95%	92%	92%	100%	100%	80%	80%	90%	95%	96%	99%
Professional Group Membership	>=90%	87%	80%	81%	80%	81%	81%	80%	80%	82%	81%	81%	83%
PDR Completion	>=90%	73%	2%	58%	75%	77%	77%	78%	5%	38%	87%	89%	89%
Annual Training Spend / Head	£275/Year	£33	£93	£150	£215	£250	£295	£353	-	£37	£96	£161	£161
Monthly Sickness Absence%	<=3%	2.6%	2.7%	2.6%	2.9%	2.5%	2.2%	2.1%	2.0%	1.9%	1.8%	1.8%	2.0%
Time to Recruit (working days)	<=40	61	62	66	57	63	63	58	62	60	59	49	45
Turnover	9% - 11%	12%	11%	11%	10%	10%	10%	11%	11%	11%	9%	8%	8%
Net Monthly Movement	TBC	22	28	32	28	45	20	60	25	8	33	45	12



Sickness Absence

- Sickness absence remains within target and the downward trend in short-term absence continues. Long-term absence is stabilising and is being actively managed within HR's monthly Case Conferences. The annual cost of sick absence is an estimated £2.33m.
- In August the top reason for sickness absence was 'Anxiety/Stress/Depression/other psychiatric illnesses'. This accounted for 47% (740 fte days) of all monthly absences; and 90% of the individual occurrences (26 of 29) are long-term cases. For the 12 months up to the end of August, this reason accounted for the largest absence share (37% of total fte days lost) and showed a general increase during this period. Investigation work to understand what underpins this and how to address it is ongoing.

Training and Development

Spend - Currently £161 per head, is a significant improvement compared to this time last year when spend was less than £30 per head. More training is now being booked following directorate TNA processes.

Training Days (Civil Service Learning)

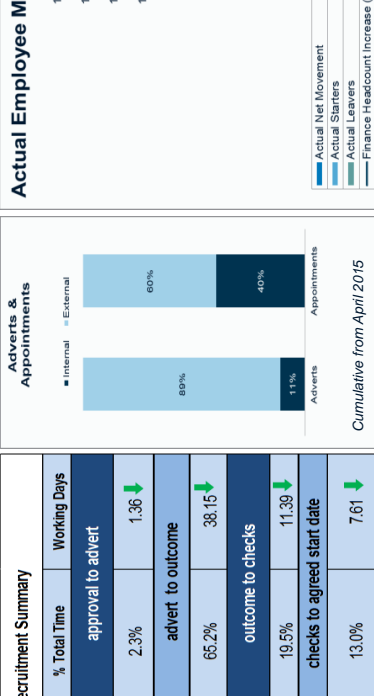
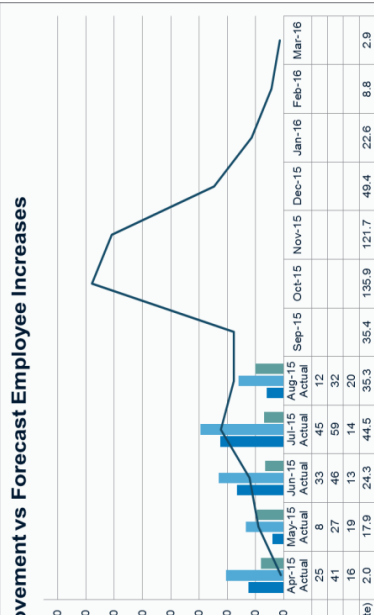
- An average of 1.02 training days per person have been booked this year on CSL.
- 32 induction courses have now been run since the launch in October.
- 1 induction event was run during August.
- A 100% positive evaluation score has been achieved.

Mandatory Training

- Technical problems have impacted on the delivery of Health and Safety Training - ICT have installed a fix to rectify known faults. A full report has been provided to the corporate systems group. IG Training is being reformatted but will not be launched from the new platform until the issues are fixed.

Engagement

- All directorates have now submitted a staff survey action plan. Overall completion of actions due against target date has risen again to 99%, with 100% being achieved in all but one plan.
- A staff recognition pilot in HR has produced positive results and will inform the development of an organisation-wide scheme.
- A meeting to discuss the format and content of the next staff survey has been held and future options have been explored. It is proposed that we proceed on the basis of the current survey for the Autumn, with a view to adopting an alternative approach next year, following the transformation process, to establish a new baseline.



Recruitment Summary	% Total Time	Working Days
Live Campaigns		
Advertising	60	approval to advert
Selection	118	advert to outcome
Appointment	112	outcome to checks
	112	checks to agreed start date
	112	13.0%

Actual Employee Movements vs Forecast Employee Increases

- Recruitment activity has slowed over the summer period with only 48 fully closed recruitment campaigns completed with 90 in July and 105 in June. However, it is expected that this will increase moving into September.
- Time to hire continues its downward trend. The low figure in August has been influenced by the smaller amount of activity, with the majority of appointments being internal. However overall we are seeing shorter timescales associated with recruitment campaigns.
- Improving our successful appointment rate continues to be a focus of attention, with the intention to start contacting passive candidates via social media for key vacancies. There has been initial testing of the approach with a view to implementing fully from the end of the month.

Transactional Recruitment

Talent Summary	Placed 14/15	Current position, 15/16	Forecasted position, 15/16
Work Experience	25	3	25
Internship	0	15	15
Apprenticeship	4	6	9
Graduate Training	10	10	20
Placement year	1	0	3

Attracting and Growing Talent

- A mid-term evaluation of the internship programme provided positive feedback from the interns, showing that individuals have engaged well with the organisation. A number of the interns have expressed interest in continuing to work for the organisation, or to join after leaving university. We are exploring the opportunities available to them. An evaluation of the programme with line managers will take place in September.
- A recruitment campaign is being planned for launch in September for a number of vacancies within the Commercial and Procurement teams. This campaign will be multi-channel and aimed at generating a large amount of interest amongst the profession.

Net Movement

- To date, within this financial year our headcount has increased by 123 net. If this rate of growth continues, we would reach a total net increase of 295 by the end of March. Current levels of activity are unlikely to reach the headcount increase forecast by finance.

KPI
KPI Owner

Data Quality
Martin Severs

Previous RAG
Current RAG
Forecast RAG

G
G
G

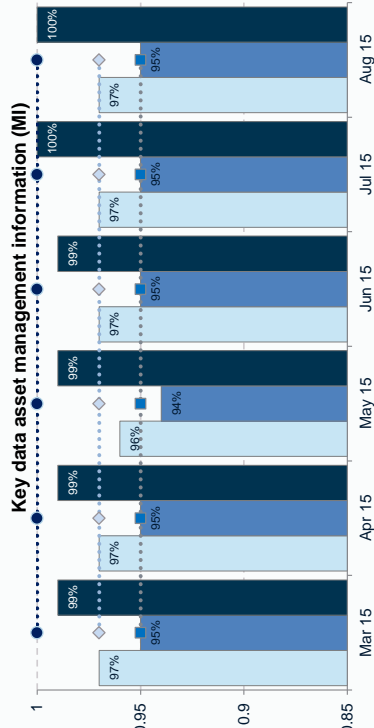
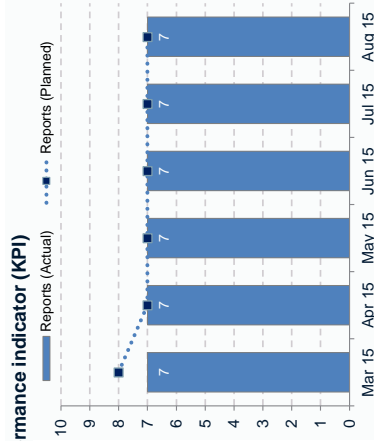
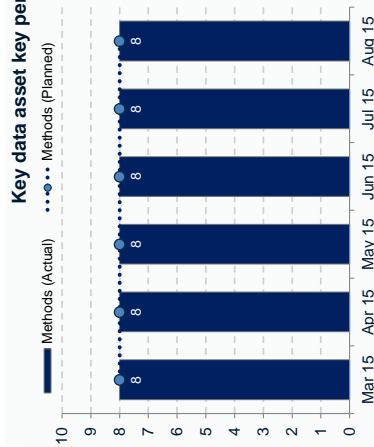
Overall Position

The overall RAG rating this month is GREEN.
Note the target profile has been rebased for FY2015/16.

Forecast: The forecast RAG is GREEN.

New data quality KPIs are planned. A paper describing those plans, and requesting Board approval for them, is included in today's set of data quality Board papers.

Notes: The data for this report is sourced from the HSCIC teams responsible for landing, assessing and reporting on the quality of the individual datasets in line with the current version of the applicable Standardisation Committee for Care Information (SCCI) approved information standard.



Key Performance Indicator (KPI) Commentary

- The KPI measures HSCIC performance in terms of access to data quality assessment methods and the reports based on the results of their application.
- The current scope is eight key datasets: Admitted Patient Care; Outpatients; Accident & Emergency; Improving Access to Psychological Therapies; Mental Health & Learning Disabilities; Diagnostic Imaging; Sexual and Reproductive Health Activity; and the National Child Measurement Programme.
- The plan for the reports has been reset to October 2015 to coincide with the first collection and assessment of the Sexual and Reproductive Health Activity Dataset using the Strategic Data Collection Service.

Management Information (MI) Commentary

- The A&E coverage issue has been resolved. This has reduced the A&E coverage figure and overall target by approximately 3% below that which was reported prior to the issue being identified.
- The validity figures for July and August 2015 are actually 99.58% and 99.53% respectively but are displayed as 100% due to rounding.
- MI measures the quality of data submitted by those data providers expected to submit data to the HSCIC in accordance with the current version of the applicable Standardisation Committee for Care Information (SCCI) approved information standard.
- Data providers are responsible for the quality of data submitted.
- The six key datasets currently in scope for these indicators are: Admitted Patient Care, Outpatients, Accident & Emergency, Improving Access to Psychological Therapies, Mental Health & Learning Disabilities and Diagnostic Imaging.

NHS Number completeness and validity by dataset - cumulative available data (September 2014 - August 2015)

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

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

Dataset level information by data quality measure - cumulative available data (September 2014 - August 2015)

Dataset coverage (%)	Completeness of reported data items (%)	Validity of completed data items (%)
98%	100%	100%
96%	100%	100%
91%	98%	100%
98%	84%	98%
99%	95%	98%
100%	92%	100%

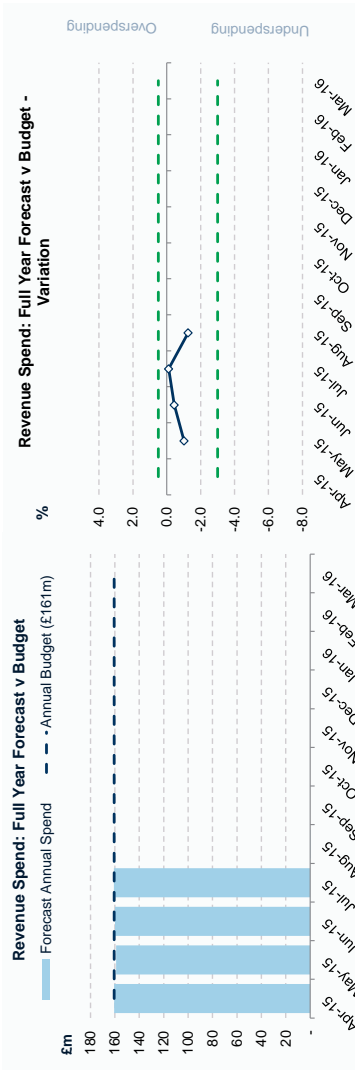
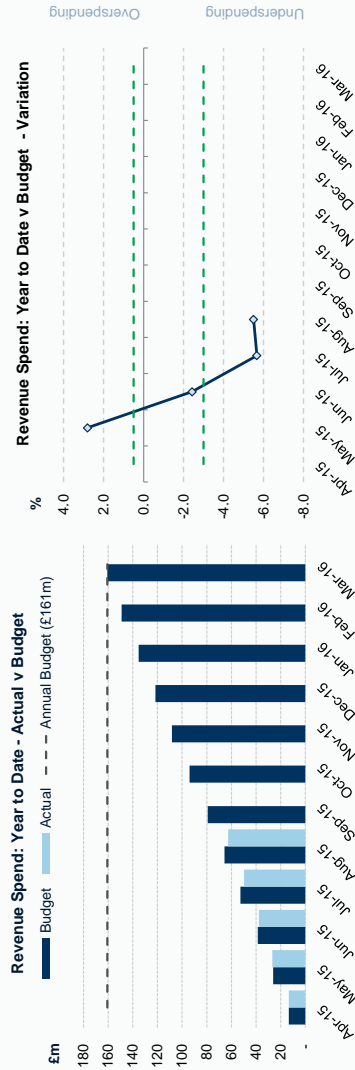
NOTE: Each dataset reports on different data items with different rules for completion and validation. Consequently, the results for completeness and validity should not be compared on a like-for-like basis.

Revenue Spend - Core & Ring-Fenced				
	Bud (£m)	Act (£m)	Var (£m)	Var (%)
Year to Date: Actual v Budget	65.7	62.0	3.6	5.5%
Full Year Forecast v Budget	160.6	158.6	2.0	1.3%

Forecast Accuracy				
	Act (£m)	F'cast (£m)	Var (£m)	Var (%)
In-month: Forecast v Actual	12.3	12.9	0.6	4.9%

Core GiA				
	Bud (£m)	Act (£m)	Var (£m)	Var (%)
Year to Date: Actual v Budget	60.4	57.2	3.2	5.3%
Full Year Forecast v Budget	148.0	146.6	1.4	1.0%

Ring-fenced GiA				
	Bud (£m)	Act (£m)	Var (£m)	Var (%)
Year to Date: Actual v Budget	5.3	4.9	0.4	8.2%
Full Year Forecast v Budget	12.6	12.0	0.6	4.7%



HSCIC Operating costs

The year-to-date outturn for the first five months of the year is £3.6m/5.5% below budget. The variance of £3.6m comprises £3.2m under budget on core GiA and £0.4m under on ring-fenced GiA. The £3.2m underspend on core GiA is largely due to delays to recruitment to vacant roles, partially offset by resultant decreases to income. The £0.4m underspend on ring-fenced GiA is also due to vacancies not being filled as early as predicted.

The forecast core GiA outturn for the full year is £2.0m/1.3% under budget; this comprises £1.4m under budget for core GiA (release of central contingency and increase in non-staff costs partially offset by reduced forecast for staff costs and an increase in income) and £0.6m under budget for ring-fenced GiA (reducing staff costs as recruitment dates for vacancies move to later in the year than budgeted).

Non-GiA income is £1.3m under budget for the year-to-date; this is partly due to the phasing of Actuals against Budget on MRIS and partly from reduced income on Choices and care data (both reflecting reduced costs) and Standards. The income forecast is £1.2m above budget for the full year. This is primarily driven from additional income from SSD, GPES and Cross-Government Programmes, partially offset by lower income on Choices (including DAS), care data, Standards and Technical Architecture.

Staff Costs are £5.0m under budget for the year-to-date and forecast £5.8m under budget for the full year. This mainly reflects recruitment running behind budgeted vacancies - most of the vacancies have now been reprofiled in the forecast to later in the year. The budget included an increase of 331 FTE over M1-5; however, permanent headcount only increased by a net 101 FTE over the period, incl. 14 summer interns (note: FTE increase figure is as at payroll date therefore may differ from HR figures for the whole of the month). The forecast now includes 377 permanent employees to join during the remainder of the year.

Non-Staff Costs are forecast to be £5.1m above budget for the full year. This includes £3.3m on Spine 2 for additional workpackages (RF), £1.0m in central ICT and £0.5m for GS1 licences in ASI.

The £(2.3)m full year variance on Unallocated Costs is due to specific savings having been recognised/identified in F&CS £(1.1)m and PDD £(1.5)m.

Contingency & Pressures

Given current known pressures (E&Y, savings to be found etc) and directorate overspends, the budgeted central contingency has effectively been utilised and has therefore been removed from the forecast.

Management action

Although tight budgets were set for Directorates for 15/16, the detailed budgets contained a significant amount of recruitment in the first quarter of the year, much of which did not materialise and has been reforecast into Q2/3. Some of this underspend on staff may be required to fund work through workpackages in place of recruitment, or may mean that income reduces where the staff were to support externally-funded work. With the removal of the corporate contingency forecast, pressures will need to be funded by Directorates releasing underspends from their respective forecasts.

Appendix 1 - Management Accounts

2014/15 HSCIC Management Accounts as at 31st August 2015

Summary Position

£'m	Year-to-Date			Full Year		
	Budget	Actual	Var	Budget	F'cast	Var
Core GIA	(60.4)	(60.4)	0.0	(148.0)	(148.0)	0.0
Ring-Fenced GIA	(5.3)	(4.9)	(0.4)	(12.6)	(12.0)	(0.6)
External Income	(25.9)	(24.6)	(1.3)	(63.3)	(64.5)	1.2
Staff Costs	66.2	61.2	5.0	162.2	156.3	5.8
Non-staff Costs	26.3	25.5	0.8	62.5	67.6	(5.1)
Unallocated Costs	(1.0)	0.0	(1.0)	(0.8)	(0.9)	0.1
Surplus/ (Deficit)	(0.0)	(3.2)	3.2	(0.0)	(1.4)	1.4
Depreciation GIA	(6.3)	(6.3)	0.0	(16.3)	(16.3)	0.0
Depreciation Cost	6.3	6.1	0.3	16.3	16.1	0.2
Surplus/ (Deficit)	0.0	(0.3)	0.3	0.0	(0.2)	0.2

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

The year-to-date outturn for the first five months of the year is £3.6m/ 5.5% below budget. The variance of £3.6m comprises £3.2m under budget on core GIA and £0.4m under on ring-fenced GIA. The £3.2m underspend on core GIA is largely due to delays to recruitment to vacant roles, partially offset by resultant decreases to income. The £0.4m underspend on ring-fenced GIA is also due to vacancies not being filled as early as predicted.

The forecast core GIA outturn for the full year is £2.0m/ 1.3% under budget; this comprises £1.4m under budget for core GIA (release of central contingency and increase in non-staff costs partially offset by reduced forecast for staff costs and an increase in income) and £0.6m under budget for ring-fenced GIA (reducing staff costs as recruitment dates for vacancies move to later in the year than budgeted).

Non-GIA income is £1.3m under budget for the year-to-date; this is partly due to the phasing of Actuals against Budget on MRIS and partly from reduced income on Choices and care data (both reflecting reduced costs) and Standards. The income forecast is £1.2m above budget for the full year. This is primarily driven from additional income from SSD, GPES and Cross-Government Programmes, partially offset by lower income on Choices (including DAS), care data, Standards and Technical Architecture.

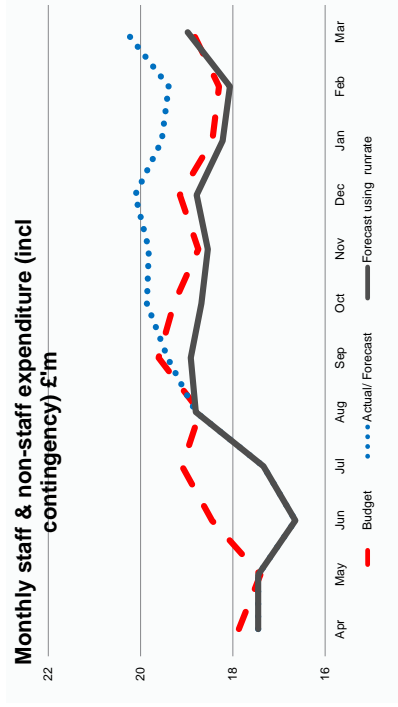
Staff Costs are £5.0m under budget for the year-to-date and forecast £5.8m under budget for the full year. This mainly reflects recruitment running behind budgeted vacancies - most of the vacancies have now been reprofiled in the forecast to later in the year. The budget included an increase of 331 FTE over M1-5; however, permanent headcount only increased by a net 101 FTE over the period, incl. 14 summer interns (note: FTE increase figure is as at payroll date therefore may differ from HR figures for the whole of the month). The forecast now includes 377 permanent employees to join during the remainder of the year.

Non-Staff Costs are forecast to be £5.1m above budget for the full year. This includes £3.3m on Spine 2 for additional workpackages (RF), £1.0m in central ICT and £0.5m for GS1 licences in ASI.

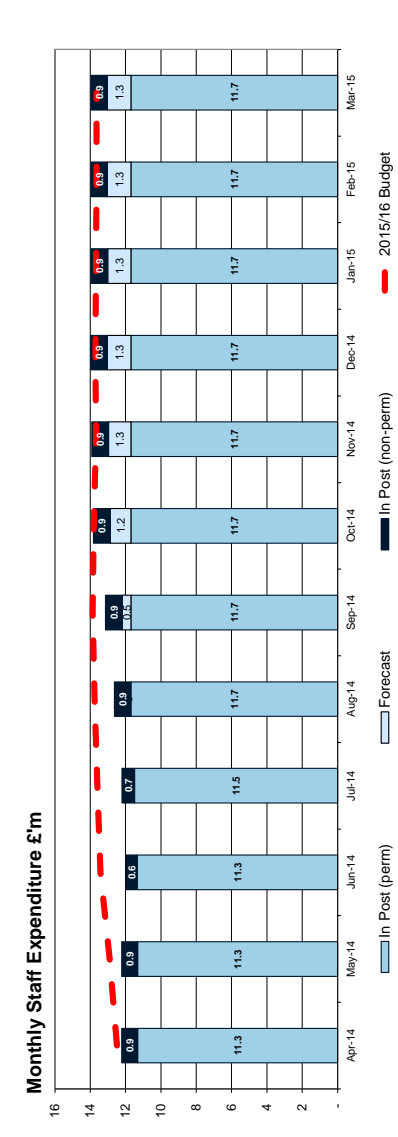
The £(2.3)m full year variance on Unallocated Costs is due to specific savings having been recognised/ identified in F&CS £(1.1)m and PDD £(1.5)m.

Contingency & Pressures

Given current known pressures (E&Y, Savings to be Found etc) and directorate overspends, the budgeted central contingency has effectively been utilised and has therefore been removed from the forecast.



Monthly trend of gross expenditure for the organisation for the original budget, the latest forecast (5 months of actual costs and 7 months of expected costs) and an extrapolation (runrate) of the position if the current staff position remained at August levels for the remainder of the year.



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

Appendix 1 - Management Accounts

2014/15 HSCIC Management Accounts as at 31st August 2015

Detail by Income/ Expenditure Type

£'m	Year-to-Date		Full Year	
	Budget	Actual	Budget	F'cast
Income				
Grant in Aid	(60.4)	(60.4)	(148.0)	(148.0)
Grant in Aid (ring-fenced)	(5.3)	(4.9)	(12.6)	(12.0)
Income	(25.9)	(24.6)	(63.3)	(64.5)
Total Income	(91.5)	(89.9)	(223.9)	(224.5)

Ring-fenced GIA - £(0.4)m YTD and £(0.6)m forecast variances reflect a reduction in expected costs, primarily in O&AS
 Non-GIA income is £1.3m under budget for the year-to-date; however, this includes £0.4m that is due to phasing of Actuals against Budget. The forecast is £1.2m above budget for the full year. This is primarily driven from additional income from SSD, GPES, Spine and Cross-Govt programmes, partially offset by lower income on Choices, care.data and Technical Architecture.

Staff Costs	
Permanent Staff	60.5
Non Permanent Staff	5.7
Total Staff Costs	66.2

£5.8m full year variance includes:

O&AS directorate (recruitment delays plus funding transferred to workpackages)	2.2
Programme Delivery (delayed recruitment against budget)	0.7
Information & Analytics directorate (delayed recruitment against budget)	1.3
Finance & Corporate Services (reduction in Contractors)	0.6
Customer Relations directorate	0.5
Other	0.5
Total	5.8

Other Costs	
Professional Fees	10.8
Information Technology	5.6
Travel & Subsistence	1.9
Accommodation	4.8
Marketing, Training & Events	0.7
Office Services	1.2
Other	1.3
Total Other Costs	26.3

Full year variance includes decreases of £3.8m on GPES (actuals incurred as ICT costs), £0.7m in F&CS (legal fees), Cross-Govt £0.7m and £0.5m in Service Management, partially offset by £1.1m increase in F&CS for estimated costs of E&Y, £3.3m increase on Spine 2, £0.5m HSCN.
 Full year variance includes £3.5m increase on GPES (budgeted under Professional Fees - will be realigned next month), £1.0m ICT and £0.5m in Tech Arochs (unbudgeted GS1 licences)
 Most Directorates are reporting/ forecasting T&S costs above budget.
 £0.4m additional Estates costs from budget, including increased costs of Skipton House and increase in rates.
 £0.4m full year variance is in Finance and offsets with variance on IT costs due to change in reporting category, post-budget. Will be realigned next month.

Unallocated Costs	
Directorate Contingency/ Savings	(0.8)
Central Contingency	(0.1)
Total	(0.9)

Directorate "Savings to be found" and/or contingencies to be used over the year. Savings figures will unwind over the course of the year as the savings are realised in Actuals. The £(2.3)m full year variance is due to specific savings have been recognised/ identified in F&CS £(1.1)m and PDD £(1.5)m
 Budget for contingency funding has been reduced to nil, given the current level of forecast spend and pressures for the organisation.

Depreciation	
Depreciation Grant-in-Aid	(6.3)
Depreciation Costs	6.3
Total	0.0

Appendix 1 - Management Accounts

2014/15 HSCIC Management Accounts as at 31st August 2015

Detail by Directorate

£'m	Year-to-Date		Budget	Actual	Var	Full Year		Budget	F'cast	Var
	Budget	Actual				Budget	F'cast			
Provider Support										
Income	(0.0)	(0.2)	0.2					(0.1)	(0.5)	0.4
Staff Costs	4.6	4.3	0.2				10.9	10.6	10.6	0.3
Other Costs	0.3	0.4	(0.1)				0.7	0.9	(0.9)	(0.2)
Contingency / Virements	0.0	0.0	0.0				(0.9)	(0.9)	10.1	0.0
Net GIA funded	4.8	4.5	0.3				10.6	10.1		0.5
Programmes Delivery										
Income	(8.6)	(8.5)	(0.1)				(20.7)	(21.1)		0.4
Staff Costs	13.9	11.7	2.2				32.2	31.5		0.7
Other Costs	4.5	4.2	0.3				11.3	10.6		0.7
Contingency / Virements	(1.0)	0.0	(1.0)				(2.5)	(0.9)		(1.6)
Net GIA funded	8.8	7.5	1.4				20.3	20.0		0.3
Operations & Assurance Services										
Income	(14.2)	(14.0)	(0.2)				(33.0)	(34.9)		1.9
Staff Costs	21.5	20.3	1.2				53.8	51.6		2.2
Other Costs	7.9	8.6	(0.7)				18.3	22.7		(4.3)
Contingency / Virements	0.2	0.0	0.2				0.9	0.7		(0.1)
Net GIA funded	15.5	15.0	0.5				39.9	40.1		(0.1)
Information & Analytics										
Income	(5.3)	(4.1)	(1.1)				(14.7)	(13.6)		(1.1)
Staff Costs	9.8	9.2	0.6				24.2	22.9		1.3
Other Costs	4.4	4.0	0.3				10.5	10.8		(0.3)
Contingency / Virements	0.1	0.0	0.1				0.4	0.2		0.2
Net GIA funded	9.0	9.1	(0.1)				20.4	20.4		0.1
Architecture, Standards & Innovation										
Income	(2.1)	(1.7)	(0.3)				(4.9)	(4.1)		(0.8)
Staff Costs	7.0	7.0	0.0				18.3	18.2		0.0
Other Costs	2.1	2.0	0.1				4.3	4.8		(0.5)
Contingency / Virements	0.3	0.0	0.3				(0.0)	(0.0)		0.0
Net GIA funded	7.3	7.2	0.1				17.7	18.9		(1.2)
Finance & Corporate Services (excl Estates)										
Income	(0.4)	(0.3)	(0.1)				(1.1)	(0.9)		(0.2)
Staff Costs	6.2	5.7	0.4				14.7	14.1		0.6
Other Costs	1.6	1.4	0.2				4.6	4.7		(0.1)
Contingency / Virements	(0.4)	0.0	(0.4)				(0.9)	0.0		(0.9)
Net GIA funded	7.0	6.8	0.2				17.4	17.9		(0.5)
Estates										
	4.2	4.3	(0.0)				9.8	10.3		(0.5)
HR & Transformation										
	1.4	1.1	0.3				3.4	3.4		0.1
Customer Relations										
	1.9	1.7	0.2				4.9	4.7		0.2
Clinical										
	0.5	0.4	0.2				1.2	1.1		0.1
HSCIC Corporate Contingency/GIA										
	(60.5)	(60.7)	0.2				(145.6)	(148.3)		2.7

£0.4m increased forecast for income is due to additional income for secondments, Proton Beam Therapy and business case assurance review service.
£0.3m forecast underspend on staff costs due to delayed recruitment and leavers not replaced.
The "Contingency/Virements" line shows Directorate Savings to be Found to be realised throughout the year.

Income - £0.4m full year forecast variance includes £2.4m increased income on GPES, Cross-Govt IT, GPSOC, CORS and SCR, partially offset by £0.9m reduction on DAS and £0.6m reduction on Choices.
Staff costs - YTD underspend of £2.2m includes £1.3m HSCN and £0.4m Choices. The full year forecast variance of £0.7m includes £0.7m HSCN and £0.9m Choices, partially offset by increased costs of £0.6m on GPSOC R
The "Contingency/Virements" line shows Directorate Savings to be Found to be realised throughout the year. Forecast has been released due to savings realised to date £(1.6)m

£1.9m additional income includes increases to Spine 2 £1.6m (additional recharge of costs to DH to be capitalised) and SSD £0.8m, partially offset by reductions in income for NHS Pathways £(0.3)m and Solution Assurance £0.6m.
£2.2m forecast reduction in Staff Costs is due to expected recruitment being delayed until later in the year, some of which relates to income reductions as above, with some savings being used to fund workpackages (see below)
£(4.3)m increase in non-staff costs is primarily due to £3.3m increase on Professional Fees for Spine 2 workpackages (related to the increased income from DH and reduced staff costs above) and £1.0m additional forecast for central ICT.

£(1.1)m year-to-date variance on Income is due to £0.4m from budget phasing of income on Medical Research (expected to unwind over the year) and £0.5m reduction in expected income on care.data. The full year income variance of £(1.1)m is primarily due to reduction in expected income on care.data £(0.7m).
£1.3m forecast underspend on staff costs includes £0.7m reduction on care.data (related to income variances above)

£(0.8)m forecast variance on Income is due to £(0.5)m reduction in expected external funding to cover IHTSDO membership, £(0.5)m reduction from ring-fenced income and DH income for capitalised headcount on Tech Archis partially offset by increased income on DSIC and NTS.
£(0.5)m overspend on non-staff costs is due to £0.5m unbudgeted costs for GS1 licences.
Although the net position on the Contingency Virements line is nil this contains £0.7m of Savings to be Found offset by £0.7m of Contingency on NTS (transferred in from I&A)

£0.6m underspend on staff costs is due to reduction in contractor costs in Commercial.
£(0.1)m overspend on non-staff costs is due to the inclusion of unbudgeted estimated costs for E&Y £(1.1)m partially offset by reduction in forecast legal fees £0.7m
The "Contingency/Virements" line shows Directorate Savings to be Found to be realised throughout the year. Forecast has been released due to savings found on reduced contractor costs and legal fees.

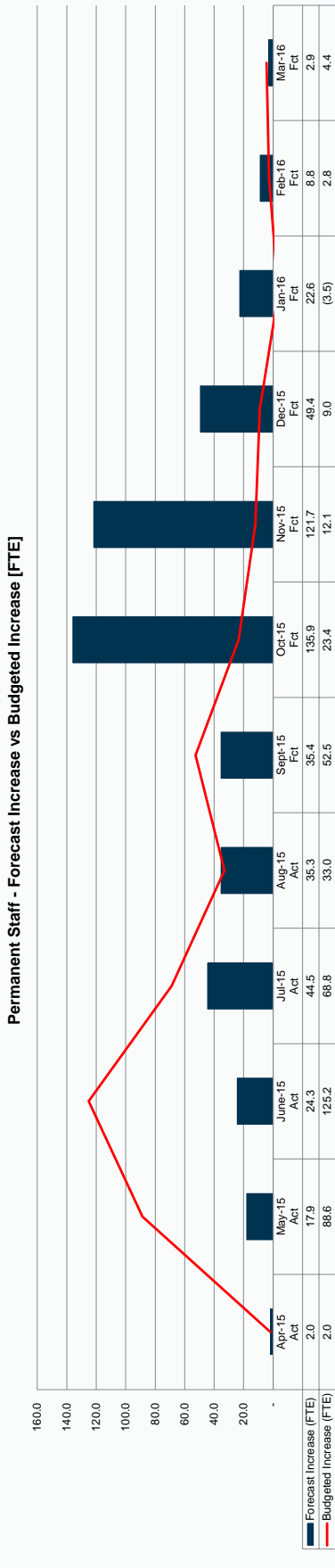
£0.5m additional Estates costs from budget, including increased costs of Skipton House and increase in rates.

Budget for contingency funding has been reduced to nil, given the current level of forecast spend and pressures for the organisation.

Appendix 1 - Management Accounts

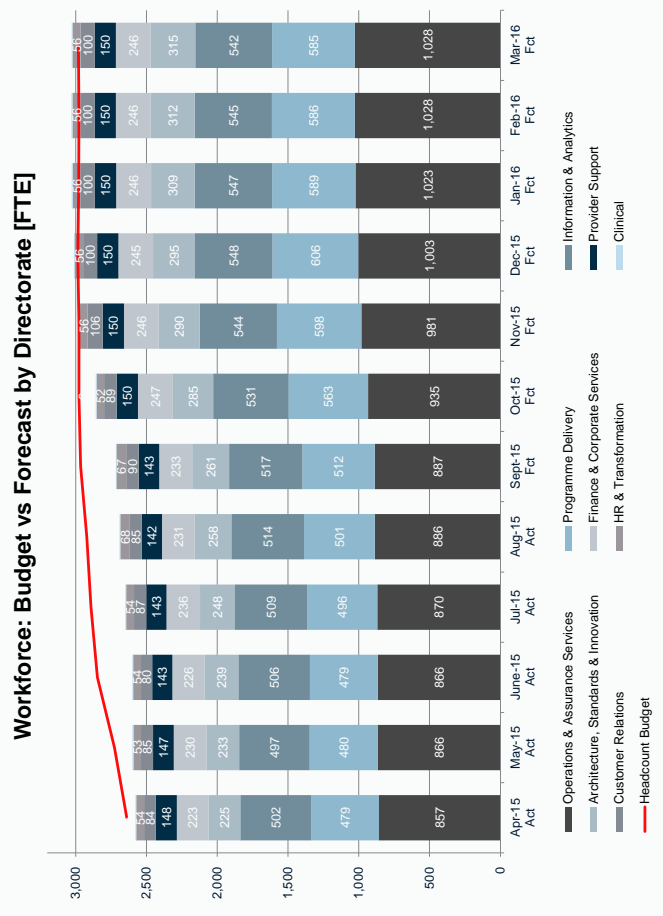
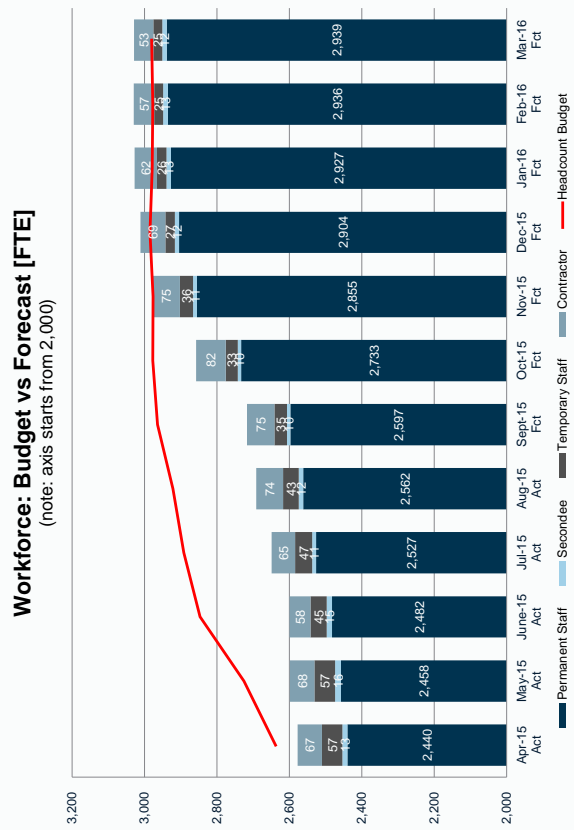
2014/15 HSCIC Management Accounts as at 31st August 2015

Headcount



The budget included an increase of 331 FTE over M1-5; however, permanent headcount only increased by a net 101 FTE over the period, incl. 14 summer interns who will leave in October. Vacancies have been moving to the right over the course of the year so far, with the peak of recruitment now being seen in October and November. The forecast now includes 377 permanent employees to join during the remainder of the year.

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



KPI
KPI Owner

Programme Achievement
James Hawkins

Appendix 2 - Programme Delivery Dashboard

PDD RAG Summary			
Previous RAG	A/G	Programme Delivery Director View	
Current RAG	A/G	Current RAG	N/A
Forecast RAG	A/G	Forecast RAG	TBC

Programme Delivery Dashboard - July 2015

Reporting Month:	Overall Delivery Confidence RAG												Key Delivery Milestones			Current year financial forecast against budget			Investment justification (BC, MoU etc) forecast spend status			
	May	Jun	Jul	Aug	Sep	Oct	RPA	Last Gate	Date	RAG	Next Gate	Status	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	
P0070 Calculating Quality Reporting Service	No	G	G	G	G	G	Low	5	Oct-2014	A/G	N/A	N/A	A	A	A	N/A	A	G	G	G	G	G
P0281 General Practice Extraction Service	No	A	A/G	A/G	A/G	A/G	TBC	4	Dec-2012	A/G	TBC	TBC	A	A	A	TBC	R-U	R-O	R-O	R-O	R-O	R-O
P0288 GP Systems of Choice Replacement	Yes	A	A/G	A/G	A/G	A/G	High	5	Apr-2015	G	TBC	Not booked	A	A	A	TBC	R-U	R-O	R-O	R-O	R-O	R-O
P0004 Child Protection – Information Sharing	Yes	A	A	A	A	A/R	Med	4	Jul-2014	A/G	5	Apr-2016	A	A	A	TBC	R-U	R-U	R-U	R-U	R-U	R-U
P0341 SCIP	Yes	G	G	G	G	G	TBC	N/A	N/A	N/A	TBC	TBC	G	G	G	TBC	G	R-O	R-O	R-O	R-O	R-O
P0372 ISP	Yes	A	A	A	A/G	A/G	TBC	N/A	N/A	N/A	TBC	TBC	A	A	A	TBC	R-O	R-U	R-U	R-U	R-U	R-U
P0301 FGMP	No	G	A/G	A/G	A/G	A/G	N/A	N/A	N/A	N/A	N/A	N/A	G	A	A	TBC	R-O	R-U	R-U	R-U	R-U	R-U
P0207 Health & Justice Information Services	Yes	A/G	A/G	A/G	A/G	A/G	Med	2	Aug-2014	A/R	3	Sep-2015	A	G	A	TBC	R	R-U	R-U	R-U	R-U	R-U
P0037 Offender Health IT	Yes	A/G	A/G	A/G	A/G	A/G	N/A	N/A	N/A	N/A	N/A	N/A	G	G	G	TBC	G	R	R	R	R	R
P0014 GP2GP	Yes	A/G	A/G	A/G	A/G	A/G	Low	4	Feb-2014	A/G	5	Sep-2015	A	A	A	TBC	R-U	R-U	R-U	R-U	R-U	R-U
P0026 NHS Choices	No	A/R	A/R	A	A	A	High	1	Apr-2015	A/R	TBC	Not Booked	G	G	G	TBC	N/A	R-U	R-U	R-U	R-U	R-U
P0190 Health and Social Care Network	No	R	R	R	A/R	A/R	High	PAR	Jan-2015	R	2	Sep-2015	A	A	A	TBC	R-U	R-U	R-U	R-U	R-U	R-U
P0196 NHSmail 2	No	A/G	A	A/R	A/R	A/R	High	3	Feb-2015	A/G	4	Sep-2015	A	A	A	TBC	R-U	R-U	R-U	R-U	R-U	R-U
P0238 NHS e-Referrals	No	A/G	A	A	A	A/G	High	4	Apr-2015	A/G	TBC	Not booked	A	A	A	TBC	G	R-O	R-O	R-O	R-O	R-O
P0051 Summary Care Record	Yes	A/G	A/G	A/G	A/G	A/G	Med	5	Apr-2015	A/G	TBC	Not booked	A	G	G	TBC	R-O	R-O	R-O	R-O	R-O	R-O
P0012 Electronic Transfer of Prescriptions	Yes	A	A	A	A	A	High	0 + 5	Apr-2015	A	5	Oct-2015	G	G	G	TBC	G	R-O	R-O	R-O	R-O	R-O

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

July's calculated delivery confidence is at 70.67%. The Calculated delivery confidence RAG remains at Amber Green. The 3-month calculated forecast Delivery Confidence (to October 2015) is Amber Green at 77.33%.

PDD View		
July-2015	A/G	70.67%
October-2015	A/G	77.33%

Sourced from Highlight Reports

KEY

Trend	↑	RAG improvement from previous month
	↔	RAG same as previous month
	↓	RAG decrease from previous month

Non Completion

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

KPI
KPI Owner

Programme Achievement
James Hawkins

Appendix 2 - Programme Delivery Dashboard

Previous RAG	A/G	Programme Delivery Director View
Current RAG	A/G	Current RAG
Forecast RAG	A/G	Forecast RAG

Programme Delivery Dashboard - July 2015

Reporting Month:	Benefits realisation confidence			Quality Management against plan			Programme / Project end date			Current Investment Justification approval status			Digital & Technology Spend Controls Status			Resourcing Against Plan			Progress against planned mitigation for risk		
	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul
P0070 Calculating Quality Reporting Service	G	G	G	G	G	G	G	G	G	G	G	G	N/A	N/A	N/A	A	A	A	TBC	TBC	TBC
P0281 General Practice Extraction Service	N/A	N/A	N/A	A	A	A	A	A	A	G	G	G	G	G	G	A	A	A	TBC	TBC	TBC
P0208 GP Systems of Choice Replacement	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	A	A	A	TBC	TBC	TBC
P0004 Child Protection – Information Sharing	A	A	A	G	G	G	G	G	G	G	G	G	G	G	G	A	A	A	TBC	TBC	TBC
P0341 SCIP	TBC	TBC	TBC	TBC	TBC	TBC	G	G	G	G	G	G	N/A	N/A	N/A	G	G	G	TBC	TBC	TBC
P0372 ISP	N/A	N/A	N/A	A	A	A	G	G	G	G	G	G	N/A	N/A	N/A	G	G	G	TBC	TBC	TBC
P0301 FGMP	N/A	N/A	N/A	TBC	TBC	TBC	G	G	G	G	G	G	G	G	G	G	G	G	TBC	TBC	TBC
P0207 Health & Justice Information Services	TBC	G	G	G	G	G	A	A	A	A	A	A	G	G	G	G	G	G	TBC	TBC	A
P0037 Offender Health IT	N/A	G	G	G	G	G	G	G	G	G	G	G	N/A	N/A	N/A	G	G	G	TBC	TBC	TBC
P0014 GP2GP	A	A	A	G	G	G	A	A	A	G	G	G	N/A	N/A	N/A	G	G	G	TBC	TBC	TBC
P0026 NHS Choices	N/A	N/A	N/A	A	A	A	A	A	A	A	A	A	N/A	N/A	N/A	G	G	G	TBC	TBC	TBC
P0190 Health and Social Care Network	N/A	N/A	N/A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	TBC	TBC	TBC
P0196 NHS Small 2	G	A	A	A	A	A	R	R	R	A	A	A	A	A	A	R	R	R	TBC	TBC	TBC
P0238 NHS e-Referrals	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	A	A	A	TBC	TBC	TBC
P0051 Summary Care Record	A	A	A	G	G	G	G	G	G	G	G	G	G	G	G	A	A	A	TBC	TBC	TBC
P0012 Electronic Transfer of Prescriptions	A	A	A	G	G	G	G	G	G	A	A	A	G	G	G	G	G	G	TBC	TBC	TBC

Overall Delivery Confidence for Programme Delivery (Calculated):

July-2015	A/G	70.67%
October-2015	A/G	77.33%

July-2015	N/A
October-2015	N/A

July's calculated delivery confidence is at 70.67%. The Calculated delivery confidence RAG remains at Amber Green. The 3-month calculated forecast Delivery Confidence (to October 2015) is Amber Green at 77.33%.

Sourced from Highlight Reports (Key RAGs)

KEY

Trend

- ↑ RAG improvement from previous month
- RAG same as previous month
- ↓ RAG decrease from previous month

Non Completion

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

KPI	Programme Achievement (other Directorates)	Prov. Sup RAG Summary	I&A RAG Summary	OxAS RAG Summary	ASI RAG Summary
KPI Owner	James Hawkins	Previous RAG	Previous RAG	Previous RAG	Previous RAG
Data Owner	Tom Dimwood (Prov Sup), Martin Severs (I&A), Rob Shaw (OxAS), Peter Couner (ASI)	Current RAG	Current RAG	Current RAG	Current RAG
	Appendix 2 - Programme Delivery Dashboard	Forecast RAG	Forecast RAG	Forecast RAG	Forecast RAG

Prov Sup Dashboard - July 2015																		
Reporting Month	Overall Delivery Confidence RAG			Assurance Delivery Confidence / Status			Key Delivery Milestones			Current year financial forecast against budget			Investment Justification (BC, Mod etc) forecast spend status					
	May	Jun	Jul	Last Gate	Date	RAG	Next Gate	Date	Status	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul
P0033 PACS	No	A	A	TBC	0	Nov-11	A	TBC	TBC	A	A	A	A-U	G	G	NA	NA	NA
P0183 South Community Programme	No	G	G	Med	3	Dec-12	A/G	5	TBC	G	G	G	G	G	A	A	A	A
P0182 South Ambulance Programme	No	A/R	A/R	Med	4	Nov-14	A/G	5	TBC	R	R	R	G	G	G	G	G	G
P0181 South Acute Programme	No	G	G	High	4	Apr-15	G	TBC	TBC	A	A	A	R-U	R-U	R-U	G	G	G
P0047 BT LSP	No	A/R	A/R	High	PAR	Mar-15	A/R	N/A	NA	A	A	A	R-U	R-U	R-U	G	G	G
P0031 CSC LSP	Yes	A/R	A/R	High	PAR	Apr-15	R	PAR	TBC	A	A	A	G	G	A	G	G	G
Overall Delivery Confidence for Prov Sup:	A			A			A			1st letter = RAG, 2nd letter = Under / overspend			1st letter = RAG, 2nd letter = Under / overspend					
July-2015	60.00%			60.00%			60.00%			The high level commentary provides further detail.			The high level commentary provides further detail.					
October-2015	A			A			A			The high level commentary provides further detail.			The high level commentary provides further detail.					

Informatics and Analytics - July 2015																		
Reporting Month	Overall Delivery Confidence RAG			Assurance Delivery Confidence / Status			Key Delivery Milestones			Current year financial forecast against budget			Investment Justification (BC, Mod etc) forecast spend status					
	May	Jun	Jul	Last Gate	Date	RAG	Next Gate	Date	Status	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul
P0306 cmo data	Yes	A/R	A/R	High	PAR	Feb-15	R	TBC	TBC	A	A	A	G	G	R	R	R	R
P0055 Metadata California Dataset	Yes	A/G	A	High	3	Jan-13	A	4	TBC	A/G	A/G	A/G	G	G	G	G	G	G
P0321 Pathfinder on DME	Yes	A/R	A/R	Med	3	Aug-14	A/R	N/A	NA	R	R	R	A-U	A-U	A-U	G	G	G
Overall Delivery Confidence for I&A:	A/R			46.67%			A			1st letter = RAG, 2nd letter = Under / overspend			1st letter = RAG, 2nd letter = Under / overspend					
July-2015	A			A			A			The high level commentary provides further detail.			The high level commentary provides further detail.					
October-2015	A			60.00%			A			The high level commentary provides further detail.			The high level commentary provides further detail.					

Operations and Assurance Services Dashboard - July 2015																		
Reporting Month	Overall Delivery Confidence RAG			Assurance Delivery Confidence / Status			Key Delivery Milestones			Current year financial forecast against budget			Investment Justification (BC, Mod etc) forecast spend status					
	May	Jun	Jul	Last Gate	Date	RAG	Next Gate	Date	Status	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul
P0050 Spine 2	No	A/G	A/G	High	5	Feb-15	G	5	TBC	G	A	A	R-O	G	G	G	G	G
P0325 Cyber Security Programme	No	A	A	High	N/A	N/A	N/A	0	TBC	A	A	A	N/A	N/A	G	G	G	G
P0335 SUS Transition	No	G	G	High	5	Jul-15	G	5	TBC	G	G	A	R-O	G	A	G	G	G
Overall Delivery Confidence for OxAS:	G			80.00%			G			1st letter = RAG, 2nd letter = Under / overspend			1st letter = RAG, 2nd letter = Under / overspend					
July-2015	G			80.00%			G			The high level commentary provides further detail.			The high level commentary provides further detail.					
October-2015	G			83.33%			G			The high level commentary provides further detail.			The high level commentary provides further detail.					

Architecture Standards and Innovation - July 2015																		
Reporting Month	Overall Delivery Confidence RAG			Assurance Delivery Confidence / Status			Key Delivery Milestones			Current year financial forecast against budget			Investment Justification (BC, Mod etc) forecast spend status					
	May	Jun	Jul	Last Gate	Date	RAG	Next Gate	Date	Status	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul
P0294 National Tenth System (NLS)	Yes	A	A	High	PVR	Jun-15	A	TBC	TBC	A	A	A	A-O	A-O	A	A	A	A
P0406 Data Services for Commissioners	Yes	A	A	Med	N/A	N/A	N/A	NR	NR	A	A	A	TBC	TBC	0	A	A	A
Overall Delivery Confidence for OxAS:	A			60.00%			A/G			1st letter = RAG, 2nd letter = Under / overspend			1st letter = RAG, 2nd letter = Under / overspend					
July-2015	A			60.00%			A/G			The high level commentary provides further detail.			The high level commentary provides further detail.					
October-2015	A			70.00%			A/G			The high level commentary provides further detail.			The high level commentary provides further detail.					

Sourced from Highlight Reports (Key POCs)

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, MIOUs 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 of information around the progression of an approval)

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

Appendix 2 - Programme Delivery Dashboard

Prov Sup RAG Summary			I&A RAG Summary			O-AS RAG Summary			ASI RAG Summary		
Previous RAG	Current RAG	Forecast RAG	Previous RAG	Current RAG	Forecast RAG	Previous RAG	Current RAG	Forecast RAG	Previous RAG	Current RAG	Forecast RAG
A	A	A	A/R	A	A	G	G	G	A	A	A/G

Prov Sup Dashboard - July 2015

Programme / Project end date	Benefits realisation confidence			Quality Management against plan			Current Investment Justification approval status			Digital & Technology Spend Controls Status			Resourcing Against Plan			Progress against planned mitigation for risk		
	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul
P0033 PACS	G	G	G	N/A	N/A	N/A	G	G	G	N/A	N/A	N/A	G	G	G	TBC	TBC	TBC
P0183 South Community Programme	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	TBC	TBC	A
P0182 South Ambulance Programme	A	A	A	A	A	A	A	A	A	A	A	A	G	G	G	TBC	TBC	A
P0181 South Acute Programme	A	A	A	G	G	G	G	G	G	G	G	G	G	G	G	TBC	TBC	A
P0047 BT LSP	R	R	R	G	G	G	A	A	A	G	G	G	G	G	G	TBC	TBC	A
P0031 CSC LSP	A	A	A	G	G	G	R	R	R	G	G	G	G	G	A	A	A	A

Overall Delivery Confidence for Prov Sup:
 July-2015 A 60.00%
 October-2015 A 60.00%

Informatics and Analytics - July 2015

Programme / Project end date	Benefits realisation confidence			Quality Management against plan			Current Investment Justification approval status			Digital & Technology Spend Controls Status			Resourcing Against Plan			Progress against planned mitigation for risk		
	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul
P0306 care.data	R	R	R	A	A	A	G	G	G	A	A	A	A	A	A	TBC	TBC	TBC
P0294 Maturity and Childrens Dataset	A	A	A	G	G	G	G	G	G	G	G	G	A	A	A	TBC	TBC	TBC
P0321 Pathfinder on DIME	N/A	N/A	N/A	R	R	R	A	A	A	N/A	N/A	N/A	R	R	R	TBC	TBC	TBC

Overall Delivery Confidence for I&A:
 July-2015 A/R 46.67%
 October-2015 A 60.00%

Operations and Assurance Services Dashboard - July 2015

Programme / Project end date	Benefits realisation confidence			Quality Management against plan			Current Investment Justification approval status			Digital & Technology Spend Controls Status			Resourcing Against Plan			Progress against planned mitigation for risk		
	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul
P0050 Spine 2	A	G	G	A	A	A	G	G	G	G	G	G	A	A	A	TBC	TBC	G
P0325 Cyber Security Programme	N/A	N/A	N/A	N/A	G	G	A	G	G	A	N/A	N/A	G	G	G	TBC	TBC	G
P0335 SUB Transition	A	A	A	G	G	G	A	A	A	A	A	A	G	G	G	TBC	TBC	G

Overall Delivery Confidence for O-AS:
 July-2015 G 80.00%
 October-2015 G 93.33%

Architecture Standards and Innovation - July 2015

Programme / Project end date	Benefits realisation confidence			Quality Management against plan			Current Investment Justification approval status			Digital & Technology Spend Controls Status			Resourcing Against Plan			Progress against planned mitigation for risk			
	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	May	Jun	Jul	
P0284 National Tariff System (NTS)	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	TBC	TBC	A	
P0406 Data Services for Commissioners	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	G

Overall Delivery Confidence for O-AS:
 July-2015 A 60.00%
 October-2015 A/G 70.00%

Sourced from Highlight Reports (Key RAGs) July-15

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 of information around the progression of an approval)

Board meeting – Public session

Title of paper:	Data Quality KPIs
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 03 (a) i
Paper presented by:	Martin Severs, Director of Information and Analytics
Paper prepared by:	John Sharp, Head of Data Quality
Paper approved by: (Sponsor Director)	Martin Severs, Director of Information and Analytics
Purpose of the paper:	To update the Board on the plan for data quality KPIs.
Key risks and issues:	Resistance to providing data for the KPIs and action not taken to improve poor KPI outcomes.
Patient/public interest:	Indirect. Publication of the data quality reports required by the KPI gives everyone, including patients and the public, an opportunity to query service provider performance in this area.
Actions required by the board:	To approve the plan for data quality KPIs.

Data Quality KPIs

Author: John Sharp, Head of Data Quality

Date: 3 September 2015

Contents

1. Executive Summary	3
2. Background	3
3. High Level Plan	3
4. Benefits	3
5. Financial Implications	3
6. Risks	3
7. Actions Required of the Board	3
8. Appendix 1 - Proposed Data Quality KPIs	4

1. Executive Summary

The paper provides the Board with an overview of the plans for developing HSCIC’s data quality KPIs. It describes the background; high level plan; and expected benefits. It also draws attention to the high level risks, together with their proposed mitigation.

2. Background

The current data quality KPI is not considered fit for purpose for the following reason:

- It does not indicate the performance of any process, product or tool used to support corporate data quality assurance policy

EMT and the Board have requested that data quality KPIs be developed that are fit for purpose.

3. High Level Plan

Corporate data quality assurance policy has not been approved yet. Consequently, a phased approach to developing the proposed KPIs is planned. The KPIs planned for earliest development are more detailed than the later KPIs as there is more certainty about their inclusion in corporate data quality assurance policy. Once corporate policy has been approved, and the supporting processes, products and tools agreed, the later KPIs will be updated with more detail.

Appendix 1 shows the proposed development plan for data quality KPIs.

4. Benefits

Developing data quality KPIs that are fit for purpose will:

- Demonstrate measurable improvement in the delivery and use of corporate data quality assurance policies, processes, products and tools
- Ensure the HSCIC meets its statutory data quality assurance responsibilities
- Support the delivery of HSCIC’s strategic objectives

5. Financial Implications

There are no direct financial implications of developing the data quality KPIs in the way described.

6. Risks

Risk	Proposed Mitigation
Resistance to providing data for the KPIs	Implementation of data quality policies and associated governance mechanisms
Action not taken to improve poor KPI outcomes	EMT to hold poor performers to account

7. Actions Required of the Board

For Board approval.

8. Appendix 1 - Proposed Data Quality KPIs

Name	Description	Estimated Reporting Date
NHS Number – Key secondary uses datasets ¹	<p>Publication of completeness and validity information for NHS Number in six key secondary uses datasets.</p> <p>Frequency: Monthly</p> <p>Level: Provider</p> <p>Style: Time series and CSV</p> <p>Measure: Information is published on the HSCIC website on the agreed dates</p>	End-Dec 2015
Key secondary uses dataset coverage	<p>Publication of coverage information for six key secondary uses datasets.</p> <p>Frequency: Monthly</p> <p>Level: National</p> <p>Style: Time series and CSV</p> <p>Measure: Information is published on the HSCIC website on the agreed dates</p>	End-Mar 2016

¹ Admitted Patient Care (APC); Outpatients (OP); Accident & Emergency (A&E); Improving Access to Psychological Therapies (IAPT); Mental Health & Learning Disabilities Dataset (MHLDDS); Diagnostic Imaging Dataset (DID)

Data Quality KPIs

Name	Description	Estimated Reporting Date
Key secondary uses dataset timeliness	<p>Publication of timeliness information for six key secondary uses datasets.</p> <p>Frequency: Monthly</p> <p>Level: National</p> <p>Style: Time series and CSV</p> <p>Measure: Information is published on the HSCIC website on the agreed dates</p>	End-Mar 2016
Linkage Data – Key secondary uses datasets	<p>Publication of completeness and validity information for NHS Number; Date of Birth; Sex; and Postcode in six key secondary uses datasets.</p> <p>Frequency: Monthly</p> <p>Level: Provider</p> <p>Style: Time series and CSV</p> <p>Measure: Information is published on the HSCIC website on the agreed dates</p>	End-Jan 2016
Linkage Data – All I&A secondary uses datasets	<p>Publication of completeness and validity information for NHS Number; Date of Birth; Sex; and Postcode where it is mandated for collection or extraction in any I&A secondary uses dataset.</p> <p>Frequency: Monthly</p> <p>Level: Provider</p> <p>Style: Time series and CSV</p> <p>Measure: Information is published on the HSCIC website on the agreed dates</p>	End- Jun 2016

Data Quality KPIs

Name	Description	Estimated Reporting Date
Key Data Items – All I&A secondary uses datasets	<p>Publication of completeness and validity information for agreed key fields appearing in any I&A secondary uses dataset.²</p> <p>Frequency: Monthly</p> <p>Level: Provider</p> <p>Style: Time series and CSV</p> <p>Measure: Information is published on the HSCIC website on the agreed dates</p>	End-Sep 2016
All I&A secondary uses dataset coverage	<p>Publication of coverage information for all I&A secondary uses datasets.</p> <p>Frequency: Monthly</p> <p>Level: National</p> <p>Style: Time series and CSV</p> <p>Measure: Information is published on the HSCIC website on the agreed dates</p>	End-Dec 2016
All I&A secondary uses dataset timeliness	<p>Publication of timeliness information for all I&A secondary uses datasets.</p> <p>Frequency: Monthly</p> <p>Level: National</p> <p>Style: Time series and CSV</p> <p>Measure: Information is published on the HSCIC website on the agreed dates</p>	End-Dec 2016

² These KPIs are expected to include the NIB Data Quality Standards currently in development

Data Quality KPIs

Name	Description	Estimated Reporting Date
Reference Data	<p>Publication of data quality information for reference data, e.g. Organisational Data Service (ODS) data.</p> <p>Frequency: tbc</p> <p>Level: tbc</p> <p>Style: tbc</p> <p>Measure: tbc</p>	End-Dec 2017
Future development	<p>Roll out data standard quality reporting for other HSCIC areas as appropriate, including primary use systems and public-facing products</p>	2016/17 and 2017/18

Board meeting – Public session

Title of paper:	Data Quality Assurance Strategy on a Page
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 03 (a) ii
Paper presented by:	Martin Severs, Director of Information and Analytics
Paper prepared by:	John Sharp, Head of Data Quality
Paper approved by: (Sponsor Director)	Martin Severs, Director of Information and Analytics
Purpose of the paper:	To update the Board on the development of data quality assurance strategy.
Key risks and issues:	The strategy needs effective collaboration with external stakeholders and the support of robust internal policy and governance to meet its objectives.
Patient/public interest:	Realisable only in the medium or longer term as the objectives are met.
Actions required by the board:	To approve the data quality assurance strategy on a page.

Data quality assurance strategy 2015-2020

Vision

By 2020 our data quality assurance services will provide the most consistent, comprehensive and accessible information available about the quality of national health and social care data

Priorities

Ensure that the impact of citizens' preferences for sharing personal data are analysed and reported.

- Develop evidence-based methods for measuring data consistency.
- Establish a standard method for analysing and reporting the reasons for, and impact of, any data inconsistencies.
- Ensure quality of identifiers supports patient-requested objections.

Establish data quality assurance as a fundamental part of standards development.

- Develop evidence-based data quality assurance assessment criteria.
- Build and maintain a library of data quality assurance assessments for use with different types of standards.
- Make sure that data quality assessments are used appropriately and the results acted upon.

Implement data quality assurance processes for all national data services.

- Categorise the different types of data service, e.g. secondary use, primary use, reference and public-facing.
- Develop and implement a data quality assurance policy for each data service type.
- Develop and implement the processes, tools and products required to support each policy.
- Develop KPIs to monitor the implementation and continued use of the processes, tools and products.
- Ensure national data quality assurance methods can be applied at local level.

Support organisations to continually improve the quality of their data and to get the best from our data quality assurance information.

- Set up and support data quality assurance groups.
- Provide easy access to evidence-based data quality improvement information via a variety of media, including an app.
- Visit organisations to provide face-to-face, hands-on support for data quality improvement.

Add value to health and care data by providing access to information about its quality.

- Build and maintain a library of data quality methods and results templates for use by the different types of data service.
- Include data quality assessment methods and results in all data services' metadata.
- Meet, or exceed, the Open Data Institute's Standard certificate level for all data quality information.

Transforming Delivery

We will transform the way we engage on data quality assurance

- Radically improve the way we engage with our partners and stakeholders.
- Show everyone who uses our data quality assurance services that that we are listening and responding to their needs.
- Provide tools to enable data providers and users to assess data quality.

We will transform the way we work on data quality assurance

- Show that we are flexible and dynamic and take on new challenges.
- Show that we take responsibility for professional development.
- Actively support the wider data quality assurance agenda, including the National Information Board 'Framework for Action'.

People focused

Professional

Values

Trustworthy

Innovative

Board meeting – Public session

Title of paper:	Secondary Uses Data Quality Assurance Policy
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 03 (a) iii
Paper presented by:	Martin Severs, Director of Information and Analytics
Paper prepared by:	John Sharp, Head of Data Quality
Paper approved by: (Sponsor Director)	Martin Severs, Director of Information and Analytics
Purpose of the paper:	To update the Board on the development of a secondary uses data quality assurance policy.
Key risks and issues:	Policies covering other data types and uses will be needed to fully meet data quality assurance strategy objectives. Failure to comply with the policy is not addressed.
Patient/public interest:	Realisable only in the medium or longer term as the policy and supporting processes, products and tools are applied.
Actions required by the board:	To approve the secondary uses data quality assurance policy.

Data Quality Assurance

Status	Draft		
Document Record ID Key			
Version	V0.8	Version Date	02/09/2015
Director Responsible for this policy	Martin Severs		
Person to contact about this policy	John Sharp		
Author	John Sharp		

HSCIC Data Quality Assurance Policy – Secondary Uses Data

Revision History

Version	Date	Summary of Changes
0.1	06/03/2015	First draft for review
0.2	01/05/2015	Updated draft based on review comments
0.3	01/06/2015	Updated draft based on review comments
0.4	10/07/2015	Major update following meetings with key stakeholders
0.5	24/07/2015	Updated draft based on review comments
0.6	30/07/2015	Updated draft based on review comments
0.7	04/08/2015	Updated draft based on additional review comments received for v0.5
0.8	07/08/2015	Updated draft following review of comments received since v0.5

Reviewers

This document has been reviewed by the following:

Reviewer name	Title / Responsibility	Date	Version
Chris Dew	Clinical Indicators Programme Manager	13/03/2015	0.1
Chris Roebuck	Interim Director of Data Dissemination	15/03/2015	0.1
Gemma Ramsey	Section Head, Primary Care	18/03/2015	0.1
Julie Stroud	Head of Profession for Statistics	17/04/2015	0.1
Kate Croft	Head of Statistical Response Unit	28/04/2015	0.1
Julie Molloy	Higher Information Analyst, Primary Care	05/05/2015	0.2
Julie Stroud	Head of Profession for Statistics	12/05/2015	0.2
Gemma Ramsay	Section Head, Primary Care	14/05/2015	0.2
Amina Butt	Senior Information Analyst, Community & Mental Health	18/05/2015	0.2
Mike Pearson	Principal Data Manager, Data Management Environment (DME)	19/05/2015	0.2
Chris Roebuck	Interim Director of Data Dissemination	24/05/2015	0.2
Mike Jones	Principal Information Analyst, NTS Data Services	28/05/2015	0.2
Andrew MacLaren	Executive Director, Information & Analytics	15/06/2015	0.3
Chris Roebuck	Interim Director of Data Dissemination	22/07/2015	0.4
Julie Stroud	Head of Profession for Statistics	24/07/2015	0.5
Richard Kavanagh	Head of Data Standards	24/07/2015	0.5

Gemma Ramsey	Section Head, Primary Care	29/07/2015	0.5
Steve Smith	Programme Head - Demographics & NHS Number, Access Control & National RA	02/08/2015	0.5
Jo Higginbottom	PDS Data Manager	02/08/2015	0.5
Tom Johnston	Senior Project Manager Demographics	02/08/2015	0.5
Pat Carter	Senior Business Analyst Demographics	02/08/2015	0.5
Chris Roebuck	Interim Director of Data Dissemination	04/08/2015	0.7
Colin Matthews	Programme Head – Productivity & Efficiency	04/08/2015	0.7
Martin Severs	Interim Executive Director, Information & Analytics	04/08/2015	0.7

Approved by

This document has been approved by the following:

Name	Signature	Title	Date	Version
tbc				

NB. The version of the policy posted on the intranet must be a pdf copy of the signed approved version.

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.

Contents

1. Introduction	5
2. Scope	6
3. Purpose	6
4. Policy statement	7
5. Governance	7
6. Review	7
7. Performance and audit	7
8. Data quality assurance directives	7
9. Roles and responsibilities	9
10. Appendix 1 – Secondary uses data quality assurance governance	10
11. Appendix 2 - Data quality characteristics	11
12. Appendix 3 – Roles and responsibilities	14
Individual roles and responsibilities	14
Group roles and responsibilities	15
13. References	16

1. Introduction

Good quality data are defined as being data that are fit for their intended use.

Good quality data are, and have always been, a key part of improving services through informed decision making, regardless of whether those decisions affect a single individual or the whole of the health and social care system.

The Francis report¹ on the Mid Staffordshire NHS Foundation Trust Public Inquiry and the Caldicott review² of information governance both acknowledged this by highlighting issues with data quality in health and social care and the impact these issues have on different uses of data.

Focus on understanding and improving data quality has continued to grow. Examples of this are the development of a False or Misleading Information (FOMI) section, Section 92³, enacted in the Care Act 2014⁴, and the publication of the United Kingdom Statistics Authority (UKSA) regulatory standard for the quality assurance of administrative data⁵.

As the trusted national provider of high-quality information, data and IT systems for health and social care, HSCIC has a duty to assure the quality of all data it collects and publishes in line with its statutory data quality role⁶; its strategy; and its corporate values. A Health Group internal audit recognised this and recommended that the HSCIC take the following actions:

- Create a formal data quality policy for the HSCIC, which outlines how the core components of good practice data quality - completeness, accuracy and validity – are to be assessed, in line with published standards.
- Develop a data quality process and control framework, which details the minimum expected control and monitoring checks to be performed by those responsible for datasets. These documented procedures should support local activities and ultimately the achievement of the strategy and objectives laid out in the overarching data quality policy. As applicable those responsible for datasets would develop and operate supplementary controls and checks in addition to the minimum control framework.

Although HSCIC has no powers to direct data providers to improve the quality of secondary uses data, it has a major role in supporting those that do. It should also ensure that the data it collects, processes and shares for primary and public facing use is subject to the most rigorous levels of quality assurance. Given its unique position as a processor, user and sharer of national health and social care data, it also has a duty to use that position to influence an understanding of the importance of data quality, and its improvement, across the health and social care sector.

¹ <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report>

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf

³ <http://www.legislation.gov.uk/ukpga/2014/23/part/2/crossheading/false-or-misleading-information>

⁴ <http://www.legislation.gov.uk/ukpga/2014/23/enacted>

⁵ <http://www.statisticsauthority.gov.uk/assessment/monitoring/administrative-data-and-official-statistics>

⁶ [http://www.legislation.gov.uk/Health & Social Care Act 2012 Chapter 7, Part 9, Chapter 2, paragraphs 265 and 266](http://www.legislation.gov.uk/Health%20&%20Social%20Care%20Act%202012/Chapter%207,%20Part%209,%20Chapter%202,%20paragraphs%20265%20and%20266)

2. Scope

HSCIC creates, collects, processes, stores, shares and uses data of different types for a variety of purposes. It also has a range of systems in place to support its data operations. All types of data collections, and the systems that support them, should have data quality assurance defined, introduced and monitored in their design, development, test and service operation activities.

As a result of the variation in data type and purpose, it is not practical to include them all in a single data quality assurance policy. Data types, and the systems that support them, have therefore been categorised as follows:

- **Secondary uses data:** Clinical and operational data collected and re-used for purposes other than direct patient care, for example, national reporting, statistical analysis, service development. Examples are Mental Health and Learning Disabilities Dataset; Guardianship under the Mental Health Act 1983 Return; Estates Return Information Collection
- **Primary uses data:** Clinical and operational data collected and used in, or to support, the direct care of service users. Examples are Personal Demographics Service (PDS); Electronic Prescription Service (EPS); Summary Care Record (SCR)
- **Public-facing data:** Data collected and subsequently made available by HSCIC specifically to support the public in making decisions about their individual care and to provide transparent service-level information. Examples are NHS Choices; e-Referral Service

The scope of this policy is:

- Secondary uses data collected (pushed and pulled); processed; stored; and shared by HSCIC

This policy applies to:

- All full-time and part-time HSCIC staff involved in secondary uses data activities whether they are employed on a permanent, interim, consultancy or other temporary basis
- All HSCIC services, programmes and projects involved in secondary uses data activities

Policies for primary uses and public-facing data and systems will be developed after discussions with relevant stakeholders have taken place and the scope and purpose of those policies is clearer.

3. Purpose

This policy defines HSCIC's:

- Directives for secondary use data quality assurance (SUDQA)
- Governance model for SUDQA
- Staff responsibilities for SUDQA

It also ensures consistency with the UK Statistics Authority's:

- Code of Practice for Official Statistics

- Regulatory standard for the Quality Assurance of Administrative Data

4. Policy statement

Every member of staff should:

- Recognise the need for good quality data and how they can contribute to it
- Be aware of their individual responsibilities with regard to data collection, storage, analysis and reporting
- Be aware of the implications of poor data quality in their area in terms of internal and external accountability, including those affecting other directorates and the HSCIC as a whole
- Report any systematic data quality issues immediately to their manager, who should ensure that remedial action is taken
- Be aware of the policies related to data quality on security and data protection

5. Governance

DQA is governed by the HSCIC DQA Steering Group. The group's structure and mandate are described in its terms of reference⁷. A governance diagram is shown in Appendix 1.

6. Review

Policy reviews will be undertaken by the HSCIC DQA Steering Committee. Reviews are on an 'as required' basis during the initial two years of the policy. This will be modified to annual reviews upon satisfactory adoption of the policy.

7. Performance and audit

Key Performance Indicators (KPIs) will be developed to routinely monitor performance against policy directives. KPIs will be reported monthly to EMT and the Board and, once approved, will be published. The KPIs will be reviewed annually to ensure they remain fit for purpose.

Audits will also be carried out to substantiate KPI results. A rolling programme of audits will be published and ad hoc audits may be undertaken. Audit reports will be produced and distributed to Executive Directors, Directors, IAOs and DQLs.

8. Data quality assurance directives

The following data quality assurance directives derive from regulatory standards⁸ and evidence-based practice^{9,10}

1. The Information & Analytics directorate must develop and chair separate secondary uses data user and data provider forums.

⁷ [to be agreed]

⁸ <http://www.statisticsauthority.gov.uk/assessment/monitoring/administrative-data-and-official-statistics/index.html>

⁹ <https://www.cihi.ca/en/data-and-standards>

¹⁰ <http://www.health.wa.gov.au/CircularsNew/attachments/662.pdf>

2. Information Asset Owners (IAOs) must:
 - a. Assign a Data Quality Lead (DQL) from existing staff to each secondary uses data asset they are responsible for. A DQL can be assigned to more than one data asset
 - b. Ensure that all demographic data in their secondary uses data assets are assessed against Personal Demographics Service (PDS) data
3. For each secondary uses data asset they have been assigned to, DQLs must:
 - a. Create a SUDQA log using the corporate template¹¹
 - b. Use the HSCIC SUDQA Toolkit¹² to assess the level of SUDQA required and record the result in the SUDQA log
 - c. Document the processes for DQ assessment and reporting. The assessment and reporting processes must:
 - i. Be commensurate with the level of DQA required following assessment using the HSCIC SUDQA Toolkit
 - ii. Be documented on the appropriate corporate template¹³
 - iii. Be linked to from the SUDQA log
 - iv. Include the six DQ characteristics described in Appendix 2. If any of them are not considered appropriate for an asset, this must be clearly indicated and the reasons documented
 - d. Use the PDS to assess the quality of all demographic data received in secondary uses data assets
 - e. Ensure assessment results are stored for future DQ reporting use
 - f. Record all mandated information in the SUDQA log
 - g. Make DQA logs available on the DQ webpages of the HSCIC website
 - h. Ensure that all data cleansing rules are published in easily accessible form¹⁴
 - i. Ensure that any major incidents around the quality of data submitted by providers are captured and appropriately followed up and escalated
 - j. IAOs for linked data assets must publish current information about the quality of linked secondary uses data assets each time the linked assets are published
4. IAOs and DQLs must:
 - a. Attend mandatory DQA training developed for their specific role¹⁵
 - b. Have their DQ responsibilities recorded as specific objectives in their annual PDRs, together with any professional development required to meet them
 - c. Adopt corporate DQA assessment and reporting tools when approved for use

¹¹ [to be agreed]

¹² [Needs to be developed - plan is to use the recently developed UKSA toolkit for quality assuring administrative data as the start point. It is unlikely to need many changes]

¹³ [to be agreed]

¹⁴ The general approach should be to focus on getting data quality right at source by feeding back to organisations, rather than central data cleansing

¹⁵ [to be agreed]

5. In addition, IAOs and DQLs, or nominated deputies, must:
 - a. Attend DQ Steering Group meetings when required
 - b. Complete actions assigned to them by the DQ Steering Group within the agreed timescales
6. IAOs and DQLs will be held accountable by Directors for ensuring the DQA directives have been followed

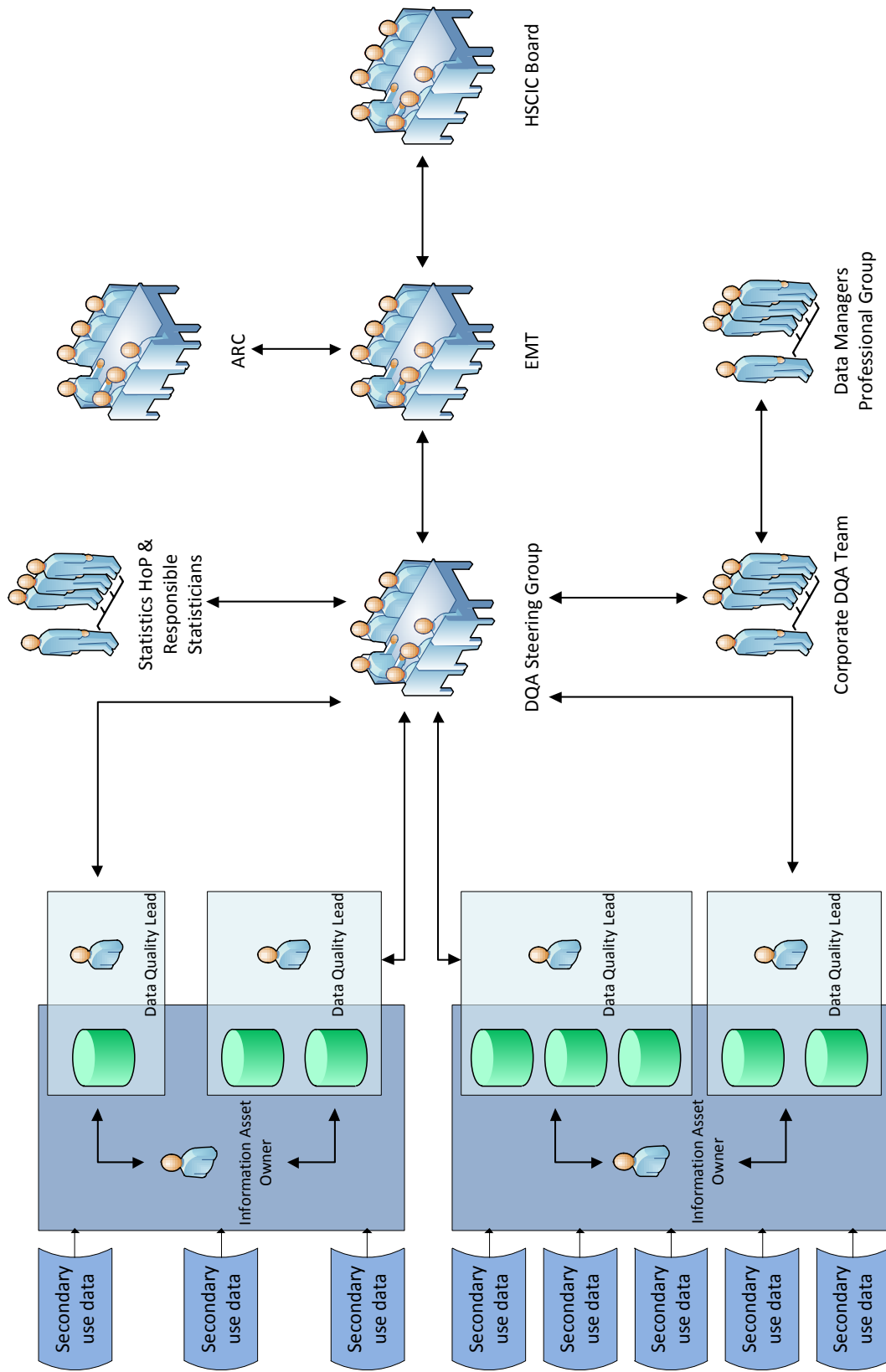
9. Roles and responsibilities

All staff have a responsibility to be aware of data quality and how it impacts on their day-to-day work. However, some individuals and groups have specific responsibilities and these are defined in Appendix 3.

These responsibilities must be reflected in individual job description and group terms of reference.

DRAFT

10. Appendix 1 – Secondary uses data quality assurance governance



11. Appendix 2 - Data quality characteristics

HSCIC has defined the following data quality characteristics for use in SUDQA. Although more than recommended by the internal audit, they are evidence-based¹⁶ and meet HSCIC's requirements. Other organisations, for example European Statistical System (ESS)¹⁷, may use different characteristics and definitions to meet their own requirements.

Characteristic	Description	Calculation	Standard presentation
Coverage	Coverage is the degree to which data have been received from all expected data suppliers.	$\frac{\text{No. of data suppliers that submitted data}}{\text{No. of data suppliers expected to submit data}}$	%
Completeness	Completeness is the degree to which data items include all expected values.	$\frac{\text{No. of data items holding a value}}{\text{No. of data items expected to hold a value}}$	%
Validity	Validity is the degree to which data collected satisfy the set of standards and business rules that govern the permitted, excluding default, values and formats for each individual field in a dataset.	$\frac{\text{No. of complete data items holding a valid (excl. default) value}}{\text{No. of complete data items}}$	%
Default	Default is the degree to which the default values specified in applicable standards and business rules have been used in the data collected.	$\frac{\text{No. of complete data items holding a default value}}{\text{No. of complete data items}}$	%

¹⁶ <http://www.cihi.ca/CIHI-ext-portal/internet/EN/TabbedContent/standards+and+data+submission/data+quality/cihi021513>

¹⁷ <http://ec.europa.eu/eurostat/documents/64157/4373903/05-Handbook-on-data-quality-assessment-methods-and-tools.pdf/c8bbb146-4d59-4a69-b7c4-218c43952214>

Characteristic	Description	Calculation	Standard presentation
Integrity	<p>Integrity is the degree to which data satisfy the set of business rules that govern the relationships between fields, records and data assets.</p> <p>Examples of integrity checks are:</p> <ol style="list-style-type: none"> 1. "IF [Ward_Type]='Maternity' AND [Gender]='Male' THEN ERROR=1", i.e. a male patient would not be treated on a maternity ward 2. Records in an appointment table have related records in a referral table, i.e. it is not permissible to have an appointment with a service without first having been referred to that service 3. NHS Number is used as a common identifier to compare the date of birth of a patient in one dataset with the data of birth for the same patient in a different dataset, i.e. they should be the same 	<p>$\frac{\text{No. of times the business rule is true}}{\text{No. of times the business rule is applied}}$</p> <p>The business rules must allow performance against them to be measured and reported. For example:</p> <p>"97% of male patients were recorded as being treated on wards suitable for males"</p> <p>"88% of appointments had a corresponding referral"</p> <p>"92% of patients with the same NHS Number in datasets X, Y and Z also had the same date of birth"</p>	%

Characteristic	Description	Calculation	Standard presentation
Timeliness	<p>Timeliness reports the time between data recording and delivery of the product that uses the data. It must be reported at three points during data processing:</p> <ol style="list-style-type: none"> 1. Time from recording of the data to submission to, or extraction of the data by, the HSCIC (supply stage) 2. Time from submission or extraction to being available for use (processing stage) 3. Time from being available for use to actual use (product delivery stage) 	<p>Date submitted – Reporting period end date</p> <p>Processing completed date – Date submitted</p> <p>Product delivery date – Processing completed date</p>	Days

12. Appendix 3 – Roles and responsibilities

Individual roles and responsibilities

Table 1 lists the specific SUDQA roles and responsibilities for individuals within HSCIC.

Role	Responsibilities
Executive Director of Information and Analytics	SUDQA Senior Responsible Owner
Executive Director	Adopt SUDQA policy across directorate
Director	Adopt SUDQA policy across sub-directorate
Information Asset Owner (IAO)	For secondary uses data assets they are responsible for: <ul style="list-style-type: none"> • Comply with required policy directives • Assign a Data Quality Lead (DQL) Attend relevant Data Managers Professional Group meetings
Data Quality Lead (DQL)	For secondary uses data assets they are assigned to: <ul style="list-style-type: none"> • Comply with required policy directives • Monitor and report on policy adoption as required by the DQA Steering Group • Provide advice and guidance to data users and providers Attend relevant Data Managers Professional Group meetings
Head of Data Quality	Update SUDQA policy consistent with EMT recommendations Provide advice and guidance on corporate DQA Manage corporate SUDQA risks and issues consistent with HSCIC risk management policy Work with partners on cross-organisational DQA activities Monitor and report on corporate compliance with the policy, developing and using KPIs where appropriate
Head of Profession for Statistics and Responsible Statisticians	Support the adoption of HSCIC SUDQA policy by statistical users of data

Table 1 - Individual roles and responsibilities

Group roles and responsibilities

Table 2 lists the specific DQA roles and responsibilities for HSCIC groups.

Role	Responsibilities
HSCIC Board	Review DQA policy annually to ensure it remains fit for purpose
Assurance and Risk Committee (ARC)	Ensure effective corporate management of DQA risks and challenge the organisation to improve if necessary
Executive Management Team (EMT)	Agree direction for DQA Manage DQA escalated risks and issues consistent with HSCIC risk management policy
Directorate Senior Management Team	Monitor and report on policy adoption across the directorate Take remedial action in areas of poor performance Manage directorate DQA risks and issues consistent with HSCIC risk management policy
Programme and Project Boards	Monitor and report on policy adoption across the programme or project Take remedial action in areas of poor performance Manage project and programme DQA risks and issues consistent with HSCIC risk management policy
DQA Steering Group	Provide operational governance for corporate DQA
Internal Audit Team	Audit and report on HSCIC use of DQA policy, process and output.
Professional Groups	Support implementation of DQA policy Recommend DQA policy improvements
Data Managers Professional Groups	Support DQA ETD Coach IAOs and DQLs if requested Ensure DQA is consistent with data management best practice

Table 2 - Group roles and responsibilities mentoring

13. References

United Kingdom Statistics Authority (UKSA) - Administrative Data and Official Statistics - Quality Assurance of Administrative Data:

<http://www.statisticsauthority.gov.uk/assessment/monitoring/administrative-data-and-official-statistics/index.html>

Health and Social Care Act 2012:

<http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

Canadian Institute for Health Information (CIHI): <http://www.cihi.ca/CIHI-ext-portal/internet/EN/TabbedContent/standards+and+data+submission/data+quality/cihi021513>

UK Government's Open Data principles: <https://www.gov.uk/service-manual/technology/open-data.html>

Health Group Internal Audit - Review of HSCIC'S Data Quality Assessment and Reporting Processes for Data Provided by Third Parties (Ref No: DHX 214 018 021) dated November 2014



HGIA Report - HSCIC
Data Quality - Final Is

Health Group Internal Audit

Reference number: DHX 214 018 021
FINAL REPORT
HSCIC
NOVEMBER 2014

Health Group Internal Audit provides an objective and independent assurance, analysis and consulting service to the Department of Health and its arms length bodies, bringing a disciplined approach to evaluating and improving the effectiveness of risk management, control and governance processes.

Health Group Internal Audit focuses on business priorities and key risks, delivering its service through three core approaches across all corporate and programme activity:

- **Review** and evaluation of internal controls and processes;
- **Advice** to support management in making improvements in risk management, control and governance; and
- **Analysis** of policies, procedures and operations against good practice.

Health Group Internal Audit findings and recommendations:

- Form the basis of an independent opinion to the Accounting Officers and Audit Committees of the Department of Health and its arms length bodies on the degree to which risk management, control and governance support the achievement of objectives; and
- Add value to management by providing a basis and catalyst for improving operations.

For further information please contact:

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REVIEW OF HSCIC'S DATA QUALITY ASSESSMENT AND REPORTING PROCESSES FOR DATA PROVIDED BY THIRD PARTIES

Overall report rating: Limited

Our work has been conducted and our report prepared solely for the benefit of the Department of Health and its arms length bodies and in accordance with a defined and agreed terms of reference. In doing so, we have not taken into account the considerations of any third parties. Accordingly, as our report may not consider issues relevant to such third parties, any use they may choose to make of our report is entirely at their own risk and we accept no responsibility whatsoever in relation to such use. Any third parties, requiring access to the report may be required to sign 'hold harmless' letters.

**Health Group
Internal Audit**

CONTENTS

PAGE

- 1. **Executive Summary** **2**
- 2. **Detailed Findings** **4**
- 3. **Action Plan** **14**

Date fieldwork completed:	24 October 2014
1 st draft report issued:	4 November 2014
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Report Author:	David Gray
Version No:	4.0
Date:	17 November 2014

Distribution List – Draft Report

Main recipient	
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Andrew Griffiths	Director of Business Services
David Wilmhurst	Head of Corporate Assurance
Simone-Davis	Head of Internal Audit

Distribution List – Final Report

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David Wilmhurst	Head of Corporate Assurance
Simone-Davis	Head of Internal Audit

NAO can request copies of final reports should they wish to do so.

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1

Executive Summary

1. Introduction

1.1 The Health and Social Care Information Centre (the "HSCIC") has a statutory responsibility within the Health and Social Care Act 2012 to assess the quality of the information that it collects from third parties against applicable published standards and subsequently publish a record of the results of its assessment.

1.2 The HSCIC's management of data quality received from data providers is generally devolved across the organisation with each programme area responsible for data quality assurance. As a consequence, programme teams have developed different data quality assessment and reporting processes and tools. This has resulted in inconsistent inputs to and outputs from the various data quality assurance processes.

1.3 The scope of this review was to assess the data collection processes from third parties and the data quality assessment methodologies and reporting mechanisms in place across the organisation for a sample of datasets. The following datasets were included within the scope of the review:

- Secondary Use Service (SUS)
- Improving Access to Psychological Therapies (IAPT)
- Safeguarding Adults Return (SAR)
- Stop Smoking Services

**Health Group
Internal Audit**

- Estates Return Information Collection (ERIC)
- Maternity & Children's Data Set (MCDS)
- Primary care extract

2. Review conclusion

2.1 The overall rating for the report is **LIMITED** – there are significant weaknesses in the framework of governance, risk management and control such that it could be or could become inadequate and ineffective.

3. Summary of Findings

3.1 Our review has identified a number of findings in respect of the way in which data quality is managed across datasets sampled and the wider HSCIC organisation.

3.2 We identified seven findings related to the way in which the quality of data is managed at the organisation. Four of these were considered to be a high or medium rated finding.

3.3 As noted above, the HSCIC has a statutory responsibility, since its inception, to assess the quality of the information that it collects from third parties against applicable published standards. Our review found that there is no overarching data quality strategy, policy or process documentation that details how the organisation should seek to meet its statutory obligations.

1

Executive Summary

3.4 A formal mandate or information standard was found not to be in place for a number of the datasets within the sample. This provides the basis for the assessment of data quality. Without a mandate in place, the HSCIC has found that certain providers are no longer providing some or all of the data required. This has a resultant impact on the quality of data and subsequent analyses and reporting performed.

3.5 It was noted that whilst there are a number of different approaches utilised by the HSCIC to assess data in respect of its completeness or validity, very limited action is performed to assess the accuracy of the data being submitted for inclusion in datasets. As a result there is a risk that the dataset reporting and output may be based on longstanding inaccurate data.

3.6 The data that is submitted as part of the SUS dataset is required to undergo data quality checks prior to being accepted for processing. We identified that the current data quality checking process is highly inflexible with limited reporting information made available to the data provider regarding the reason for failure. Linked to the timescales involved in the data submission process this can mean that gaps exist in a provider's data as they cannot complete the required steps to clean the submitted data prior to the data submission process closing.

3.7 In addition to these findings, positive observations were also noted and shared with management. In particular,

- A Head of Data Quality has been appointed with a specific remit to enhance and improve data quality assurance across the organisation;
- There is a good deal of automated data quality assessment processes in place, across a variety of datasets, that helps to ensure data quality checks can be performed quickly and efficiently;
- The organisation provides reporting on data quality for each dataset alongside the publication of its results;
- It was noted that strong communication and relationships had been developed with the data providers as a result of the efforts made in rectifying issues and providing assistance as required; and
- The organisation provides, specifically where a formal specification has been defined, clear and transparent details on the data quality expectations e.g. validation requirements, for each dataset.

1

Executive Summary

3.8 The table below summarises the number of recommendations by rating:

	Total Recs	High	Medium	Low
Overall management of data quality	4	1	1	2
Dataset specific findings	3	0	2	1
Overall	7	1	3	3

3.9 Section 2 of this report includes specific and detailed recommendations against observations. However, the recommendations below are a useful summary encapsulating common themes.

- A minimum expectation of data quality requirements should be implemented for each dataset through supporting policy and procedure documentation;
- Dataset owners need to be aware of the actual and potential data users of their output and understand implications of decisions made regarding data; and
- Data quality is embedded throughout the lifecycle of a dataset.

3.10 Further analysis of each recommendation is provided in Sections 2 and 3.

Health Group Internal Audit

4. Action Required

4.1 Public Sector Internal Audit Standards requires you to:
 4.1.1 consider the recommendations made in Section 2; and
 4.1.2 complete section 3 (Agreed Action Plan) detailing what action you are intending to take to address the individual recommendations, the owner of the planned actions and the planned implementation date. The agreed action plan will then form the basis of subsequent audit activity to verify that the recommendations have been implemented effectively.

4.2 Finally, we would like to thank management for their help and assistance during this review.

2

Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
Overall management of data quality				
HIGH	1	<p>Lack of overall data quality policy and supporting procedural documentation</p> <p>The HSCIC has a statutory responsibility to assess the quality of the information it collects from third parties against published standards and to publish the results of this assessment.</p> <p>During our review we identified that a formal data quality policy has not yet been created and as a result no formal overarching strategy has been put in place ensuring the quality of data. For example, whilst defined information standards have been developed that set out specific details of the data to be captured there is limited acknowledgement of these requirements within any of the data quality documentation maintained for datasets. These standards set the baseline for the dataset and should be acknowledged and embedded into the relevant documentation, assessments and checks.</p> <p>In addition it was noted that for each of the datasets that were included within this review a different approach to handling data, and the assessment of its quality, was taken. The underlying cause for this was attributed to a lack of standardised principles or procedures, across the different dataset teams.</p> <p>We did note that steps are being taken to increase</p>	<p>Without a formal data quality policy, supported by applicable procedural documentation and defined data standards that include data quality requirements, there is an increased risk that the HSCIC cannot meet its statutory obligations as minimum expected standards for data are not known and subsequently not assessed and reported on.</p>	<p>We recommend that the HSCIC take the following actions in light of the finding noted:</p> <ul style="list-style-type: none"> a) Create a formal data quality policy for the HSCIC, which outlines how the core components of good practice data quality - completeness, accuracy and validity – are to be assessed, in line with published standards. b) Develop a data quality process and control framework, which details the minimum expected control and monitoring checks to be performed by those responsible for datasets. These documented procedures should support local activities and ultimately the achievement of the strategy and objectives laid out in the overarching data quality policy. As applicable datasets would operate supplementary controls and checks in addition to the minimum control framework.

**Health-Group
Internal Audit**

2

Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
		the focus upon data quality, with teams beginning to liaise with the Head of Data Quality on how they can enhance data quality.		
MEDIUM	2	<p>Inability to ascertain accuracy of data submitted</p> <p>There are currently over 100 approved and published information standards. The standards set out the required data to be submitted by the provider and where available form the basis of the data quality assessment by the HSCIC. The in-draft international standard on data quality (ISO8000) outlines the fundamentals of data quality:</p> <ul style="list-style-type: none"> • Completeness – have all necessary records been submitted / processed; • Accuracy – has the correct information been included within the submission; and • Validity – are the records from a valid source and meet defined requirements such as type, structure and length. <p>During our review we noted that checks were in place, for the majority of datasets over the completeness and validity of the submissions.</p> <p>However, we identified that there was limited checks or verification performed to assess the accuracy of the information that is being submitted by providers, with only the SUS dataset having a check performed in respect of the PbR data elements</p>	<p>Without appropriate checks to ensure data is submitted accurately there is a risk that the quality of the data will be impaired and affect any analysis or reporting performed.</p>	<p>We recommend that the HSCIC take the following actions in light of the finding noted:</p> <ul style="list-style-type: none"> a) Management investigates mechanisms by which they can assess the accuracy of the data that is submitted. Potential approaches could include: <ul style="list-style-type: none"> • Targeted audit checks on providers who have regular issues with data submission or alternatively on those datasets which are most significant. These checks could be performed either by HSCIC or HGIA; or • Completion of self-assessment return detailing how/where key values within a data submission have been obtained or derived from.

Health Group
Internal Audit

2

Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
		<p>within the dataset. We were informed that some datasets will look to perform a limited set of 'percentage' checks on certain values but these are highly subjective and judgement based and could be based on inherently incorrect information.</p>		
<div style="border: 1px solid black; padding: 2px; display: inline-block;">LOW</div>	3	<p>Lack of control in respect of estimated data submissions</p> <p>As part of the individual data submissions that comprise a dataset it was noted that there may be instances when a provider is required to estimate the data they are to submit.</p> <p>During our review we identified that where a number of weaknesses in respect of the current treatment of estimates:</p> <ul style="list-style-type: none"> • There is no requirement for estimated data to be flagged or notified to the HSCIC when it is being submitted by the individual data provider. As a result it is not possible for HSCIC to determine the volume of estimated data within a dataset and subsequently account for this in any analysis performed. Where the HSCIC has been required to perform estimation this will be noted in the relevant data quality report associated with the formal dataset output; • Where estimated data is submitted by data providers no explanatory information is 	<p>By not ensuring that sufficient controls are in place regarding the reliability of estimated data there is an increased risk that it could impact upon the analysis and output performed on the received data.</p>	<p>We recommend that the HSCIC take the following actions in light of the finding noted:</p> <p>a) A formal standard should be developed, distributed and agreed with providers in respect of the procedures to be followed when estimated data is to be used.</p> <p>The standard should outline that where estimated data is used this should be clearly flagged by the provider. In addition any estimates should either be supported by appropriate narrative regarding the method used or alternatively performed using an agreed approach as defined by the HSCIC.</p> <p>Following agreement of the standard with providers,</p>

2

Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
		<p>required to be submitted by the data provider to detail the means by which the estimate was derived and subsequently be reviewed by the HSCIC for appropriateness; and</p> <ul style="list-style-type: none"> No formal guidance on how to perform estimates is issued by the HSCIC to enable a valid and consistent approach to be followed. <p>It has been highlighted by management that the extent to which estimated data submitted would be low and limited to only aggregate submissions. The expectation is that all other data provided would be actuals.</p>		<p>appropriate assistance and guidance should be provided to assist with the transition to the new process.</p> <p>b) Each dataset should seek regular assurance, such as an annual re-confirmation process or upon release of a change to the information standard, from the data providers that the data being submitted are actuals. Guidance, as detailed above should be made available to explain the process to be followed in the event of any data requiring estimation.</p>
<p>LOW</p>	<p>4</p>	<p>Potential efficiencies through functional re-organisation</p> <p>The operational activities involved within the assessment of the data quality of a dataset follow a similar set of activities, irrespective of dataset, incorporating structural and record level data quality checks.</p> <p>Our review identified that the current operational structure within HSCIC is that each of the individual dataset owners, and respective teams, are responsible for all aspects of dataset management. This includes the collection, assessment of data</p>	<p>Through working in isolated teams and the use of non-standardised processes there is an increased risk of inefficient resource usage and potential duplication of effort.</p>	<p>We recommend that the HSCIC take the following actions in light of the finding noted:</p> <p>a) A review is undertaken of HSCIC's existing operational structure in respect of how it manages the data and datasets it is responsible for and looks to utilise a more centralised approach in respect of data collection and data quality</p>

Health Group
Internal Audit

2

Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
		<p>quality, issue rectification, data analysis and reporting of the final dataset.</p> <p>Each of the individual teams is working to its own method and approach for each of the different stages in the lifecycle of the dataset, when there are potential efficiencies that can be gained through re-organising and centralising elements of the dataset management process.</p> <p>Through centralising aspects of the initial collection and data quality assessment a consistent approach can be undertaken and benefits such as root-cause analysis could be felt across the organisation rather than limited to a single team.</p>		<p>assessment.</p> <p>The central team would be responsible for monitoring each of the datasets and ensuring that the required data quality standards during collection and initial data quality assessment are met. The data would then be distributed to the relevant dataset team for analysis and reporting. It would be the individual teams' responsibility to assess the appropriateness of the data in the wider context of the dataset as a whole.</p>
Dataset specific findings				
MEDIUM	5	<p>Inconsistent level of data being submitted by data providers to datasets.</p> <p>The specific requirements and justification for a dataset should be clearly documented within a published information standard or equivalent document that provides details of the specific content, format of the data to be submitted by providers and basis for the data to be collected and processed.</p> <p>From our review of the datasets included within the sample we identified one of the seven had specific</p>	<p>When submission of datasets is not mandated, there is a risk that the estimates or alternatives used to compensate for missing data could impact on the accuracy of the output upon which decisions will be based.</p>	<p>We recommend that the HSCIC take the following actions in light of the finding noted:</p> <p>a) HSCIC should undertake a review of existing datasets to determine the extent to which information standards are defined but the submission of some or all data is not mandatory. An assessment</p>

2

Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
		<p>examples whereby decisions had been made by the data provider to omit some or all of the data required.</p> <p>We identified that as part of the Stop Smoking Services dataset one individual local authority has ceased submitting any data to the HSCIC. We noted that the returns used for the dataset were mandatory as part of the previous PCT regime. However, a review of the most recent version of the Information Standard found that there was no mandatory requirement on the data to be submitted and as a result the decision has been made by one authority to not provide the information. Due to the nature of the particular local authority in question it was possible for the HSCIC to perform a roll-forward of the prior period values and reporting on the data could be performed. In the event that data is required to be continually rolled forward or more authorities decide to not provide the data it will become increasingly challenging for a usable dataset to be produced by the HSCIC.</p> <p>In addition, instances were highlighted of information, specifically financial information, not being submitted by a number of providers. Discussion with the dataset owner found that whilst this information was not critical to the primary reporting of the return, its omission impacted upon the capability for comparison and potential analyses</p>	<p>For example Public Health England (PHE) has a specific action within its business plan in respect of smoking cessation. Without complete and accurate information being submitted PHE may not be able to make as informed decisions as possible.</p> <p>The HSCIC reports on missing data but is not ultimately responsible for ensuring its submission. This responsibility rests with those sponsoring the dataset and its associated standard.</p>	<p>should subsequently be undertaken to understand any impact on level and quality of data submissions.</p> <p>In addition, where data is found to not be submitted as expected the HSCIC should liaise with the provider to understand the underlying root cause and seek to reach a mutually agreeable solution. This process should have an associated escalation process to enable for the responsibility for resolution to be passed to those organisations that have sanctions and other controls at their disposal.</p> <p>b) Where necessary formal mandates or standards should be developed to ensure that complete submissions are received from all participants. Conversely, instances may be identified where a dataset is no longer required and can therefore be stopped.</p>

Health Group
Internal Audit

2

Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
		that could be performed such as cost analysis.		
MEDIUM	6	<p>Inflexible SUS data quality checks</p> <p>The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of further reporting and analyses, such as example Hospital Episode Statistics (HES) data. The management and processing of the SUS data returns is currently outsourced to BT.</p> <p>During our review we identified that the current data quality assessment processes for the SUS data have a number of inherent weaknesses, including:</p> <ul style="list-style-type: none"> The data quality assessment of the submitted SUS data XML files is performed in a rigid and inflexible manner. In the event of a data quality check failure being identified no further data quality checking is performed on the data until the error is rectified. If a file is unable to be fully validated the data will not be processed onto the SUS system and data will be missing for that particular provider; Where a data quality error has occurred on the XML file the reporting of the exception is limited. Details are reported of the specific record which has caused the failure but the 	<p>The process of submitting SUS data is dictated by a number of strict deadlines. By not providing detailed reporting and a flexible data quality assessment mechanism that reviews a file in totality for all errors, there is a risk that providers may not be able to rectify any data quality errors prior to the final processing deadline. As a result data will be missing from the SUS database which could impact upon the various analyses and reporting performed on the dataset.</p>	<p>We recommend that the HSCIC take the following actions in light of the finding noted:</p> <ol style="list-style-type: none"> The HSCIC should continue with its plan to replace the existing SUS system, with NTS, including insourcing the operation and management of the SUS database. Within the new system detailed and timely reporting of data quality errors is developed made available to data providers and the HSCIC to enable appropriate rectification. Reporting should provide a full summary of results across all transactional data quality rules, with details of the nature and location in the file of the specific failure.

2

Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
		<p>level of information pertaining to the cause of the failure is limited e.g. "Field value is inconsistent". Individual data providers are then required to interpret and attempt to rectify the error based on this information. There are in-built deadlines within the SUS submission process which require swift turnaround of any reported errors and without sufficient detail of identified errors the time taken to rectify them may not be sufficient; and</p> <ul style="list-style-type: none"> The internal SUS team responsible for managing any data quality issues, within HSCIC, has limited access to data quality assessment results and details of where data quality issues have occurred. This impacts upon their ability to provide guidance and support to the provider <p>We have been notified by management that the current system used for the management of SUS is to be replaced by an in-house HSCIC system, NTS, following the conclusion of BT's contract at the end of 2014. The in-house system is intended to have improved data quality assessment and reporting.</p>		
	7	<p>Data quality requirements not incorporated into dataset planning process</p> <p>The Maternity and Children Dataset (MCDS), which consists of three individual datasets, and Primary</p>		
LOW			By not ensuring that appropriate proven data	We recommend that the HSCIC take the following actions in light of the finding

Health Group
Internal Audit

2

Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
		<p>care extract are both currently in development and planning of implementation. Both datasets have defined requirements in respect of the data to be captured.</p> <p>From our review of the to date activities in designing and implementing each dataset we noted that the level of planning surrounding the way in which the quality of data will be assessed and reported has been limited.</p> <p>For the MCDS extract we identified that the formal data quality checks on the xml data submissions files have been defined and align to the formal data dictionary. However, the team responsible for managing the dataset outlined that they have not yet defined what specific data quality checks are to be undertaken on the submitted information once it has passed the initial file and record level data quality checks. For example, these checks do not place the data in any form of context and do not allow for a more detailed assessment to take place. It was stated that the team is looking to receive initial data submissions first prior to defining the data quality assessment requirements. As noted there are three individual datasets that make up MCDS with the first due to go live in April 2015.</p> <p>In addition, we identified that the primary care extract dataset does not have any formally</p>	<p>quality checks and processes are in place prior to the receipt of the first data submissions there is a risk that data may be received that does not meet expected standards that is not identified and subsequently allowed to reside within the dataset.</p>	<p>noted:</p> <p>a) As part of the development of any dataset a specific workflow or phase should be put in place to ensure that data quality is embedded from the outset and that appropriate data quality checks and rules are developed.</p> <p>As the nature and scope of the data may change over time appropriate post go-live checkpoints should be established to ensure that the most relevant data quality checks remain in place.</p>

2

Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
		<p>published data quality rules. We were provided with an initial draft set of eight data quality rules that would be performed at initial processing. However, the rule set is simplistic in nature and does not cover the full set of data to be submitted. The team responsible for the dataset confirmed that further work was required in respect of the data quality rules to be applied. One of the highlighted issues in respect of developing a formal framework for the dataset is that there is still piloting and consultation taking place which may impact upon what is and is not received. This impacts the capability to put in place certain data quality assessment requirements.</p>		

3 Action Plan

Customer to provide details of planned action; owner and implementation date. Action taken will later be assessed by Health Group Internal Audit, and therefore the level of detail provided needs to be sufficient to allow for the assessment of the adequacy of action taken to implement the recommendation to take place.

To be completed by Health Group Internal Audit as part of the recommendation follow-up process

№	RECOMMENDATION	RATING	AGREED ACTION	OWNER & PLANNED IMPLEMENTATION DATE	OBSERVATIONS: RECOMMENDATION / AGREED ACTION IMPLEMENTED?	FURTHER ACTION REQUIRED?
1	<p>a) Create a formal data quality policy for the HSCIC, which outlines how the core components of good practice data quality - completeness, accuracy and validity – are to be assessed, in line with published standards.</p> <p>b) Develop a data quality process and control framework, which details the minimum expected control and monitoring checks to be performed by</p>	H	<p>a) Create a draft formal data quality policy to support consistency of data quality practice across the HSCIC.</p> <p>b) Develop a data quality process and control framework that supports delivery of the data quality policy.</p>	<p>Head of Data Quality 31 January 2015</p> <p>Head of Data Quality 31 March 2015</p>		

Health Group
Internal Audit

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	those responsible for datasets. These documented procedures should support local activities and ultimately the achievement of the strategy and objectives laid out in the overarching data quality policy. As applicable datasets would operate supplementary controls and checks in addition to the minimum control framework.					
2	a) Management investigates	M	a) Potential approaches will be	Head of Data Quality 30 June 2015 (to		

Health Group Internal Audit

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<p>mechanisms by which they can assess the accuracy of the data that is submitted. Potential approaches could include:</p> <ul style="list-style-type: none"> Targeted audit checks on providers who have regular issues with data submission or alternatively on those datasets which are most significant. These checks could be performed either by HSCIC or 		<p>investigated, including: developing HSCIC audit capability; data provider CEO sign off of data submissions; using data linkage to highlight potential inaccuracies between datasets.</p>	<p>complete the investigation – any further action will be determined by the outcome of the investigation).</p>		

Health Group Internal Audit

3

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	HGIA; or <ul style="list-style-type: none"> <li data-bbox="587 1592 855 1832">Completion of self-assessment return detailing how/where key values within a data submission have been obtained or derived from. 					
3	a) A formal standard should be developed, distributed and agreed with providers in respect of the procedures to be followed when estimated data is to be used. The standard should outline that where estimated	L	a) The scale of the problem will be investigated with input from the HSCIC Head of Profession for Statistics and NHS England colleagues. b) If the investigation establishes that the scale of the problem is significant, a set	Head of Data Quality 30 June 2015 (to complete the investigation – any further action will be determined by the outcome of the investigation). TBC on completion of a) above.		

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<p>data is used this should be clearly flagged by the provider. In addition any estimates should either be supported by appropriate narrative regarding the method used or alternatively performed using an agreed approach as defined by the HSCIC.</p> <p>Following agreement of the standard with providers, appropriate assistance and guidance should be provided to assist</p>		<p>of options to resolve the issue, including cost and benefit analysis, will be produced, taking the audit recommendations into account.</p>			

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<p>with the transition to the new process.</p> <p>b) Each dataset should seek regular assurance, such as an annual re-confirmation process or upon release of a change to the information standard, from the data providers that the data being submitted are actuals. Guidance, as detailed above should be made available to explain the process to be followed in the event of any data requiring</p>					

Health Group Internal Audit

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Nº RECOMMENDATION	RATING	AGREED ACTION	OWNER & PLANNED IMPLEMENTATION DATE	OBSERVATIONS: RECOMMENDATION / AGREED ACTION IMPLEMENTED?	FURTHER ACTION REQUIRED?
		estimation.			
4 a) A review is undertaken of HSCIC's existing operational structure in respect of how it manages the data and datasets it is responsible for and looks to utilise a more centralised approach in respect of data collection and data quality assessment. The central team would be responsible for	L	a) The recommendation will be fed into an ongoing review of the overall Information and Analytics directorate structure.	Head of Data Quality 31 December 2014 (to feed the recommendation to the Information & Analytics directorate review – any further action will be dependent on the outcome of that review).		

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<p>monitoring each of the datasets and ensuring that the required data quality standards during collection and initial data quality assessment checks are met. The data would then be distributed to the relevant dataset team for analysis and reporting. It would be the individual teams' responsibility to assess the appropriateness of the data in the wider context of the dataset as a</p>					

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	whole.					
5	<p>a) HSCIC should undertake a review of existing datasets to determine the extent to which information standards are defined but the submission of some or all data is not mandatory. An assessment should subsequently be undertaken to understand any impact on level and quality of data submissions.</p> <p>In addition, where</p>	M	<p>a) A review of existing datasets with published standards will be undertaken to establish which datasets are mandated and which are voluntary. The results will be documented.</p> <p>The results will be used to understand the potential impact on data quality.</p> <p>The liaison and escalation process will be documented in the new data</p>	<p>Head of Data Quality 31 January 2015</p> <p>Head of Data Quality 31 March 2015</p> <p>Head of Data Quality 31 March 2015</p>		

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<p>data is found to not be submitted as expected the HSCIC should liaise with the provider to understand the underlying root cause and seek to reach a mutually agreeable solution. This process should have an associated escalation process to enable for the responsibility for resolution to be passed to those organisations that have sanctions and other controls at their disposal.</p>		<p>quality policy and the supporting process and control framework.</p> <p>b) The potential impact of missing submissions on data quality (see a) above) will be incorporated in SCCI data quality reviews. This will ensure it is considered when new collections and extractions go through the SCCI process or when existing collections and extractions are reviewed through the process.</p>	<p>Head of Data Quality 30 September 2015 (to align with other developments in relation to data quality standards).</p>		

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	<p>b) Where necessary formal mandates or standards should be developed to ensure that complete submissions are received from all participants. Conversely, instances may be identified where a dataset is no longer required and can therefore be stopped.</p>					
6	<p>a) The HSCIC should continue with its plan to replace the existing SUS system, with NTS, including in-sourcing the</p>	M	<p>a) Continue with NTS development.</p>	<p>Graham Spearing, NTS Programme – ongoing.</p>		

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<p>operation and management of the SUS database.</p> <p>b) Within the new system detailed and timely reporting of data quality errors is developed and made available to data providers and the HSCIC to enable appropriate rectification. Reporting should provide a full summary of results across all transactional data quality rules, with details of the nature and location in the file of the</p>		<p>b) The recommendation will be fed into the NTS Programme.</p>	<p>Graham Spearing, NTS Programme. Currently scheduled for 2018/19.</p>		

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specific failure. .					
7 a) As part of the development of any dataset a specific workstream or phase should be put in place to ensure that data quality is embedded from the outset and that appropriate data quality checks and rules are developed. As the nature and scope of the data may change over time appropriate post go-live	L	a) The recommendation will be documented in the new data quality policy and the supporting process and control framework.	Head of Data Quality 31 March 2015		

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	checkpoints should be established to ensure that the most relevant data quality checks remain in place.					

Health Group
Internal Audit

4

Report Rating - Definitions

Substantial	In my opinion, the framework of governance, risk management and control is adequate and effective.
Moderate	In my opinion, some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.
Limited	In my opinion, there are significant weaknesses in the framework of governance, risk management and control such that it could be or could become inadequate and ineffective.
Unsatisfactory	In my opinion, there are fundamental weaknesses in the framework of governance, risk management and control such that it is inadequate and ineffective or is likely to fail.

Board meeting – Public session

Title of paper:	Data Quality Assurance - Next Steps
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 03 (a) iv
Paper presented by:	Martin Severs, Director of Information and Analytics
Paper prepared by:	John Sharp, Head of Data Quality
Paper approved by: (Sponsor Director)	Martin Severs, Director of Information and Analytics
Purpose of the paper:	To seek Board approval for progressing with the next steps needed for the development of our data quality assurance function.
Key risks and issues:	Technology constraints prevent reporting tool development.
Patient/public interest:	Realisable only in the medium or longer term as the strategy, policy and supporting processes, products and tools are applied.
Actions required by the board:	To approve the proposed actions.

Data Quality Assurance Next Steps

Author: John Sharp, Head of Data Quality

Date: 11 September 2015

Contents

1.	Purpose	3
2.	Background	3
3.	Proposed actions	3
4.	Actions Required of the Board	3

1. Purpose

The purpose of this briefing paper is to seek Board approval for progressing with the next steps needed for the development of our data quality assurance function.

2. Background

The following documents have been submitted to the Board for approval:

- Data quality assurance strategy on-a-page
- Secondary used data quality assurance policy
- Data quality KPI development plan

To be effective, the strategy; policy; and KPIs, and the tools used to support them, require a further action to be taken. Action is also needed to link this internal work with external data quality assurance initiatives. This will make sure that work with similar objectives is developed in collaboration with our partners, customers and suppliers.

3. Proposed actions

Proposed action	Owner(s)
Technology assessment of robustness of current Excel based interactive reporting tool	John Sharp and Mike Truran
Harmonise HSCIC data quality reporting tool with NIB 2.2 Data Quality Standards	John Sharp and Chris Roebuck
Ensure HSCIC KPIs are consistent with NIB 2.2 Data Quality Standards	John Sharp and Chris Roebuck
Progress staff responsibilities for data quality assurance through JNCC	John Sharp and Rachael Allsop
Ensure Secondary Uses Data Quality Assurance Policy integration with HSCIC Policy Portfolio	John Sharp and Nicholas Oughtibridge
Assess secondary uses data and publish the results of those assessments in line with the above	John Sharp and Chris Roebuck
Take the robust data quality assessments and publish through MyNHS	Chris Roebuck, John Sharp and James Hawkins
Enable Trust representatives to use the interactive reporting tool to query published data quality assessments and learn from it as an initial step, possibly through a NIB event and/or HSCIC workshop	John Sharp and Chris Roebuck

4. Actions Required of the Board

Approve the proposed actions.

Board meeting – Public session

Title of paper:	HSCIC Transformation Update
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 03 (b)
Paper presented by:	Rachael Allsop
Paper prepared by:	Jenny Allen, Head of Human Resources, Operations
Paper approved by: (Sponsor Director)	Rachael Allsop
Purpose of the paper:	To remind Board members of the original vision and objectives for the HSCIC Transformation Programme, provide a review of progress to date and set out plans for a more radical approach going forward.
Key risks and issues:	Scale of the transformational change proposed and potential impact across the organisation.
Patient/public interest:	Indirect – increased productivity, efficiency and effectiveness within the organisation of benefit to the wider health and social care system.
Actions required by the board:	The Board are asked to note the contents of the report.

HSCIC Transformation Update

Rachael Allsop
10th September 2015

Contents

Contents	3
1. Introduction	4
2. Background	4
3. Review	5
4. Next Steps	5
5. Conclusion	6
Appendix 1 – Transformation Vision and Scope	7
Appendix 2 – Progress of Transformation Projects	8
Appendix 3 - Operating Model and Portfolios visual	15

1. Introduction

The purpose of this paper is to remind Board members of the original vision and objectives for the HSCIC Transformation Programme, provide a review of progress to date and, in the light of that review, set out plans for a more radical approach going forward.

2. Background

Successive strategies have identified a requirement for the people who make up the organisation to change the way in which they work in order that the HSCIC becomes:-

“A high performing organisation with a reputation as an outstanding place to work”.

We envisaged that our people would:-

- fully engage with our values
- genuinely engage in delivering the strategy
- operate as 'true professionals'
- flex their contributions to support organisational priorities
- take personal responsibility for their actions, and
- act as advocates for the HSCIC

And the HSCIC would become:-

- productive and efficient
- recognised as delivering high quality products and services, and
- highly valued by its customers

To deliver these ambitions a Transformation Programme was established, staffed by a small (4.0wte) core team, supplemented by a Transformation Lead in each Directorate. The approach approved by the Board at various meetings, most recently on 31 March 2015, has been to develop within the programme a series of projects under 4 cross-cutting themes as illustrated at Appendix 1.

It was envisaged that if everything in the plan was completed and implemented by everybody in the manner intended, then this would force a change in the culture. Effectively this was built on the premise that culture change programmes per se are less likely to work than driving behaviour change through compliance with new processes combined with the recruitment of new people more aligned with the new approach than with our inheritance.

3. Review

At the EMT Time out (8/9 July 2015) the opportunity was taken to review progress to date. Appendix 2 details the progress of each project, but overall the conclusions were:-

- Transformation had become a low priority for the organisation (core team depleted; transformation leads redeployed onto more pressing work).
- Many of the 'people projects' relied on effective line management for implementation which in parts of the organisation either did not exist or was hostile to change.
- Cross- organisational working was relatively poor as individuals prioritised their programme or directorate above corporate success.
- We have a shortage of top talent in places and tend to recruit/promote in our own image.
- There is inconsistency in productivity and efficiency.
- We have not agreed an approach to quality.
- We are not yet valued by our customers.
- The culture has not yet perceptibly changed.

As the projects have not all been completed and, where they have they may not have been implemented as intended/designed, it is not possible to comment on the extent to which they would have ultimately changed the culture.

Repeated employee surveys tell us that each team believes their own performance to be excellent and any organisational reputational issues to be caused by A N Other team. Additionally, practical examples from across the organisation as well as anecdote reveal that individuals in general associate far more with their programme or directorate culture than they do with an organisational culture. This may be appropriate but if so, the sub-cultures need to be aligned to deliver rather than impede organisational success. Right from the top of the organisation there are very few individuals who routinely adopt a corporate perspective.

The dominant sub-cultures currently overwhelm all efforts to make change. This, combined with some gaps in talent and absence of line management in places, produces a huge pressure to retain the status quo - as inadequate as that is perceived by most to be.

4. Next Steps

At the EMT time out in July, the appetite of directors for a more radical transformational change moving to resource pools and operating as appropriate more like a Professional Services organisation was explored. In effect the change proposed will necessitate an overhaul of both the operating model and the organisational design for the HSCIC. The proposed move to resource pools will separate out the supply of resources (people and money) from the demand for work and delivery of that work with Directors overseeing portfolios of work in place of the existing directorate structure – the proposed operating model and portfolios are attached as Appendix 3 to this paper.

It is anticipated that this revised operating model and organisational design will facilitate a more customer focussed approach and underpinned with a cultural change programme to

embed the existing products of the People Transformation programme, will address the issues highlighted in the review above.

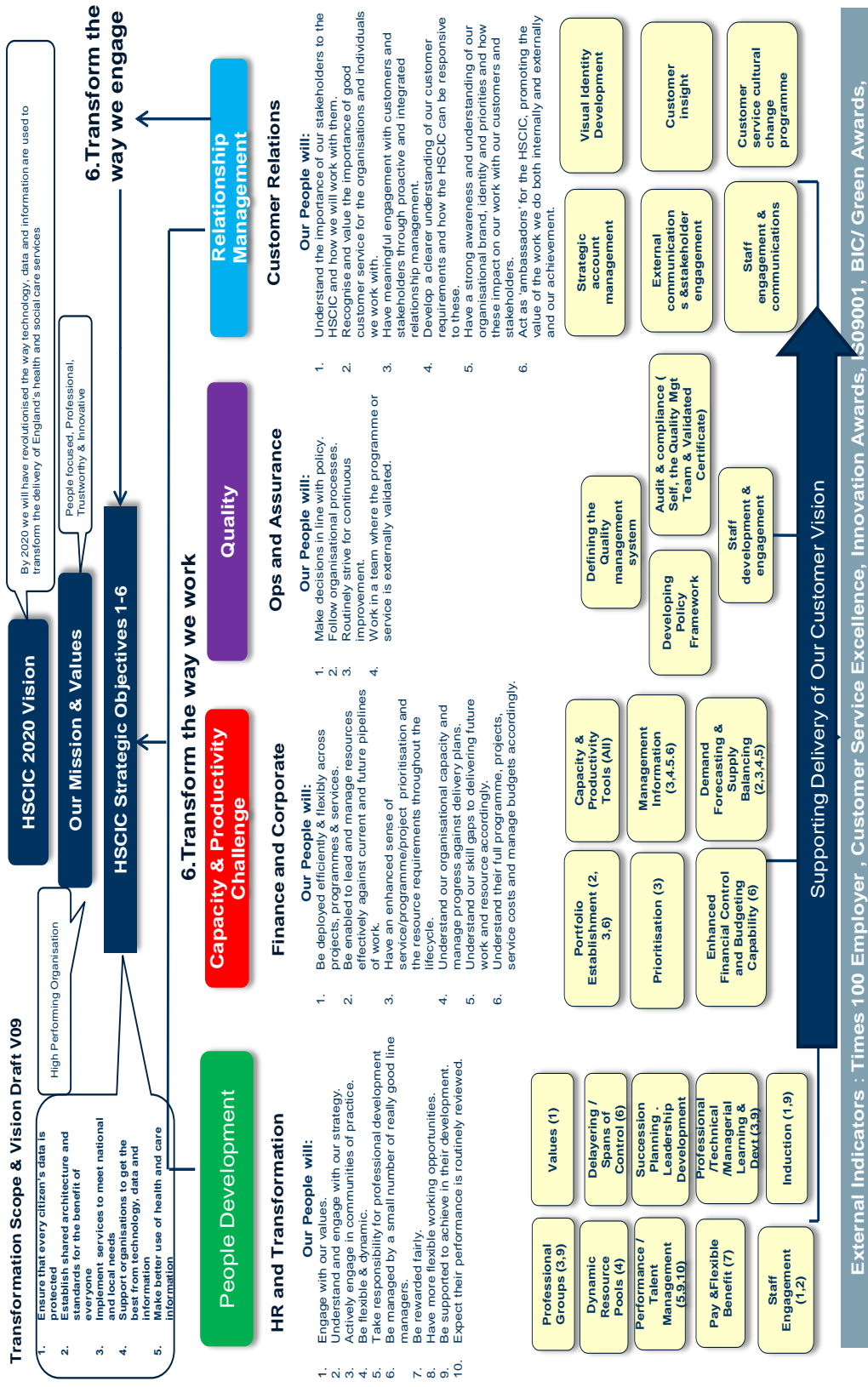
This proposal has previously been informally tested with the Board who are supportive of it and it has now been announced to staff at the All Hand conference on 10 September. A senior leadership team has been compiled with representation from each directorate to formulate a detailed programme plan including options for implementation taking into account resources, timescales, roles and responsibilities as well as the impact of the change on the organisation including existing business as usual and our staff. It is acknowledged that it is crucial to secure not only organisational and senior leadership for this change, but the engagement and involvement of all staff to effectively implement and sustain the transformation change required.

5. Conclusion

The transformation approach is failing to deliver the required level/speed of change. The work done has not been wasted and largely needs to continue to completion as an essential pre-requisite and underpinning for future activity, but it should be regarded as continuous quality improvement rather than transformational change. However, if our vision is to become a high-performing organisation with a reputation as an outstanding place to work is to be realised then we need a significant amount of disruptive change to overwhelm the status quo. It is suggested that the revised operating model and organisational design will provide the opportunity to introduce a radical and disruptive change within the organisation which will have this impact.

The Board are asked to note the contents of this report.

Appendix 1 – Transformation Vision and Scope



Appendix 2 – Progress of Transformation Projects

The following outlines progress of each of the projects incorporated in Appendix 1 under each pillar.

Pillar 1: People Development

1. Professional Groups

Our people will:

“Actively engage in communities of practice - inspired by and updated with the wider knowledge, intelligence and experience of their Professional Bodies”.

“Be supported to achieve, through our investment in their professional, technical, managerial and leadership development”

Status:

- Phase 1 deliverables i.e.: career ladders, competency frameworks & job descriptions (JDs) incomplete after initial delivery date of June 2014.
- 19 (86%) career ladders and competency frameworks now complete.
- 70% of forecasted generic JDs have been evaluated with the majority of remainder scheduled for evaluation in early September.
- Cessation of recruitment to old job descriptions planned for 30th September.
- Phase 2 overall planning immature for the majority of professions.

2. Dynamic Resource Pools

Our people will:

“Be flexible and dynamic, with the will to take on new assignments and challenges”

Status:

- Individual consultations with PPD staff continue in all directorates (except O&A).
- The resource pools are now operational (except O&A)
- The Summary stats are as follows (excluding O&A):
 - Total staff affected: 579
 - 90% of Individual Consultations have been held
 - 27% of staff who have been sent letters have signed and returned acceptance letters.
 - Focus next on the ‘sweep up’ of Individual Consultations including resolving any Appeals along with commencing O & A Individual Consultations

3. Performance and Talent Management

Our people will:

“Take responsibility for professional development”

“Be supported to achieve in their development”

“Expect their performance is routinely reviewed”

Status

- 85% PDR compliance for 2014/15 (target of 96%).
- Staff at 9, 8D, 8C assessed against the ‘9 box grid’ for the start of 2015/16.
- Facility for professional, personal and managerial competency to be assessed within the PDR.

4. Pay and Flexible Benefit

Our people will:

“Be rewarded fairly, taking account of national and local labour market conditions, and are provided with flexible reward options”.

- Development and implementation of a more robust and strategic approach to the application of Recruitment and Retention Premia, using a clear evidence base to inform Remuneration Committee decisions on the payment of existing RRP to existing and new roles.
- Significant improvements in sourcing and reporting labour market information, including subscription to a national ICT salary survey, to identify where RRP may be required to compete in the marketplace.
- Implemented procedure for agreeing starting salaries in development to ensure consistency and fairness in approach across the business.
- Commenced review of additional allowances and other payments to ensure that they are only paid where there is a legitimate justification to do so.
- Draft pay and reward strategy being produced for consideration by the Remuneration Committee.
- Improving data quality around protected characteristics to inform and extend equal pay reporting and equality more generally.
- Exploring opportunities to harmonise terms and conditions following TUPE transfers
- On-going development and implementation of staff benefits.

5. Staff Engagement – please refer to point 26

6. Values

Our people will:

“Be fully engaged with our values”.

Status

- Agreed the organisational values in early 2014 overcoming initial resistance across parts of the organisation.
- Embedded the opportunity for a values conversation to occur within the PDR.
- Values based recruitment underway but evidence demonstrated during selection is not necessarily converted into action in the workplace.

7. Delaying & Spans of Control; and

8. Succession Planning/ Leadership Development

Our people will:

“Be managed by a smaller number of really good line managers”.

Status:

- A new leadership forum was established in March 2015 with membership identified through ‘9 Box Grid’ process.
- Less than 50% of the Leadership Forum is fully engaged currently.
- There are circa 700 line managers in the HSCIC with an average ratio of 1 manager to 3.4 staff.
- 5x5 spans of control are variable across the organisation and is meeting some resistance from senior people.

9. Professional / Technical Managerial Learning & Development

Our people will:

“Be actively engaged in communities of practice”.

“Be supported to achieve in their development”.

Status

- 2145 staff have registered for Civil Service Learning (CSL)
- 213 gateway applications and working on improvements to training supply.
- Devolution has created a shift in culture towards directorates taking a greater interest in training for staff
- Unclear relationship between PDRs and priorities for investment of time and money.

10. Induction

Our people will:

“Engage with our values”

“Be supported to achieve in their development”

Status:

- 365 people have attended 32 Corporate Induction since 14th October 2014 - no delegates awaiting Corporate Induction events.

- An average positive evaluation score of 98.33% has been received since Corporate Induction began with a focus on continuous improvement.

Pillar 2: Capacity and Productivity Challenge

11. Portfolio Establishment; and

12. Prioritisation

Our people will:

“Have an enhanced sense of service/programme/project prioritisation and the resource requirements throughout the lifecycle”.

“Understand their full programme, projects, service costs and manage budgets accordingly”.

Status:

- Prioritisation of the portfolio is now complete and a process is in place for all future work.
- The Portfolio office is working with each directorate to ensure all work is represented on the portfolio.
- However more work will be needed as we continue with rolling-out into BAU.

13. Enhanced Financial Control and Budgeting Capability

Our people will:

“Understand their full programme, projects, service costs and manage budgets accordingly”.

Status / Next Steps:

This area will focus on:

- Day Rate calculation.
- Agree Administrative codes - Absence, Non chargeable time.
- Capital v Revenue costing and alignment of Portfolio/Services with accounting codes.
- Chart of Accounts set up.
- Tagetik Enhancements and data quality checks.

14. Capacity and Productivity Tools

Our people will:

“Be deployed efficiently and flexibly across projects, programmes & services”.

“Be enabled to lead and manage resources effectively against current and future pipelines of work”.

“Have an enhanced sense of service/programme/project prioritisation and the resource requirements throughout the lifecycle”.

“Understand our organisational capacity and manage progress against delivery plans”.

“Understand skill gaps to delivering future work and resource accordingly”.

“Understand their full programme, projects, service costs and manage budgets accordingly”.

Status:

- Full ABR/Resource Forecasting and Planning Business Requirements approved and Office 365 selected.
- Next steps are focused on customisation of the Office Tool, Planning and Pilot roll-out. The timeframe for Implementation is:
 - **Build**
 - Phase 1 to continue (Completion mid-September) in parallel with
 - Phase 2 build (Completion end-October)
 - **Pilot of solution to be run with 4 areas throughout October;**
 - Programme Delivery; Solutions Assurance within Operations and Assurance Services; Finance and Corporate Services and Information and Analytics
 - Circa 100-120 employees
 - Lessons learnt, issue resolution and change period to run for majority of November
 - **Roll-out by Directorate approach**
 - Phase 1 – End-November and running through to December
 - Phase 2 – January and running through to end-February
 - **Training** - phased and linked to pilot and roll-out starting in September and running through to February.

15. Management Information

Our people will:

“Have an enhanced sense of service/programme/project prioritisation and the resource requirements throughout the lifecycle”.

“Understand our organisational capacity and manage progress against delivery plans”.

“Understand our skill gaps to delivering future work and resource accordingly”.

“Understand their full programme, projects, service costs and manage budgets accordingly”.

Status / Next Steps:

- A suite of reports enhanced via ABR/Resource Forecasting Information are being developed as part of the roll out.

16. Demand Forecasting and Supply Balancing – this links into 11-15 in terms of how the overall approach to capacity and productivity is managed.

Pillar 3 Quality

17-20. Defining the Quality Management System / Developing the Policy Framework / Information Governance / Audit & Compliance / Staff Development

Our people will:

“Make decisions in line with policy”.

“Follow organisational processes”.

“Routinely strive for continuous improvement”.

“Work in a team where the programme or service is externally validated”.

Status:

- Whilst work has continued on some aspects of the Quality Pillar across the organisation, the overall approach to developing a cohesive Quality Management Strategy in respect of attaining external accreditation was agreed to be a “middle order” priority for Transformation at the EMT Timeout at the 8th and July.
- A meeting has been held to re-scope how we seek to implement the quality management across organisation with further planning meetings to follow.

Pillar 4: Relationship Management

21. Strategic Account Management

Our people will:

“Understand the importance of our stakeholders to the HSCIC and how we will work with them”.

“Have meaningful engagement with customers and stakeholders through proactive and integrated relationship management”.

Status:

- The Strategic Account Management approach was agreed by EMT (April 2015)
- The first tranche of strategic account managers have been recruited to cover:
 - Supplier liaison and international markets
 - Business Intelligence
 - National health agencies
 - Research and life sciences
 - Social care/integration

22. Visual Identity Development

Our people will:

“Have a strong awareness and understanding of our organisational brand, identity and priorities and how these impact on our work with our customers and stakeholders”.

Status:

- A new visual identity has been developed and is planned to be rolled out by the end of October.

23. External communication and stakeholder engagement

Our people will:

“Have meaningful engagement with customers and stakeholders through proactive and integrated relationship management”.

Status:

- A new external communications/stakeholder engagement team has been created with a senior lead appointed
- Supplier and researcher communications and engagement plans are underway.

24. Customer Insight

Our people will:

“Recognise and value the importance of good customer service for the organisations and individuals we work with”.

Status:

- A small customer insight team is currently being recruited.

25. Staff engagement and communications

Our people will:

“Act as ‘ambassadors’ for the HSCIC, promoting the value of the work we do both internally and externally and our achievement”.

Status:

- An independent review of HSCIC staff engagement and communications has been delivered.
- An action plan is being implemented to improve the communications with staff.

26. Customer Service Cultural Change programme

Our people will:

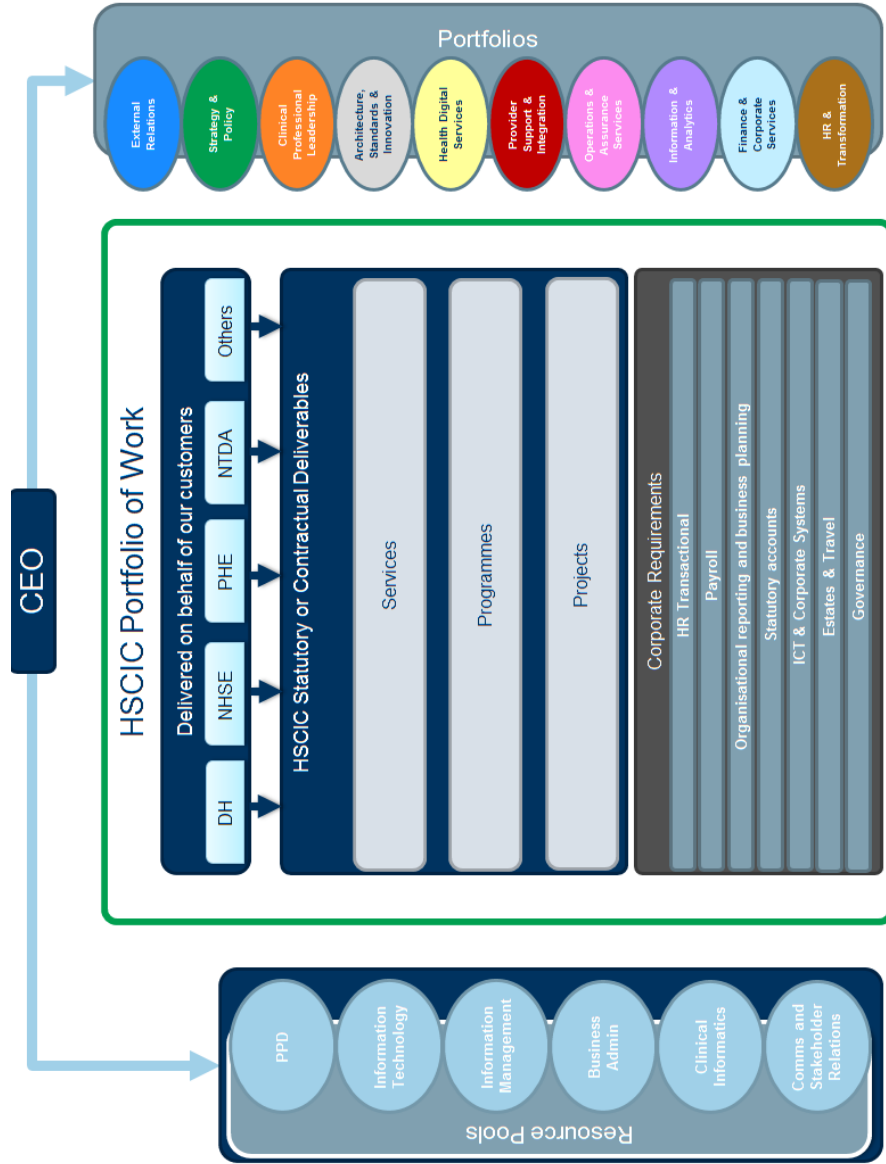
“Develop a clearer understanding of our customer requirements and how the HSCIC can be responsive to these”.

“Act as ‘ambassadors’ for the HSCIC, promoting the value of the work we do both internally and externally and our achievement”.

Status:

- A brief has been drafted to procure an external supplier to advise on the development and delivery of a programme of activity on cultural change, strengthening our customer service orientation and leadership development.
- The procurement exercise is underway with initial responses received and being reviewed.

Appendix 3 – Operating Model



Board Strategy Session

Title of paper:	Pipeline of Investment Decisions and Directions
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 03 (c)
Paper presented by:	Carl Vincent Director of Finance & Corporate Services
Paper prepared by:	David Wilmshurst – Head of Corporate Assurance, Stuart Bailey – Principal PMO Manager
Paper approved by: (Sponsor Director)	Carl Vincent Director of Finance & Corporate Services
Purpose of the paper:	To provide a pipeline of Investment Decisions and Directions to inform Board discussions and identify future issues.
Justification for inclusion in private board:	Standing Item requested by Board.
Key risks and issues:	None
Patient/public interest:	Indirect: Improved visibility of HSCIC work plan
Actions required by the board:	<p>The HSCIC Board are asked to comment on the current pipelines and identify where there are items they would like to review further where this is not already indicated.</p> <p>The Board's attention is drawn to the most imminent investments which are HSCN and care.data in the next few months, the Board may want to request attendance at a future meeting.</p>

Pipeline of Investment Decisions and Directions

Author:

**David Wilmshurst – Head of Corporate Assurance,
Stuart Bailey – Principal PMO Manager**

Date: 23/9/2015

Contents

Contents	2
Background	3
Actions Required of the Board	3
Annex 1 – Pipeline of future investment decisions / commitment of resources	4
Annex 2 – Directions Planner	17

Background

In response to the HSCIC Board's request for an earlier view of items which are likely to require approval or might be of strategic interest to the Board a paper submitted to the 15 July meeting proposed the format of the attached **Investment Pipeline**.

The table, attached as Annex 1, sets out proposed investment decisions and commitment of resources. It covers:

- (a) HSCIC expenditure – funded from Grant-in-Aid (GIA)
- (b) HSCIC expenditure – funded from other income
- (c) DH funded programmes – HSCIC delivery
- (d) HSCIC commitment to deliver work / programmes

It has been produced using a range of information sources including: Portfolio Database; project plans; IAAPs and discussions with individual teams. The table represents an initial draw down of this information and as such is expected to improve over time.

As this was discussed so recently at the 2 Sept meeting, there has been little change in the information presented here. The IPPMA case has been removed from this pipeline as this has now been approved at all necessary levels within HSCIC.

Also provided as Annex 2 is the current **Directions Pipeline** table showing Directions:

- that have been issued
- that are in place having been reviewed by the HSCIC Board, but not yet issued
- that are in the process of being prepared for consideration by the HSCIC Board, and
- that may be required

At the time of writing, there are 5 Directions on the agenda for the 23rd September meeting:

- Type 2 Objections (DH)
- Assuring Transformation (NHSE)
- Genomics (DH)
- E-Med 3 (DH on behalf of DWP)
- Female Genital Mutilation (FGM) dataset (DH).

Actions Required of the Board

The HSCIC Board are asked to comment on the current pipelines and identify where there are items they would like to review further where this is not already indicated.

The Board's attention is drawn to the most imminent investments which are HSCN and care.data in the next few months, the Board may want to request attendance at a future meeting.

Annex 1 – Pipeline of future investment decisions / commitment of resources

Investment decision categories:

- a) Programmes / work where the HSCIC incurs the expenditure – funded from GIA
- b) Programmes / work where the HSCIC incurs the expenditure – funded from other income sources
- c) Programmes delivered by the HSCIC, but where expenditure is incurred by the DH (and does not appear in the HSCIC Accounts)
- d) HSCIC commitment to deliver work / programmes (excluding Directions under s254 from the DH or NHSE)

The following table is ordered by: known investments which are recommended for Board approval; followed by those where the timing is TBC, but the approval level is still recommended to be the Board; followed by other investments. A number of data points are still being validated.

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
HSCN	(a) and (c) OBC	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 PSNH project will deliver a Public Services Network for Health, which will be aligned and accredited to PSN standards	TBC	23 Sept	29 Sept	£920m	James Hawkins	HSCIC Board

Pipeline of Investment Decisions and Directions

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
Care.Data	(a) and (b) OBC	The Care.Data programme, this initiative will ensure that there is more rounded information available to citizens, patients, clinicians, researchers and the people that plan health and care services. Our aim is to ensure that the best possible evidence is available to improve the quality of care for all	TBC	Oct	Nov	TBC	Martin Severs	HSCIC Board
Data Services Programme	Category TBC – PBC	Delivery of a scalable, accessible and fit for purpose data services platform and operating model providing efficient and secure hosting of HSCIC's key data services, improving the way we collect, analyse, disseminate and publish data.	TBC	TBC	Date TBC	£5-10m (as per draft Brief)	Peter Counter	HSCIC Board (TBC)
Shared Business Services (SBS) Replacement Programme	a) Programme/ work where the HSCIC incurs the expenditure – funded from GIA	The HSCIC's HR, Commercial Delivery, Finance and Business Services departments are currently supported by the SBS solution under a contract that expires in 2018. The Department of Health	TBC	TBC	N/A	<£5m (programme is currently developing a brief)	Carl Vincent	HSCIC Board (TBC)

Pipeline of Investment Decisions and Directions

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
		has a requirement for all of its arm's length bodies (ALBs) to deliver year on year efficiencies in their back office functions. The DH had negotiated for themselves and their ALBs to transition to the ISSC1 solution and the HSCIC agreed to join this initiative.						
GPSoC Replacement	(a) and (c) FBC (Framework extension)	To provide a contractual vehicle for the supply and development of GP clinical IT systems for all Practices in England, following expiry of the extended GPSoC call off agreements in March 2014.	Date TBC	Date TBC	Dec – TBC	>£50m	James Hawkins	HSCIC Board (TBC)
NHS e-Referral Service Programme	(a) and (c) Consolidated FBC	The NHS e-Referral Service Programme will deliver an open, modern, electronic referral service, improving patient outcomes and delivering paperless referrals by 2015.	Date TBC	Date TBC	Date TBC	TBC	James Hawkins	HSCIC Board (TBC)

Pipeline of Investment Decisions and Directions

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
National Tariff System	(a) and (b) pre-Discovery PBC	<p>The National Tariff System (NTS) programme will provide national solutions that implement the national payment system as defined by NHS England and Monitor.</p> <p>This will be achieved via implementation of a national system and enabling products which initially provide core Payment by Results (PbR) functionality for hospitals providing NHS care.</p> <p>Over the longer term it will deliver emerging national policy requirements and meet additional business requirements of users.</p>	TBC	TBC	Date TBC	£93-123m (as per draft, pre-Discovery PBC)	Peter Counter	HSCIC Board (TBC)
Summary Care Record (SCR) Phase 2	(a) And (c) PBC	<p>There is an increasing demand from across health and social care to maximise the potential of SCR to support the provision of better, safer and more joined up care. There are a number of strategic and policy drivers that have emerged recently supporting the future development, including the 'National Information Board (NIB)</p>	TBC	TBC	TBC	Circa £10m (but TBC as business is being developed)	James Hawkins	HSCIC Board (TBC)

Pipeline of Investment Decisions and Directions

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
		Personalised Health and Care 2020 Framework for Action (2014) where SCR is referenced in the 2.1 workstream.						
EPS Release 3	(a) and (c) PBC	Beverley Bryant, Director of Strategic Systems and Technology, NHS England has requested that the HSCIC considers developing EPS further to enhance the service for patients and end users. Known as EPS Release 3, this new project will involve the development of functionality and enhancements over and above those defined in the ETP Business Case extension	TBC	TBC	TBC	Circa £27m	James Hawkins	HSCIC Board (TBC)
SNOMED CT in Primary Care	a) Programme/ work where the HSCIC incurs the expenditure – funded from GIA	The primary purpose of the SNOMED CT in Primary Care Programme is to ensure that all primary care systems fully adopt SNOMED CT as the single clinical terminology by the end of December 2016. The move to a single clinical	TBC	TBC	TBC	£7.5m	Peter Counter/James Hawkins	HSCIC Board (TBC)

Pipeline of Investment Decisions and Directions

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
		terminology using SNOMED CT has been government strategy for many years and is a fundamental requirement with regard to government aspirations for data sharing, interoperability and the move to data extraction from the additional burden of data collection.						
Spine Demographics Reporting Service	(a) and (c) FBJ	A new Spine Demographics Reporting Service (SDRS), providing regular bulk extracts of patient primary care registration and demographic data, is required to support NHS England's Primary Care Support Transformation Programme and to enable the successful bidder to drive through the required business transformation.	-	-	Sept	£4.4m	Rob Shaw	HSCIC CEO
Primary Care Registration Management	(a) and (c) FBJ	The provision of this solution is a pre-requisite deliverable of the NHS England Primary Care Support Transformation Programme's contract with their intended national, single primary care support	-	-	Sept	£5.05m	Rob Shaw	HSCIC CEO

Pipeline of Investment Decisions and Directions

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
Health & Justice Information Services – Phase 1: Residential Detention	(b) FBC (HSCIC has been commissioned to deliver a business case for NHS E and costs are recharged)	supplier. 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	Sept	TBC	Nov / Dec (inc NHSE approvals)	Dependent on procurement outcome	James Hawkins	HSCIC CEO (endorsement)
Summary Care Record (SCR) National Implementation for Community Pharmacy	TBC – HSCIC will recharge NHS England for full recovery costs within the agreed funding envelope.	HSCIC has been requested by NHS England to deliver SCR to the 11,647 community pharmacies in England. This is following a successful proof of concept (POC) project delivered by the SCR programme providing access to 140 pharmacies. This work is directly referenced in the NIB strategy and the Five Year Forward View. The objective is to provide all pharmacies with the necessary existing technology and business change needed to	TBC	TBC	TBC	Circa £8m	James Hawkins	TBC

Pipeline of Investment Decisions and Directions

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
		successfully access SCR in order to realise the benefits identified in the POC.						
GPES Continuity	(a) and (c) TBC as currently at programme Brief stage with caveats to clear	The vision for the GPES Continuity programme is to deliver improvements to the current service or a replacement service that would allow HSCIC to deliver legitimate data extracts from GP systems on behalf of customers that are complete, accurate, relevant, accessible and timely GP practice data.	TBC	TBC	TBC	Circa £4m (but TBC as business case yet to be developed)	James Hawkins	TBC
Digital Assessment Service	b) Programmes / work where the HSCIC incurs the expenditure – funded from other income sources	The Digital Assessment Service ("DAS") was previously provided by NHS Direct. This organisation ceased to exist on 31st March 2014. NHS England commissioned HSCIC to provide a reduced version of this service from 1 April 2014 until 31st March 2015 under the previous MOU and have now requested the service continue until termination on the 5th	TBC	TBC	TBC	£1.7m	James Hawkins	HSCIC CEO

Pipeline of Investment Decisions and Directions

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
		January 2016.						
Child Sexual Abuse (CSA) data set	d) HSCIC Commitment to deliver work / programmes as part of a POSA	<p>HSCIC has been asked to support the Department of Health's (DH) commitment to develop, collect and publish child sex abuse information, providing</p> <ul style="list-style-type: none"> • improvements in understanding the current prevalence of child sexual abuse • support NHS England in the commissioning of appropriate services • support the ongoing recording of child sexual abuse, when it has been disclosed 	N/A	N/A	N/A	£566k	James Hawkins	HSCIC CEO
Support for MOD Defence Medical Services	(b) HSCIC costs will be recharged under a POSA	The Ministry of Defence (MOD) Headquarters Surgeon General (HQ SG) is responsible for the co-ordination and management of the Defence Medical Services' (DMS) portfolio of information technology	N/A	N/A	N/A	£220k?	James Hawkins	Director of Finance and Corporate Services

Pipeline of Investment Decisions and Directions

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
		services. These assist the delivery of health care services to the Armed Forces and their personnel. This includes the Defence Medical Information Capability Programme (DMICP), which provides an integrated Electronic Healthcare Record for all service personnel, and work to develop and implement a replacement system for DMICP through the MOD's CORTISONE Programme.						
Oxygen Pilot	(a) Programme/ work where the HSCIC incurs the expenditure – funded from GIA	The Project Oxygen Pilot is a mobile solution that enables clinicians to view patient data held in PDS, SCR and CP-IS without a smartcard. The Pilot is a limited clinical trial at a small number of NHS Trusts.	N/A	N/A	N/A	£461,000	Tom Denwood	Director of Finance and Corporate Services
Mobile enabled access and services for professionals	a) Programme/ work where the HSCIC incurs the expenditure – funded from GIA	Mobile enabled access and services for professionals aims to help advance the use of mobile technology (incl. wearables) that can help health and care organisations to improve the safety, efficiency and effectiveness of their services, for example:	N/A	N/A	N/A	£178,000	Tom Denwood	Director of Finance and Corporate Services

Pipeline of Investment Decisions and Directions

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
NHS Citizen Identity Project	a) Programme/ work where the HSCIC incurs the expenditure – funded from GIA	<ul style="list-style-type: none"> • Mobile access to HSCIC services for direct care / professional use; • Mobile working and mobile EPR that for patient engagement / data capture at the point of care; • Device/mobile generated data shared with professionals to enable remote monitoring/intervention; • Use of mobile 'apps' to support clinical practice, e.g. medication calculators and risk assessments. <p>The NHS Citizen Identity Project ("PN0394 NHS Citizen Identity Project, Scope and Feasibility) has been established to deliver an approach that a citizen can use to verify their identity and create a trusted single digital identity to transact online with multiple national health and social care services, such as booking appointments and online repeat prescriptions for all care services.</p>	N/A	N/A	N/A	<p>P1 Brief – Approved 5/5/15 - £136,882</p> <p>P2 Brief – 3/8/15 - £284,970</p>	James Hawkins	Director of Finance and Corporate Services

Pipeline of Investment Decisions and Directions

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
Patient Preferences/preferences for sharing Programme	a) Programme/ work where the HSCIC incurs the expenditure – funded from GIA	The HSCIC Board has decided that the HSCIC should manage Type 2 Objections using a HSCIC-owned and managed process. Whilst no firm date has been agreed for the implementation of this, the working assumption is that the initial implementation will be in FY15/16. The HSCIC is also to play a lead role in the delivery of the NIB Framework for Action Workstream 4 “Build and sustain public trust: deliver a road map to consent based information sharing and assurance of safeguards”.	TBC	TBC	N/A	£486k	Martin Severs	TBC
Genomics Support Service	d) HSCIC Commitment to deliver work / programmes as part of a POSA	Genomics is set to transform elements of health care research and delivery. Genomics England Ltd has been established by the Department of Health as a Limited Company with a 3 year goal to analyse 100,000 genomes in the pursuit of understanding	TBC	TBC	N/A	£0.5 - £1m	Carl Vincent/Peter Counter	CEO/Director of Finance and Corporate Services

Pipeline of Investment Decisions and Directions

Project/ Programme	Investment decision category	Description	HSCIC Board Initial view	HSCIC Board Approval	Planned date for DH Informatics Portfolio Mgt. Board	Approx. Whole Life Cost	Exec Dir.	Recommended approval level
		cancer and rare conditions, classification and treatments.						
eMED3	b) Programmes / work where the HSCIC incurs the expenditure – funded from other income sources	Conversion of the current paper eMED3 certificate (fit notes) handwritten by GPs into an electronic form available in all NHS CFH GPSoC systems	TBC	TBC	N/A	£453k	James Hawkins	Director of Finance and Corporate Services

Annex 2 – Directions Planner

HSCIC DIRECTIONS PLANNER											UPDATED: 04/09/2015
NUMBER	DIRECTION REQUIRED	ORIGINATOR	HSCIC DIRECTORATE / BUSINESS AREA / TEAM	HSCIC CONTACT	BRIEF DESCRIPTION	SCI INVOLVEMENT (Y / N)	DATA FLOW REQUIRED BY	UPDATE / CURRENT STATUS	FEE (Y / N)	HSCIC Board Oversight	DIRECTIONS ISSUED
	DIRECTIONS ISSUED										
1	NHS Choices	DH	NHS Choices Delivery Programme Delivery	Cleveland Henry	Establishment and operation of systems for the Delivery Functions for NHS Choices and Additional Systems Delivery Functions for NHS Choices	TBC	01/08/2013	This Direction is now in place and has been issued	Y	27/09/2013	29/07/2013
2	Primary Care Data	NHSE	Care data programme: I&A	Eve Roodhouse	Establishment and operation of a system for the extraction of primary care information and linkage to Hospital Episodes Statistics	TBC	TBC	This Direction will be revoked following the issue of the Collection and analysis of Primary Care Data (care.data) Direction presented to the HSCIC Board on 15/07/2015	N/A	15/01/2014	19/12/2013
3	Annual Accounts	DH	Finance, Finance & Corporate Services	Steve Leathley	Establishment and operation of a system for the preparation of annual financial accounts	N	N/A	This Direction is now in place and has been issued	N	17/06/2014	10/03/2014
4	Data Services for Commissioners	NHSE	DSIC team	Kemi Adenubi	Establishment and operation of systems for the collection and analysis of Local Commissioning Data, Clinical Registry Data and Historic PCT Data to deliver Data Services for Commissioners	N	24/03/2014	This Direction has been revoked following the issue of the Data Services for Commissioners' Direction on 31/07/2015	Y	15/01/2014	20/03/2014
5	Spine Services	DH	Spine Services; O&S	Andrew Meyer	Establishment and operation of systems for the collection and analysis of information as are necessary to deliver the Spine services	N	22/08/2014	This Direction has been revoked following the issue of the Spine Services 2' Direction on 05/12/2014	N	03/09/2014	22/08/2014
6	Learning Disability Census	DH	Mental Health; I&A	John Varlow	Establishment and operation of systems for the collection and analysis of information on specialised mental or behavioural health issues	N	30/09/2014	This Direction is now in place and has been issued	Y	28/01/2014	23/09/2014
7	Spine Services 2	DH	Spine Services; O&S	Andrew Meyer	Establishment and operation of systems for the collection and analysis of information as are necessary to deliver the Spine services	N	Existing dataflow	This Direction is now in place and has been issued	N	28/01/2015	05/12/2014
8	Assuring Transformation Data Collection	NHSE	Mental Health; I&A	John Varlow	Establishment and operation of the Assuring Transformation Data Collection System re learning disabilities	Y	06/01/2015	This Direction will be revoked following the issue of the Assuring Transformation' Direction due to be presented to the HSCIC Board on 23/09/2015	Y	28/01/2015	23/12/2014
9	Female Genital Mutilation (FGM) Immigration Health Charge	DH	Programme Delivery	John Varlow	Establishment and operation of systems for the collection and analysis of information from relevant organisations to be known as 'the FGM Information System'	Y	01/04/2015	This Direction is now in place and has been issued	Y	31/03/2015	31/03/2015
10	Maternity data set	DH	Spine 2 Team	Iain McQuillan	Establishment and operation of systems for the collection and analysis of information to facilitate NHS charging for overseas visitors or migrants	N	06/04/2015	This Direction is now in place and has been issued	Y	01/04/2015	29/04/2015
11	Children and Young People's Health Services (CYPHS)	NHSE	Community Mental Health Team; I&A	John Varlow	Establishment and operation of a system for the collection of the information from relevant organisations from a system to be known as "the Maternity Services Information System"	Y	01/06/2015	This Direction is now in place and has been issued	Y	29/04/2015	21/05/2015
12	Cancer Waiting Times	NHSE	Community Mental Health Team	John Varlow	Establishment and operation of systems for the collection and analysis of person-based information for children and young people in contact with CYPHS	Y	01/10/2015	This Direction is now in place and has been issued	Y	29/04/2015	21/05/2015
13	Data Services for Commissioners (DSIC)	NHSE	Graham Ambrose Service Manager for the Cancer Waiting Time data base (O&A)	Graham Ambrose	To provide a legal basis for the continued operation of systems (established since 01/04/2013) for the collection and analysis of Cancer Waiting Times data.	Y	Existing dataflow	This Direction is now in place and has been issued	Y	15/07/2015	29/07/2015
14	Mental Health Services Data Services (including CAMHS)	NHSE	DSIC Team	Kemi Adenubi	Review/update of existing Direction which included specific date for review	N	Ongoing as it is a review	This Direction is now in place and has been issued. Please note that this Direction revokes the previous DSIC Direction (4) issued in March 2014. This Direction will be reviewed by 30/09/2016	Y	15/07/2015	31/07/2015
15	Mental Health Services Data Services (including CAMHS)	NHSE	Community Mental Health Team; I&A	John Varlow	Update the MH and LD data set to include new data items and incorporate CAMHS to create single MH Services data Set	Y	01/01/2016	This Direction is now in place and has been issued	Y	10/06/2015	31/07/2015

NUMBER	DIRECTION REQUIRED	ORIGINATOR	HSCIC DIRECTORATE / BUSINESS AREA / TEAM	HSCIC CONTACT	BRIEF DESCRIPTION	SCI INVOLVEMENT (Y / N)	DATA FLOW REQUIRED BY	UPDATE / CURRENT STATUS	FEE (Y / N)	HSCIC Board Oversight	DIRECTIONS ISSUED
DIRECTIONS IN PLACE PENDING ISSUE											
16	Dementia Prevalence	NHS E	Primary Care; I&A	John Varlow	Extraction of aggregate information via GPES. Currently part of QOF. Some additional data items	Y	31/08/2015	Currently awaiting SCCI approval, but has been presented to the HSCIC Board	Y	15/07/2015	TBC
17	UK Genetic Testing Data	NHS E & devolved authorities	Clinical Audit Team; I&A	John Varlow	Collection of genetic testing data from labs in the UK. SCCI process is for collection is not standard, so full documentation is NOT produced	Y	AS-AP - originally due 31/03/15	NHS E clarifying legal basis in relation to devolved authorities via legal counsel	Y	15/07/2015	TBC
18	Collection and analysis of Primary Care Data (care.data)	NHS E	care.data programme	Eve Roodhouse	care.data Pathfinder collection and analysis	N	TBC	This Direction is now in place, but awaiting input from Dame Fiona Caldicott (following review date for the evaluation of Pathfinder collection and analysis) before it can be issued by NHS E	Y	15/07/2015	TBC

NUMBER	DIRECTION REQUIRED	ORIGINATOR	HSCIC DIRECTORATE / BUSINESS AREA / TEAM	HSCIC CONTACT	BRIEF DESCRIPTION	SCCI INVOLVEMENT (Y / N)	DATA FLOW REQUIRED BY	UPDATE / CURRENT STATUS	FEE (Y / N)	HSCIC Board Oversight	DIRECTIONS ISSUED
DIRECTIONS IN PROGRESS											
19	Type 2 Objections	DH	Preferences Programme Strategy	Rowena Herbert	Directing HSCIC to collect information from GP practices about patients who object to personally identifiable data flowing out of HSCIC	N	System to uphold objections in place by Jan-16	HSCIC Project Team aiming for September Board, but this is still to be confirmed by DH	N	23/09/2015	TBC
20	Assuring Transformation	NHS E	Community Mental Health; I&A	John Varlow	Amendments to existing data set with data additional items required	Y	Nov-15	Documentation for Direction due to be in final draft by 20 Aug	Y	23/09/2015	TBC
21	caredata Objections	DH	Caredata Programme	Eve Roodhouse	Directing HSCIC on the treatment of information about patients who object to the collection of data from GP practices by the HSCIC	N	Needs to be in place prior to pathfinder data flow	HSCIC Project Team aiming for September Board, but this is still to be confirmed by DH	TBC	23/09/2015	TBC
22	Female Genital Mutilation (FGM) dataset	DH	Project and Programme delivery	Tracey Harrington	Please note that this is an additional Direction to the FGM dataset (1) to develop a national system which will flag any girls at risk	TBC	28/08/2015	This system is now live following a 'letter of comfort' from the DH with a Direction to follow in due course	TBC	23/09/2015	TBC
23	Genomics	DH	Genomics Programme	John Willshire	The establishment and operation of information systems (i.e. the hosting, operation and service management of applications and systems) that are part of the 100,000 Genomes Project	N	Sep / Oct 2015	Delayed from Sept Board due to DH legal capacity issues	TBC	25/11/2015	TBC
24	Pulmonary Hypertension Clinical Audit	NHS E	Clinical Audit; I&A	John Varlow	Collecting data from Trusts to run clinical audit. Work is directly commissioned via NHS E – not a HQIP audit	N	CAG expires Apr 16	A direction will be required from Apr 2016	Y	27/01/2016	TBC
25	Breast Implant Register	DH	Analytical Services; I&A	John Varlow	Collection of data on breast implants from across all providers (NHS and non NHS)	Y	Jul-16	HSCIC asked to take forward the implementation of the registry following the pilot evaluation	Y	27/01/2016	TBC

NUMBER	DIRECTION REQUIRED	ORIGINATOR	HSC/DIRECTORATE/ BUSINESS AREA/ TEAM	HSC CONTACT	BRIEF DESCRIPTION	SCI INVOLVEMENT (Y/N)	DATA FLOW REQUIRED BY	UPDATE / CURRENT STATUS	FEE (Y/N)	HSC Board Oversight	DIRECTIONS ISSUED
DIRECTIONS STILL TO BE CONFIRMED / FINALISED											
26	Cancer Waiting Times - Link with diagnostic imaging data	NHSE	Graham Ambrose Service Manager for the Cancer Waiting Time data base (O&A)	Graham Ambrose	The establishment and operation of information systems to collect two additional items of Cancer Waiting Times (CWT) data in addition to those included in the initial CWT Direction (no. 13)	TBC	TBC	NHSE to confirm timescales for this Direction	TBC	TBC	TBC
27	Workforce minimum data set (WIMDS)	DH	Workforce and Facilities Team, I&A	John Varlow	Workforce MDS is a subset of National Workforce data set	Y (Update required in Aug-15)	Next collection Sep-15	Delayed from Sept Board due to SCI requirements and capacity to take this forward	TBC	TBC	TBC
28	Clinical Audit	NHSE	Clinical Audit Team, I&A	John Varlow	Collection of a range of clinical audit data	N	TBC	NHSE to confirm timescales for this Direction	Y	TBC	TBC
29	Dissemination of ONS data	DH	Information Governance (IG)	TBC	Legal basis for IG to onwardly share ONS data	N	TBC	DH to confirm timescales for this Direction	TBC	TBC	TBC
30	eMED3	DH (on behalf of the DWP)	GPSoc Programme	TBC	Collection of identifiable fitnote data from GP practices for anonymisation and analysis	N	TBC	DH to confirm timescales for this Direction	TBC	TBC	TBC
31	Live Birth data	DH	Demographics	Steve Smith	Dissemination of PDS data about neonates to LAs, to allow LAs to contact parents	TBC	DH have committed to resolve this 'by the summer'	DH to confirm timescales for this Direction	TBC	TBC	TBC
32	Long Term Conditions (LTC) and/or Medically Unexplained Symptoms (MUS)	NHSE	Community Mental Health Team; HES; I&A	John Varlow	Expansion IAPT programme to include people with LTC/MUS. HES / IAPT linkage to meet application for data from Surrey. Direction may be required to enable data to flow to HSCIC if consent or other legal basis not in place	N	One-off data flow from pilots to HSCIC	On hold as there are consent issues. NHS England are consulting with their Caldicott Guardian to consider their approach	TBC	TBC	TBC
33	Learning Disabilities GPES extract	NHSE	Mental Health; I&A	John Varlow	GPES extract to support LD Mortality Review	N	On hold	This Direction is currently on hold until the care data pathfinder programme is complete	TBC	On hold	On hold
34	Anti-psychotics	DH	Clinical Audit; I&A	John Varlow	Patient level data extracted directly from GP systems on dementia patients with a prescription for anti-psychotics. National / sub regional reports compiled. Was collected about 3 years ago but not recently so it would need a direction if commissioned	TBC	On hold	This Direction is currently on hold until the specification is finalised	TBC	On hold	On hold

Board meeting – Public session

Title of paper:	HSCIC Patient Objections Direction
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 04 (a)
Paper presented by:	Martin Severs, Caldicott Guardian and Lead Clinician
Paper prepared by:	Trevor Anders, Programme Manager Preferences for Data Sharing Programme
Paper approved by: (Sponsor Director)	Martin Severs, Caldicott Guardian and Lead Clinician
Purpose of the paper:	To enable the views of the Board to be considered as part of the formal consultation on the draft Direction prior to it being signed by the Secretary of State. This consultation is in line with the agreed HSCIC process.
Key risks and issues:	<p>The Direction provides a legal basis for HSCIC to collect the patient objection data from GP's and must be in place before data can flow from Nov 2015. It also makes it mandatory for GP practices to provide the data to HSCIC.</p> <p>Patient objection data are essential for the implementation of an IT solution to uphold objections in any data disseminations from the HSCIC due to be in place from Jan 2016. Therefore, the draft Direction is brought to the Board to enable all key deadlines to be met.</p> <p>This Direction is presented with the caveat that it is necessary for a simple, additional Direction to be created to support the collection of 'counts' information on the number of patients that have opted out of sharing their identifiable data outside of the GP practice for purposes beyond their direct care.</p> <p>If the Direction is delayed then there may be an impact on the timetable agreed with the Secretary of State, therefore it is recommended that the HSCIC Executive Management Team review and identify any issues with the additional Direction, without requiring a return to the HSCIC Board for further consultation.</p>

Patient/public interest:

Indirect

Actions required by the board:

Consider the draft Direction and identify any issues or concerns as part of the formal consultation process.

Delegate authority to the HSCIC Executive Management Team to provide formal feedback on the additional Direction.

HSCIC Patient Objections Direction

Formal consultation with the HSCIC Board

Martin Severs

23rd Sept 2015

Contents

Contents	2
Background	3
Issues	3
Strategy Implications	4
Stakeholder Implications	5
Financial Implications	5
Actions Required of the Board	5

Background

Since late 2013 patients have been able to register an objection to the HSCIC sharing their patient identifiable data for purposes beyond their direct care, referred to as type 2 objections, by asking their GP practice to record the objection code on their medical record at the GP practice. The HSCIC has been tasked by the Secretary of State to develop a system to enable type 2 objections to be implemented across all HSCIC data disseminations by January 2016. A Direction is required to provide a legal basis for HSCIC to collect the patient objection data from GPs and to enable HSCIC to issue a Data Provision Notice which mandates GP practices to comply with a request for the data by HSCIC under the Health & Social Care Act 2012.

HSCIC needs to collect the code, date code recorded and NHS number for each of the patients that have recorded a type 2 objection with their GP in order to enable the HSCIC to act upon these objection codes. In addition it has been agreed with Martin Severs (acting in his capacity as Caldicott Guardian) and ratified by the Joint GP Information Technology Committee (JGPITC) that:

- a. there should be an HSCIC notification to all general practices 6 weeks before a specific data collection takes place and
- b. in recognition of their role as data controllers that general practices need to undertake a positive action to be included in the data collection process.

Issues

A plan for delivery has been agreed with a business implementation date signed off by the Secretary of State. Key deadlines include the need for the objections data to start to be collected on a monthly basis using GPES from around end of November – early December (subject to GPES scheduling). This will enable the HSCIC to ensure the data has been successfully received and processed by the new IT solution to create the objection data asset in order to be certain that the objections data asset is ready to be utilised immediately from the business go live in January 2016. The business go live will be the point from which the other objection data purging IT solutions (currently in development) will start to use the objection data asset to apply the objection codes to data disseminations.

A key milestone is the issuing of a Direction from the Department of Health (DH) which must be in place:

- before the data can flow (Nov/Dec 2015) and
- is required to enable HSCIC to issue a Data Provision Notice (DPN) allowing a minimum 6 weeks' notice to GP practices as part of new GPES governance procedures (early Oct 2015).

It has been agreed that the most effective way to collect that data from the practice is to use the Calculating Quality Reporting Service (CQRS) & GPES. Where GPES is being used, the Calculating Quality Reporting System (CQRS) will be used to provide general practices with the ability to make a positive action to be included in the data collection.

It is important that the Direction can be issued in a timely manner in order that the agreed timetable can be maintained by the HSCIC to implement patient objections across HSCIC data disseminations from January 2016. Subject to the Direction being considered by the HSCIC Board and issued by DH, the drafting of the DPN is taking place in parallel to work towards the issue of the DPN at the beginning of October.

In accordance with our agreed process the draft Direction is brought to the Board for formal consultation to enable the views of the Board to be fed back to DH prior to the Direction being issued. It has been reviewed internally by EMT, Information Governance and HSCIC lawyers and is attached at appendix 1.

The draft Direction attached is subject to an additional Direction being raised to include the collection of aggregate level practice counts of the number of type 1 objections requested and withdrawn. Type 1 objections are a request by the patient that none of their identifiable data is shared outside of the GP practice for purposes beyond their direct care. This additional requirement is in line with the DH published response to the Caldicott Review "Information: To Share Or Not To Share? The Information Governance Review" published in April 2013. In Section 7.15 of the response it was noted that the HSCIC would monitor the rate of objections. Without this inclusion the HSCIC will continue to be unable to identify the true rate of both type 1 and type 2 objections that currently exist within the system.

It is proposed that the Board give their views on this as part of the consultation process and delegate authority to the HSCIC Executive Management Team to provide formal feedback on the additional Direction.

For information, a further Direction will be required from DH to cover the application of objection codes to HSCIC disseminations and it is anticipated this will be brought to the Board for consultation in November 2015.

Strategy Implications

This Direction will enable a comprehensive collection of objections data which supports HSCIC strategic vision and values as follows:

Strategy

- Ensuring that every citizen's data is protected.
- Making better use of health and social care information.

Value

- Trustworthy – act with integrity, impartiality and openness and in the best interest of the public.

Ensuring the HSCIC is seen to act in accordance with patient wishes will help in building public trust in the organisation's role of collecting and using data. This will in turn enable HSCIC to fulfil its statutory functions to be the trusted source of health and care data in England as well as making that data available for care professionals to inform decisions, assist policymakers, and facilitate better commissioning of health and care services.

Stakeholder Implications

Key stakeholders include the Department of Health and NHS England; both support the commencement of a robust system to uphold patient objections by the HSCIC in line with a timetable that has been agreed with Secretary of State. In addition, this system allows the HSCIC to provide assurance to the public that their wishes in terms of the use of their personal data are complied with in a comprehensive and consistent manner.

The implementation of a comprehensive mechanism to manage patient objections will also provide assurance to GPs who have registered the opt-outs in their patients' records.

Financial Implications

The HSCIC Objections Management Project as part of the Preferences for Data Sharing Programme has been established to take forward the implementation of patient objections.

A resource budget for the project team has been established and funding is through existing GIA.

Actions Required of the Board

Consider the draft Direction and identify any issues or concerns as part of the formal consultation process.

Delegate authority to the HSCIC Executive Management Team to provide formal feedback on the additional Direction.

Appendix 1 Draft Direction

D I R E C T I O N S

NATIONAL HEALTH SERVICE, ENGLAND

**The Health and Social Care Information Centre (Patient Objections)
Directions 2015**

The Secretary of State for Health gives the following Directions in exercise of the powers conferred by sections 254(1) and (6), 262(5), 274(2) and 304(9), (10) and (12) of the Health and Social Care Act 2012⁽¹⁾ and regulation 32 of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013⁽²⁾.

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

Citation, commencement and interpretation

1.—(1) These Directions may be cited as the Health and Social Care Information Centre (Patient Objections) Directions 2015 and come into force on [].

(2) In these Directions—

“the Act” means the Health and Social Care Act 2012;

“GP Practice” means the business operated by—

- (a) a person with whom the Board has entered into a general medical services contract under section 84 of the NHS Act⁽³⁾ (general medical services contracts: introductory) for the provision of medical services under Part 4 of that Act or as a consequence of a property transfer scheme made under section 300 of the Act (transfer schemes);
- (b) a person with whom the Board has entered into an arrangement under section 92 of the NHS Act⁽⁴⁾ (arrangements by the Board for the provision of primary medical services) for the provision of medical services under Part 4 of that Act or has entered into such arrangements as a consequence of a property transfer scheme under section 300 of the Act which require the provision by that person of primary medical services; or
- (c) a person with whom the Board has made contractual arrangements for the provision of primary medical services under section 83(2) of the NHS Act⁽⁵⁾ (primary medical services) for the provision of medical services under Part 4 of that Act or as a consequence of a property transfer scheme made under section 300 of the Health and Social Care Act 2012;

“HSCIC” means the Health and Social Care Information Centre, established by section 252(1) of the Act;

“the NHS Act” means the National Health Service Act 2006⁽⁶⁾;

“NHS number” means the number, consisting of 10 numeric digits, which serves as the national unique identifier used for the purpose of safely, accurately and efficiently sharing information relating to a registered patient across the whole of the health service in England;

⁽¹⁾ 2012 c.7 (“the Act”).

⁽²⁾ S.I. 2013/259.

⁽³⁾ Section 84 was amended by paragraph 31 of Schedule 4 to the Act

⁽⁴⁾ Section 92 was amended by paragraph 36 of Schedule 4 to the Act.

⁽⁵⁾ Section 83 was amended by paragraph 30 of Schedule 4 to the Act.

⁽⁶⁾ 2006 c. 41 (“the 2006 Act”).

“patient” means a person who receives NHS services and includes a woman who is pregnant or breast-feeding or who has recently given birth;

“patient objections information” means information relating to registered patients and held in information technology systems used by GP Practices, consisting of—

- (a) the NHS Number;
- (b) the code identifying the existence of a Type 2 patient objection or a withdrawn Type 2 patient objection; and
- (c) the date a code under (b) was inputted on to the record of the registered patient;

“person identifiable information” means information which—

- (a) is in a form which identifies an individual to whom the information relates; or
- (b) enables the identity of an individual to whom the information relates to be ascertained;

“registered patient” means—

- (a) a patient who is recorded by the Board as being on the list of patients of a person referred to in sub-paragraph (a), (b) or (c) of the definition of GP Practice; or
- (b) a patient whom a person referred to in sub-paragraph (a), (b) or (c) of the definition of GP Practice has accepted for inclusion in the person’s list of patients, whether or not notification of that acceptance has been received by the Board, and who has not been notified the Board as having ceased to be on that list;

“Type 2 patient objection” means a request expressed by a registered patient lodged with a GP Practice, that indicates that person identifiable information that relates to the patient must not be disseminated or published by HSCIC;

“withdrawn Type 2 patient objection” means a statement expressed by a registered patient lodged with a GP Practice, that indicates that the patient to whom a Type 2 patient objection applied, no longer wishes for person identifiable information that relates to the patient not to be disseminated or published by HSCIC.

The patient objections information system

2.—(1) The Secretary of State directs HSCIC to establish and operate a system for the collection and analysis of patient objections information.

(2) In exercising the functions conferred by, and in accordance with, these Directions, HSCIC must take the steps described in sub-paragraph (3) in relation to patient objections information.

(3) The steps referred to in sub-paragraph (2) are that HSCIC must —

- (a) identify patient objections information in a GP Practice that relates to a particular registered patient in relation to whom there is a Type 2 patient objection or withdrawn Type 2 patient objection;
- (b) collect the patient objections information described in sub-paragraph (3)(a) from the GP Practice where the information is held;
- (c) analyse the information described in sub-paragraph (3)(a) by linking the information with other person identifiable information held by HSCIC which must include the NHS number that relates to the registered patient referred to in sub-paragraph (3)(a);
- (d) hold information to which sub-paragraph (3)(b) applies, and information obtained from the analysis described in sub-paragraph (3)(c), securely from other information held by HSCIC.

(4) The Secretary of State may, in a notice in writing to HSCIC, specify—

- (a) further steps that HSCIC must take in relation to the information obtained from the analysis described in sub-paragraph (3)(c); or
- (b) the form, manner and timing of any dissemination of the information required by such a notice under sub-paragraph (4)(a).

(5) The Secretary of State must specify, in a notice in writing to HSCIC, the first date when HSCIC is to collect patient objections information pursuant to sub-paragraph (3)(b).

(6) HSCIC must establish a procedure to ensure that patient objections information is collected and analysed in accordance with sub-paragraph (3) in a timely manner, as far as reasonably practicable.

Systems delivery functions

3.—(1) The Secretary of State directs HSCIC to exercise such systems delivery functions of the Secretary of State as are expedient to enable it to carry out the functions described in paragraph 2.

(2) The Secretary of State may make payments to HSCIC for things done in the exercise of the function described in sub-paragraph (1).

Policies or guidance of the Secretary of State

4. In exercising any function described in these Directions, HSCIC must act in accordance with such priorities, policies, advice or guidance of the Secretary of State as the Secretary of State may notify in writing to HSCIC.

Signed by the Secretary of State for Health

Date

Parliamentary Under Secretary of State
Department of Health

Board meeting – Public session

Title of paper:	Assuring Transformation Update Direction
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 04 (b)
Paper presented by:	Martin Severs, Interim Director of Information and Analytics and Lead Clinician (Caldicott Guardian)
Paper prepared by:	Robert Cavalleri, Specialist Learning Disabilities Project Lead
Paper approved by: (Sponsor Director)	Martin Severs, Interim Director of Information and Analytics and Lead Clinician (Caldicott Guardian)
Purpose of the paper:	To enable the views of the Board to be considered as part of the formal consultation on the draft Direction prior to it being signed by the Secretary of State. This consultation is in line with the agreed HSCIC process
Key risks and issues:	Undue delay associated to consultation processes would frustrate delivery of a stated business high priority for NHS England. This risks reputational damage to HSCIC.
Patient/public interest:	<p>Direct: information shared is used by NHS England to inform and drive system change with learning disability commissioners.</p> <p>Indirect: information shared is used by NHS England and the Department of Health to assure Ministers and the Transforming Care Assurance Board.</p> <p>Benefits associated to this information flowing from HSCIC will continue and be uninterrupted.</p>
Actions required by the board:	Consider the draft Direction and to identify any issues or concerns as part of the formal consultation process.

Updated Direction from NHS England for the Assuring Transformation Collection

Formal consultation with the HSCIC Board

Robert Cavalleri

23rd September 2015

Contents

Contents	2
Background	3
Issues	3
Strategy Implications	4
Stakeholder Implications	4
Financial Implications	4
Actions Required of the Board	4

Background

The Assuring Transformation Collection was adopted from NHS England and information standards notice published on the 6th January 2015. Data previously collected by NHS England had been criticised by the public accounts committee¹ and a recommendation made to collect “...real-time data on the number of people with learning disabilities and challenging behaviour in mental health hospitals.”

In advance of the Mental Health Services Dataset going live the Assuring Transformation Collection provides this data. The information is collected from specialist learning disability commissioners in clinical commissioning groups or specialist commissioning hubs via the Clinical Audit Platform but uniquely uses a contemporary or live data submission capability. This information is used in monitoring the effectiveness of the Transforming Care change programme and at a local level in challenging commissioning performance and thereby directly influencing patient care.

NHS England directs HSCIC to implement this collection and requires that the questions posed to data submitters is varied to reflect it's current priorities.

Issues

NHS England is seeking to update the current Direction to ensure legal authorisation is in place to maintain the functioning and flow / dissemination of information from commissioners of inpatient services for people with learning disabilities.

In accordance with our agreed process the draft Direction is brought to the Board for formal consultation to enable the views of the Board to be fed back to NHS England prior to the Direction being issued. The draft Direction has been reviewed internally by EMT, and received consideration by Information Governance and suggestion by them that this Direction does not require attention by HSCIC's lawyers.

HSCIC Board is asked to consider the format of this draft Direction. This draft includes a detailed schedule which sets out the analysis and reporting requirements. It is considered that this approach is inconsistent with the current accepted standard for Directions; an example being Directions for the Mental Health Services Dataset (signed 31 July 2015) and does not serve NHS England's purposes well in that it is not agile.

Experience gained from providing information under the current Direction suggests that this revised draft Direction would better serve its purpose if the related schedule could be removed. NHS England and HSCIC could then agree and amend a work package under the provision of services agreement (POSA) framework. This would enable HSCIC to provide a more flexible and responsive service to our customer to support them in delivering their commitments under Transforming Care.

The draft is attached at appendix 1.

¹ <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmpublic/973/973.pdf>

Strategy Implications

This is a current service provided by the HSCIC and the Direction replaces an existing Direction like for like. Therefore it is not anticipated that there will be any strategy implications.

Stakeholder Implications

It is not anticipated that there will be any stakeholder implications.

Financial Implications

This is an existing service provided by the HSCIC and there are no specific financial implications from the changes proposed. HSCIC invoice for this work on a quarterly basis.

Actions Required of the Board

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

Appendix 1 Draft Direction

DIRECTIONS

NATIONAL HEALTH SERVICE, ENGLAND

The Health and Social Care Information Centre (Establishment of Information Systems for NHS Services: Assuring Transformation Data Collection) Directions 2015

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), 262(3)(b), 262(7) 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. – (1) These Directions may be cited as The Health and Social Care Information Centre (Establishment of Information Systems for NHS Services: Assuring Transformation Data Collection) Directions 2015 and shall come into force on **DD** October 2015.

(2) The Health and Social Care Information Centre (Establishment of Information Systems for NHS Services: the Assuring Transformation Data Collection) Directions 2014 are hereby revoked.

2. In these Directions–

“The 2012 Act”	means the Health and Social Care Act 2012 ² ;
"Assuring Transformation Data"	Any data collected pursuant to these Directions or pursuant to the Health and Social Care Information Centre (Establishment of Information Systems for NHS Service: the Assuring Transformation Data Collection) Directions 2014;
“The Board”	means the National Health Service Commissioning Board ³ ;
“CAP”	means Clinical Audit Platform, which is a system delivery function of the HSCIC that uses a secure interface for the

² 2012 c7

³ 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.

	collection of confidential information;
"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 Standards Notice;
"Information Standards Notice"	means the document published by or on behalf of the Board or the Secretary of State to confirm the making or amendment of an Information Standard, summarise its purpose and scope, reference the documentation in which the details of the Standard are set out and mandate compliance with it;
"HSCIC"	means the Health and Social Care Information Centre ⁴ ;
"Identifiable Data"	means information which is in a form which identifies any individual to whom the information relates or enables the identity of such an individual to be ascertained;
"Learning Disability Census Data"	means data collected by the HSCIC under The Health and Social Care Information Centre (Learning Disability Census) Directions 2014 or any identical or similar datasets collected at the request or direction of the Secretary of State for Health which relate to periods earlier than or subsequent to the period in which those Directions are in force;
"Learning Disability Cohort Patient"	means a person in an in-patient bed for mental and/or behavioural healthcare who has either learning disabilities and/or autistic spectrum disorder (including Asperger's syndrome);
"Regional Team"	means a division of the Board which holds budgetary and commissioning responsibilities on behalf of the Board;
"Relevant Organisation"	means an organisation type that is listed under "Applies to" in the Specification;
"SCCI2007"	is the unique reference number for the Assuring Transformation Collection Information Standard;
"Specification"	means the Assuring Transformation Collection Specification that has been published by the Board version 0.X dated DD/MM/YYYY (Document ID: SCCI 2007 Amd XX/XXXX , Document Title: Assuring Transformation Change Request) and annexed to these Directions at Annex A or any subsequent amended version of the same document that is published by the Board;

⁴ The Health and Social Care Information Centre is a body corporate established under section 252(1) of the Health and Social Care Act 2012

“Technical Output Specification” means the Assuring Transformation v 2.0 Technical Output Specification version 0.6 dated 20/08/2015 and annexed to these Directions at Annex B or any subsequent amended version of the same document that is published by the Board.

Establishing and Operating the Assuring Transformation Data Collection 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 Assuring Transformation Data Collection System”.

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

(3) Pursuant to its powers under sections 254(1) and 254(6) of the 2012 Act, the Board directs HSCIC to carry out the activities described in sub-paragraph (1):

- (a) in accordance with the criteria in the Specification and in the Technical Output Specification;
- (b) in particular through making the CAP available to CCGs and Regional Teams in the form specified in the Technical Output Specification; and
- (c) generally in such a way as to enable and facilitate compliance with Information Standards Notice SCCI2007.

Analysis and Reporting

4. – (1) Pursuant to the Board's powers under sections 254(1) and 254(6) of the 2012 Act, the HSCIC is further directed to analyse the data collected pursuant to these Directions, including by such reference or linkage to other Assuring Transformation Data and to Learning Disability Census Data as the HSCIC determines is necessary: –

- (a) to validate the data;
- (b) to produce reports in compliance with paragraph 4(2).

(2) The HSCIC is further directed as follows:

- (a) pursuant to section 260(4)(a) of the 2012 Act, the HSCIC is directed to produce such reports as are specified in the Schedule to these Directions or in any amended specifications as may be notified to the HSCIC from time to time; and
- (b) pursuant to sections 262(3)(b) of the 2012 Act, the HSCIC is directed to produce and disseminate to the Board the reports described in paragraphs 2(1) and (2) of the

Schedule in a form and manner that complies with any relevant approvals or conditions under the Section 251 Regulations.

S254(3) - Requirement for these Directions

5. In accordance with section 254(3) of the 2012 Act, the Board confirms that it is necessary or expedient for it to have the information which will be obtained through the HSCIC complying with these Directions in relation to the Board's functions in connection with the provision of NHS Services. In particular the information obtained through compliance with these Directions will facilitate or enable the achievement of the purposes of Information Standard SCCI2007 that are described in the Specification.

Managing Patient objections

6. Pursuant to the Board's powers under sections 254(1) and (6) of the 2012 Act, HSCIC is directed to establish the Assuring Transformation Data Collection System in such a way as to ensure that where an objection has been made by or on behalf of a Learning Disability Cohort Patient to the provision of their confidential information by a CCG or Regional Team to the HSCIC or the Board, the HSCIC will only collect that information where this would be in accordance with any guidance issued by NHS England with regard to the management of or response to such objections.
7. The HSCIC is directed by the Board pursuant to paragraph 3 of these Directions to put measures in place as part of the establishment and operation of the Assuring Transformation Data Collection System to ensure that where the HSCIC holds a record of any Learning Disability Cohort Patient's objection to the onward disclosure of their Identifiable Data by the HSCIC any dissemination of information pursuant to these Directions shall, in respect of that Patient, only include data that is not Identifiable Data.

Fees and Accounts

8. 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.
9. The HSCIC must keep proper accounts, and proper records in relation to the accounts, in connection with the Assuring Transformation Data Collection System.

Review of these Directions

10. These directions will be reviewed when the Board approves changes to the Assuring Transformation Data Collection and when any material amendment is made to the

Information Standard SSCI2007. This review will include consultation with the HSCIC as required by sub-section 254(5) of the 2012 Act (powers to direction Information Centre to establish information systems).

Signed by authority of the NHS Commissioning Board

[INSERT DATE]

**Sir Bruce Keogh
Caldicott Guardian**

Annex A – Assuring Transformation Collection Specification



SCCI 2007 Assuring
Transformation - Spe

Annex B – Assuring Transformation Technical Output Specification



SCCI 2007 Assuring
Transformation - Techn

Analysis and reporting requirements for the Assuring Transformation Data Collection.

[DN: Schedule to be amended as necessary to reflect new dataset]

1. The reports for publication are described as outputs 1, 2, 3 and 4 in paragraphs 3 and 4 of this Schedule.
2. The reports for dissemination to the Board only are defined in paragraphs 3 and 4 of this Schedule as follows:
 - (1) output 5;
 - (2) output 6.
3. **Outputs outline**

Output	Style	Domain	Format	Suppression rules
1. Counts and trends	Primary analysis type data	Public - quarterly	Tableau (queryable) & excel/csv (for counts)	Rules apply
2. Cross tabs	Secondary analysis type data	Public - quarterly	Tableau (queryable)	Rules apply
3. Quarterly report	Drawing out key facts of the above two	Public - quarterly	PDF	Rules apply
4. Quarterly Easy read	Simple version of the executive summary	Public - quarterly	PDF	Rules apply
5. Management Information	Excel flat file	Internal - monthly	excel	Unsuppressed
6. Assuring Transformation Data compared to Learning Disability Census Data	Counts by commissioner/provider	Internal – one off	excel	Unsuppressed

1.1 Notes

- Suppression rules for collections under 10,000 mean that for ALL data published; all numbers will be rounded to the nearest 5. Values 0-4 will be suppressed by *.
- Where possible, figures will be released at CCG level. However with HSCIC suppression rules, this may mean some previously released data is no longer released and may result in CCG level data being meaningless. This may result in a future decision to not report at CCG level for some measures.
- Although the measures listed below will remain, their description and/or title may change so that the AT output is in line with LD output and will be easier for users to compare between the two.

- Any future CCG mergers will be accounted for as the data presented will follow the organisational structure at reporting date.
- Tableau is an interactive graphics tool. HSCIC have created 3 test pages for the Board to see how data can be represented.
 - Counts - https://public.tableausoftware.com/views/PrimaryJune4/Primaryanalysis?:embed=y&:display_count=no
 - Trends - https://public.tableausoftware.com/views/TimeSeries/TimeSeries?:embed=y&:display_count=no
 - Cross tabs - https://public.tableausoftware.com/views/TransferDateCrosstab/Transferdatecrosstab?:embed=y&:display_count=no
- The easy read document is to be produced by Change will incur costs on an per issue basis. A charge to cover development and costs will be made to The Board. This will be on a cost recovery basis only.

4. Outputs detail

The table below details all the figures that will be published for the 31st March 2015 collection. If changes in the questions mean the published figures will alter slightly this is documented. HSCIC expects to add to this series with additional analysis, this could be analysis that becomes standard or special features throughout the publication life of the AT work.

The following colour codes apply to new measures.

- Measures in **green** have been suggested by HSCIC.
- Measures in **blue** have been suggested by The Board.
- Text in **red** denote that the measure is using a new question will be subject to testing and as such the level of detail to be published is to be determined.
- Note that regional level split was not previously published for all items, HSCIC suggest that this is now published.

1. Counts and trends														
Area				Regional total x4				CCG level x211	Counts and trends	Measure/indicator	Question (S)	Calculation	Notes	Change from NHS(E) release
Data quality										Total number of returns and missing		count of returns		Determined via new 'submission button'
Patients	x	x	x	x	x	x	x	C&T	Number of patients	Q1	count of NHS number		Same. However, the	

																			distinction of NHS number or not will not be reported on as a valid number is required for data submission
Registered	x	x	x	x	x	x	x	x	C&T	Number of patients recorded as being on a register or not	Q8	count of yes/no to 'is the patient on a register...'						Same	
Care Co-ordinator	x	x	x	x	x	x	x	x	C&T	Number of patients with and without a care co-ordinator	Q19	count of yes/no to 'does patient have care co-ordinator'						Same	
Last Review	x	x	x	x	x	x	x	x	C&T	Number of patients who had their last formal care plan review within the following time periods; 0 - 4 weeks, 4 - 8 weeks, 8 - 12 weeks, 12 - 26 weeks, 26 - 52 weeks, 52+ weeks	Q20	number of days between snapshot date, review date, sorted by time bands, then counted	Risk with the continuous data upload process					Same	
Transfers	x	x	x	x	x	x	x	x	C&T	Number of patients with and without a transfer date	Q26	count of yes/no to 'agreed date of planned transfer'						Same	
	x	x	x	x	x	x	x	x	C&T	Number of patients with a planned date of transfer; 0 – 3 months, 3 – 6 months, 6 – 12 months, 1 – 2 years, 2 – 5 years, 5+ years	Q26a	number of days between snapshot date, planned transfer date, sorted by time bands, then counted	Risk with the continuous data upload process					Same	
LA Awareness	x	x	x	x	x	x	x	x	C&T	Local Authority awareness of patient the transfer to their area, yes, no, don't know	Q25	count of yes, no, don't know to 'is local authority aware of transfer to their area'						New option of 'don't know'	

	x	x	x	x	x	x	x	C&T	Number of patients with a planned date of transfer where the Local Authority is aware of transfer to their area	Q25 Q26	count of those who answered yes to 'agreed date of planned transfer' and yes to 'local authority aware of transfer to them'		
Advocacy	x	x	x	x	x	x	x	C&T	Number of patients who make use of an independent advocate	Q17	count of yes to 'does patient make use of...'		Reworded question, no longer about 'access to' but 'use of'... so issues with comparable figures
	x	x	x	x	x	x	x	C&T	Number of patients with an independent advocate by type	Q17b, c, d, e, f	counts of yes answers to each advocate type		Non-instructed advocate replaces 'self-advocate'
	x	x	x	x	x	x	x	C&T	Reasons for not using an advocacy	Q17a	count of the different answers		
Inpatient Setting	x	x	x	x	x	x	x	C&T	Number of patients by the type of in-patient setting within which patients are receiving care	Q14b	counts of the different ward types, high, med secure etc..		Slightly different answer options
Patient Flow	x	x	x	x	x	x	x	C&T	Number of patients referred (admitted) to in-patient care in last quarter	Q9a	count of number of admissions for date within this quarter	Risk with the continuous upload process.	Slightly reworded question about commencement with provider, not hospital
	x	x	x	x	x	x	x	C&T	Number of patients that have been transferred out of in-patient care in last quarter	Q28	count of actual transfers that fall within this quarter.	Risk with the continuous upload process	Q28 is used now instead of Q26a once the patient has actually transferred
Reasons	x	x	x	x	x	x	x	C&T	Number of patients who are not considered appropriate for transfer to the community and the	Q27 a-m	counts of yes for each a-m option		Extra options available

										reasons why not				
Gender	x	x	x	x	x	x	x	x	C	Number of patients recorded as Male, female, indeterminate	Q3	counts of male, female and indeterminate		New count on indeterminate
Age	x	x	x	x	x	x	x	x	C	Number of patients within each age range at the time of collection; under 18, 18 - 34, 35 - 64, 65 and over	Q2	Derived from date of birth		Same
Diagnostic category	x	x	x	x	x	x	x	x	C	Counts of those with LD, Autism, both or neither	Q12b or Q12a	Counts of diagnosis		New question, Q12a may be better, analysis needs to be done
Ethnicity	x	x	x	x	x	x	x	x	C	Ethnicity of patients	Q4	Count of ethnicity type		New questions. Broad categories may be used
Mental Health	x	x	x	x	x	x	x	x	C&T	Number of patients who are detained under the auspices of the Mental Health Act (1983)	Q13	Counts of the different sections of the Mental Health Act		Extra options available
Distance	x	x	x	x	x	x	x		C&T	Distance from home	Q5b, Q11c	Counts of number of patients in the distance bands 'same as ward, up to 10km, 10-20km, 20-50km, 50-100km, 100km or more'		Possibly CCG level, data will need to be interrogated
Out of area placement	x	x	x	x	x	x	x		C&T	Import, export of patients per region	Q5b, Q11c, also need commissioner code	Counts of difference between residence and ward stay per region		Possibly CCG level, data will need to be interrogated
Length of stay	x	x	x	x	x	x	x		C&T	Length of stay	Q9a (to create derivation)	Counts of patients per length of stay bands		Derivation based on admission date
	x	x	x	x	x	x			C&	Average length of	Q9a (to create	Overall average		New calculation,

								T	stay	derivatio n)	(mean and median) length of stay in years		needs checking
	x	x	x	x	x	x		C& T	Total length of stay	Q9b (to create derivatio n)	Counts of patients per length of stay bands		New calculation, needs checking - Not sure how accurate this data item will be
Discha rge	x	x	x	x	x	x		C& T	Considered for discharge through CTO	Q16	Counts of yes/no		
	x	x	x	x	x	x		C& T	Discharge agreed by....	Q22a-f	Counts of options a-f		No longer 'don't know' option
	x	x	x	x	x	x		C& T	Reasons for not discharge	Q21	Counts of answer options		New questions, data quality checks needed
Compl iance	x	x	x	x	x	x		C& T	Compliance under CQC standards	Q15	Counts of the answer options		

2. Cross tabs

Area	England total x1	CCG total x1	SCT total x1	Regional total x4	Area team total x25	SCT level x10	CCG level x211	Counts and trends	Measure/indicator	Question (S)	Calculation	Notes	Change from NHS(E) release
Transf er dates	x	x	x	x	x	x		C	Length of stay and transfer date status	Q26a Q9a	count of patients by planned transfer time bands (h) x length of stay in this hospital time bands (v)		Same, through slightly re-worded Q9a about provider not hospital
	x	x	x	x	x	x		C	In-patient setting and transfer date status	Q26a Q14b	count of patients by planned transfer time bands (h) x ward type (v)		Same, through more options for Q14b
	x	x	x	x	x	x		C	Age and transfer	Q26a	count of patients by		Same

										date status	Q2	planned transfer time bands (h) x age bands (v)		
	x	x	x	x	x	x	x	x	C	Local care coordinator by transfer date status	Q26a Q19	count of patients by planned transfer time bands (h) x care a co-ordinator (v)		Same (4& 5 merged)
	x	x	x	x	x	x	x	x	C	All transfer status and all LA awareness	Q26a Q25	count of patients by planned transfer time bands (h) x LA awareness (v)		Q25 has new 'don't know' option
	x	x	x	x	x	x			C	Transfer plans with agreed date and who has agreed the transfer plan	Q26a Q22	count of patients by planned transfer time bands (h) x who has agreed the transfer (v)		Same
In-patient details	x	x	x	x	x	x			C	In-patient setting and reason for admission	Q12b Q14b	Count of patients by main diagnostic reason on admission (h) x ward type (v)		More options for diagnostic category, aggregated options for ward type
	x	x	x	x	x	x			C	Primary reason for admission and detention under the Mental Health Act (including MoJ)	Q13 Q12b	Count of patients by mental health act section (h) x diagnostic reason on admission (v)		More options for diagnostic category
	x	x	x	x	x	x			C	Inpatient setting and detention under the Mental Health Act (including MoJ)	Q13 Q14b	Count of patients by mental health act section (h) x ward type (v)		Aggregated options for ward type
	x	x	x	x	x	x			C	Length of stay and review dates	Q20 Q9a	Count of patients by number of weeks since last review		Same, through slightly re-worded Q9a about

												(h) x length of stay (v)		provider not hospital
	x	x	x	x	x	x		C	In-patient setting and date of review	Q20 Q14b		Count of patients by number of weeks since last review (h) x ward type (v)		Aggregated options for ward type
	x	x	x	x	x	x		C	Inpatient setting and age (Under 18 and Over 18)	Q2 Q14b		Count of patients by age under or over 18 (h) x ward type (v)		Aggregated options for ward type
	x	x	x	x	x	x		C	In-patient setting and advocacy (access to advocacy, type of advocate)	Q17 Q17b-f Q14b		Count of patients by access, making use of and type of advocacy (h) x ward type (v)	Questions changed slightly around having access, making use of advocate	Cannot show those who have access to advocate but don't use it
	x	x	x	x	x	x		C	In-patient setting and Community Treatment Order	Q16 Q14b		Count of patients by whether patient considered for discharge via community treatment order (h) x ward type (v)		Aggregated options for ward type
	x	x	x	x	x	x		C	Length of stay and in-patient setting	Q14b Q9a		Counts of patients by ward type (h) x length of stay groups (v)		Aggregated options for ward type slightly reworded Q9a about provider not hospital
	x	x	x	x	x	x		C	Length of stay and Mental Health Act	Q13 Q9a		Counts of patients by MHA class (h) x length of stay groups (v)		slightly reworded Q9a about provider not hospital
Transf	x	x	x	x	x	x		C	Setting the person	Q23		Counts of patients by	Check this is	More HSCIC

er									will transfer to		where they will transfer to	just for those who have transfer date	options for Q23, they will need aggregating up
	x	x	x	x	x	x		C	Transfer dates and Setting the person will transfer to	Q26a/Q28 Q23	count of patients by planed transfer time bands (h) x where will they transfer to (v)		More HSCIC options for Q23, they will need aggregating up Use Q28 rather than Q26a?
	x	x	x	x	x	x		C	Transfer date status and date of review	Q26a/Q28 Q20	count of patients by planed transfer time bands (h) x last review groupings (v)		Use Q28 rather than Q26a?
	x	x	x	x	x	x		C	Reasons for no transfer (if no date given) and length of stay	Q26 Q27a-m Q9a	Reasons for not transfer (h) (given that there is no transfer date given x length of stay (v)		New calculation would need checking.
	x	x	x	x	x	x		C	Reasons for no transfer (if no date given) and MHA	Q26 Q27a-m Q13	Reasons for not transfer (h) (given that there is no transfer date given x MHA (h)		New calculation would need checking.
	x	x	x	x	x	x		C	Non transfer reasons and ward security level	Q28 Q14a	Counts of patients by reason for not transferring (h) x security level (v)		New calculation would need checking
3. Quarterly report													

Area	England total x1	CCG total x1	SCT total x1	Regional total x4	Area team total x25	SCT level x10	CCG level x211	Counts and trends	Measure/indicator	Question (S)	Calculation	Notes	Change from NHS(E) release
Counts and returns	x	x	x					C&T	Total number of patients receiving in-patient care	Q1	Count of patients		
	x	x	x					C&T	Patients transferred this quarter	Q28	Count of those transferred out in this quarter		New use of Q28 to measure actual movement not proposed transfer date
	x	x	x					C&T	Patients admitted this quarter	Q9a	Count of new those admitted in this quarter		
	x	x	x					C&T	Patients on a local register or not	Q8	Count of 'yes'/'no' to 'is the patient on a register...'		
Level of care	x	x	x					C&T	Number of patients with and without a care co-ordinator	Q19	Count of yes and no to 'does patient have a care co-ordinator..'		
	x	x	x					C&T	Number of weeks since the last review	Q20	Number of days since last review (displayed in time bands) in weeks		
	x	x	x					C&T	Number of patients with and without access to an independent advocate	Q17	Count of yes and no to 'does patient have access to independent advocate..'		
	x	x	x					C&T	Type of independent advocate, number of patients for each type	Q17b-f	Count of yes to each advocate type		
Characteristics of the	x	x	x					C	Age of patients by age band	Q2	patients date of birth used to calculate age then	Unlikely to change much	




Health & Social Care
Information Centre

Assuring Transformation

Collection Specification

October 2015

			
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Implementation Manager	Robert Cavalleri	Version	0.3
Author	Anna Cale	Version Date	17/08/2015

Amendment History:

Version	Date	Amendment History
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0.4		

Approvals:

Name	Title/Responsibility	Version	Date
Robert Cavalleri	Implementation Manager	1.0	
Netta Hollings	Programme Manager		

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Contents

Glossary	4
1 Overview	6
1.1 Related Documents	8
2 Introduction	9
3 Health and Care Organisations	14
3.1 Requirements	15
3.2 Conformance Criteria	17
4 IT System Suppliers	17
4.1 Requirements	17
5 Appendix 1	18
Base Validations	18
6 Appendix 2	19
Questions	19
7 Appendix 3	41
Consent Guidance	41

Glossary

Term	Acronym	Definition
Assuring Transformation	AT	Assuring Transformation data collection
Area Team	ATm	There are 12 NHS England geographic Area Teams plus 3 in London following a restructure at the end of 2014.
Caldicott Guardian		Nominated senior person who oversees information governance.
Care and Treatment Review	CTR	Care and Treatment Review
CAP system	CAP	The Clinical Audit Platform. This is a secure data input platform designed specifically to collect data for national audits. It can be accessed at https://clinicalaudit.hscic.gov.uk/ using a single sign-on account.
Clinical Commissioning Group	CCG	Primary care trusts (PCTs) used to commission most NHS services and controlled 80% of the NHS budget. On April 1 2013, PCTs were abolished and replaced with clinical commissioning groups (CCGs). CCGs have taken on many of the functions of PCTs and in addition some functions previously undertaken by the Department of Health;
Commissioning Support Unit	CSU	Commissioning support units provide a range of commissioning support services to NHS commissioners, including clinical commissioning groups (CCGs), NHS England, acute trusts and local government.
Data Dictionary	DD	The NHS Data Model and Dictionary provides a reference point for assured information standards to support health care activities within the NHS in England.
Data Template		This is a blank CSV template which can be populated with data for the Assuring Transformation Collection.
Health and Social Care Information Centre	HSCIC	The HSCIC is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care. It is an executive non-departmental public body, sponsored by the Department of Health.
Information Standards Notice	ISN	Information Standards Notices (ISNs) are published by SCCI to announce new or changes to information standards or data collections, including those formerly licensed under the Review of Central Returns (ROCR) procedure
Learning Disabilities Census	LDC	The Learning Disability Census provides an individual record-level snapshot of inpatients with learning disabilities, autistic spectrum disorder and/or behaviour that challenges, and the services they receive, for service users who were inpatients in NHS and independent services at midnight on 30 September annually.
Look up tables		Excel tables which contain a list of Organisations related to the collection.
Mental Health Services Data Set	MHSDS	The MHSDS is a patient level, output based, secondary uses data set which will deliver robust, comprehensive, nationally consistent and comparable person-based information for children, young people and adults who are in contact with Mental Health Services.

Term	Acronym	Definition
Operational Guidance		This provides collection specific guidance on how to use the Clinical Audit Platform.
Organisation Code (Org Code)		This relates to the ODS code for an Organisation or Organisation Site. More information can be found at http://systems.hscic.gov.uk/data/ods .
Personal Identifiable data	PID	Personal information about identified or identifiable individuals, including dead as well as living people e.g. Name, Address, Postcode, Date of birth, NHS number.
Registration document		This is a document required by the HSCIC to be sent from the submitting organisation's Caldicott Guardian which provides contact details for data submitters who have been approved to handle PID. This information is used to allow users access to the CAP system
Standardisation Committee for Care Information	SCCI	The SCCI replaces the Information Standards Board for Health and Social Care (ISB) and is a sub-group of the National Information Board (NIB). Empowered by the Health and Social Care Act 2012 the SCCI has delegated responsibility for approving information standards for the health and social care system in England
Single Sign On Account	SSO	Single Sign-On Account. This is an account which allows the user to access HSCIC data submission platforms that they are registered for.

1 Overview

The Health and Social Care Information Centre (HSCIC) is working in partnership with NHS England to deliver the Assuring Transformation collection. Previously managed by NHS England, HSCIC assumed responsibility for this collection in January 2015. The Assuring Transformation collection is mandated under the Health and Social Care Act 2012.

This document defines the mandatory patient level Assuring Transformation (AT) Information Standard and Data Collection (SCCI2007). The data is collected using the Clinical Audit Platform (CAP) system. This document summarises the collection and required changes; provides signposting to sources of supporting information and related documentation; and details overarching requirements and conformance criteria.

Standard	
Standard Number	SCCI 2007
Standard Title	Assuring Transformation
Description	<p>Assuring Transformation is a data collection that has been developed in response to <i>Transforming Care: A national response to Winterbourne View Hospital and Winterbourne View Review: Concordat: A Programme of Action</i>. The Concordat, published by the Department of Health in December 2012, aims to ensure that all people with learning disabilities receive the health care and support they need in the most appropriate setting.</p> <p>This data collection monitors the progress of moving people with learning disabilities to community settings. The collection refers to patients with a diagnosed learning disability, autism or Asperger syndrome.</p> <p>The purpose of the data collection is to ensure that the public reporting on progress to implement the NHS commitments in the Concordat is transparent and robust. It will also be used to triangulate with the Learning Disability Census completed by providers. This process is important for informing and assuring the Learning Disabilities Transforming Care Programme.</p> <p>Formerly managed by NHS England, this data collection transferred to the Health and Social Care Information Centre (HSCIC) from 06 January 2015. As a result, commissioners now submit data to the HSCIC's Clinical Audit Platform (CAP).</p> <p><u>In Scope</u></p> <p>Data should be recorded for each individual person who meets these requirements:</p> <ul style="list-style-type: none"> • An NHS commissioner is responsible for commissioning their care, and

	<ul style="list-style-type: none"> The person has an in-patient bed for mental and/or behavioural healthcare needs and has learning disabilities or autistic spectrum disorder (including Asperger's syndrome) <p>If commissioners have not commissioned in-patient care for people who meet the above definition in the relevant period they will still be required to submit a 'nil' return.</p> <p>Out of Scope</p> <ul style="list-style-type: none"> People in accommodation not registered with the Care Quality Commission as hospital beds People in beds for physical healthcare People who do not have either learning disabilities or autism <p>If you have <u>not</u> commissioned in-patient care for people who meet the above definition in the relevant period, you will still be required to submit a 'nil' return.</p>
Applies to	All commissioners of learning disability services must comply with this information standard. This includes clinical commissioning groups, commissioning support units and NHS England specialised commissioning hubs. s.
Release	
Release Number	Amd 37/2015
Release Title	Assuring Transformation v 2.0
Description	<p>The amendment to this standard will include:</p> <p>Minor changes to the established question set to improve the validity, accuracy and reliability of responses.</p> <ul style="list-style-type: none"> Redundant questions relating to ex-inpatients of Winterbourne View have been removed. Addition of new questions relating to pre- admission and review through Care and Treatment Reviews (CTR) have been included. This information is already routinely collected by submitters, and including it in this collection will not add additional burden as it will enable NHS England to retire local collections that currently collect these data. There are also amendments to the wording of existing questions, and the inclusion of a small number of additional values where applicable, in order to align the collection with items in the NHS Data Model and Dictionary. There are also minor changes to validations within the Clinical Audit Platform (CAP) system to improve the robustness of the data when captured, and improvements to guidance provided to submitters.
Implementation	System Suppliers

Completion Date	<p>From 30 November 2015, systems MUST be fully conformant with this standard.</p> <p>Care Providers</p> <p>From 30 November 2015, all commissioners of learning disability services MUST be able to collect information locally.</p>
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1.1 Related Documents

A comprehensive set of documents has been developed to assist submitters responsible for the Assuring Transformation Information Standard and Data Collection. Documentation includes:

- Implementation Guidance
- Technical Output Specification
- Operational Guidance

All documents can be found on the Assuring Transformation webpage:

<http://www.hscic.gov.uk/assuringtransformation>

The website also includes further supporting documents and video tutorials to assist submitters.

Further documentation, including the ISN and Change Specification can be found on the Information Standards and Collections page for this standard:

<http://www.hscic.gov.uk/isce/publication/SCCI2007>

Summary of Key Documents

Ref #	Title	Definition
1	Implementation Guidance	User document providing full details of the collection and the question set, and the requirements for users to implement the collection.
2	Technical Output Specification	Technical user reference document detailing the questions, values and data requirements for the collection.
4	Operational Guidance	Detailed technical user guidance for submitting data on the Clinical Audit Platform (CAP) system.
5	Registration Form	To register for the AT collection, submitters will need to complete a registration form electronically. One form is required for each organisation.

7	Change Specification	Details the changes to the standard / collection required for this release.
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Related Standards and References

Ref #	Reference	Title
LD Census	http://www.hscic.gov.uk/ldcensus	Learning Disability Census
MHSDS	http://www.hscic.gov.uk/mhsds	Mental Health Services Data Set
Data Dictionary	http://www.datadictionary.nhs.uk/	NHS Data Model and Dictionary

2 Introduction

Assuring Transformation

Assuring Transformation is a data collection that was introduced in response to the Winterbourne View scandal in 2012. The collection looks at patients with a diagnosed learning disability, autism or Asperger's syndrome in an in-patient hospital setting. This data is submitted by Clinical Commissioning Groups (CCGs), Commissioning Support Units (CSUs), NHS England specialised commissioning teams/hubs and Area Teams (ATm) for secure mental health and child and adolescent mental health in-patient services. The collection also supports the identification of other areas for improvement.

This collection is mandatory and from February 2015 CCGs, CSUs and specialised commissioning teams have been required to upload their monthly data to the HSCIC via the Clinical Audit Platform (CAP) system.

Background

The Department of Health published *Transforming Care: A national response to Winterbourne View Hospital*¹ and the *Concordat: Programme of Action*² in December 2012. The first document describes the facts about Winterbourne View, the changes needed in the system and looks at what the Government needs to do based on the lessons learnt. The review of services received indicated that failings were widespread within the operating

¹ <https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response>

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213217/Concordat.pdf

organisation but importantly also evident across the wider care system. The Concordat and sixty-three actions detailed within the review seek to address poor and inappropriate care and achieve the best outcomes for people with a learning disability or autism, who may also have mental health needs or behaviour that challenges.

The purpose of this data collection is to ensure that the public reporting on progress to implement the NHS commitments in the *Winterbourne View Concordat* is transparent and robust. It is also used to triangulate with the Learning Disability Census completed by providers each year on 30th September. This process is important for informing The Winterbourne View Joint Improvement Programme.

It is an accepted principle that services should be local, care and treatment should be appropriate and there should be a substantial and sustained reduction in hospital placements. Taking part will help monitor progress towards these goals.

Structure of data / collection

The purpose of this data collection is to ensure that the public reporting on progress to implement the NHS commitments in the *Winterbourne View Concordat* is transparent and robust. It is also used to triangulate with the Learning Disability Census completed by providers on 30 September each year.

The collection comprises inpatients with 'a bed' normally designated for the treatment or care of people with a learning disability or those with 'a bed' designated for mental illness treatment or care who have been diagnosed or understood to have a learning disability and/or autistic spectrum disorder.

Data are provided by English commissioners and healthcare is typically provided in England (although care commissioned in England and provided elsewhere in the UK will not be excluded). There is a slight difference in scope between this collection and the Learning Disability Census since the Census comprises data from *providers* based only in England, but does include care provided in England but commissioned from other UK countries.

Data are collected from Clinical Commissioning Groups (CCGs) and Specialist Commissioning Teams (SCTs) NHS England specialised commissioning teams/hubs and Area Teams (ATm). In some cases Clinical Support Units (CSUs) submit data on behalf of one of more CCGs.

From February 2015, responsibility for its collection and publication was transferred to the HSCIC. This addressed key requirements around the improvement of data quality and reporting frequency. The revised collection methodology supports real time data capture using a "live" system that commissioners are required to update as and when changes occur in the care of a patient who falls in scope of the collection. This has resulted in a significant burden reduction on the part of service commissioners / data submitters.

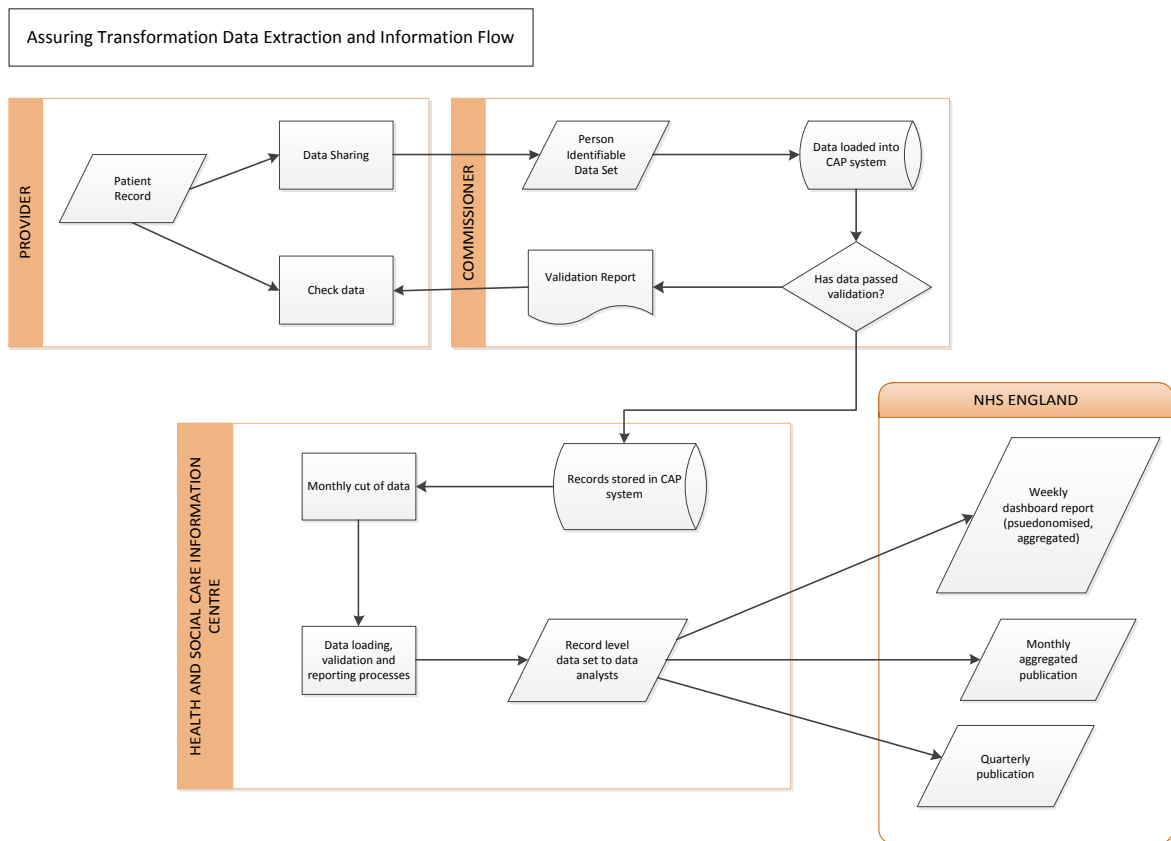
The HSCIC reports on these data on a monthly, quarterly and annual basis and all figures will be experimental in status whilst we develop these statistics.

Further detail and instruction are included in the Technical Output Specification, Implementation Guidance and Operational Guidance documents on the HSCIC AT website:

<http://www.hscic.gov.uk/assuringtransformation>

Data Flow Diagram

The following diagram demonstrates the high level data extraction and information flow process for the collection of Assuring Transformation data. This shows the flow from Provider organisations to Commissioners of Learning Disability Services, the flow from Commissioners to the HSCIC, the validation and reporting processes and NHS England reporting requirements.



Information Governance and Consent

(Summary of IG requirements here, CAG approval, ref to Appendix 3 Consent Guidance – TBC)

A Direction from NHS England is in place for the collection of the data. The flow of data from providers to CCGs has a confirmed legal basis or a section 251 is in place approval from CAG (CAG 8-02(a-c)2014) provides legal cover for the collection of information by CCGs and NHS England Area Teams.

Section 4 (2(b)) of the Direction details the basis for dissemination of the data by the HSCIC to NHS England. A Memorandum of Understanding is in place to sustain this collection for 2 years and is signed by HSCIC and NHS England.

Fair Processing Notice?

Publication of CAG approval letter?

Consent

Consent Guidance is available on the Assuring Transformation website, and in Appendix 3 of this Specification document.

This guidance focuses on information sharing between providers taking part in the Assuring Transformation Collection and the Health and Social Care Information Centre (HSCIC). In particular the guidance explains what providers need to do when a patient wishes to prevent information from identifying them or information held about them by the HSCIC being used for purposes other than direct care. We wish to support providers to assist patients to better understand their rights and, under the Data Protection Act, to give them the information they need to make decisions about how information about them is used.

Richard- an update iro CAG conditions- patient leaflet / fair processing publication is required. Andy T has this in hand I believe.

Data Quality

Data are collected via the Clinical Audit Platform (CAP) which allows a number of validations to be built in. The detailed validation rules can be viewed under section 4 of the 'instruction and guidance notes' found on the Assuring Transformation web page <http://www.hscic.gov.uk/assuringtransformation>

The system has been designed central to the patient using NHS number and date of birth as unique identifiers. The system is set up such that:

- For each NHS number there can only be one open episode of care during the period;
- There can be multiple closed episodes of care for each NHS number within a period;
- The system is 'live' and commissioners are expected to change information in the system as and when on an ongoing basis;
- Currently HSCIC analysts take a 'snap shot' of the system at the end of each month and use this to report on the position at the end of the month and admissions and discharges within the month.

Although patients can have more than one episode in a period due to short hospital stays, at the end of the reporting period there can only be one open episode per patient. Investigation of the data found that some duplicates were being recorded in the system due to data submitters altering key information used to identify unique episodes without closing a previous episode of care. HSCIC have been investigating this and working with submitters to resolve the issue and improve data quality.

Submission of records

CCGs, SCTs, NHS England specialised commissioning teams / hubs and Area Teams (ATm) are expected to keep records up to date on an ongoing basis. The HSCIC currently assess whether a CCG/SCT has done this by checking to see if the CCG/SCT has made any alterations to any of the records during the period. If no records have been altered (due to no change in patient circumstances) then the CCG/SCT should select the 'submission confirmation' option to confirm that their data is correct for this period.

Changes to the collection / questions

There have been a number of changes to the Assuring Transformation collection, including new and amended questions and the removal of questions previously included. Full details of the changes are detailed in the Technical Output Specification and Implementation Guidance on the Assuring Transformation website:

<http://www.hscic.gov.uk/assuringtransformation>

3 Health and Care Organisations

The following NHS commissioners are responsible for ensuring the completion of the data collection:

- NHS Clinical Commissioning Groups.
- NHS England specialised commissioning teams/hubs for secure mental health and child and adolescent mental health in-patient services.

The data return must be completed by the commissioning organisation ONLY. There is a separate data return (census) for Providers to complete.

The collection may be completed on behalf of an NHS commissioner by a Commissioning Support Unit (CSU) or other commissioners in a pooled budget.

If the collection is being completed by a Commissioning Support Unit (CSU) on behalf of a Clinical Commissioning Group (CCG) the CSU should complete a separate return for each CCG that is contributing to the pooled budget.

NHS England specialised mental health commissioning teams should submit one return for each team.

Please note: A separate return has to be completed for each commissioning organisation that has the statutory responsibility for commissioning the care for all relevant patients.

- For pooled budget arrangements one commissioner only, must take responsibility for returning the patient's data
- If you are a commissioner and someone for whom you have a statutory duty to commission care meets the definition then a return is needed for your organisation.

The in-scope definition is:

"The collection will consider in-patients receiving treatment / care in a facility registered by the Care Quality Commission as a hospital operated by either an NHS or independent sector provider. The facility will provide mental or behavioural healthcare in England. Record level returns will reflect only in-patients or individuals on leave with a bed held vacant for them.

The individual will have 'a bed' normally designated for the treatment / care of people with a learning disability or will have 'a bed' designated for mental illness treatment / care and will be diagnosed or understood to have a learning disability and / or autistic spectrum disorder."

This should include patients of:

- Any age.
- Any level of security (general/low/medium/high).
- Any status under the Mental Health Act (informal or detained).

People not included:

- People in accommodation not registered with the CQC as hospital beds.
- People in beds for physical health care.

- People who do not have either learning disabilities or autism."

The data collection team has received a number of queries about this definition, which have asked whether people should only be included if they have a 'primary diagnosis of LD'. The guidance from NHS England's National Clinical Director for Learning Disability is as follows:

For our purpose whether or not a person is recorded as having a primary diagnosis of LD is not relevant, and should not be used as a criterion for inclusion in this data collection. If a person is in a specialist hospital bed (either MH or LD) and that person has a Learning Disability or Autism, then that person is included in the Assuring Transformation data return.

Collection of data

A cut of the data in the Clinical Audit Platform (CAP) will be taken at midnight on the last day of every month. This is not dependant on working days.

3.1 Requirements

Documents listed on point 1.1 will be sent with this document and be posted on the HSCIC website.

Requirements	
1	In Scope Commissioners MUST be fully conformant with the Assuring Transformation requirements (<i>See Implementation Guidance</i>), including the capture and flow of the data items to the Clinical Audit Platform (CAP).
Scoping	
2	The review of the 'in scope' and 'out of scope' sections of this collection specification SHOULD be carried out by the organisational Commissioning lead for Learning Disabilities.
Feasibility Assessment	
3	Commissioners MUST review the Implementation Guidance which defines the patient-level data items that contacts need to submit onto the Clinical Audit Platform. The Implementation Guidance provides additional information on data items in the data set specification. Commissioners SHOULD review this document to better understand the scope, national guideline recommendations, definitions and rules underpinning the data items.
4	Whilst service commissioners will be predominantly collecting the data they SHOULD NOT rely on the Providers to provide them with this information. The data submission process MUST meet the specifications defined in the Implementation Guidance.
5	The Commissioners SHOULD be familiar with the collection as this has already been collected by NHS England on a quarterly basis, and on a monthly basis by HSCIC since February 2015. With the Implementation Guidance the Commissioners will have a better understanding of how data items are

	validated. The data submission process MUST meet the specifications defined in the Implementation Guidance.
Information Governance	
6	<p>The Implementation Guidance provides information on the Information Governance (IG) issues surrounding the data set. Caldicott Guardians MUST review the (IG) Guidelines in the Implementation Guidance, Appendix C: User Terms and Conditions of Access, which clarify:</p> <ul style="list-style-type: none"> - How data submission, storage and reporting processes handle identifiable and sensitive data and - How Fair Processing should be conducted and objections should be best managed to comply with the Confidentiality Advisory Group conditions of approval.
Constructing a data submission file	
7	It is not stipulated how data should be collected locally; therefore, data MAY come from several sources or from a local data warehouse, which collates information from various systems for this reason we have provided a CSV data template which can be populated with their information in order to be accepted by the CAP system.
8	<p>Commissioners MUST review the Implementation Guidance to understand how a data submission is to be constructed and transferred. There will also be a data template available on the HSCIC Assuring Transformation website. This data template can be used to upload data into the CAP system once it has been populated with their information.</p> <p>All records MUST be submitted as per instructions laid out in the Implementation Guidance, which is essentially an instruction manual for the file creation and submission process.</p>
9	<p>Commissioners MUST ensure that their data is up to date on a monthly basis.</p> <p>If there have been no amendments within the month, then the Commissioners MUST use the system and press the Submission Confirmation button to confirm that there are no amendments for the month - enabling data from that Commissioning organisation to be included in analysis.</p> <p>Commissioners then SHOULD update these records on an as required basis so that their data is maintained and up to date during and at the end of each month. Commissioners MUST observe the collection schedule that will be published in advance on the HSCIC Assuring Transformation website.</p>
Access to the Clinical Audit Platform	
10	<p>The Commissioners MUST register for access to the Clinical Audit Platform (for further information please see Appendix D of the Implementation Guidance).</p> <p>Registration SHOULD be based on current organisation details.</p> <p>All submitters MUST submit data through the Clinical Audit Platform. The CAP system does not require an N3 connection but does require internet access.</p>
11	The Commissioners MUST resolve inherent errors and address data quality issues. The CAP system will identify any data which do not pass the validation

	criteria. As such it is impossible for Commissioners to submit invalid data.
Issue and maintenance	
12	To support the implementation of this Information Collection, Commissioners SHOULD highlight any persistent issues. This feedback mechanism provides appropriate information to developers to improve the implementation and data collection processes for future consideration towards a data set change or, indeed, further implementation phases.

3.2 Conformance Criteria

- The submission process includes data validation tests to ensure the data is of sufficient quality – uploaders **SHOULD** ensure that data is conformant with the type specified (please see Appendices 1 and 2). The presence of any records that do not conform to the collection specification and corresponding data validation rules will lead to the record being rejected and subject to revised data processing until such point that uploads will be achievable via the system. Uploaders **SHOULD** continue to revise and resubmit data until such point that it is accepted by the CAP system.
- Validation reports are available to download which identify the specific issues requiring action by the provider. Record uploaders **SHOULD** use these to guide their data quality improvement activities.
- Validations are described in the Implementation Guidance. Data Submitters **MUST** reference this in order to correct errors.

4 IT System Suppliers

4.1 Requirements

Documents listed below (available for download from the HSCIC assuring transformation website (www.hscic.gov.uk/assuringtransformation)) **MAY** be read and reviewed to help understand the requirements and enable the implementation of the collection if considered necessary:

- Implementation Guidance
- Technical Output Specification

5 Appendix 1

Base Validations

Q1 This must be a valid NHS number with 10 digits and no spaces.

Q11b can only be answered if the patient is admitted from another hospital, i.e. if Q5a is code 49, 51, 53 or 87. If Q5a is not coded 49, 51, 53 or 87 then Q11b should be left blank.

If Q17a is code 0 'General' or 4 'PICU' then Q17b must **not** be 1.

If Q17a is code 1 'low secure' 2 'medium secure', 3 'high secure' then Q17b must be 1.

If Q20a is No, Q20b must be answered (Q20c-g should be left blank).

If Q20a is Yes, Q20c-g must be answered (Q20b should be left blank).

Q32 cannot be a date in the future.

If Q35 is code 14 'No transfer currently planned' or 15 'Patient died' then Q36 and Q37 should be left blank.

If Q35 is code 14 'No transfer currently planned' or 15 'Patient died' then Q38a should be N 'No'

Q36 should only be answered if the patient is transferring to a community setting (code 1, 2, 3, 4 or 5 at Q35). If Q35 is not code 1, 2, 3, 4 or 5 Q36 should be left blank.

If Q38a is Yes, Q38b must be answered.

If Q33 is code 6, Q39a-l must be answered.

6 Appendix 2

Questions

Question	Old Q number	New coding required
PERSONAL INFORMATION		
Q1 NHS Number of patient?	Q1	Mandatory Format/length n10 Provide the patient's unique NHS number with no spaces, letters or punctuation.
Q2 Patient's date of birth?	Q2	Mandatory Format/length an10 NHS number of patient Patient's date of birth is required in the following format: DD-MM-CCYY
Q3 Gender of patient?	Q3 (additional code added)	Mandatory Format/length n1 National Codes: 1 Male 2 Female 9 Not specified (unable to be classified) X Not Known (PERSON STATED GENDER CODE not recorded)
Q4 Patient's ethnic category?	Q4	Mandatory Format/length an2

This must be the patient's own decision of their ethnic category.

National Codes:

White

- A** British
 - B** Irish
 - C** Any other White background
- Mixed*
- D** White and Black Caribbean
 - E** White and Black African
 - F** White and Asian
 - G** Any other mixed background
- Asian or Asian British*
- H** Indian
 - J** Pakistani
 - K** Bangladeshi
 - L** Any other Asian background
- Black or Black British*
- M** Caribbean
 - N** African
 - P** Any other Black background
- Other Ethnic Groups*
- R** Chinese
 - S** Any other ethnic group
 - Z** Not stated

99 Not known

Q5 Submitting CCG	Q (previously not numbered)	Mandatory	Format/length an3
			Commissioner Code (e.g CCG code or Local Authority code. Lookup tables available on the Assuring Transformation website.)

Q6 Originating CCG	New	Mandatory Format/length an3
	Commissioner Code (e.g CCG code or Local Authority code. Lookup tables available on the Assuring Transformation website.)	
Q7a What was the patient's source of admission? ³	Q5a	<p data-bbox="502 313 534 694">Mandatory Format/length n2</p> <p data-bbox="558 313 590 694">Code as</p> <p data-bbox="622 313 925 694">19 Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with no fixed abode.</p> <p data-bbox="941 313 1037 694">29 Temporary place of residence when usually resident elsewhere (e.g. hotels, residential educational establishments)</p> <p data-bbox="1053 313 1085 694">39 Penal establishment, Court, or police station</p> <p data-bbox="1101 313 1197 694">49 NHS other hospital provider - high security psychiatric accommodation in an NHS hospital provider (NHS trust)</p> <p data-bbox="1212 313 1260 694">51 NHS other hospital provider - WARD for general PATIENTS or the younger</p>

³ Please consult the glossary for further information around low and medium secure settings.

<p>physically disabled or A & E department</p> <p>53 NHS other hospital provider - WARD for PATIENTS who are mentally ill or have learning disabilities</p> <p>54 NHS run care home</p> <p>65 Local Authority residential accommodation i.e. where care is provided</p> <p>66 Local Authority foster care</p> <p>85 Non-NHS (other than Local Authority) run care home</p> <p>87 Non NHS run hospital</p> <p>88 Non-NHS (other than Local Authority) run Hospice</p>	<p>Q7b Full Post Code (with a space) of source of admission?</p> <p>Q5b</p>	<p>Mandatory Format/length an8</p> <p>Full postcode of source of admission</p> <p>If not known use (ZZ99 3WZ)</p>
<p>Full postcode of source of admission</p> <p>If not known use (ZZ99 3WZ)</p>	<p>Q8 What is the postcode of the patient's home address?</p> <p>New</p>	<p>Mandatory Format/length an8</p> <p>Full postcode of source of admission</p> <p>If not known use (ZZ99 3WZ)</p>
<p>Code as</p> <p>1 Guardianship</p> <p>2 Appointeeship⁴</p>	<p>Q9 Is the patient subject to...</p> <p>Q6</p>	<p>Mandatory Format/length n1</p>

⁴ An Appointee is a person authorised by the Department for Work & Pensions (DWP) to claim, collect and use benefits on behalf of a claimant who lacks mental or physical capacity to handle their own affairs.

	<p>3 Both</p> <p>4 Neither</p> <p>9 Don't Know</p>	
COMMISSIONER INFORMATION		
Q10 Is the patient on a register ⁵ Q8 as required by the commitment in 'Transforming Care: A national response to Winterbourne View Hospital' and the 'Concordat'?	Code as Y Yes N No	Mandatory Format/length an1
IN-PATIENT CARE INFORMATION		
Q11a Date that this hospital admission commenced with this provider? Q9a	Date of admission to this hospital spell with this provider. The format required: DD-MM-CCYY	Mandatory Format/length an10
Q11b Date of the first admission to any hospital as part of this continuous period of inpatient care? Q9b	Only required if patient was admitted from another hospital setting, i.e. if Q5a is coded 49, 51, 53, 87 The format required: DD-MM-CCYY	Dependant on Q5a Format/length an10
Q12 When the patient was first	New	Mandatory Format/length an2

Appointeeship is only applicable where the person is receiving state benefits only and has little savings (less than £5,000).

⁵ This register should have been established by the former Primary Care Trusts in January 2013 and handed over to Clinical Commissioning Groups on 31 March 2013

admitted to hospital, was this admission planned or unplanned?	1 Planned Admission 2 Unplanned Admission 9 Not Known		Mandatory	Format/length an5
Q13a Current provider organisation code?	Q10a Please enter the NHS code for the Provider organisation ⁶ .		Mandatory	Format/length max an255
Q13b Current provider organisation name?	Q10b Please enter the name for the Provider organisation		Mandatory	Format/length an5
Q14a Current provider (site) location code?	Q11a Please enter the code for the actual hospital or facility at which in-patient care is being provided		Mandatory	Format/length max an255
Q14b Current provider (site) location name?	Q11b Please enter the name of the actual hospital or facility at which in-patient care is being provided		Mandatory	Format/length an8
Q14c Postcode (with a space) of the hospital where the patient has received treatment?	Q11c Full postcode of hospital		Mandatory	Format/length n1
Q15a Which of the following categories best describes the patient?	Q12a Code as 1 The patient has a learning disability only 2 The patient has a learning disability and		Mandatory	Format/length n1

⁶ If you do not know the codes, please look at the supporting documents on the following website www.hscic.gov.uk/assuringtransformation, if the organisation is not on the list, please contact ATData@hscic.gov.uk

<p>autistic spectrum condition</p> <p>3 The patient has an autistic spectrum condition only</p> <p>4 None of the above</p>	<p>Q15b On admission day what was the main diagnostic category of the patient? (current stay)</p> <p>Q12b</p>	<p>Mandatory Format/length n1</p>
<p>Code as</p> <p>1 Mental illness</p> <p>2 Learning Disability</p> <p>3 'Challenging Behaviour'⁷</p> <p>4 Personality Disorder</p> <p>5 Autistic Spectrum Disorder including Asperger's Syndrome</p> <p>6 'Self Harm'</p> <p>7 Other</p>	<p>Q16 Is this patient detained under the auspices of the Mental Health Act (1983)?</p> <p>Q13</p>	<p>Mandatory Format/length n2</p> <p>National Codes:</p> <p>1 Informal</p> <p>2 Formally detained under Mental Health Act Section 2</p> <p>3 Formally detained under Mental Health Act Section 3</p> <p>4 Formally detained under Mental Health Act Section 4</p> <p>5 Formally detained under Mental Health Act Section 5</p>

⁷ Challenging behaviour and self-harm have been put in as options despite not being diagnostic categories as they can be principal reasons for admission.

- Act Section 5(2)
- 6** Formally detained under Mental Health Act Section 5(4)
- 7** Formally detained under Mental Health Act Section 35
- 8** Formally detained under Mental Health Act Section 36
- 9** Formally detained under Mental Health Act Section 37 with section 41 restrictions
- 10** Formally detained under Mental Health Act Section 37
- 12** Formally detained under Mental Health Act Section 38
- 13** Formally detained under Mental Health Act Section 44
- 14** Formally detained under Mental Health Act Section 46
- 15** Formally detained under Mental Health Act Section 47 with section 49 restrictions
- 16** Formally detained under Mental Health Act Section 47
- 17** Formally detained under Mental Health Act Section 48 with section 49 restrictions
- 18** Formally detained under Mental Health Act Section 48
- 19** Formally detained under Mental Health Act Section 135
- 20** Formally detained under Mental Health Act Section 136
- 31** Formally detained under Criminal

<p>Procedure (Insanity) Act 1964 as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991</p> <p>32 Formally detained under other acts</p> <p>34 Formally detained under Mental Health Act Section 45A</p> <p>35 Subject to guardianship under Mental Health Act Section 7</p> <p>36 Subject to guardianship under Mental Health Act Section 37</p> <p>37 Formally detained under Mental Act Section 45A (Limited direction in force)</p> <p>38 Formally detained under Mental Health Act Section 45A (Limitation direction ended)</p> <p>98 Not applicable</p> <p>99 Not known</p>	<p>Mandatory Format/length n1</p>
<p>Q17a What is the ward security level?</p>	<p>Q14a</p> <p>Code as</p> <p>0 General (non-secure)⁸</p> <p>1 Low Secure</p> <p>2 Medium Secure</p> <p>3 High Secure</p> <p>4 Psychiatric Intensive Care Unit (PICU),</p>

⁸ This would also include locked rehabilitation.

<p>Q17b What is the ward type?</p> <p style="text-align: right;">Q14b</p> <p style="text-align: right;">Mandatory Format/length n1</p> <p>If Q17a is code 0 'General' or 4 'PICU' then Q17b must not be 1. If Q17a is code 1 'low secure' 2 'medium secure', 3 'high secure' then Q17b must be 1.</p> <p>Code as</p> <ol style="list-style-type: none"> 1 Low, Medium and High secure forensic beds 2 Acute admission beds within specialised learning disability units 3 Acute admission beds within generic mental health settings 4 Forensic rehabilitation beds 5 Complex continuing care and rehabilitation beds 6 Other beds including those for specialist neuropsychiatric conditions 9 Other 	<p>Q18 Is the service currently deemed compliant in relation to <u>all</u> the CQC Essential Standards?</p> <p style="text-align: right;">Q15</p> <p style="text-align: right;">Mandatory Format/length n1</p> <p>Code as</p> <ol style="list-style-type: none"> 1 Yes 2 No 3 Not yet inspected 4 Not regulated by CQC as outside England
<p>Q19 Has this patient been considered for discharge through</p> <p style="text-align: right;">Q16</p> <p style="text-align: right;">Mandatory Format/length an1</p> <p>Code as</p>	

the use of a Community Treatment Order ⁹ as defined in the Mental Health Act (2007)?	Y Yes N No		
ADVOCACY			
Q20a Does the patient make use of independent advocacy?	Q17	Mandatory	Format/length an1
If No, answer Q20b		Code as	
If Yes, answer Q20c-g		Y Yes N No	
Q20b, if Q20a is No, why not?	Q17a	Dependant on Q20a	Format/length n1
		If Q20a is No, Q20b must be answered (Q20c-g should be left blank).	
		Code as	
		1 Patient chose not to use service 2 Patient currently on waiting list for service 3 No independent service available 7 Other	
Q20c, if Q20a is Yes, does this patient have an independent advocate?	Q17b	Dependant on Q20a	Format/length an1
		If Q20a is Yes, Q20c-g must be answered (Q20b should be left blank).	
Family member (someone who		Y Yes	

⁹ Community Treatment Orders were introduced in November 2008 by new sections 17A-G being inserted into the Mental Health Act (1983) by the Mental Health Act (2007). In the Code of Practice it is called Supervised Community Treatment; in the Act those subject to CTOs are called community patients. Please state if, for this current episode of in-patient care, such an order/option of care has been considered for the patient.

has been asked by, or given permission by the patient, to represent them)	N No X Don't know	
Q20d, If Q20a is Yes, does this patient have an independent advocate? ¹⁰		Dependant on Q20a Format/length an1
Independent person (someone who has been asked by, or given permission by the patient, to represent them)	Y Yes N No X Don't know	If Q20a is Yes, Q20c-g must be answered (Q20b should be left blank).
Q20e, If Q20a is Yes, does this patient have an independent advocate?		Dependant on Q20a Format/length an1
A formal Independent Mental Capacity Advocate (IMCA)	Y Yes N No X Don't know	If Q20a is Yes, Q20c-g must be answered (Q20b should be left blank).
Q20f, If Q20a is Yes, does this patient have an independent advocate?		Dependant on Q20a Format/length an1
An Independent Mental Health Advocate (IMHA)	Y Yes N No	If Q20a is Yes, Q20c-g must be answered (Q20b should be left blank).

¹⁰ An independent advocate can be a neighbour, friend, relative, volunteer from an advocacy organisation or a paid independent advocate. A family member is only considered to be independent if the person has expressly chosen them as an independent advocate. The Mental Capacity Act (2005) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for them. The Act introduces several new roles, bodies and powers, all of which support the Act's provisions. One of the new services created by the Act is the Independent Mental Capacity Advocacy (IMCA) Service, which introduces the new role of the Independent Mental Capacity Advocate (IMCA). The Mental Health Act (2007) created the role of the independent mental health advocate (IMHA).

	X	Don't know	
Q20g, If Q20a is Yes, does this patient have an independent advocate?	Q17f	Q17f	Dependant on Q20a Format/length an 1
Non-instructed advocate ¹¹		<p>If Q20a is Yes, Q20c-g must be answered (Q20b should be left blank).</p> <p>Y Yes</p> <p>N No</p> <p>X Don't know</p>	
Q21 Are members of the patient's family currently involved in discussing the patient's care plan?	Q18	<p>Code as</p> <p>1 Yes</p> <p>2 No – at the request of the patient</p> <p>3 No – access restrictions on family</p> <p>4 No family involved</p> <p>5 No family living</p> <p>9 Don't know</p>	Mandatory Format/length n1
Q22 Does the organisation providing advocacy currently hold the QPM Award Advocacy Quality Performance Mark	New	<p>Y Yes</p> <p>N No</p>	Mandatory Format/length n1

¹¹ Non-instructed advocacy is used when it is not possible to get consent from a person, or get a clear idea about the person's views and wishes. This is not the same as the person refusing consent, or being uncertain about their choices. Usually when a person lacks mental capacity, it means they cannot understand the information that has been explained to them, or they are unable to remember the information long enough to think about it or they are unable to communicate their views. In this instance a non-instructed advocate will ensure the person's rights are upheld and that all options for them are explored. They will represent the person's interests by ensuring that alternative courses of action are considered and they will support the person to participate as fully as possible in decision making processes.

(QPM) Award?			
CASE MANAGEMENT AND TRANSFERS TO COMMUNITY OR INPATIENT SETTINGS			
Q23 Did the patient have a pre-admission Care and Treatment Review (CTR)?	New	<p>Y Yes</p> <p>N No</p>	Mandatory Format/length an1
Q24 If Yes, when did this take place?	New	<p>The format required:</p> <p>DD-MM-CCYY</p>	Dependant on Q23 Format/length an10
Q25 If No, did the patient have a post-admission CTR?	New	<p>Y Yes</p> <p>N No</p>	Dependant on Q23 Format/length an1
Q26 If the patient did have a post-admission CTR, when did this take place?	New	<p>The format required:</p> <p>DD-MM-CCYY</p>	Dependant on Q25 Format/length an10
Q27 Date of most recent CTR	New	<p>The format required:</p> <p>DD-MM-CCYY</p>	Mandatory Format/length an10
Q28 Outcome of most recent CTR	New	<p>Code as:</p> <p>1 Ready for discharge, discharge plan in place</p>	Mandatory Format/length an1

<p>& discharge date in next 3 months</p> <p>2 Ready for discharge, discharge plan in place & discharge date in next 6 months</p> <p>3 Ready for discharge- no discharge plan</p> <p>4 Not ready for discharge- needs to be in a hospital bed for care & treatment.</p>	<p>New</p> <p>Mandatory Format/length an10</p>
<p>The format required: DD-MM-CCYY</p>	
<p>Q30 Was the patient admitted for respite care only?</p> <p>Code as Y Yes N No</p>	<p>New</p> <p>Mandatory Format/length an1</p>
<p>Q31 Does the patient have a named locality care co-ordinator/care manager?</p> <p>Code as Y Yes N No</p>	<p>Q19</p> <p>Mandatory Format/length an1</p>
<p>Q32 Date of the most recent formal review or assessment¹² of this patient's individual care plan.</p> <p>Q20 (wording change)</p>	<p>Q20</p> <p>Mandatory Format/length an10</p> <p>Q32 cannot be a date in the future.</p>

¹² Formal review means that a formal record of the review has been made and shared with the person, their family, care and/or advocate, other key providers and commissioners. This may include a Care Programme Approach (CPA) review.

<p>The format required: DD-MM-CCYY</p>		
<p>Q33 Details of patient's care plan</p>	<p>Q21 (options 4 and 5 removed)</p>	<p>Mandatory Format/length n1</p>
<p>Code as</p> <p>1 Currently not dischargeable because of level of behaviour that presents a risk to the person of others, or mental illness</p> <p>2 Currently receiving active treatment plan, discharge plan not in place</p> <p>3 Working towards discharge to identified placement or with discharge plan in place</p> <p>6 No onward placement available, delayed transfer of care</p>		
<p>Q34a Is the plan for discharge/transfer agreed by the following: Patient?</p>	<p>Q22a</p>	<p>Mandatory Format/length an1</p>
<p>If there is no discharge plan in place answer N for Q34a - f</p> <p>Code as</p> <p>Y Yes</p> <p>N No</p>		
<p>Q34b Is the plan for discharge/transfer agreed by the following: Family/carer?</p>	<p>Q22b</p>	<p>Mandatory Format/length an1</p>
<p>Code as</p> <p>Y Yes</p>		

		N No	
		9 Not Applicable (No Family/Carer)	
Q34c Is the plan for discharge/transfer agreed by the following: Advocate	Q22c	Code as Y Yes N No	Mandatory Format/length an1
Q34d Is the plan for discharge/transfer agreed by the following: Provider clinical team?	Q22d	Code as Y Yes N No	Mandatory Format/length an1
Q34e Is the plan for discharge/transfer agreed by the following: Local community support team?	Q22e	Code as Y Yes N No	Mandatory Format/length an1
Q34f Is the plan for discharge/transfer agreed by the following: Commissioners?	Q22f	Code as Y Yes N No	Mandatory Format/length an1
Q35 Where will the patient transfer to? (Or notification of patient death)	Q23	Code as 1 Independent Living 2 Supported Housing 3 Family home with support	Mandatory Format/length n2

<p>4 Residential Care 5 Residential School 6 Low Secure Beds 7 Medium Secure Beds 8 High Secure Beds 9 Acute admission beds within specialised learning disability units 10 Acute admission beds within generic mental health setting 11 Forensic rehabilitation beds 12 Complex continuing care and rehabilitation beds 13 Other beds including those for specialist neuropsychiatric conditions 14 No transfer currently planned 15 Patient died 16 Other</p>	<p>Q24</p> <p>Q36 If Q35 is 1, 2, 3, 4, 5</p> <p>Full post code (with a space) of the proposed community setting, if known?</p>	<p>Dependant on Q35 Format/length an8</p> <p>If Q35 is code 14 'No transfer currently planned' or 15 'Patient died' then Q36 and Q37 should be left blank.</p> <p>Q36 should only be answered if the patient is transferring to a community setting (code 1, 2, 3, 4 or 5 at Q35). If Q35 is not code 1, 2, 3, 4 or 5 Q36 should be left blank.</p> <p>Postcode of the proposed community setting</p> <p>If not known use (ZZ99 3WZ)</p> <p>Mandatory Format/length an1</p> <p>If Q35 is code 14 'No transfer currently planned' or 15 'Patient died' then Q36 and Q37 should be left blank.</p> <p>Code as</p> <p>Y Yes N No</p>
<p>Q25</p> <p>Q37 Is the relevant Local Authority aware of the planned transfer of this patient to their area?</p>	<p>Q25</p>	<p>Format/length an1</p>

	X	Don't know	
Q38a Is there an agreed date for the planned transfer?	Q26	Mandatory	Format/length an1
		If Q35 is code 14 'No transfer currently planned' or 15 'Patient died' then Q38a should be N 'No'	
		Code as	
		Y Yes	
		N No	
Q38b If Q38a is Yes, date of planned transfer	Q26a	Dependant on Q38a	Format/length an10
		If Q38a is Yes, Q38b must be answered.	
		The format required:	
		DD-MM-CCYY	
If Q21 is coded 1, 2, 3, 4 or 5 then Q27a to Q27l should not be answered. Go to Q28			
Q39a If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Q27a	Code each response below as Yes or No	Format/length an1
		Dependant on Q33	Format/length an1
		If Q33 is code 6, Q39a-l must be answered.	
		Code as	
		Y Yes	
		N No	
Lack of agreed health care funding			
Q39b If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Q27b	Dependant on Q33	Format/length an1
		If Q33 is code 6, Q39a-l must be answered.	
		Code as	
		Y Yes	
		N No	
Lack of agreed social care			

funding	
<p>Q39c If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?</p> <p>Awaiting further non-acute (including CCG and mental health) NHS care (including intermediate care, rehabilitation services, etc.)</p>	<p>Q27c</p> <p>Dependant on Q33 Format/length an 1</p> <p>If Q33 is code 6, Q39a-1 must be answered.</p> <p>Code as</p> <p>Y Yes</p> <p>N No</p>
<p>Q39d If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?</p> <p>Awaiting residential home placement or availability</p>	<p>Q27d</p> <p>Dependant on Q33 Format/length an 1</p> <p>If Q33 is code 6, Q39a-1 must be answered.</p> <p>Code as</p> <p>Y Yes</p> <p>N No</p>
<p>Q39e If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?</p> <p>Awaiting nursing home placement or availability</p>	<p>Q27e</p> <p>Dependant on Q33 Format/length an 1</p> <p>If Q33 is code 6, Q39a-1 must be answered.</p> <p>Code as</p> <p>Y Yes</p> <p>N No</p>
<p>Q39f If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?</p> <p>Awaiting care package in own</p>	<p>Q27f</p> <p>Dependant on Q33 Format/length an 1</p> <p>If Q33 is code 6, Q39a-1 must be answered.</p> <p>Code as</p> <p>Y Yes</p>

	N	No	
home			
Q39g If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date? Awaiting community equipment and adaptations	Q27g		Dependant on Q33 Format/length an1 If Q33 is code 6, Q39a-l must be answered. Code as Y Yes N No
Q39h If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date? Patient or family choice	Q27h		Dependant on Q33 Format/length an1 If Q33 is code 6, Q39a-l must be answered. Code as Y Yes N No
Q39i If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date? Lack of local health service provision	Q27i		Dependant on Q33 Format/length an1 If Q33 is code 6, Q39a-l must be answered. Code as Y Yes N No
Q39j If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date? Lack of social care support	Q27j		Dependant on Q33 Format/length an1 If Q33 is code 6, Q39a-l must be answered. Code as Y Yes N No
Q39k If Q33 is coded 6, what are the reasons for this patient's	Q27k		Dependant on Q33 Format/length an1

<p>planned transfer of care not having an agreed date? Lack of suitable housing provision</p>	<p>Code as Y Yes N No</p>	<p>If Q33 is code 6, Q39a-l must be answered.</p>
<p>Q39l If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date? Other</p>	<p>Code as Y Yes N No</p>	<p>Dependant on Q33 Format/length an1 If Q33 is code 6, Q39a-l must be answered.</p>
<p>Q40 If the patient has already been discharged, what is the actual date that the discharge happened, or date that the patient died?</p>	<p>This date should only be entered if the patient has left the ward The format required: DD-MM-CCYY</p>	<p>Q28 Format/length an10</p>

7 Appendix 3

Consent Guidance

Guidance and support for care staff considering patient objections

This guidance focuses on information sharing between providers taking part in the Assuring Transformation Collection and the Health and Social Care Information Centre (HSCIC). In particular the guidance explains what providers need to do when a patient wishes to prevent information from identifying them or information held about them by the HSCIC being used for purposes other than direct care.

We wish to support providers to assist patients to better understand their rights and, under the Data Protection Act, to give them the information they need to make decisions about how information about them is used.

What do you need to do?

You should inform patients that although data collected by the collection will flow to the HSCIC they can object to it leaving the HSCIC for purposes beyond their direct care in any way that identifies them. You should also tell the patient that there are a few exceptions to this.*

If a patient objects to information that identifies them leaving the HSCIC and being used for purposes beyond direct care then they, their carer, advocate or professional person acting on their behalf, must contact their GP and ask them to note this objection in the patient's medical records. The GP will then add an appropriate code to the patient's record subject to certain exceptions.

For more comprehensive information about objections please read the full guidance notes at <http://www.hscic.gov.uk/ldcensus>

For more information about how the HSCIC looks after and shares information go to: <http://www.hscic.gov.uk/patientconf>

* Exceptions are; (i) when the information does not identify the patient (ii) information needed for the direct care of the patient (iii) in serious situations where there is a legal requirement to provide the information (such as a court order or in the event of a civil or public health emergency)

There is also an Easy Read document available on the HSCIC website (www.hscic.gov.uk/assuringtransformation)

Technical Output Specification

Assuring Transformation v 2.0



Purpose of this document

The purpose of this document is to define the data items that make up the Assuring Transformation v2.0 data collection. Each data item is fully described including the expected format, valid values and validations.

This document should be read in conjunction with the Assuring Transformation Specification and Implementation Guidance documents, available on the Assuring Transformation website: <http://www.hscic.gov.uk/assuringtransformation>

Document Control

Version	Date Issued	Summary of Change	Owner
0.1	10/07/2015	First draft	Anna Cale
0.2	16/07/2015	Minor amendments	Anna Cale
0.3	21/07/2015	Further amendments	Anna Cale
0.4	23/07/2015	Further amendments	Anna Cale
0.5	05/08/2015	Further amendments after NHS DMDS review	Anna Cale
0.6	20/08/2015	Final Draft	Anna Cale

Technical Output Specification

Assuring Transformation v 2.0



Health & Social Care
Information Centre

Summary of Changes

Previous Question Number	Question	New Question Number	Change Type	Existing Value	Proposed Value	Comments	Change Specification ID
Q7	Is the patient a former resident of Winterbourne-View-Hospital? If Yes, please answer the following questions, if No, go to Q8	n/a	Deletion of question	n/a	n/a	Question removed from collection	AT001
Q7a	Has the patient previously been subject to multiple (more than one) moves/placement breakdown?	n/a	Deletion of question	n/a	n/a	Question removed from collection	AT002
Q7b	Has the service been subject to special measures or deemed non-compliant by the CQC during the past 12 months?	n/a	Deletion of question	n/a	n/a	Question removed from collection	AT003
Q7c	Have any safeguarding concerns been raised in relation to the current service during the past 12 months?	n/a	Deletion of question	n/a	n/a	Question removed from collection	AT004
Q7d	If Q7c is Yes, is the alert still active?	n/a	Deletion of question	n/a	n/a	Question removed from collection	AT005
Q7e	If service closed, at what date?	n/a	Deletion of question	n/a	n/a	Question removed from collection	AT006
Q7f	Has the service been subject to any whistle blowing actions during the past 12 months?	n/a	Deletion of question	n/a	n/a	Question removed from collection	AT007
Q7g	Has support been provided related to any potential trauma experienced at Winterbourne-View? If Yes, answer Q7h If No, answer Q7i	n/a	Deletion of question	n/a	n/a	Question removed from collection	AT008
Q7h	If Q7g is Yes, Please describe the support provided	n/a	Deletion of question	n/a	n/a	Question removed from collection	AT009
Q7i	If Q7g is No, Was any support required or requested?	n/a	Deletion of question	n/a	n/a	Question removed from collection	AT010

Q21	Details of patient's care plan	Q33	Deletion of value	n/a	[4] Requires indefinite IP-care because of behavioural needs	AT011	Value removed from question
Q21	Details of patient's care plan	Q33	Deletion of value	n/a	[5] Requires indefinite IP-care because of physical needs	AT012	Value removed from question
Q3	Person stated gender code	Q3	Amended question	n/a	n/a	AT013	Question amended to align with NHS Data Model and Dictionary
Q3	Person stated gender code	Q3	New Value	NEW	[9] Indeterminate (unable to be classified as either male or female)	AT014	Additional value added to existing question
Q3	Person stated gender code	Q3	New Value	NEW	[X] Not known (person stated gender code not recorded)	AT015	Additional value added to existing question
Q13	Mental Health Act legal status classification code	Q16	Amended question	n/a	n/a	AT016	Question amended to align with NHS Data Model and Dictionary
Q13	Mental Health Act legal status classification code	Q16	New Value	NEW	[37] Formally detained under Mental Health Act Section 45A (limited direction in force)	AT017	
Q13	Mental Health Act legal status classification code	Q16	New Value	NEW	[38] Formally detained under Mental Health Act Section 45A (limited direction ended)	AT018	Additional value added to existing question
Q13	Mental Health Act legal status classification code	Q16	New Value	NEW	[98] Not Applicable	AT019	Additional value added to existing question
Q13	Mental Health Act legal status classification code	Q16	New Value	NEW	[99] Not known	AT020	Additional value associated with an existing question
Q22b	Is the plan for discharge/transfer agreed by the following: Family/carer?	Q34b	New Value	NEW	[9] Not applicable (No Family/carer)	AT021	Additional value added to existing question
n/a	Originating CCG	Q6	New Question	n/a	n/a	AT022	Additional value added to existing question
n/a	Postcode of usual address	Q8	New Question	n/a	n/a	AT023	Additional value added to existing question
n/a	When the patient was first admitted to hospital, was this admission planned or unplanned?	Q12	New Question	n/a	n/a	AT024	Additional value added to existing question
n/a	When the patient was first admitted to hospital, was this admission planned or unplanned?	Q12	New Value	NEW	[1] Planned admission	AT025	Additional value added to existing question
n/a	When the patient was first admitted to hospital, was this admission planned or unplanned?	Q12	New Value	NEW	[2] Unplanned admission	AT026	Additional value added to existing question
n/a	When the patient was first admitted to hospital, was this admission planned or unplanned?	Q12	New Value	NEW	[9] Not known	AT027	Additional value added to existing question
n/a	Does the organisation providing advocacy currently hold the QPM Award Advocacy Quality Performance Mark (QPM) Award?	Q22	New Question	n/a	n/a	AT028	Additional value added to existing question

n/a	Does the organisation providing advocacy currently hold the QPM Award Advocacy Quality Performance Mark (QPM) Award?	Q22	New Value	NEW	[Y] Yes	New value associated with new question	AT029
n/a	Does the organisation providing advocacy currently hold the QPM Award Advocacy Quality Performance Mark (QPM) Award?	Q22	New Value	NEW	[N] No	New value associated with new question	AT030
n/a	Did the patient have a pre-admission Care and Treatment Review (CTR)?	Q23	New Question	n/a	n/a	New question	AT031
n/a	Did the patient have a pre-admission Care and Treatment Review (CTR)?	Q23	New Value	NEW	[Y] Yes	New value associated with new question	AT032
n/a	Did the patient have a pre-admission Care and Treatment Review (CTR)?	Q23	New Value	NEW	[N] No	New value associated with new question	AT033
n/a	If Yes, when did this take place?	Q24	New Question	n/a	n/a	New question Dependent on Q23 The format required: DD-MM-CCYY	AT034
n/a	If No, did the patient have a post-admission CTR?	Q25	New Question	n/a	n/a	New question Dependent on Q23	AT035
n/a	If No, did the patient have a post-admission CTR?	Q25	New Value	NEW	[Y] Yes	New value associated with new question Dependent on Q23	AT036
n/a	If No, did the patient have a post-admission CTR?	Q25	New Value	NEW	[N] No	New value associated with new question Dependent on Q23	AT037
n/a	If the patient did have a post-admission CTR, when did this take place?	Q26	New Question	n/a	n/a	New question Dependent on Q25 The format required: DD-MM-CCYY	AT038
n/a	Date of most recent CTR	Q27	New Question	n/a	n/a	New question The format required: DD-MM-CCYY	AT039
n/a	Outcome of most recent CTR	Q28	New Question	n/a	n/a	New question	AT040
n/a	Outcome of most recent CTR	Q28	New Value	NEW	[1] Ready for discharge, discharge plan in place & discharge date in next 3 months		AT041
n/a	Outcome of most recent CTR	Q28	New Value	NEW	[2] Ready for discharge, discharge plan in place & discharge date in next 6 months	New value associated with new question	AT042
n/a	Outcome of most recent CTR	Q28	New Value	NEW	[3] Ready for discharge- no discharge plan	New value associated with new question	AT043
n/a	Outcome of most recent CTR	Q28	New Value	NEW	[4] Not ready for discharge- needs to be in a hospital bed for care & treatment.	New value associated with new question	AT044
n/a	Date of next scheduled CTR	Q29	New Question	n/a	n/a	New question The format required: DD-MM-CCYY	AT045
n/a	Was the patient admitted for respite care only?	Q30	New Question	n/a	n/a	New question	AT046
n/a	Was the patient admitted for respite care only?	Q30	New Value	NEW	[Y] Yes	New value associated with new question	AT047

n/a	Was the patient admitted for respite care only?	Q30	New Value	NEW	[N] No	New value associated with new question	AT048
Q1	NHS Number	Q1	Amended question	n/a	n/a	Question amended to align with NHS Data Model and Dictionary	AT049
Q2	Person birth date	Q2	Amended question	n/a	n/a	Question amended to align with NHS Data Model and Dictionary	AT050
Q4	Ethnic Category	Q4	Amended question	n/a	n/a	Question amended to align with NHS Data Model and Dictionary	AT051
Q5a	Source of Admission Code (Hospital Provider Spell)	Q7a	Amended question	n/a	n/a	Question amended to align with NHS Data Model and Dictionary	AT052
Q9a	Start Date (hospital provider spell)	Q11a	Amended question	n/a	n/a	Question amended to align with NHS Data Model and Dictionary	AT053
Q10a	Organisation code (of provider)	Q13a	Amended question	n/a	n/a	Question amended to align with NHS Data Model and Dictionary	AT054
Q10b	Organisation name	Q13b	Amended question	n/a	n/a	Question amended to align with NHS Data Model and Dictionary	AT055
Q11a	Site code (of treatment)	Q14a	Amended question	n/a	n/a	Question amended to align with NHS Data Model and Dictionary	AT056
Q11c	Postcode of location of care activity	Q14c	Amended question	n/a	n/a	Question amended to align with NHS Data Model and Dictionary	AT057
Q15	Is the service currently deemed compliant in relation to all the CQC Essential Standards?	Q18	Amended value	[1] Yes	[Y] Yes	Question amended to align with NHS Data Model and Dictionary	AT058
Q15	Is the service currently deemed compliant in relation to all the CQC Essential Standards?	Q18	Amended value	[2] No	[N] No	Question amended to align with NHS Data Model and Dictionary	AT059
Q15	Is the service currently deemed compliant in relation to all the CQC Essential Standards?	Q18	Amended value	[3] not yet inspected	[3] Not known (not yet inspected)	Question amended to align with NHS Data Model and Dictionary	AT060
Q15	Is the service currently deemed compliant in relation to all the CQC Essential Standards?	Q18	Amended value	[4] Not regulated by CQC as outside England	[4] Not Applicable (Not regulated by CQC as outside England)	Question amended to align with NHS Data Model and Dictionary	AT061

Technical Output Specification

Assuring Transformation v 2.0



Health & Social Care
Information Centre

Technical Output Specification

Question Number	Question	Code	Code Definition	Status	Format/length	Information Requirements (purpose) and other comments	Question Group	Validation Rules	Error/Warning Messages	Previous Question Number
Q1	NHS Number			Mandatory	m10	Provide the patient's unique NHS number with no spaces, letters or punctuation. Question aligned with NHS Data Model and Dictionary.	Personal Information			1
Q2	Person birth date			Mandatory	an10	<p>Patent's date of birth required in the following format: DD-MM-CCYY</p> <p>Question aligned with NHS Data Model and Dictionary.</p>	Personal Information			2
Q3	Person stated gender code	1 2 9 X	Male Female Indeterminate (unable to be classified as either male or female) Not Known (PERSON STATED GENDER CODE not recorded)	Mandatory	an1	Gender of patient. Question aligned with NHS Data Model and Dictionary.	Personal Information			3
Q4	Ethnic Category	A B C D E F G H I J K L M N P R S Z 99	White British Irish Any other White background Mixed White and Black Caribbean White and Black African White and Asian Any other mixed background Asian or Asian British Indian Pakistani Bangladesh Any other Asian background Black or Black British Caribbean African Any other Black background Other Ethnic Groups Chinese Any other ethnic group Not stated Not known	Mandatory	an2	This must be the patient's own decision of their ethnic category. Question aligned with NHS Data Model and Dictionary.	Personal Information			4
Q5	Submitting CCG			Mandatory	an3	Commissioner Code (e.g. CCG code or Local Authority code. Lookup tables available on the Assuring Transformation website.)	Personal Information			Already existing but no previous Q number
Q6	Originating CCG			Mandatory	an3	Commissioner Code (e.g. CCG code or Local Authority code. Lookup tables available on the Assuring Transformation website.)	Personal Information			NEW

Q7a	Source of Admission Code (Hospital Provider Spell)	19	Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes warden accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with no fixed abode.	an2	Question aligned with NHS Data Model and Dictionary.	15a
		29	Temporary place of residence when usually resident elsewhere (e.g. hotels, residential Educational Establishments)			
		39	Penal establishment, Court, or police station / Police Custody Suite			
		49	NHS other Hospital Provider - high security psychiatric accommodation in an NHS hospital provider (NHS trust or NHS Foundation Trust)			
		51	NHS other Hospital Provider - WARD for general PATIENTS or for other physical illness or 8 E-episodes			
		53	NHS other Hospital Provider - WARD for PATIENTS who are not able to have Learning Disabilities			
		54	NHS run Care Home			
		65	Local Authority residential accommodation i.e. where care is provided			
		66	Local Authority foster care			
		85	Non-NHS (other than Local Authority) run Care Home			
		87	Non-NHS run hospital			
		88	Non-NHS (other than Local Authority) run Hospice			
Q7b	Full Post Code (with a space) of source of admission?			an8	Full postcode of source of admission. If not known use ZZ99 3WZ	15b
Q8	Postcode of usual address			an8	Full postcode of address. If not known use ZZ99 3WZ. Pseudo Postcodes are available on the ODS website	NEW
Q9	Is the patient subject to:	1	Guardianship	an1	Question aligned with NHS Data Model and Dictionary	6
		2	Appointedship[1]			
		3	Both			
		4	Neither			
		9	Don't Know			
Q10	Is the patient on a register[2] as required by the commitment in Transforming Care: A national response to Wintbourne View Hospital and the Concordat?	Y	Yes	an1	[1] An Appointee is a person authorised by the court to claim, collect and use benefits on behalf of a claimant who lacks mental or physical capacity to handle their own affairs.	8
		N	No		[2] This register should have been established by the former Primary Care Trusts in January 2013 and handed over to Clinical Commissioning Groups on 31 March 2013	
Q11a	Start date (hospital provider spell)			an10	Date of admission to this hospital spell with this provider. The format required: DD-MM-CCYY	9a
Q11b	Date of the first admission to any hospital as part of this continuous period of inpatient care?			an10	Question aligned with NHS Data Model and Dictionary	9b
Q12	When the patient was first admitted to hospital, was this admission planned or unplanned?	1	Planned admission	an2	Dependant on Q5a	NEW
		2	Unplanned admission		Only required if patient was admitted from another hospital setting, i.e. if Q7a is coded 49, 51, 53, 87. The format required: DD-MM-CCYY	
		9	Not known		Q11b can only be answered if the patient is admitted from another hospital, i.e. if Q7a is coded 49, 51, 53 or 87. If Q7a is not coded 49, 51, 53 or 87 then Q11b should be left blank.	
Q13a	Organisation code (code of provider)			an3, an5, an6	Please enter the NHS code for the Provider organisation[3].	10a
Q13b	Organisation name			max an255	[3] If you do not know the codes, please look at the supporting documents on the following website: www.nhs.uk/assuringsupport/information , if the organisation is not on the list, please contact ATData@hscic.gov.uk	10b

Q14a	Site code (of treatment)			Mandatory	min an5, max an6	Please enter the code for the actual hospital or facility at which in-patient care is being provided. Question aligned with NHS Data Model and Dictionary.	In-Patient Care Information		11a
Q14b	Current provider (site) location name?			Mandatory	an255	Please enter the name of the actual hospital or facility at which in-patient care is being provided. Question aligned with NHS Data Model and Dictionary.	In-Patient Care Information		11b
Q14c	Postcode of location of care activity			Mandatory	max an8	Postcode (with a space) of the hospital where the patient has received treatment. Question aligned with NHS Data Model and Dictionary.	In-Patient Care Information		11c
Q15a	Which of the following categories best describes the	1 2 3 4	1 2 3 4	Mandatory	an1		In-Patient Care Information		12a
Q15b	On admission day what was the main diagnostic category of the patient? (current stay)	1 2 3 4 5 6 7	1 2 3 4 5 6 7	Mandatory	an1	1) Challenging behaviour and self-harm have been put in as options despite not being diagnostic categories as they can be principal reasons for admission.	In-Patient Care Information		12b
Q16	Mental Health Act legal status classification code	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 31 32 34 35 36 37 38 98 99	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 31 32 34 35 36 37 38 98 99	Mandatory	an2	Is this patient detained under the auspices of the Mental Health Act (1983)? Question aligned with NHS Data Model and Dictionary.	In-Patient Care Information		13
Q17a	What is the ward security level?	0 1 2 3 4	0 1 2 3 4	Mandatory	an1		In-Patient Care Information		14a
Q17b	What is the ward type?	1	1	Mandatory	an1		In-Patient Care Information	1) Q17a is code 0 'General' or 4 'PICU' then Q17b must not be 1.	14b

Q18	Is the service currently deemed compliant in relation to all the CQC Essential Standards?	<p>2 Acute admission beds within specialised learning disability units</p> <p>3 Acute admission beds within generic mental health settings</p> <p>4 Forensic rehabilitation beds</p> <p>5 Complex continuing care and rehabilitation beds</p> <p>6 Other beds including those for specialist neuropsychiatric condition</p> <p>7 Other</p> <p>8 Yes</p> <p>9 No</p> <p>10 Not known (Not yet inspected)</p> <p>11 Not applicable (Not regulated by CQC as outside England)</p>	Mandatory	an1	In-Patient Care Information	If Q17a is code 1 'low secure' 2 'medium secure', 3 'high secure' then Q17b must be 1.	15
Q19	Has this patient been considered for discharge through the use of a Community Treatment Order(s) as defined in the Mental Health Act (2007)?	<p>1 Yes</p> <p>2 No</p>	Mandatory	an1	In-Patient Care Information	(5) Community Treatment Orders were introduced in November 2008 by new sections 17A-C being inserted into the Mental Health Act (1983) by the Mental Health Act 2007.	16
Q20a	Does the patient make use of independent advocacy?	<p>1 Yes</p> <p>2 No</p>	Mandatory	an1	Advocacy		17
Q20b	If No, answer Q20c-g	<p>1 Patient chose not to use service</p> <p>2 Patient currently on waiting list for service</p> <p>3 No independent service available</p> <p>4 Other</p>	Dependant	an1	Advocacy	If Q20a is No, Q20b must be answered (Q20c-g should be left blank).	17a
Q20c	If Q20a is Yes, does this patient have an independent advocate?	<p>1 Yes</p> <p>2 No</p> <p>3 Don't know</p>	Dependant	an1	Advocacy	If Q20a is Yes, Q20b-g must be answered (Q20b should be left blank).	17b
Q20d	If Q20a is Yes, does this patient have an independent advocate? (Someone who has been asked by or given permission by the patient, to represent them)	<p>1 Yes</p> <p>2 No</p> <p>3 Don't know</p>	Dependant	an1	Advocacy	If Q20a is Yes, Q20b-g must be answered (Q20b should be left blank).	17c
Q20e	If Q20a is Yes, does this patient have an independent advocate? (A formal Independent Mental Capacity Advocate (IMCA))	<p>1 Yes</p> <p>2 No</p> <p>3 Don't know</p>	Dependant	an1	Advocacy	If Q20a is Yes, Q20b-g must be answered (Q20b should be left blank).	17d
Q20f	If Q20a is Yes, does this patient have an independent advocate? (An Independent Mental Health Advocate (IMHA))	<p>1 Yes</p> <p>2 No</p> <p>3 Don't know</p>	Dependant	an1	Advocacy	If Q20a is Yes, Q20b-g must be answered (Q20b should be left blank).	17e
Q20g	If Q20a is Yes, does this patient have an independent advocate? (Non-IMCA/IMHA)	<p>1 Yes</p> <p>2 No</p> <p>3 Don't know</p>	Dependant	an1	Advocacy	If Q20a is Yes, Q20b-g must be answered (Q20b should be left blank).	17f
Q21	Are members of the patient's family currently involved in discussing the patient's care plan?	<p>1 Yes</p> <p>2 No - at the request of the patient</p> <p>3 No - access restrictions on family</p> <p>4 No family involved</p>	Mandatory	an1	Advocacy	If Q20a is Yes, Q20b-g must be answered (Q20b should be left blank).	18

Q22	Does the organisation providing advocacy currently hold the OFM Award Advocacy Quality Performance Mark (OPM) Award?	Y N	No Yes Don't know	Mandatory	an1	If Q26a, 1 or g is Yes then Q22 must be answered	Case Management and Transfers to Community or Inpatient Settings	If Q26a, 1 or g is Yes then Q22 must be answered	NEW
Q23	Did the patient have a pre-admission Care and Treatment Review (CTR)?	Y N	Yes No	Mandatory	an1		Case Management and Transfers to Community or Inpatient Settings		NEW
Q24	If Yes, when did this take place?			Dependant	an10	Dependant on Q23 The format required: DD-MM-CCYY	Case Management and Transfers to Community or Inpatient Settings		NEW
Q25	If No, did the patient have a post-admission CTR, when did this take place?	Y N	Yes No	Dependant	an1	Dependant on Q23 The format required: DD-MM-CCYY	Case Management and Transfers to Community or Inpatient Settings		NEW
Q26	If the patient did have a post-admission CTR, when did this take place?	Y N	Yes No	Dependant	an10	Dependant on Q25 The format required: DD-MM-CCYY	Case Management and Transfers to Community or Inpatient Settings		NEW
Q27	Date of most recent CTR			Mandatory	an10	The format required: DD-MM-CCYY	Case Management and Transfers to Community or Inpatient Settings		NEW
Q28	Outcome of most recent CTR	1 2 3 4	Ready for discharge, discharge plan in place & discharge date in next 3 months Ready for discharge, discharge plan in place & discharge date in next 6 months Ready for discharge- no discharge plan Not ready for discharge- needs to be in a hospital bed for care & treatment.	Mandatory	an1		Case Management and Transfers to Community or Inpatient Settings		NEW
Q29	Date of next scheduled CTR			Mandatory	an10	The format required: DD-MM-CCYY	Case Management and Transfers to Community or Inpatient Settings		NEW
Q30	Was the patient admitted for respite care only?	Y N	Yes No	Mandatory	an1		Case Management and Transfers to Community or Inpatient Settings		NEW
Q31	Does the patient have a named locally care coordinator/care manager?	Y N	Yes No	Mandatory	an1		Case Management and Transfers to Community or Inpatient Settings		19
Q32	Date of the most recent formal review or assessment(8) of this patient's individual care plan.			Mandatory	an10	The format required: DD-MM-CCYY (8) Formal review means that a formal record of the review has been made and shared with the person, their family, care and/or advocate, other key providers and commissioners. This includes a Care Programme Approach (CPA) review.	Case Management and Transfers to Community or Inpatient Settings	Q32 cannot be a date in the future.	20
Q33	Details of patient's care plan	1 2 3 4 5 6	Currently not dischargeable because of level of behaviour that presents a risk to the person of others, or mental illness Currently receiving active treatment plan, discharge plan not in place Working towards discharge to identified placement or with discharge plan in place No onward placement available, delayed transfer of care	Mandatory	an1		Case Management and Transfers to Community or Inpatient Settings		21
Q34a	Is the plan for discharge/transfer agreed by the patient?	Y N	Yes No	Mandatory	an1		Case Management and Transfers to Community or Inpatient Settings		22a
Q34b	Is the plan for discharge/transfer agreed by the following: Family/carer?	Y N	Yes No	Mandatory	an1		Case Management and Transfers to Community or Inpatient Settings		22b
Q34c	Is the plan for discharge/transfer agreed by the following: Associate?	Y N	Yes No	Mandatory	an1		Case Management and Transfers to Community or Inpatient Settings		22c
Q34d	Is the plan for discharge/transfer agreed by the following: Provider/Clinical Team?	Y N	Yes No	Mandatory	an1		Case Management and Transfers to Community or Inpatient Settings		22d
Q34e	Is the plan for discharge/transfer agreed by the following: Local Community Support Team?	Y N	Yes No	Mandatory	an1		Case Management and Transfers to Community or Inpatient Settings		22e
Q34f	Is the plan for discharge/transfer agreed by the following: Commissioners?	Y N	Yes No	Mandatory	an1		Case Management and Transfers to Community or Inpatient Settings		22f
Q35	Where will the patient transfer to? (Or notification of patient death)	1 2	Independent Living Supported Housing	Mandatory	an2		Case Management and Transfers to Community or Inpatient Settings		23

3	Family home with support	Dependant	max arb	Dependant on Q35 If not known use (Z399 3WZ)	Case Management and Transfers to Community or Inpatient Settings	Q36 should only be answered if the patient is transferring to a community setting (codes 1, 2, 3, 4)	24
4	Residential Care	Mandatory	an1	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 14, No transfer currently planned or 15 Patient currently planned, Q38b through Q39i should be left blank.	25
5	Residential School	Mandatory	an1	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 14, No transfer currently planned, or 15 Patient currently planned, Q38b through Q39i should be left blank.	26
6	Low Secure Beds	Dependant	an10	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 14, No transfer currently planned, or 15 Patient currently planned, Q38b through Q39i should be left blank.	26a
7	Medium Secure Beds	Dependant	an10	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 14, No transfer currently planned, or 15 Patient currently planned, Q38b through Q39i should be left blank.	27a
8	High Secure Beds	Dependant	an10	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 14, No transfer currently planned, or 15 Patient currently planned, Q38b through Q39i should be left blank.	27b
9	Acute admission beds within specialised learning disability units	Dependant	an1	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 6, Q39a-i must be answered.	27c
10	Acute admission beds within generic mental health setting	Dependant	an1	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 6, Q39a-i must be answered.	27d
11	Forensic rehabilitation beds	Dependant	an1	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 6, Q39a-i must be answered.	27e
12	Complex continuing care and rehabilitation beds	Dependant	an1	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 6, Q39a-i must be answered.	27f
13	Other beds including those for specialist neuropsychiatric conditions	Dependant	an1	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 6, Q39a-i must be answered.	27g
14	No transfer currently planned	Dependant	an1	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 6, Q39a-i must be answered.	27h
15	Patient died	Dependant	an1	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 6, Q39a-i must be answered.	27i
16	Other	Dependant	an1	Dependant on Q33, Q38a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q35 is code 6, Q39a-i must be answered.	27j
Q36	If Q35 is 1, 2, 3, 4, 5 Full post code (with a space) of the proposed community setting. If known?	Y					
Q37	Is the relevant Local Authority aware of the planned transfer of this patient to their area?	X					
Q38a	Is there an agreed date for the planned transfer?	X					
Q38b	If Q38a is Yes, date of planned transfer	N					
Q38c	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Y					
Q38d	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	N					
Q38e	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Y					
Q38f	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	N					
Q38g	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Y					
Q38h	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	N					
Q38i	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Y					
Q38j	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	N					
Q38k	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Y					
Q38l	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	N					
Q38m	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Y					
Q38n	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	N					
Q38o	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Y					
Q38p	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	N					
Q38q	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Y					
Q38r	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	N					
Q38s	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Y					
Q38t	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	N					
Q38u	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Y					
Q38v	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	N					
Q38w	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Y					
Q38x	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	N					
Q38y	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	Y					
Q38z	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date?	N					

Q39i	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date? Lack of local health service provision	Y N	Yes No	Dependant an1	Dependant on Q33. If Q33 is coded 1, 2, 3, 4 or 5 then Q39a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q33 is code 6, Q39a-i must be answered. If Q39a is Yes, Q39b must be answered (Q39a-i should be left answered)	27i
Q39j	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date? Lack of social care support	Y N	Yes No	Dependant an1	Dependant on Q33. If Q33 is coded 1, 2, 3, 4 or 5 then Q39a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q33 is code 6, Q39a-i must be answered. If Q39a is Yes, Q39b must be answered (Q39a-i should be left answered)	27j
Q39k	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date? Lack of suitable housing provision	Y N	Yes No	Dependant an1	Dependant on Q33. If Q33 is coded 1, 2, 3, 4 or 5 then Q39a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q33 is code 6, Q39a-i must be answered. If Q39a is Yes, Q39b must be answered (Q39a-i should be left answered)	27k
Q39l	If Q33 is coded 6, what are the reasons for this patient's planned transfer of care not having an agreed date? Other	Y N	Yes No	Dependant an1	Dependant on Q33. If Q33 is coded 1, 2, 3, 4 or 5 then Q39a to Q39i should not be answered. Go to Q40	Case Management and Transfers to Community or Inpatient Settings	If Q33 is code 6, Q39a-i must be answered. If Q39a is Yes, Q39b must be answered (Q39a-i should be left answered)	27l
Q40	Discharge date (hospital provider spell) or Person death date	N	No	Dependant an10	If the patient has already been discharged, what is the actual date that the discharge happened, or date that the patient died? The date should be entered if the patient has left the ward The format required: DD-MM-CCYY Question aligned with NHS Data Model and Dictionary.	Case Management and Transfers to Community or Inpatient Settings		28

Board meeting – Public session

Title of paper:	e-Med 3 Directions
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 04 (c)
Paper presented by:	James Hawkins, Director of Programmes Delivery, HSCIC
Paper prepared by:	Michael Howley, GP IT Programme, HSCIC
Paper approved by: (Sponsor Director)	James Hawkins, Director of Programmes Delivery, HSCIC
Purpose of the paper:	To request ratification by the HSCIC board of the e-Med 3 Direction for the extraction of Fit Note Data
Key risks and issues:	Damage to HSCIC's reputation as a safe haven if there are public concerns about the collection and dissemination of the data.
Patient/public interest:	Patient interest in Government access to information about them.
Actions required by the board:	To ratify the proposed Secretary of State Direction.

E-med 3 Direction: Fit Note Aggregated Data

Consideration and approval of directions

Author: James Hawkins

Date 23 September 2015

Contents

Contents	2
Background to fit note directions	3
Technical aspects	4
Risks and Issues	
Actions Required of the Board	4

Background to Fit Note and Directions

Purpose of the direction and data flow

The direction provides the legal basis for HSCIC to extract de-identified information relating to the prescribing of fit notes from GP systems. The extraction will be further checked for any possible identifiers, and aggregated to GP practice and CCG level. GP practice-level information will be disseminated to a limited number of Department of Work and Pensions (DWP) analysts, and the CCG-level data will be published.

The purpose of the aggregated data is to provide DWP with a range of anonymised data derived from computer generated Med 3 forms e.g. count of the number of fit notes issued by GPs under broad diagnosis categories. The aggregated data will be anonymous and does not include any personal identifiable data.

DWP will utilise the data to provide a baseline of prescribing levels before the introduction of Fit for Work, a new service that provides an occupational health assessment.

DWP will also review high level geographical differences in fit note prescribing and to assess whether this changes over time as a result of a communications programme to all GPs on referring to Fit for Work.

The published CCG level statistics will be of use to health agencies, including Public Health England, to supplement public health datasets.

HSCIC has worked with the Department of Health and with DWP colleagues to ensure that:

- All patient objections registered with GPs relating to the flow of data from the GP practice will be respected
- No record level, or identifiable data will be made available to DWP, only aggregated statistical data
- The fields extracted are the minimum required for the purposes, and that suppression of small numbers is in place to ensure data de-identification within the aggregated dataset.

Staff from DWP have shared the plans for the data extraction with the ICO and IIGOP and continue to keep them updated, in addition they have also discussed the extraction with the British Medical Association (BMA). The BMA is content with the use of aggregated data at CCG level and access by DWP to aggregated GP practice-level data.

DH believe that it is in the public interest for aggregated data to be made available to DWP as this permits effective evaluation of a major new programme which contributes directly to the health management of the individuals referred to it. It is also important to understand high level geographical differences in fit note prescribing as this contributes to the wider debate on the efficient use of health service resources, and to the broader identification of public health geographical difference. Pursuant to section 254(5) of the Health and Social Care Act 2012, the Department is therefore consulting HSCIC before giving a direction.

Technical Aspects

System design

1. A facility to extract e-med3 (fit note) data was originally designed into GP systems, but this functionality is currently switched off.

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2. Discussions have taken place with all four GP system suppliers to ensure that the extraction is de-identified, that patient objections can be respected and that historical data dating back to December 2014 can be collected before any data is extracted from GP systems to the HSCIC. The back dating is required as the Fit for Work Service commenced roll-out in December 2014.
 3. HSCIC will then validate that submissions meet the specified, de-identified schema and will aggregate data, suppressing small numbers .
 4. Work with system suppliers is ongoing, and it is intended that system changes from at least one supplier will be in place to permit the first extraction to take place in November 2015.

Risks and Issues

- The extraction is required to support an analysis of a major new programme, the Fit for Work programme, which commenced in December 2014 and which enables GPs to refer patients after four weeks of sick leave to a service to support return to work, in the form of an occupational health assessment..
- DWP and DH recognise that some patients may express concern that even anonymised, de-identified and aggregated data is being provided to DWP. DH has therefore been clear that any patient objections to data leaving the GP practice must be respected, even though this is a stage beyond what the law requires in respect of de-identified data. GP practices will also provide a link via their websites to additional information on the DWP section of gov.uk.
- The Fit for Work (FfW) service has already started and is being rolled out. It is therefore important that initial data, backdated to December 2014, is available as soon as possible to provide a baseline for the evaluation of the service.
- The directions are presented for Board consideration and approval.

Actions Required of the Board

The Board is requested to consider and approve the directions.

Board meeting – Public session

Title of paper:	FGM Risk Indication System Directions
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 04 (d)
Paper presented by:	James Hawkins, Director of Programmes Delivery, HSCIC
Paper prepared by:	Alex Elias, Cross Government Programmes Director, HSCIC Tracey Harrington, Senior Project Manager, FGMP, HSCIC
Paper approved by: (Sponsor Director)	James Hawkins, Director of Programmes Delivery, HSCIC
Purpose of the paper:	To request ratification by the HSCIC board of the FGMP Risk Indication System Direction for the establishment and operation of the system.
Key risks and issues:	Damage to HSCIC's reputation as a safe haven if there are public concerns about the collection and use of the data
Patient/public interest:	Patient interest in cross Government access to information about them.
Actions required by the board:	To ratify the proposed Secretary of State Direction.

FGM Risk Indication System

Proposal for a Secretary of State Direction to Cover the Establishment and Operation of the Female Genital Mutilation (FGM) Risk Indication System

Alex Elias

23 September 2015

Contents

Contents	2
Executive Summary	3
Background	3
System Overview	3
Use of Information	3
Financial Implications	3
Communications & Engagement	4
Risks	4
Next Steps	4
Actions Required of EMT	5
Appendix A – Membership of the FGM Clinical Stakeholders and Royal Colleges Working Group	6
Appendix B – FGM Risk Indication System Direction	7
Appendix C -- Letter of Comfort in Relation to the FGM RIS Error! Bookmark not defined.	

Executive Summary

The Female Genital Mutilation (FGM) Risk Indication System provides the capability to mark on a girl's healthcare record that she is potentially at risk of FGM.

Until December 2015, DH and HSCIC will work with a number of early implementation sites, to understand use of the FGM Risk Indication System in practice, prior to a full programme launch in early 2016.

The establishment and operation of the FGM Risk Indication System is supported by a Direction. The Direction was provided by the Department of Health (DH) to HSCIC for ratification at the 23 September HSCIC Board meeting.

The board is asked to approve the FGM Risk Indication System Direction.

Background

System Overview

In March 2015, DH commissioned HSCIC to establish and operate the FGM Risk Indication System, as part of their wider FGM Prevention programme. The aim of this programme is to improve the NHS' response to FGM, including the safeguarding of girl's potentially at risk of FGM.

The FGM Risk Indication System provides the capability for a healthcare professional to mark on a girl's healthcare record that she is potentially at risk of FGM and for other healthcare professionals treating the girl to see this information. The use of this system aims to support safeguarding across the continuum of a female child's development from birth to 18.

The FGM Risk Indication System has been developed as part of the NHS Spine. Until December 2015, DH and HSCIC will work with a number of early implementation sites, to understand use of the FGM Risk Indication System in practice, prior to a full programme launch in early 2016.

Access to the system will be controlled via a secure NHS smartcard, for those staff who are authorised to use this.

Use of Information

An extract of data held within the FGM Risk Indication System will be provided on a regular basis to named individuals at NHS England and for the duration of the FGM Prevention programme. NHS England will be able to analyse this data, and provided all standard measures are undertaken to aggregate this data and ensure that individuals cannot be identified, reports will be provided to partner agencies with an identified need, for management reporting purposes.

Financial Implications

The establishment and operation of the FGM Risk Indication System is fully funded by DH through the DH Provision of Services Agreement (POSA) from the Children, Families and Social Inclusion Department.

Communications & Engagement

1. The business case for the establishment and operation of the FGM Risk Indication System was developed by HSCIC and assured and endorsed by relevant subject matter experts across HSCIC and DH. Full business case approval was granted by DH in March 2015.
2. The detailed design and development of the FGM Risk Indication System was carried out in collaboration with the wider DH FGM Prevention Programme team. An early view of the system was presented to the DH FGM Clinical Stakeholders and Royal Colleges Working Group. Feedback from this group on the establishment and operation of the system was positive. The membership of the FGM Clinical Stakeholders and Royal Colleges Working Group can be found in Appendix A.
3. The introduction of the FGM Risk Indication System was announced publically by Jane Ellison MP, at the International Day of Zero Tolerance to FGM on the 6th February 2015, as part of the Government's measures to bring to an end FGM in the UK. The news article relating to this announcement was published on the gov.uk website¹.
4. Information about the introduction of the FGM Risk Indication System was made available within the "Female Genital Mutilation Risk & Safeguarding Guidance for professionals" published by DH in March 2015. A hard copy of this document has been sent to every GP practice in England and has also been published on the gov.uk website².
5. It is recognised that successful implementation and take up of use of the system relies on clinical engagement. The DH, through the FGM Prevention programme, will lead a communication strategy, working with HSCIC and NHS England, to raise knowledge and awareness of the FGM Risk Indication System to support implementation.
6. DH and HSCIC will work with a number of early implementation sites, to understand the use of the system in practice. Feedback from these sites will be used to inform the full programme launch of the system, forecast for early 2016.

Risks

1. The potential risk of damage to HSCIC's reputation as a safe haven for health and social care information, if there are public concerns about the collection and use of this data. Key messages relating to the use of the system will be jointly agreed between DH, NHS England and HSCIC. In the event of any concerns being raised, responses will be agreed by all parties and published via the agreed communications channels.

Next Steps

Under section 254 of the Health and Social Care Act 2012, the Secretary of State will Direct HSCIC to establish and operate the FGM Risk Information System. This Direction was provided by DH to HSCIC and is included in Appendix B of this submission.

¹ <https://www.gov.uk/government/news/new-measures-to-end-fgm-on-international-day-of-zero-tolerance>.

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf

Actions Required of the Board

The HSCIC Board is asked to ratify the FGM Risk Indication System Direction.

Appendix A – Membership of the FGM Clinical Stakeholders and Royal Colleges Working Group

The FGM Clinical Stakeholders and Royal Colleges Working Group is jointly chaired by DH and NHS England. The group is attended by representatives from:

- Heart of England Foundation Trust
- London Councils
- Wandsworth CCG
- NHS England
- Guy's and St Thomas' NHS Foundation Trust
- Central and North West London NHS Foundation Trust
- Coventry University
- Forward UK
- Bristol CCG
- Local Government Association
- Metropolitan Police
- Department for Education
- Royal College of General Practitioners
- Royal College of Midwives
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- UCLH Foundation Trust
- Greater Manchester CSU
- Health Education England
- Unite
- NHSE
- The Health and Social Care Information Centre
- Department of Health

Appendix B – FGM Risk Indication System Direction

Children, Families and Communities
Richmond House, Room 311
79 Whitehall
London SW1A 2NS

Andy Williams
Chief Executive, Health and Social Care
Information Centre
1 Trevelyan Square
Boar Lane
Leeds LS1 6AE
10 September 2015

Dear Andy

I am writing to provide a direction to the Health and Social Care Information Centre to establish and operate the Female Genital Mutilation Risk Indication System (FGM RIS). This system will support the ongoing safeguarding of girls at risk of FGM, therefore supporting efforts to prevent FGM from happening. This is different from the earlier FGM Enhanced Dataset, which is a data collection for women and girls who already have FGM.

On 1 April 2013, the National Institute of Health and Clinical Excellence (Constitution and Functions) and Health and Social Care Information Centre (Functions) Regulations 2013 came into effect.

The regulations make provision for Secretary of State to direct the Health and Social Care Information Centre to exercise functions on his behalf to develop or operate information or communications systems, referred to as “systems delivery functions” under section 274 of the Health and Social Care Act 2012 (“the 2012 Act”).

Under section 254 of the 2012 Act, the Secretary of State may also direct the HSCIC to establish and operate a system for the collection and analysis of information.

HSCIC are required to disseminate information aggregated at the level of NHS organisations, to authorised personnel at NHS England, under s.261(5)(d) of the 2012 Act. The relevant functions of NHS England concern the purposes of arranging for the provision of services specified in Schedule 4 to the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

Following the letter of comfort sent on 12 August 2015, please accept this letter as the formal direction to the Health and Social Care Information Centre to exercise the functions in relation to the FGM Risk Indication System, details of which are set out in the attached schedule.

The system should be implemented at 2200hrs on 27 August 2015, allowing for the early adopters of the system to begin the planned implementation in September 2015.

Yours sincerely

Flora Goldhill

Director for Children, Families and Communities

0207 210 5054

Flora.goldhill@dh.gsi.gov.uk

Schedule: Female Genital Mutilation Risk Indication System Secretary of State directs the Health and Social Care Information Centre to exercise

System Scope

1. The Female Genital Mutilation Risk Indication System (FGM RIS) will provide the capability for healthcare professionals to record when it has been identified that a girl under 18 is potentially at risk of FGM, and for professionals treating the girl later in her childhood to see this information.
2. The system will be made up of four key elements:
 1. The core service: an extension of the Summary Care Record Application (SCRa), to allow a healthcare professional to record and/or view if a girl is potentially at risk of FGM;
 2. A data extract published to NHS England on a regular basis, for management reporting purposes;
 3. Integration capabilities, to allow data held within the FGM RIS to be shared with local systems; and
 4. A service wrap, to support the ongoing maintenance and use of the system.

System Purpose

3. Use of the system will:
 - Make available risk of FGM information in a uniform and secure manner across all relevant care settings in England;
 - Support the local safeguarding responsibilities of clinicians;
 - Help to avoid harm and respect the dignity of those at risk of FGM, by supporting the prevention of FGM;
 - Improve the awareness of risk of FGM, supporting research opportunities in this area; and
 - Support the appropriate allocation of resources and commissioning of services for FGM prevention.
4. The new system, developed by the Health and Social Care Information Centre (HSCIC), has been commissioned by the Department of Health (DH) as part of the wider programme of work, known as the FGM Prevention programme, to improve the NHS' response to FGM and the subsequent management of patients and safeguarding for girls at risk of FGM.
5. The system aims to support safeguarding across the continuum of a female child's development from birth to 18 - this is particularly important because the most likely point for identifying that a girl is potentially at risk of FGM is when she is born to a mother with FGM.

FGM RIS / SCRa System Users

6. The main groups of healthcare professionals most likely to have visibility of the factors associated with the potential risk of FGM, and therefore be users of the system who would set or remove the indicator, are:

- GPs;
 - Midwives;
 - School nurses;
 - Health visitors.
7. It will also be used, by viewing once the indicator has been set, by:
- Clinicians working in NHS Travel Centres;
 - Clinicians working in Acute Trusts;
 - Clinicians working in unscheduled care, such as primary care out of hours services, minor injury units and A&E;
 - Clinicians working in Mental Health Trusts.
8. Only limited individuals at the Health and Social Care Information Centre will have access to run the reports within the system, and collate the information held. This access will be controlled in line with standard national system reporting functions within HSCIC.
9. There will finally be named individuals at NHS England and the Department of Health who will receive anonymised reports of the information. This will be to support the quality and management of the system, and to support the provision and commissioning of associated safeguarding services.
10. The reports will provide information on the following data items, with minor changes to be agreed as required between the Department and HSCIC.
- a. When and where an indicator was set
 - b. When and where and why an indicator was removed
 - c. When and where an indicator was viewed.

This information will be provided in aggregate form split by organisation.

11. The following groups are expected to make use of aggregate information once it has been extracted and anonymised by HSCIC, to support the commissioning of services, allocation of resource and research in support of FGM prevention:
- Clinical Commissioning Groups (CCGs);
 - Multi Agency Safeguarding Hubs (MASH);
 - Local Safeguarding Children Boards (LSCB);
 - Police Borough Commands;
 - Children's Social Services;
 - National Government.

Timeframe

12. The core system will go live in late August 2015.
13. An early adopter phase of the core service will run from September 2015 to December 2015.

14. National implementation of the core service will launch in January 2015.
15. Local system integration capabilities will be made available from October 2015.
16. Local systems integration to run from October 2015 to March 2019

Approach to the upholding of patient objections to the collection of information

17. Parents or guardians of the child will be able to object to this system being used and this will be processed through an agreed fair processing objection route.
18. The parent or guardian will be given information under a fair processing route to inform them of how this information will be used. If an objection is raised, this will lead to a case by case review of each objection, undertaken locally with due regard and input from safeguarding professionals, to identify if it is in the best interests of the patient for data processing to stop, or whether the processing should continue and the objection be overridden. If overridden, the justification will be recorded within the local healthcare record. In relation to the system, if the objection is upheld, then the indicator will not be set on the child's record and if the objection is overridden, then the indicator will be set on the record.

Use of information

19. A data extract will be provided to NHS England on a regular basis, for management reporting purposes.
20. Authorised personnel at NHS England will be given access to the report, for the purposes of arranging for the provision of services specified in Schedule 4 to the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.
21. This extract will be provided to agreed named individuals at NHS England. This will not be published or given to any other individuals.
22. The reports will provide information on the following data items, as outlined in paragraph 10. This information will be provided in aggregate form split by organisation. The same data items will also be provided in aggregate form identified according to at which GP practice the individuals are registered for primary healthcare services.
23. NHS England will be able to analyse the report and, provided all standard measures are undertaken including aggregating information and taking measures to ensure that individuals cannot be identified from the reports, these can be shared with partner agencies for management purposes, with the expectation that this will include children's social services, LSCBs, MASHs, police borough commands, CCGs and other Government agencies with an identified need.

Board meeting – Public session

Title of paper:	IG Strategy
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 04 (e)
Paper presented by:	Rob Shaw, Director of Operations and Assurance Services Professor Martin Severs, Caldicott Guardian, HSCIC
Paper prepared by:	Christina Munns, Programme Manager, Information Governance & Standards Assurance
Paper approved by: (Sponsor Director)	Peter Hall, Director of Information Governance & Standards Assurance
Purpose of the paper:	To seek approval of the IG Strategy, for publication.
Key risks and issues:	This document aims to mitigate key Information Governance risks and issues.
Patient/public interest:	Direct – the public will benefit from the continuous improvement to Information Governance practice which will be realisable in the medium term.
Actions required by the board:	Review, comment and approval for post-design publication, subject to any changes agreed.

HSCIC Information Governance Strategy

Ensuring that all our staff are committed to the safe and efficient handling of information

Christina Munns

8 September 2015

v.0.8 Draft for review and approval

Contents

<i>PART 1: The Strategy</i>	5
Annex 1: Milestone Plan	11
Annex 2: Drivers of the Strategy	12
<i>PART 2: The Strategic Implementation Plan</i>	14

DRAFT

HSCIC Information Governance Strategy

Executive Summary

Information is the core business of the HSCIC and it is our duty to keep it safe whilst continuously improving our information services for our customers and for the benefit of health and social care.

This document sets out our strategy for continuously improving the way we look after information and highlights how this will benefit our customers who receive information and secure IT systems, our staff, and above all the public upon whose trust our organisation depends. We want to create an environment which ensures all staff make a personal commitment to keeping information safe as “everyone’s business.”

Throughout this document we use the term ‘information’ to mean both data and information, unless it is a quote or specified as data only.

Our vision is to earn the public’s trust by ensuring that all our staff are committed to the safe and efficient handling of information

We have committed to:

- clearly communicate what we do with information and how we keep it safe
- continuously improve our information services for the benefit of health and care
- foster an environment of continuous learning
- shape the highest standards of behaviour and integrity, fit for the digital revolution
- proactively seek oversight.

This strategy and first year implementation plan sets out what we will do to achieve our ambition. It outlines the **policy** that must be followed, the **practice** we need to adopt to implement the policy and the **tools** that will be available to help staff know what to do and to know when they are doing it well.

The strategy will lay the foundations for continuous improvement. It is supported by a first year implementation plan summarised in Annex 1 and detailed in Part 2.

PART 1: The Strategy

Our vision is to earn the public's trust by ensuring that all staff are committed to the safe and efficient handling of information

Introduction

The first principle of the HSCIC's 5 year Strategy is "Ensuring every citizen's data is protected". Implementing this strategy will help us to deliver against this principle in line with the *HSCIC's Code of Practice on Confidential Information*.

Each one of us has a vital role to play in the delivery of high quality health and adult social care services. Care services cannot be provided safely and effectively without timely information, often held within secure IT systems. Indeed NHS and social care services can depend as much on information as they do on medicines and other essential care interventions.

The work we do helps to underpin important services. We make sure that information is reliably handled – including its collection, analysis, publication and dissemination. We also assure the security of IT systems for care, protecting the confidentiality, availability and integrity of the information they hold. We are a key part of the health and care workforce.

We must manage information safely, securely and effectively, not only for care purposes but also for the effective running of the organisation – including the management of confidential information about staff and commercial contracts which support system delivery.

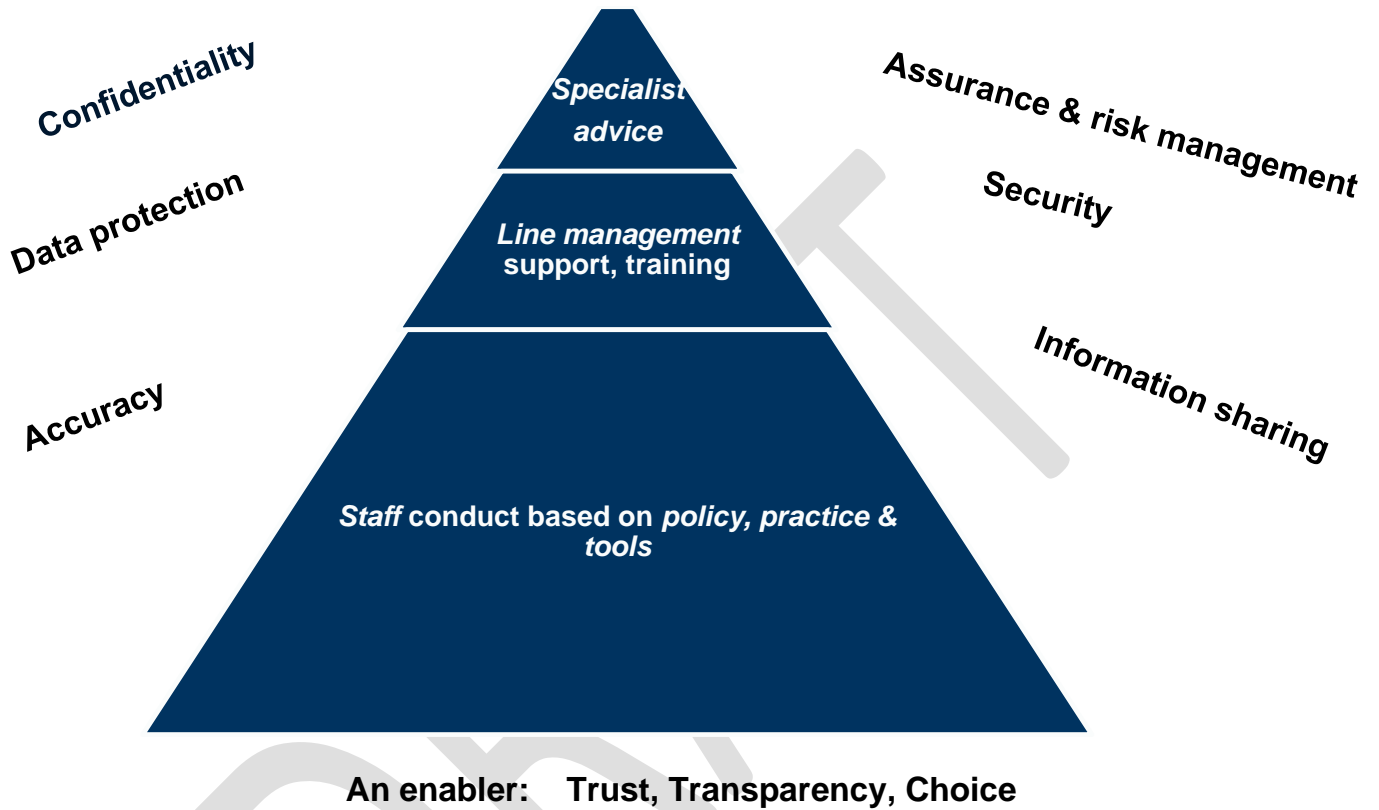
We need to ensure that our people, processes and technology operate to the highest standard so that the public and our customers can have confidence in us - particularly against the backdrop of the digital revolution. We must continuously improve capability so that we can further develop an excellent reputation as *the* health and care sector leader in handling information and assuring the security of IT systems that hold data to support care, such as the Spine.

The HSCIC is already a key contributor to the safeguarding of information within the wider health and social care sector. For example, it is host to the Information Governance Alliance, delivers the IG Toolkit and leads the National Cyber Security Programme. Although the first year plan does not focus on external activities, it aims to reinforce the internal building blocks which are required to deliver world class advisory and support services for the external health and social care community.

This is the first year of a rolling strategy in which we aim to develop an environment across our organisation that encourages staff to make a personal commitment to keeping information safe. People will know what their responsibilities are and how to access the more specialist advice which is available to support them. They will appreciate their own roles and how they can support colleagues. In doing this, everyone will be able to consider both the end-to-end flow of information across the organisation and beyond.

PLACEHOLDER IN ADVANCE OF GRAPHIC

IG is Everyone's Business...



Staff will know their **responsibilities**
and how to access support

To achieve these outcomes we have developed five principles:

STRATEGIC PRINCIPLES

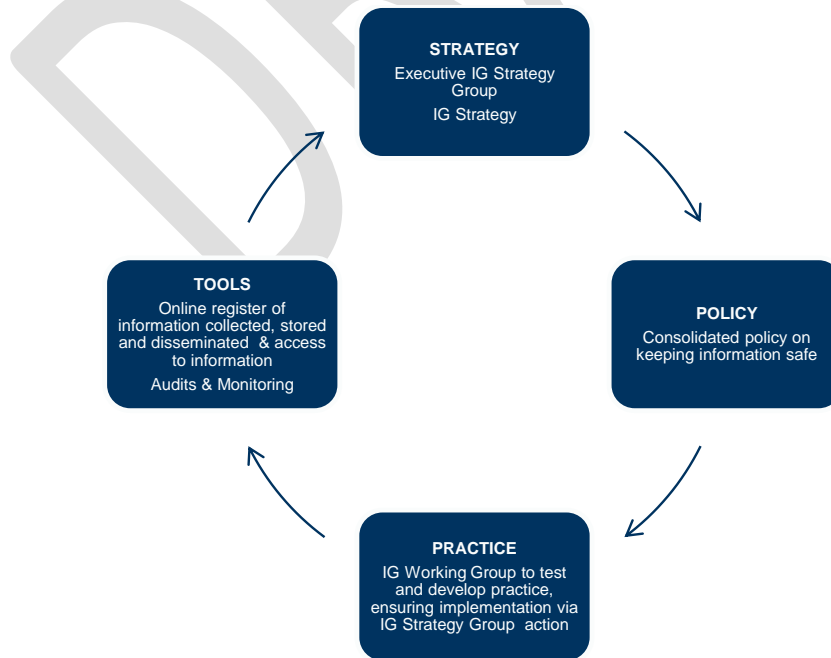
- Principle 1: Clearly communicate what we do with information and how we keep it safe, to earn the public's trust.

Principle 2: Continuously improve our information services for our customers and for the benefit of health and social care.

- Principle 3: Foster an environment of continuous learning, being open about opportunities to improve, while being clear that avoidable information breaches are unacceptable.
- Principle 4: Shape the highest standards of behaviour and integrity fit for the digital revolution among all our staff.
- Principle 5: Proactively seek oversight and welcome monitoring and constructive challenge as part of transparency.

In the pages that follow we will examine these principles in turn and outline the benefits they will bring for our staff, customers and the public. To achieve each we outline the **policy** we must adhere to, the **practices** that we need to adopt to support implementation, and the **tools** that will help staff know what to do and show they are doing it well. A key role of the **executive IG Strategy Group** is to monitor implementation and commission adjustments to policy and practice which supports our aim of continuous improvement.

PLACEHOLDER IN ADVANCE OF GRAPHIC: 'The continuous improvement cycle'



Principle 1: Clearly communicate what we do with information and how we keep information safe

For the public to have confidence in us they need to know how we safely manage their information.

Our strategic vision

The public will be able to easily access information about what we do with their information and how it is done in a secure and legal way, respecting their wishes.

Benefits

For the public: Easy access to information about how we handle confidential information, a greater understanding of access rights and the ability to make more informed decisions about who to share their information with.

For our customers: The rules for accessing data and for providing systems that hold health and care data will be set out clearly and transparently.

For our staff: Will know their responsibilities and what the specialist IG function offering is and when to use it.

Will be able to secure information and to securely access information, to spot suspicious activity, and feel confident in reporting it early.

HSCIC programme staff will be able to cost and plan for tailored IG advice early in a project and have one interface to serve their needs.

Underpinning HSCIC Value:



Principle 2: Continuously improve our information services

We have to achieve a careful balance, avoiding taking too long to release information for the benefit of health and social care while at the same time not releasing it prematurely or inappropriately.

The customer experience – whether as recipients of secure systems or information – will transform due to the efficiency of our processes, services and communications.

Our Strategic Vision

We will be recognised as *the* health and care sector leader in data dissemination, releasing it appropriately without unnecessary delay, in accordance with the law.

We will be *the* credible source of health and care IT system security assurance.

Benefits

For the public: Reassurance that their information is kept safe, released in accordance with the law and used appropriately, for the benefit of health and care.

For our customers: Data applicants will receive data in a secure and timely manner so that research is conducted as quickly as possible leading to service improvement.

Will have one place to discuss any concerns, feedback or complaints.

Will receive timely and clear advice or guidance on technical controls required for secure systems that hold patient or service user data.

For our staff: Will be given tools to ensure that their practices are in accordance with best practice and the Code of Practice on Confidential Information.

Will be equipped to address any customer queries in a timely manner.

Underpinning HSCIC Value:



Principle 3: Foster an environment of continuous learning

Learning must be facilitated by fostering an environment of open and honest reporting of near misses, feedback and issues which may lead to complaints.

Our Strategic Vision

A transparent approach will be taken to mistakes and customer feedback, so that the whole organisation learns from these events and improves practice in the future. The reporting of near misses will be incentivised and the organisation will ensure that staff are supported in the learning process to improve capability and competence.

Benefits

For the public: Reassurance that their information is kept secure and handled confidentially in a transparent way by competent and capable staff.

For our customers: Awareness that feedback is actively encouraged and knowledge that near misses will be acted upon constructively and openly.

For our staff: Able to learn from the experience of all staff and feel confident in reporting near misses, feedback and opportunities to improve.

Understand their personal responsibilities and what they need to do to minimise the risk of mistakes and complaints.

Underpinning HSCIC Value:



Principle 4: Shape the highest standards of behaviour and integrity, fit for the digital revolution

On matters of integrity and security it is essential that we operate to a uniformly high standard, both in digital and real world environments. We aim to equip all staff to fully embrace the digital revolution safely and securely.

Our Strategic Vision

The culture of the HSCIC will embody the values of “trustworthy, professional, people-focussed and innovative.” Confidentiality will be embedded so firmly in everyday working practice that it is second nature. Everyone will know what their required standards of behaviour and personal responsibilities are. Staff will have early awareness of risks, threats and vulnerabilities and best practice mitigations.

Benefits

For the public: Reassurance that the highest standards of behaviour and integrity are to be expected of HSCIC staff and that behaviour falling short of that is unacceptable.

For our customers: Reassurance that the staff they meet with are expected to behave to the highest standards of integrity and to be competent in safely handling confidential information.

For our staff: Know what behaviour is expected of them and be committed and equipped to act accordingly, in full knowledge of the consequences of not doing so. Staff will be trained to be safe online and exploit digital technology opportunities.

Underpinning HSCIC Value:



Principle 5: Proactively seek oversight

Oversight and scrutiny are an important part of building trust and confidence and of continuous learning. Oversight is a necessary component of transparency.

Our Strategic Vision

External scrutiny will be planned proactively and the results will be made transparent to staff. We will learn from the outcome of these oversight and scrutiny activities and check that appropriate improvements are made. Likewise, internal scrutiny will be part of the continuous learning activities of all staff and will include the proactive monitoring of internal systems for any unusual behaviours or activity.

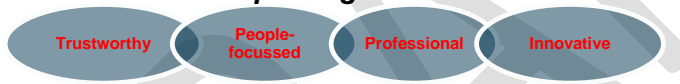
For the public: Reassurance that scrutiny of the way that the HSCIC handles information and develops secure systems is transparent and welcomed.

For our customers: A clear understanding of requirements for handling information.

Reassurance that the HSCIC's handling of information will be overseen and audited, both on a technical and behavioural level.











For our staff: Awareness that monitoring and oversight are part of transparency efforts and that the focus will be on ensuring good practice is embedded firmly in everyday practice.

Will have a mechanism through which to suggest agile audits on any practices which they feel would benefit from continuous improvement activities.

Underpinning HSCIC Values:

Annex 1: Milestone Plan (illustrative - TBC)

HSCIC's IG Strategy – High-level Milestone Plan : Year 1

Q3 2015-16 (Oct-Dec)	Q4 2015-16 (Jan -Mar)	Q1 2016-7 (Apr - Jun)	Q2 2016-7 (July - Sept)
<p> Online Access to Personal Confidential Data tool live, to replace manual process (Director of Data Dissemination, Oct 2015)</p> <p> IG Web Content re-launched, (Director of Customer Relations, Oct 2015)</p> <p> IG Working Group IGSSG sub-group established through which to assess holistic assurance for IG practice (IGWG Chair, Nov 2015)</p> <p> IAO tailored training delivered (SIRO, Nov 2015)</p> <p> Consolidated policy finalised for publication (Director of IGSA, Dec 2015)</p>	<p> IG KPIs established and published (IGWG Chair, Jan 2016)</p> <p> Early warning tool for threats and vulnerabilities established (as part of CareCERT) including protective monitoring of priority systems (Head of Infrastructure Security, March 2016).</p>	<p> Final Online Data In, Data Stored and Data Out Registers delivered, to replace manual processes (Director of Data Dissemination, March-April 2016)</p>	<p> Progress Report and Year 2 IG Strategy published (IGSA Programme Manager, Oct 2015)</p> <p></p>

 Product

 Milestone

Annex 2: Key Drivers of the Strategy

The following pieces underpin the whole strategy:

- NIB Workstream 4: Building and maintaining public trust
- HSCIC's Strategy, Principle 1: "Ensuring that every citizen's data is protected"

	Law	Caldicott	HSCIC values	Code of Practice on Confidential Information	ISO 27001 (at domain level)
Principle 1 Clearly communicate what we do with information and how we keep it safe	DPA 1. Fair & lawful DPA 2. Purposes DPA 3. Adequacy DPA 4. Accuracy DPA 5. Retention DPA 6. Rights (subject Access Rights, damage and distress, preventing direct marketing, automated decision making, correcting inaccurate personal data, compensation)	IGOP recommendations 1. Justify the purpose(s) 2. Don't use patient identifiable information unless it is necessary 3. Use the minimum necessary patient-identifiable information 4. Access to patient identifiable information should be on a strict need-to-know basis	Trustworthy	1. Establish purpose Req. 1.5 Inform individuals on proposed usage 2. Use standards 3. Recognise objections 6. Share information Req. 31 & 32 Legal basis for sharing Req. 32 & 33 Data release register Req. 22.c. Access the confidentiality, information security and data protection skills, knowledge and experience necessary to meet the organisation's assessed needs.	1. Security policy 2. Asset management 6. Communications & Operations environment 7. Access control 8. Information systems, acquisition, maintenance and development
Principle 2 Improve our information services for our customers	Health and Social Care Act s. 263 & 265	7. The duty to share information can be as important as the duty to protect patient confidentiality	People focussed	6. Share Information. Req. 40 – 44 Restricted sharing of information	10. Business Continuity Management
Principle 3 Foster an		5. Everyone with access to patient	Innovative	Req. 22 – 26 – f. Document, adopt and review an	2. Organisation of Information Security

<p>environment of continuous learning</p>		<p>identifiable information should be aware of their responsibilities 6. Understand and comply with the law</p>		<p>information risk policy and information risk management strategy covering the handling of confidential information. These should be owned by a Senior Information Risk Owner with appropriate support. Req. 22. e. Document, implement and review a formal information security risk assessment and management programme for key Information Assets.</p>	<p>9. information Security Incident Management</p>
<p>Principle 4 Shape the highest standards of behaviour and integrity fit for the digital revolution</p>			<p>Professional</p>	<p>Req. 22. b. Provide staff with awareness and training in the correct handling of confidential information.</p>	<p>4. HR security 5. Physical and environmental security</p>
<p>Principle 5 Proactively seek oversight</p>			<p>All values</p>	<p>Req. 19.a. Define and implement comprehensive policies for the management of confidential information with required strategies and/or improvement plans. Req. 22. d. Establish and implement appropriate audit procedures to monitor access to confidential information.</p>	<p>11. Compliance</p>

PART 2: The Strategic Implementation Plan (illustrative - TBC)

Principle 1: Clearly communicate what we do with information and how we keep it safe		
Policy (owner, date)	Practice (owner, date)	Tools (owner, date)
<p>Publish an overarching policy on keeping information safe (Director of Information Governance and Standards Assurance (IGSA), Dec 2015).</p>	<ul style="list-style-type: none"> Set practice which ensures that the end-to-end information flow is documented transparently and controlled appropriately (Director of IGSA & Director of I&A, March 2016). Refresh the HSCIC's IG web pages to ensure they are clear and accessible (Director of Customer Relations, Oct 2015). Harness the value of the IG Working Group and reconstitute appropriately (IG Working Group (IGWG) Chair, Oct 2015) to ensure the practice underpinning works operationally and is cascaded appropriately, developing Key Performance Indicators (KPIs) to complement existing IG Toolkit assurance (IGWG Chair, Jan 2016) Host the Independent Group Advising (on) Release of Data (IGARD) (Director of IGSA, Dec 2015). 	<ul style="list-style-type: none"> Publish consolidated online data registers moving from existing manual processes to an online version transparently showing what data comes in to the organisation, what data is held and what data is sent out (Director of Data Dissemination, March-April 2016). Develop an online tool to move manual approval and recording of staff access to personal confidential data (PCD) to an online model (Director of Data Dissemination, Oct 2015). Reinforce tailored training and education for Information Asset Owners to empower them further as key roles within the HSCIC (SIRO, Nov 2015). Reiterate roles and responsibilities for all staff, emphasising what the role of the generalist is through service agreements, linked to transformation activity (Director of IGSA, March 2016). Build a consolidated information management and security skills matrix to support professional development (Director of IGSA, Nov 2015). Maximise its value by creating a single interface for specialist IG advice to make the specialist offering simple, tailored and informed (Director of IGSA, Dec 2015).
Principle 2: Continuously improve our information services for our customers		
<p>Ensuring the overarching policy provides clarity on collections, dissemination, analysis and publications, in line with the Code of</p>	<ul style="list-style-type: none"> Practices from the Code of Practice on Confidential Information are embedded and cascaded throughout the organisation (Director of IGSA, March 2016). Relationship management function in place to manage concerns before they become 	<ul style="list-style-type: none"> Staff awareness on best practice on handling queries and complaints raised (Director of Customer Relations, Nov 2015). Key Performance Indicators established and published (e.g. time taken for disseminations) (IGWG Chair & Director of Customer Relations, Jan 2016).

<p>Practice on Confidential Information (Director of IGSA, Dec 2015).</p>	<p>complaints (Director of Customer Relations, Dec 2015).</p>	<ul style="list-style-type: none"> • Customer feedback forums to proactively address customer requirements (Director of Data Dissemination, Dec 2015). • Data sharing framework contract and agreement with data recipients to be upgraded (Director of I & A, Dec 2015).
<p>Principle 3: Foster an environment of continuous learning</p>		
<p>Ensure the overarching policy includes information risk management (Director of IGSA, Dec 2015) and mechanisms to ensure that the organisation supports staff with the appropriate knowledge and awareness in line with the Cyber Security People Strategy (Director of HR & Transformation, Dec 2015).</p>	<ul style="list-style-type: none"> • Develop good practice examples of the handling of incidents, near misses, feedback, complaints and lessons learned, alongside unacceptable practice (Head of Infrastructure Security, Director of Customer Relations, IGWG Chair, Jan 2016). • Ensure cross-organisational handling of strategic information loss risks (Programme Manager, IGSA, Nov 2015). 	<ul style="list-style-type: none"> • Develop an incident management framework to support a single reporting tool for incidents (Head of Infrastructure Security, Jan 2016). • Develop a corporate-wide lessons learned mechanism (Head of Infrastructure Security, March 2016). • Establish incentives for near miss and feedback reporting – both incidents and complaints (Head of Infrastructure & Director of Customer Relations, March 2016). • Enhance tailored staff training and education according to types and quantity of information handled, including line management training (Director of IGSA for content, Director of O&AS to secure the technical platform & Director of HR & Transformation to ensure compliance is monitored, March, 2016). • Monitor that staff moving to different roles within the organisation receive a tailored induction for the responsibilities of the new role (Director of HR & Transformation, December, 2015). • Establish agile audits to ensure fit for purpose policy/practice is developing iteratively in response to lessons learned (Director of IGSA, Mar 2016). • Further develop training on statistical disclosure techniques for relevant staff, in line with the UK Statistics Authority Code of Practice (2009) which all of the HSCIC’s practice on statistical disclosures

<p>Publish the overarching policy outlining safe digital behaviours (Director of IGSA, Dec 2015).</p>	<p>Principle 4: Shape the highest standards of behaviour and integrity fit for the digital revolution</p> <ul style="list-style-type: none"> Develop clear examples of required behaviour and unacceptable behaviour/practices (IGWG Chair with all IGSG members, Jan 2016). 	<p>adheres to (Head of Profession for Statistics, December 2015).</p> <ul style="list-style-type: none"> Co-ordinate cross-organisational oversight to monitor behaviours/practices and champion exemplary behaviours (IGWG Chair, Dec 2015). Run comprehensive security awareness training to equip digital age users to be safe online (Head of Infrastructure Security, Feb 2015). Ensure that ‘grand parents’ (line managers of line managers) receive training to fully understand their responsibilities for staff in relation to information governance, starting with EMT (Director of HR & Transformation, April 2015). Professional Group for IG reinforces the behaviour and integrity expected (Director of IGSA, Dec 2015). IG embedded within transformation plans to support and enable organisation-wide cultural change (Director of HR & Transformation & Director of IGSA, Oct 2015).
<p>Communicate to staff through the overarching policy that continuous monitoring and oversight are a necessary part of transparency (Director of IGSA, Dec 2015).</p>	<p>Principle 5: Proactively Seek Oversight</p> <ul style="list-style-type: none"> Publish an audit schedule, for recipients of data (Head of IG, Dec 2015). Publish good practice to support ISO 27001 certification for relevant departments (Director of IGSA, Oct 2016). Develop audit capability and an agile auditor resource pool linked to the work of the IGWG (Director of IGSA, Dec 2015). Report to the National Data Guardian on implementation of IGOP recommendations (SIRO, quarterly). 	<ul style="list-style-type: none"> Develop an early warning tool for threats and vulnerabilities (as part of CareCERT) including protective monitoring of priority systems (Head of Infrastructure Security, March 2016). Audit material and criteria published (Head of IG, Dec 2015). Independent audit of the HSCIC’s IG Toolkit (SIRO, March 2016). Enhancement of the IG Toolkit requirements for the HSCIC to ensure that key performance indicators specific to the business of the HSCIC are included (Director of IGSA, March 2016).

Board meeting – Public session

Title of paper:	Independent Group Advising on the Release of Data (IGARD) Consultation
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 04 (f)
Paper presented by:	Martin Severs, Interim Director of Information and Analytics and Lead Clinician (Caldicott Guardian)
Paper prepared by:	Martin Severs, Interim Director of Information and Analytics and Lead Clinician (Caldicott Guardian)
Paper approved by: (Sponsor Director)	Martin Severs, Interim Director of Information and Analytics and Lead Clinician (Caldicott Guardian)
Purpose of the paper:	To feedback the results of the Independent Group to Advise on Data Dissemination
Justification for inclusion in private board:	Work in progress, which is going to be made public. This published work needs strategic decisions from the Board and includes advice on how to deal with the feedback on organisations and their interactions that the HSCIC Board is not accountable for
Please specify the key risks and issues:	The key risks and issues concern: <ol style="list-style-type: none"> 1. The balance of IGARD membership 2. The role of IGARD as advisory or decision making 3. The extent of IGARD scope 4. The Consultation feedback report content
Patient/public interest:	Direct
Actions required by the board:	<ul style="list-style-type: none"> • Advise on lay and stakeholder representation • Confirm open recruitment path / approach • Confirm IGARD status as advisory to the Board • Consider whether IGARD could provide IG assurance to SCCI and whether this service should be offered to NIB for incorporation into SCCI • Confirm arrangements for developing a formal response to the consultation. The authors would

advise the “You said; we did” approach which follows the thematic analysis in Appendix A

- Bring final proposals back to November meeting OR implement as advised at this Board meeting and bring an update to the November meeting
-

IGARD Consultation

Review and analysis of responses

Martin Severs

23rd September 2015

Contents

Contents	2
Background	3
Issues	3
Strategy Implications	3
Stakeholder Implications	3
Financial Implications	3
Risks	3
Actions Required of the Board	4
Appendix A	5

Background

This paper provides an overview of the analysis of the 43 responses received to the Independent Group Advising on the Release of Data (IGARD) consultation, which ran from 16 June – 31 August 2015.

The HSCIC Board is asked to advise on the redrafting of the IGARD Terms of Reference in response to the thematic analysis of the IGARD consultation responses (see Appendix A). The HSCIC Board are being consulted on the outcomes of the consultation before commencing the transition to IGARD (scheduled October this year). The proposals to replace the Data Access Advisory Group (DAAG) by IGARD have been to EMT previously.

Issues

Strategy Implications

This proposal aligns with HSCIC plans to replace DAAG and GPES Independent Advisory Group's (IAG) data dissemination functions with IGARD. The proposals for IGARD were designed to improve transparency, accountability and consistency of decision-making and to significantly enhance the public reputation of HSCIC. The key strategy implications for the HSCIC Board are;

- Consider issues in terms of themes identified
- Confirm IGARD status as advisory to the Board
- Consider whether IGARD could provide IG assurance to the Standardisation Committee for Care Information (SCCI) and if so should this offer be made to NIB?

Stakeholder Implications

The proposals have been developed following a period of consultation with key stakeholders and the public (Appendix A). The key issues relating to stakeholders are;

- Advise on lay & stakeholder representation
- Confirm open recruitment path / approach
- Confirm arrangements for developing formal response to the consultation

Financial Implications

At this stage the proposals do not require any additional financial considerations other than those already approved by EMT for the running of DAAG / IGARD, but broadening the membership may well have financial implications.

Risks

The IGARD consultation – review and analysis of responses, details the key risks associated with the proposed transition to IGARD. The most significant risk is reputational to the HSCIC if we are *not* seen to respond appropriately to the consultation. One other significant risk relates to concerns about the SCCI process, which represents a threat to IGARD in terms of its ability to function and gain the confidence of the public and key stakeholders. The HSCIC

Board is asked to consider whether IGARD could provide IG assurance to SCCI and it is recommend to explore this further.

Actions Required of the Board

The HSCIC Board are asked to:

- Advise on lay and stakeholder representation
- Confirm open recruitment path / approach
- Confirm IGARD status as advisory to the Board
- Consider whether IGARD could provide IG assurance to SCCI and whether this service should be offered to NIB for incorporation into SCCI
- Confirm arrangements for developing a formal response to the consultation. Suggest the “You said; we did” approach which follows the thematic analysis in Appendix A
- Delay implementation [from October] and bring final proposals back to November meeting OR implement as advised at this Board meeting and bring an update to the November meeting

Appendix A

IGARD Consultation – Review and analysis of responses

Introduction

The consultation on the draft terms of reference for the proposed new *Independent Group Advising on the Release of Data* (IGARD) ran from 16th June to 31st August 2015. Forty-three organisations and individuals responded, and these are listed in appendix 1. Responses were received via the online web form, by electronic document and by letter. Responses were collated by Deborah Raven and analysed by Nicholas Oughtibridge and Alan Hassey using a qualitative, thematic approach to explore and categorise the responses.

Most of the respondents had clearly gone to considerable effort to provide detailed and thoughtful feedback. Many were broadly supportive of the direction of travel proposed in the consultation, but most respondents felt that the proposals could go further in terms of facilitating access to data, wider stakeholder membership, transparency and clarity of purpose. In general terms, responding organisations were principally concerned about getting access to data, while individual responses were mostly concerned with privacy issues¹. Overall, the responses represent both a significant opportunity and challenge to HSCIC.

This paper presents the IGARD consultation responses as a set of linked themes (synthesis) and offers commentary (analysis) on how HSCIC might respond.

Theme 1: Role of IGARD within HSCIC’s information functions (purpose)

Responses: Many respondents reiterated their recent concerns about the difficulties they are experiencing getting access to data and felt that HSCIC took a “risk averse”² approach to data disseminations. This was also reflected in comments suggesting that promoting access to data should be explicitly included in the IGARD Terms of Reference³ (ToR) and aligned to

¹ Anonymous patient/service user/citizen

² Health Statistics User Group, Academy of Medical Sciences (joint response), Health Statistics User Group, Farr Institute of Health Informatics Research, Macmillan Cancer Support, Nuffield Trust, Methods Analytics & R Willmer. Tech UK

³ Nuffield Department of Population Health Univ. Oxford, Centre for Longitudinal Studies UCL

the HSCIC Code of Practice on Confidential information (CoP). Several respondents highlighted the link between better access to data and the 7th Caldicott Principle⁴. Improved clarity and making explicit those areas where IGARD will provide advice is required⁵ in terms of IGARD's primary and secondary purposes.

Comment: The analysis suggests that respondents are unclear about the DAAG / IGARD role as an *advisory group* to the HSCIC board rather than a decision-making body. The ToR could be modified to more closely reflect the functions of HSCIC, but the main role of IGARD will be to provide advice around the governance of data releases. To some extent IGARD is acting as a "lightning conductor" for dissatisfaction with the HSCIC data dissemination process. The response should be reflected in IGARD's membership, ways of working and ToR, but must also be coherent across the organization in terms of Service Levels (SLAs), communications and transparency.

Theme 2: IGARD membership / chair

Responses: There was a clear consensus amongst respondents that the IGARD membership needed to be more informed and better reflect the user community interests⁶. Suggestions included membership from academia, local authorities, CCGs, and NHS providers and having a pool of domain-specific members available to advise on the breadth of applications⁷. There was strong support for an open process of appointment for members and the chair⁸ and some support for the chair to be appointed by the National Data Guardian (NDG)⁹. Others suggested IGARD should be accountable to the NDG rather than HSCIC¹⁰ and the need to be clear about the relationship between IGARD and HSCIC. There was strong support for lay membership¹¹ of IGARD from many respondents. Meetings and membership should be sufficiently frequent and robust to meet the business needs of applicants¹².

Comment: The role of HSCIC members on IGARD was queried and in the light of the responses, we suggest the IGARD ToR should be amended to clarify that HSCIC representatives would not be voting members of IGARD but act as and be renamed as *advisers* to the Group (e.g. Head of IG, Caldicott Guardian, statistician & SCCI

⁴ Nuffield Trust, Univ. Leeds

⁵ Health Research Authority (HRA)

⁶ Farr Institute, Nuffield Dep't Pop Health Oxford, Academy of Medical Sciences, NHS England, Health Statistics User Group, BMJ, Nuffield Trust, Tech UK, Centre for Health Economics, Univ. York, Macmillan Cancer Support, IMS Health, CPRD

⁷ Centre for Longitudinal Studies UCL

⁸ Macmillan Cancer Support

⁹ Methods Analytics, Macmillan Cancer Support

¹⁰ Tech UK

¹¹ Academy of Medical Sciences, Independent IG Oversight Panel, A Chuter, HRA, Macmillan Cancer Support, IMS Health, K Randle

¹² Nuffield Dep't Pop Health Oxford, Academy of Medical Sciences, Macmillan Cancer Support

representative) potentially supported by external advisers¹³ (e.g. DH Policy & HRA Secretariat). The IGARD ToRs should be updated to include a lay perspective, which could be by representation, and it may be helpful to get further advice from respondents on how this might best be achieved.

Theme 3: IGARD transparency

Responses: There was strong support for further moves to enhance IGARD's transparency¹⁴. This included having partially or fully open meetings, openness of process and publication of documentation around decision criteria, an appeal process¹⁵, the data dissemination process and publication of all papers for consideration at IGARD. Minutes should continue to be published and agendas made available in advance¹⁶ so that observers and applicants might attend. IGARD should be able to demonstrate clarity and consistency of decision-making¹⁷ and there is a need for clarity about exactly what decisions IGARD might take in relation to applications¹⁸. There were **no** calls to withhold information that might be provided on a commercial in confidence basis (including responses from the commercial sector¹⁹). There was support for applicants attending IGARD meetings to support their applications²⁰.

Comment: Nearly all respondents called for increased transparency of IGARD's processes, in terms of its ways of working and decision-making. Respondents indicated this would be essential in creating public trust and confidence in the system²¹. Documents that support IGARD's processes (e.g. application check-lists, appeals process) should be in the public domain and it seems sensible to revise the types of decisions IGARD might make to improve clarity and align as far as possible with bodies such as HRA CAG (e.g. approve with "conditions" rather than "caveats"). As far as possible IGARD meetings should be held in public (and attendees should declare Cols etc.)²² or otherwise be open to the public (e.g. Webex broadcast) – which would remove the need for observers to be able to attend in person.

Theme 4: IGARD independence & governance

Responses: This area is closely linked to themes 2 & 3 above and again received many comments around clarity of purpose and ways of working. Several respondents questioned

¹³ HRA

¹⁴ Academy of Medical Sciences, Nuffield Trust

¹⁵ Farr Institute, Independent IG Oversight Panel, BMJ, HRA

¹⁶ medConfidential, Tech UK

¹⁷ Nuffield Trust, IMS Health, ABPI

¹⁸ Monitor

¹⁹ Methods Analytics

²⁰ Health Statistics User Group, Univ. Leeds, Macmillan Cancer Support, IMS Health

²¹ Macmillan Cancer Support

²² Macmillan Cancer Support

how independent IGARD would be and sought further clarity around its relationship to HSCIC²³. IGARD should report on its activities, service levels and be open to receive feedback from the user community²⁴. The Standard Operating Procedures (SOPs) should be clarified to include a register of interests, a requirement for members, advisers and observers to declare Conflicts of Interest (ColS). Members should also be clearly accountable for their actions and the rules for challenge²⁵, dismissal, attendance at meetings and reappointment should be published. A majority of the independent members should be present for any meeting to be quorate²⁶, with an agreed level of support from HSCIC advisers and the IGARD secretariat. Concerns were expressed about lack of clarity around the role and responsibilities for any IGARD sub-groups or “lite” process. This should include any actions taken under delegated authority²⁷. Any such arrangements should be explicit and reported both back to IGARD and reflected in the Group’s minutes.

Comment: It will be important for HSCIC to establish to what degree IGARD can be independent of HSCIC and where and how it should be accountable. HSCIC / IGARD should establish ways of seeking advice and feedback from external forums²⁸ that might include, for example; the academic community, the Health Statistics User Group and Tech UK. The role of the IG / IGARD secretariat would be absolutely crucial in managing the relationship between HSCIC & IGARD and assuring the suitability of applications for consideration by IGARD. The secretariat would also manage the IGARD processes as set out in the ToR and SoPs and help coordinate the end-to-end process (see theme 5).

Theme 5: Single view of end-to-end process

Responses: Many respondents highlighted their concerns that the process for data applications was not well understood, transparent or joined-up²⁹. The DARS/IGARD process should provide more support for applicants³⁰. Several responses highlighted the need for there to be a clear and agreed description of the roles and relationships between the various organisations that have responsibilities to release data (e.g. SCCI, CAG, ONS, Arms Length Bodies and regulators³¹). There should be as little duplication as possible with a joined-up process covering all aspects of health and care³². This links closely to theme 1, with a need for clarity around the purpose of IGARD so that it is responsible for advising on all confidential data disseminations where HSCIC is in control of the data (e.g. DSCROs & the IG Toolkit). Concerns were expressed about the SCCI process and there is evidence of low

²³ Nuffield Dep’t Pop Health Oxford, Academy of Medical Sciences, NHS England, medConfidential, Tech UK

²⁴ NHS England, BMJ, Nuffield Trust, Tech UK, Monitor, ABPI, Centre for Longitudinal Studies UCL

²⁵ Anonymous, patient/service user/citizen

²⁶ NICE, Nuffield Trust

²⁷ NHS England, BCS PHCSG, Monitor

²⁸ Farr Institute, Cerner, Methods Analytics, Tech UK, Centre for Longitudinal Studies UCL

²⁹ Nuffield Dep’t Pop Health Oxford, Academy of Medical Sciences,

³⁰ Farr Institute

³¹ Monitor, Centre for Longitudinal Studies UCL

³² HRA, Centre for Longitudinal Studies UCL

confidence in that process³³, particularly in terms of end-to-end (E2E) capabilities. Comments were also raised about whether governance of data from collection to dissemination was complete³⁴ and whether the confusion left gaps in some areas with duplication in others. Most respondents felt that it should be much easier to follow an application through the various internal (e.g. BAAS, DARS, CRM, Contact Centre) and external (e.g. SCCI, CAG, RECs) pathways needed to gain approval³⁵ and gather supporting information along the way without unnecessary duplication or other process overhead. There were also calls for all data custodians to work together in a streamlined and harmonized way³⁶.

Comment: Concerns expressed in terms of the E2E process led us to ask whether HSCIC should consider asking IGARD to oversee the linkage and analysis of data internally and potentially also oversee HSCIC collections³⁷. However, removing that responsibility from SCCI and bringing it into HSCIC would not be a simple matter as SCCI has responsibilities across health and care and not just for HSCIC. Any such decision would have to be taken by the National Information Board (NIB). The key recommendation here is that there must be a clear E2E process that should facilitate assurance of disseminations and collections as a continuum rather than separate processes³⁸. At the very least there should be better coordination of documentation, reporting and cross-group representation. This E2E process should include requests for data and directions. Any exclusions to IGARD’s oversight should be clearly and explicitly stated (e.g. release to other agencies and government departments).

Theme 6: IG “thorny issues”

The consultation has highlighted several areas that represent current and future IG challenges for HSCIC. These will need to be considered in terms of the purpose and scope of IGARD and any advice it may receive. They should be carefully considered as part of the response to the consultation on the IGARD ToRs and will inform subsequent redrafting. The IG Strategy Group might take ownership of these issues. They include:

- Issues of consent for old studies³⁹ and the problems this presents to researchers. It ties in closely with responses under theme 1.
- Challenges presented by CCGs in terms of risk stratification⁴⁰ and local data flows (including to and from DSCROs)
- Local authorities in terms of their public health functions and their duties & powers (e.g. use of NHS number)
- Intellectual property in terms of HSCIC’s rights to share data and the rights of recipients to receive data (forms, scales & assessments)⁴¹

³³ medConfidential, BCS PHCSG

³⁴ Anonymous, patient/service user/citizen

³⁵ medConfidential

³⁶ Macmillan Cancer Support

³⁷ BCS PHCSG

³⁸ medConfidential

³⁹ Univ. Leeds, HRA

⁴⁰ Cerner

⁴¹ M Chappell

- Standards for dissemination and the HSCIC Code of Practice (de-identification and anonymisation of data)
- Clarity around “sensitive” data definitions⁴²
- Requirements for data controllers to publish fair-processing notices⁴³
- The pending CAG regulations
- The pending requirements for respecting patient preferences⁴⁴
- Legislative advice and challenge around the Health & Social Care Act 2012, The Care Act 2014⁴⁵ and the Health and Social Care Act (Quality and Safety) 2015.
- Availability of data or sample data to support product development and benchmarking⁴⁶.

Conclusion

The responses to the IGARD consultation clearly demonstrated the scope of the challenge facing HSCIC in terms of striking the balance between appropriate corporate and information governance⁴⁷ and making data available for legitimate purposes to the wider health and care community. The responses strongly encourage HSCIC to go beyond the consultation version of the IGARD ToR in terms of clarity of scope and purpose, expertise, accountability, transparency and independence.

However, there is a deeper issue here in which the respondents want IGARD to almost be representative of the interest groups rather than viewing it from the citizen moral, ethical and “how do I feel perspective”. So while IGARD may move to a larger and more expert panel, it may well risk becoming more partisan, simply reflecting the views of stakeholders rather than providing independent advice and guidance to HSCIC.

It will be a challenge to develop these ideas further in an updated IGARD ToR to specifically address the themes identified and present a coherent and accountable process that is fit for purpose and has the confidence of the public and stakeholders.

Alan Hassey (8/9/15)

Acknowledgements: Deborah Raven, Nicholas Oughtibridge

⁴² Farr Institute, Nuffield Dep’t Pop Health Oxford, NHS England, Health Statistics User Group, HRA

⁴³ medConfidential

⁴⁴ HRA

⁴⁵ E Britton, IMS Health

⁴⁶ Tech UK

⁴⁷ medConfidential

Appendix 1 - Respondents

A Chuter
ABPI
Academy of Medical Sciences (Joint Response)
Anonymous
Anonymous
Anonymous
Anonymous
Anonymous
Anonymous
BCS PHCSG
Birmingham Children's Hospital NHS FT
BMJ
Centre for Health Economics, Univ. York
Centre for Longitudinal Studies UCL
Cerner
Clinician
Colchester Hospital University FT
Clinical Practice Research Datalink (CPRD)
Data Analysis
E Britton
Farr Institute of Health Informatics Research
General management
HRA
IMS Health
Independent IG Oversight Panel
K Randle
M Chappell
Macmillan Cancer Support
medConfidential
Methods Analytics

Methods Analytics

Monitor

NHS England (draft response)

NICE

North Devon NHS Trust

Nuffield Department of Population Health Univ. Oxford

Nuffield Trust

ONS

R Willmer

Tech UK

Univ Leeds

University researcher

Yeovil DH NHS FT

Board meeting – Public session

Title of paper:	Board Terms of Reference Annual Review
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 05 (a) ii, v, vi
Paper presented by:	Chair
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:	<p>The Terms of Reference (ToR) for the Board and its sub-committees have been reviewed as part of the annual review and a number of changes proposed.</p> <p>Board approval is sought for the revised (ToR) for the following committees:</p> <ul style="list-style-type: none">• HSCIC Board• Assurance and Risk Committee (ARC)• Remuneration Committee
Key risks and issues:	It is important that these documents are kept up to date and relevant; otherwise there is a risk that business will not be transacted and/or conducted correctly.
Patient/public interest:	The documents record the Standing Orders and Standing Financial Instructions for the HSCIC and set out the terms of reference under which the statutory meetings of the HSCIC operate.
Actions required by the board:	<p>Board approval is sought for the revised ToR of the following committees:</p> <ul style="list-style-type: none">• HSCIC Board• Assurance and Risk Committee (ARC)• Remuneration Committee



Corporate Governance Meeting Terms of Reference Annual Review

A summary of proposed amendments to ToR

Author: Annabelle McGuire, Secretary to the Board

Date: September 2015

Contents

1	Background	3
1.1	Proposed amendments to HSCIC Board ToR	3
1.2	Proposed amendments to ARC ToR	3
2	Actions Required of the Board	3

1 Background

1. As part of the annual review the Terms of Reference (ToR) for the HSCIC Board, the Assurance and Risk Committee (ARC) and the Remuneration Committee have been reviewed and a small number of changes proposed.
2. The Terms of Reference for the Board and for the ARC have been reviewed and approved by the ARC at its meeting on 16 September 2015.
3. The Terms of Reference for the Remuneration Committee have been reviewed and approved by the Remuneration Committee at its meeting on 07 August 2015.

1.1 Proposed amendments to HSCIC Board ToR

4. The proposed changes to the HSCIC Board ToR have been detailed below:
 - Board member attendance requirements have been updated to reflect that Board members must attend all Board meetings. Board members that are absent for two consecutive Board meetings (or more than three in a twelve month period) may be removed from office.
 - It is no longer necessary for observers to register their attendance with the Secretary to the Board as registration is undertaken via the HSCIC web site.
 - The frequency of private/ commercial in confidence sessions were removed as this information was duplicated within the Terms of Reference.
 - The job title of the Executive Director of Human Resources was amended to read Executive Director of Human Resources and Transformation.

1.2 Proposed amendments to ARC ToR

5. The proposed changes to the ARC ToR have been detailed below:
 - Membership changes: The Non-Executive Director Chair of the IACSC will be a member of the ARC.
6. There are no proposed changes to the following committee:
 - Remuneration Committee

2 Actions Required of the Board

7. Board approval is sought for the revised (ToR) for the following sub-committees of the Board:
 - HSCIC Board
 - Assurance and Risk Committee (ARC)
 - Remuneration Committee



Health & Social Care
Information Centre

Health and Social Care Information Centre (HSCIC)

Assurance and Risk Committee Terms of Reference

Date: 2015-16

Contents

1	Introduction	3
2	Constitution	3
3	Membership	3
4	Quorum	3
5	Attendance	3
6	Access	3
7	Frequency	4
8	Authority	4
9	Duties	4
9.1	Internal Control and Risk Management	4
9.2	Internal Audit	5
9.3	External Audit	5
9.4	Other Assurance Functions	5
9.5	Management	6
9.6	Financial Reporting	6
10	Reporting	6

1 Introduction

These terms of reference have been produced based on the specimen good practice versions provided in both the Department of Health and HM Treasury Audit Committee Handbooks. They have been slightly amended to reflect the views and wishes of the Committee members.

2 Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Assurance and Risk Committee.

3 Membership

The Assurance and Risk Committee will be appointed by the Board from amongst the independent non-executive Directors of the HSCIC and will comprise four members.

The Chair of the HSCIC Board will not be a member of the Assurance and Risk Committee. The Board will appoint the Chair of the Committee from amongst the independent non-executive Directors and this appointment will be reviewed on an annual basis.

The Non-Executive Director Chair of the Information Assurance and Cyber Security Committee will be a member of the Assurance and Risk Committee.

4 Quorum

A quorum will be three members – one of whom must be the Committee Chair.

5 Attendance

The Chief Executive, Director of Finance and Corporate Services, Director of Operations and Assurance Services (to provide cover for information governance and information risks, and who is the HSCIC Senior Information Risk Owner) and representatives from internal and external Audit, will normally attend the committee meetings.

However, at least once a year the Assurance and Risk Committee will meet with external and internal auditors without any Executive Board Director present.

A representative from the Department of Health sponsor team may also be invited to attend.

The secretary of the Assurance and Risk Committee will be the HSCIC Secretary to the Board.

6 Access

Representatives of internal and external audit and the Local Counter Fraud Specialist will have free and confidential access to the Chair of the Committee.

7 Frequency

Meetings shall be held not less than four times a year, but may meet more regularly if circumstances require. The external or internal auditors may request a meeting if they consider that one is necessary.

8 Authority

The Assurance and Risk Committee is authorised by the Board:

- To investigate any activity within the terms of reference. It is authorised to seek any information that it requires from any employee and all employees are directed to cooperate with any request made by the Assurance and Risk Committee
- To obtain outside legal or independent professional advice, at the HSCIC's expense, and to secure the attendance of external specialists with relevant experience and expertise if it considers this necessary.

9 Duties

The duties of the Assurance and Risk Committee are:

9.1 Internal Control and Risk Management

The Assurance and Risk Committee shall review and monitor the effectiveness of the system of integrated governance, risk management and internal control including information governance, security and data quality risks.

In particular, the Assurance and Risk Committee will review the adequacy of and make recommendations to the Board as appropriate on:

- All risk and control related disclosure statements, (in particular the Annual Governance Statement) together with any accompanying Internal Audit statements, prior to the endorsement of the Board
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The structures, processes and responsibilities for identifying and managing key risks facing the organisation
- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in the Controls Assurance Standards and other relevant guidance
- The operational effectiveness of policies and procedures

Assurance and Risk Committee Terms of Reference

- The policies and procedures for all work related to fraud, corruption and whistleblowing – including appointment of a Local Counter Fraud Specialist and to enable the Local Counter Fraud Specialist to attend Assurance and Risk Committee meetings when required.
- In carrying out this work the Assurance and Risk Committee will primarily utilise the work of Internal Audit, external audit and other assurance functions. It will also seek reports and assurances from directors and managers as appropriate. It will record key risk management messages and decisions requiring attention in meeting minutes, for publication and dissemination across HSCIC.

9.2 Internal Audit

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

- Reviewing and making recommendations to the Board on the appointment of the internal Audit service, the audit fee and any questions of resignation and dismissal
- Reviewing the internal audit programme, considering the major findings of internal audit investigations (and management's response), and ensuring co-ordination between the internal and external auditors
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- Annual review of the effectiveness of the Internal Audit function.

9.3 External Audit

The Assurance and Risk Committee will review the work and findings of the external Auditor and take account of the implications and management responses to their work. This will include:

- Acknowledging the appointment of the external Auditor by the Comptroller and Auditor General
- Discussing with the external Auditor, before the audit commences, the nature and scope of the audit, ensuring co-ordination, as appropriate with other external bodies (e.g. shared services) and agreeing the audit fee
- Reviewing and making any recommendations to the Board as necessary on external Audit reports, including value for money reports and annual management letters, together with the management response.

9.4 Other Assurance Functions

The Assurance and Risk Committee will review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

In addition, the Assurance and Risk Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Assurance and Risk Committee's own scope of work.

9.5 Management

The Assurance and Risk Committee will request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

The Assurance and Risk Committee may call directors and managers to appear before it to account for:

- Audit reports receiving a high priority rating (red or red amber) to explain the action being taken to address the concerns raised and the timescale for doing so.
- Non-delivery of agreed management actions to address audit concerns within the timescales set.
- Any other matters the Assurance and Risk Committee consider relevant in connection with risks and issues on the HSCIC Strategic Risk Register.

9.6 Financial Reporting

The Assurance and Risk Committee will review the Annual Financial Statements and make recommendations to the Board focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Major judgemental areas
- Significant adjustments resulting from audit.

10 Reporting

The minutes of the Assurance and Risk Committee meetings will be formally recorded and submitted to the Board.

A briefing will be provided as a standing item on the Committee's agenda from the Director of Operations and Assurance Services on all risk and assurance issue discussions held by or arising from the Information Assurance and Cyber Security Committee.

The Assurance and Risk Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the

Assurance and Risk Committee Terms of Reference

Assurance Framework, the completeness and adequacy of risk management in the organisation and the integration of governance arrangements.

The Assurance and Risk Committee will annually review its terms of reference and its own effectiveness and recommend any necessary changes to the Board.

Health and Social Care Information Centre

Remuneration Committee Terms of Reference

Date: 2015-16

Contents

1	Constitution	3
2	Membership	3
3	Quorum	3
4	Attendance	3
5	Authority and Responsibilities	3
6	Review	4

Remuneration Committee Terms of Reference

1 Constitution

The HSCIC Board hereby resolves to establish a committee of the Board to be known as the Remuneration Committee. The Remuneration Committee will meet as required by the Chair of the Board but this would normally be at least three times a year.

2 Membership

The Remuneration Committee will be appointed by the Board from amongst the independent non-executive Directors of the HSCIC and will consist of the Board Chair, who will act as Chair of the Committee and three non-executive directors.

3 Quorum

A quorum shall be the Chair and two non-executive directors.

4 Attendance

The Chief Executive and Director of Human Resources will attend the meetings in an advisory capacity but will withdraw when a matter concerning their remuneration package or other matter of individual confidentiality is being discussed or documented.

The Secretary to the Board will attend to minute the meetings but will be required to withdraw when requested by the Chair.

5 Authority and Responsibilities

The Board has delegated full responsibility to the Remuneration Committee to:

- Make recommendations to the Department of Health (DH) on the level of the remuneration packages of the CEO and other executive directors within the provisions of the Pay Framework for Very Senior Managers (VSMs) or successor arrangements
- Determine pay arrangements for medical and other staff groups who are not subject to AfC, VSM or TUPE protected terms and conditions of employment
- Maintain an overview of senior non-medical staff pay (currently defined as over £100,000 per annum, including any award of Performance Related Pay) to ensure that pay remains consistent with public pay policy
- Approve the level of any annual performance related pay awards to HSCIC staff on ex-Civil Service terms and conditions
- Approve the annual performance objectives and targets of executive Directors
- Monitor and evaluate the performance of VSMs and make recommendations to DH) on any proposed annual performance pay awards within the total of VSM pay bill which may be used for performance related pay (as set annually by DH, taking account of the recommendations of the Senior Salaries Review Body)
- Ensure that pay arrangements are appropriate in terms of Equal Pay requirements.
- Consider and approve redundancy payments and other (often TUPE related) exceptional matters

Remuneration Committee Terms of Reference

- Ensure that all matters relating to pay and conditions that require approval from the Department of Health Remuneration Committee or other external authority are submitted for approval and that the decisions of those bodies are appropriately implemented.

6 Review

The membership and terms of reference of the Remuneration Committee will be reviewed annually.



Health & Social Care
Information Centre

Health and Social Care Information Centre (HSCIC)

Board Terms of Reference and Code of Practice

Date: 2015-16

Contents

1	Constitution	3
2	Membership	3
3	Quorum	3
4	Attendance	3
5	Access	4
6	Frequency	4
7	Appendix A	5

7.1	Current Members of the Board	5
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1 Constitution

The Health and Social Care Information Centre (HSCIC) 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 the HSCIC must comprise:

- At least six non-executive members including the Chair
- Not more than five other executive members who are employees of the HSCIC and are appointed by the non-executive members. One of the executive members must be appointed as the Chief Executive Officer (CEO) but the appointment may not be made without the approval of the Secretary of State. The first CEO was appointed by the Secretary of State.

Further details including the conduct of meetings and the roles and responsibilities of the Chair, Board, CEO and the Senior Independent Director are set out in the Corporate Governance Manual.

The HSCIC Secretary to the Board will minute the Board meetings.

3 Quorum

Meetings are quorate when at least one-third of the membership is present (including at least two non-executives, one of whom must be the Chair or Vice-Chair).

4 Attendance

Board meetings will be attended by other members of the Executive Management Team (see appendix A) in addition to Board members. They will not have voting rights.

Whilst in office a Board Member is expected to attend the majority of statutory Board meetings. A Board Member may be removed from office if he/she is absent from more than two consecutive statutory meetings (or more than three meetings in any twelve month period) unless at the Chair's discretion the absence is due to illness or another reason agreed by the Chair. In such circumstances the Chair can allow a Board Member to remain in post.

Observers, such as members of the public, the Department of Health Sponsor team, representatives of other stakeholder organisations and representatives of the press can also attend the meetings.

5 Access

Observers may attend all formal meetings of the HSCIC Board but will be required to withdraw upon the Board or Committee resolving:

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

Observers wishing to attend must register their interest via the HSCIC 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 HSCIC website five working days before the meeting date. Queries about the public session can be raised by notifying the Secretary to the Board (execofficeteam@hscic.gov.uk) beforehand so that these, at the discretion of the Chair, may be covered as part of the Board discussion.

A short time will also be built in at the end of each meeting to take questions from any observers that have been notified to the Secretary to the Board, and as agreed by the Chair, prior to the meeting.

From time to time, the Board might need to consider commercial or staff in confidence agenda items that cannot be discussed in public. In that event a private session will also be held without any observers.

6 Frequency

The Board will meet at least six times a year in public.

7 Appendix A

7.1 Current Members of the Board

7.1.1 The Non- Executive Board Members

- Kingsley Manning - Chair
- Sir Nick Partridge - Deputy Chair
- Sir Ian Andrews – Senior Independent Director
- Sir John Chisholm
- Professor Maria Goddard
- Dr Sarah Blackburn

7.1.2 The Executive Directors (with voting rights):

- CEO
- Director of Operations and Assurance Services
- Director of Finance and Corporate Services
- Director of Human Resources and Transformation
- (vacancy)

7.1.3 Other members of the Executive Management Team:

(In attendance at the Board without voting rights):

- Provider Support Director
- Director of Programmes
- Directory of Strategy
- Director of Information and Analytics
- Director of Customer Relations
- Chief Technology Officer
- Caldicott Guardian and Lead Clinician
- Secretary to the Board

Board meeting – Public session

Title of paper:	HSCIC Board Forward Business Schedule
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 03 03 (b)
Paper presented by:	Chair
Paper prepared by:	Annabelle McGuire, Secretary to the Board
Paper approved by: (Sponsor Director)	None
Purpose of the paper:	This paper details the HSCIC Board forward business schedule for the financial year 2015-16. Please note this schedule is subject to change.
Key risks and issues:	N/A
Patient/public interest:	Corporate Governance – decision making
Actions required by the board:	To note for information

HSCIC – Draft Public Board Business Schedule 2015-16

29 April 2015	10 June 2015	15 July 2015	23 Sept 2015	25 Nov 2015	27 Jan 2016	30 Mar 2016
<p>Accountability Register of Interests Minutes of previous meeting (Mar) – to ratify Progress on Action Points Board Forward Business Schedule 2015-16 Reports from sub-committees: • Assurance and Risk 22/04/2015</p>	<p>Accountability Register of Interests Minutes of previous meeting (Apr) – to ratify Progress on Action Points Board Forward Business Schedule 2015-16 Annual Report and Accounts for 2014-2015 for HSCIC – for approval</p>	<p>Accountability Register of Interests Minutes of previous meeting (June) – to ratify Progress on Action Points Board Forward Business Schedule 2015-16 Reports from sub-committees: • Assurance and Risk • Information Assurance and Cyber Security Committee Information Assurance and Cyber Security Committee Terms of Reference Schema Delegation of Authorities – briefing note</p>	<p>Accountability Register of Interests Minutes of previous meeting (July) – to ratify Progress on Action Points Board Forward Business Schedule 2015-16 Reports from sub-committees: • Assurance and Risk • Information Assurance and Cyber Security Committee • Remuneration Committee</p>	<p>Accountability Register of Interests Minutes of previous meeting (Sep) – to ratify Progress on Action Points Board Forward Business Schedule 2015-16 Reports from sub-committees: • Assurance and Risk • Information Assurance and Cyber Security Committee</p>	<p>Accountability Register of Interests Minutes of previous meeting (Nov) – to ratify Progress on Action Points Board Forward Business Schedule 2015-16 and 2016-17 Arrangements for the Annual Review of Board Effectiveness Reports from sub-committees: • Assurance and Risk • Information Assurance and Cyber Security Committee</p>	<p>Accountability Register of Interests Minutes of previous meeting (Jan) – to ratify Progress on Action Points Board Forward Business Schedule 2015-16 and 2016-17 Scheme of Delegation of Authorities – for review Annual Review of Board Effectiveness Report Reports from sub-committees: • Assurance and Risk • Information Assurance and Cyber Security Committee</p>
<p>Supervising Management Board Performance Pack Forthcoming Statistical Publications Review of the National Back Office Tracing Service – Interim Progress Report</p>	<p>Supervising Management Board Performance Pack – for information only Forthcoming Statistical Publications – for information only</p>	<p>Supervising Management Board Performance Pack Forthcoming Statistical Publications Data Release Review: Audit Status Report Staff Personal Development Review Report Care data note – Board approvals and budget position</p>	<p>Supervising Management Board Performance Pack (i) Data Quality Key Performance Indicator Plan (paper) – for information (ii) Data Quality Strategy on a Page (paper) – for information Forthcoming Statistical Publications Transformation Programme Mid-Year Report 2015-16</p>	<p>Supervising Management Board Performance Pack Forthcoming Statistical Publications Review of the National Back Office Tracing Service - Final Report Electronic Referral Service – Lessons Identified</p>	<p>Supervising Management Board Performance Pack Forthcoming Statistical Publications Data Release Review: Audit Status Report</p>	<p>Supervising Management Board Performance Pack Forthcoming Statistical Publications Information Assurance and Cyber Security Annual Report 2015-16 Transformation Programme Report 2015-16</p>
<p>Strategy Formulation Health and Social Care Innovation Centre (Immigration Charge) Directions 2015</p>	<p>Strategy Formulation No agenda items</p>	<p>Strategy Formulation UK Genetic Testing Directions Data Service for Commissioners Directions Care data revised NHS England Directions Directions: Data Extractions for the Department of Work and Pensions Fit to Work Programme HSCIC Social Care Work Update</p>	<p>Strategy Formulation Type 2 Objections Direction Assuring Transformation Update Direction Genomics Direction E-med 3 Direction: Fit Note Aggregated Data HSCIC Information Governance Strategy Streamlining the Independent Information Governance Advice to HSCIC</p>	<p>Strategy Formulation Update on the HSCIC (Immigration Health Charge) Directions Directions: Female Genital Mutilation Prevention Project Care data DH Direction on Objections</p>	<p>Strategy Formulation Breast Implant Registry Direction</p>	<p>Strategy Formulation Directions - TBC</p>
<p>Planning</p>	<p>Planning No agenda items Business Plan 2015-16 – for approval</p>	<p>Planning</p>	<p>Planning</p>	<p>Planning</p>	<p>Planning</p>	<p>Planning</p>
<p>April and May 2015</p>	<p>June 2015</p>	<p>July and August 2015</p>	<p>Sept and Oct 2015</p>	<p>Nov and Dec 2015</p>	<p>Jan and Feb 2016</p>	<p>Mar 2016</p>
<p>Key Meetings • Executive Management Team - weekly • Board Strategy Session – 25 February • Remuneration Committee – 30 March</p>	<p>Key Meetings • Executive Management Team - weekly • Board Strategy Session – 20 May • Assurance and Risk Committee – 10 June</p>	<p>Key Meetings • Executive Management Team - weekly • Information Assurance and Cyber Security Committee – 01 July • Remuneration Committee – 07 August</p>	<p>Key Meetings • Executive Management Team – weekly • Board Strategy Session – 02 September • Information Assurance and Cyber Security Committee – 15 September • Assurance and Risk Committee – 16 September</p>	<p>Key Meetings • Executive Management Team – weekly • Board Strategy Session – 28 October • Information Assurance and Cyber Security Committee – 10 November • Assurance and Risk Committee – 10 November</p>	<p>Key Meetings • Executive Management Team – weekly • Board Strategy Session – 16 December • Assurance and Risk Committee – 13 January • Information Assurance and Cyber Security Committee – 13 January</p>	<p>Key Meetings • Executive Management Team – weekly • Board Strategy Session – 24 February • Information Assurance and Cyber Security Committee – 15 March</p>

Board meeting – Public session

Title of paper:	HSCIC Statistical Publications
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 07 (a)
Paper presented by:	For information
Paper prepared by:	Claire Thompson, Statistical Governance Manager
Paper approved by: (Sponsor Director)	Julie Stroud, Interim Director and Head of Profession for Statistics
Purpose of the paper:	This paper describes HSCIC Official Statistics publications planned for 23 September to 30 November 2015, media coverage for press released Official Statistics publications and web activity for publications released in between June and August 2015.
Key risks and issues:	N/A
Patient/public interest:	Overview of HSCIC Statistical Publications
Actions required by the board:	For information

HSCIC Statistical Publications

Author Julie Stroud

Date 18 September 2015

Contents

Contents	2
Purpose	3
Background to HSCIC Official Statistics	3
Forthcoming Publications	3
Official and National Statistics	3
Clinical Audits	7
User and Media Activity	8
June 2015 Publications	8
June 2015 Publications continued	9
July 2015 Publications	10
July 2015 Publications continued	11
August 2015 Publications	11
August 2015 Publications continued	12
August 2015 Publications continued (2)	13
Actions Required of the Board	13

Purpose

This paper describes HSCIC Official Statistics publications planned for May to July 2015, media coverage for press released Official Statistics publications and web activity for publications released in March 2015.

Background to HSCIC Official Statistics

At 02 July 2014, the HSCIC is responsible for 104 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.

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 the administrative and management data sources.

“Experimental statistics” are new Official Statistics that are under-going evaluation. A key part of this evaluation is user engagement whereby the HSCIC invites readers to comment on the publications, which helps to inform future releases.

Most HSCIC 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].

Forthcoming Publications

Official and National Statistics

Dates for forthcoming publications are confirmed approximately six to eight weeks ahead of publication; until this point, the HSCIC announces only the planned month of publication.

September (23rd to end)

New releases

- | | |
|-------------------|--|
| 23 September 2015 | Female Genital Mutilation - April-June 2015, Experimental Statistics, Enhanced Dataset (monthly release) |
| 30 September 2015 | Seven Day Services - January to December 2014 - Experimental Statistics (quarterly release) |

Biennial

None scheduled for the remainder of September.

Annual

- | | |
|-------------------|---|
| 23 September 2015 | NHS Immunisation Statistics, England - 2014-15 [NS] |
| 24 September 2015 | Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) - 2014/15 |

Quarterly

None remaining scheduled for September.

Monthly

24 September 2015	NHS Staff Earnings Estimates - Estimates to June 2015, Provisional statistics
24 September 2015	NHS Workforce Statistics - June 2015, Provisional Statistics
24 September 2015	NHS Sickness Absence Rates - May 2015, Provisional Statistics
25 September 2015	Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - August 2015
30 September 2015	Provisional Accident and Emergency Quality Indicators for England - June 2015, by provider
30 September 2015	Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2015 - June 2015

Ad hoc

None scheduled for the remainder of September.

October

New releases

None scheduled for October.

Biennial

None scheduled for October.

Annual

06 October 2015	Personal Social Services Adult Social Care Survey, England - 2014-15
06 October 2015	Measures from the Adult Social Care Outcomes Framework, England - 2014-15
06 October 2015	Community Care Statistics: Social Services Activity, England - 2014-15 report [NS]
14 October 2015	Estates Returns Information Collection - England 2014/15
14 October 2015	Sexual and Reproductive Health Services, England - 2014/15 [NS]
23 October 2015	Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to Supervised Community Treatment - Annual figures, 2014/15
23 October 2015	Mental Health Bulletin - Annual Statistics, 2014/15
28 October 2015	Safeguarding Adults - England, 2014-15, Experimental Statistics
29 October 2015	Quality and Outcomes Framework, Achievement, prevalence and exceptions data - 2014-15
30 October 2015	Dental Earnings and Expenses - 2013-14 Additional Analysis

Quarterly

- 15 October 2015 Numbers of Patients Registered at a GP Practice - October 2015
- 27 October 2015 Statistics on NHS Stop Smoking Services in England - April 2015 to June 2015
- 28 October 2015 Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, April 2014 - March 2015

Monthly

- 02 October 2015 HES-MHLD Data Linkage Report - Summary Statistics, June 2015
- 02 October 2015 Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - July 2015
- 02 October 2015 Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - June 2015
- 07 October 2015 NHS Safety Thermometer Report - England September 2014 - September 2015
- 08 October 2015 Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2015 to May 2015
- 08 October 2015 Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2014 to March 2015 - October 2015 Release
- 09 October 2015 HES-DID Data Linkage Report - Provisional Summary Statistics, April 2015 to May 2015 (Experimental Statistics)
- 09 October 2015 Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - May 2015
- 16 October 2015 Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - September 2015
- 20 October 2015 Mental Health and Learning Disabilities Statistics - Monthly report: Final July 2015 and Provisional August 2015
- 20 October 2015 Improving Access to Psychological Therapies Report - July Final, August Primary 2015 and Quarter 1 2015/16
- 21 October 2015 Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), September 2015, Experimental Statistics
- 22 October 2015 NHS Workforce Statistics - July 2015, Provisional Statistics
- 22 October 2015 NHS Sickness Absence Rates - April 2015 to June 2015
- 22 October 2015 NHS Staff Earnings Estimates - July 2015, Provisional Statistics
- 23 October 2015 Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - April 2015
- 27 October 2015 Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2015 - July 2015; Special topic - Victorian Diseases
- 27 October 2015 Provisional Accident and Emergency Quality Indicators for England - July 2015, by provider
- 30 October 2015 HES-MHLD Data Linkage Report - Summary Statistics, July 2015

Other

01 October 2015 NICE Technology Appraisals in the NHS in England (Innovation Scorecard) - to March 2015, experimental statistics

November 2015

New releases

- Data on written complaints in the NHS - 2015/16 Quarter 1, Experimental

Biennial

None scheduled for November.

Annual

- Cervical screening programme - Statistics for 2014-15 [NS]
- General Pharmaceutical Services - 2005/6 - 2014/15 [NS]
- Hospital Episode Statistics: Admitted patient care - 2014-15 [NS]
- National Child Measurement Programme, England - 2014/15 school year [NS]
- NHS Maternity Statistics, England - 2014-15
- Personal Social Services: Expenditure and Unit Costs, England - England 2014-15 Final Release [NS]
- Prescribing Costs in Hospitals and the Community - England, 2014-15
- Psychological Therapies, Annual report on the use of IAPT services - England - 2014/15

Quarterly

- Deprivation of Liberty Safeguards (DoLS) – Monthly Summary Statistics - 2015/16 Quarter 2
- Learning Disability Services Quarterly Statistics - Learning Disability Services Quarterly Statistics - Q2 2015/16
- NHS Dental Statistics for England - Quarter 1, 2014-15
- NHS Outcomes Framework indicators - November 2015 release

Monthly

- HES-DID Data Linkage Report - Provisional Summary Statistics, April 2015 to June 2015 (Experimental Statistics)
- HES-MHLD Data Linkage Report - Summary Statistics, August 2015
- Improving Access to Psychological Therapies Report - August Final, September Primary 2015 and most recent quarterly data (Quarter 1 2015/16)

- Learning Disability Services Monthly Statistics - Commissioner census (Assuring Transformation), October 2015, Experimental Statistics
- Mental Health and Learning Disabilities Statistics - Monthly report: Final August 2015 and Provisional September 2015
- NHS Safety Thermometer Report - England October 2014 - October 2015
- NHS Sickness Absence Rates - July 2015, Provisional Statistics
- NHS Staff Earnings Estimates - August 2015, Provisional Statistics
- NHS Workforce Statistics - August 2015, Provisional Statistics
- Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2014 to March 2015 - November 2015 Release
- Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2015 to June 2015
- Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses - October 2015

Other

None scheduled for November.

Clinical Audits

Clinical Audits are not currently classified as Official Statistics. The Code of Practice for Official Statistics is followed as best practice during the production cycle but the release processes differ.

September 2015

None scheduled for the remainder of September.

October 2015

None presently scheduled.

November 2015

AUDIT: National Pregnancy in Diabetes Audit - National Pregnancy In Diabetes Audit covering pregnancies ending 31st December 2014

AUDIT: National Oesophago-Gastric Cancer Audit - Oesophago-Gastric Consultant Outcomes Publication 2015

AUDIT: National Bowel Cancer Audit - 2015 Bowel Consultant Outcomes Publication

User and Media Activity

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. The totals in the table include all media units to 18 September 2015.

Bars in the tables below indicate the scale of interest generated by each publication.

June 2015 Publications

Publication	Date	Unique page views	Media units
CCG Prescribing Data - January to March 2015	04/05/2015	636	
HES-DID Data Linkage Report - Provisional Summary Statistics, April 2014 to January 2015 (Experimental Statistics)	05/06/2015	89	
HES-MHLD Data Linkage Report - Summary Statistics, February 2015	05/06/2015	179	
• NHS Safety Thermometer Report - England May 2014 - May 2015	10/06/2015	585	
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2013 to March 2014 - June 2015 Release	11/06/2015	188	
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2014 to January 2015	11/06/2015	467	
Ambulance Services, England - 2014-15 [NS]	17/05/2015	508	
NHS Continuing Healthcare Activity - England, Quarter 4, 2014-15	17/05/2015	316	
Statistics on Women's Smoking Status at Time of Delivery: England - April 2014 to March 2015	18/06/2015	1,657	71
Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation) - May 2015, Experimental Statistics	19/06/2015	371	
Improving Access to Psychological Therapies Report - March Final and April Primary	23/06/2015	1,098	

June 2015 Publications continued

Publication	Date	Unique page views	Media units
Mental Health and Learning Disabilities Statistics - Monthly report: Final March 2015 and Provisional April 2015	23/06/2015	610	
NHS Sickness Absence Rates - February 2015, Provisional Statistics	24/06/2015	339	
NHS Staff Earnings Estimates - Estimates to March 2015, Provisional statistics	24/06/2015	364	
NHS Workforce Statistics - March 2015, Provisional statistics	24/06/2015	832	
• CCG Indicators - June 2015 release	25/06/2015	1,234	
Focus on - The Health and Care of Young People - 2015	25/06/2015	1,923	54
Statistics on Alcohol, England - 2015 [NS]	25/06/2015	2,158	31
Provisional Accident and Emergency Quality Indicators for England - March 2015, by provider	30/06/2015	228	
Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2014 - March 2015; Special topic - Hospital Dentistry	30/06/2015	937	12

July 2015 Publications

Publication	Date	Unique page views	Media units
HES-MHLDDS Data Linkage Report, Summary Statistics - Mar 15	03/07/2015	185	
Prescriptions Dispensed in the Community, England Statistics for England - 2004-2014	07/07/2015	841	80
NHS Safety Thermometer Report England June 2014 - June 2015	08/07/2015	569	
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England April 2013 to March 2014 - July 2015 Release	09/07/2015	224	
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England April 2014 to February 2015	09/07/2015	516	
HES-DID Data Linkage Report Provisional Summary Statistics, April 2014 to February 2015 (Experimental Statistics)	10/07/2015	203	
General Ophthalmic Services activity statistics England, year ending 31 March 2015	16/07/2015	120	
Numbers of Patients Registered at a GP Practice - July 2015	16/07/2015	848	
Improving Access to Psychological Therapies Report - April Final and May Primary 2015 + Quarter 4 2014/15	21/07/2015	1,008	1
Learning Disability Services Monthly Statistics Commissioner census (Assuring Transformation) - June 2015, Experimental Statistics	21/07/2015	176	
Mental Health and Learning Disabilities Statistics Monthly report: Final April 2015 and Provisional May 2015	21/07/2015	853	
NHS Sickness Absence Rates - January 2015 to March 2015 and Annual Summary 2010-11 to 2014-15	22/07/2015	1,314	20
NHS Staff Earnings Estimates - April 2015, Provisional Statistics	22/07/2015	313	
NHS Workforce Statistics - April 2015, Provisional statistics	22/07/2015	812	
Smoking, Drinking and Drug Use among Young People in England, 2014	23/07/2015	2,890	107

July 2015 Publications continued

Publication	Date	Unique page views	Media units
Provisional Accident and Emergency Quality Indicators for England - April 2015, by provider	24/07/2015	262	13
Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2015	24/07/2015	913	13
Summary Hospital-level Mortality Indicator (SHMI) Deaths associated with hospitalisation, England - January 2014 - December 2014	29/07/2015	257	
HES-MHLD Data Linkage Report Summary Statistics - April 2015	31/07/2015	176	0

August 2015 Publications

Publication	Date	Unique page views	Media units
Deprivation of Liberty Safeguards (DoLS) – Monthly Summary Statistics 2015/16, Quarter 1	04/08/2015	765	
Health and Wellbeing of 15-year-olds in England Smoking Prevalence – Findings from the What About YOUTH? Survey 2014	04/08/2015	1,983	96
Guardianship under the Mental Health Act, 1983 England, 2014-15	05/08/2015	536	
HES-DID Data Linkage Report Provisional Summary Statistics, April 2014 to March 2015 (Experimental Statistics)	07/08/2015	135	
Patient-Led Assessments of the Care Environment (PLACE) England, 2015	11/08/2015	7,489	58
NHS Safety Thermometer Report England, July 2014 - July 2015	12/08/2015	424	
Prescribing for diabetes in England - 2005/06 to 2014/15	12/08/2015	1,438	67
Finalised Patient Reported Outcome Measures (PROMs) in England - April 2013 to March 2014	13/08/2015	763	

August 2015 Publications continued

Publication	Date	Unique page views	Media units
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2014 to March 2015	13/08/2015	930	
NHS Vacancies Survey England 2014/15 - NHS Jobs based proxy administrative data, Provisional, Experimental Statistics	18/08/2015	2,091	1
Hospital Episode Statistics: Deaths within 30 days of a hospital procedure or of an emergency admission to hospital - Financial year 2012/13	19/08/2015	243	
NHS Outcomes Framework indicators - August 2015 release	19/08/2015	603	
Statistics on NHS Stop Smoking Services in England - April 2014 to March 2015	19/08/2015	1,372	
NHS Dental Statistics for England 2014-15, Annual report	20/08/2015	1,121	42
NHS Sickness Absence Rates April 2015, Provisional Statistics	20/08/2015	416	
NHS Staff Earnings Estimates May 2015, Provisional Statistics	20/08/2015	207	
NHS Workforce Statistics May 2015, Provisional Statistics	20/08/2015	725	
Learning Disability Services Monthly Statistics Commissioner census (Assuring Transformation) - July 2015, Experimental Statistics	21/08/2015	294	
Learning Disability Services Quarterly Statistics Commissioner census (Assuring Transformation) - Q1 2015/16, Experimental Statistics	21/08/2015	235	
Improving Access to Psychological Therapies Report May Final, June Primary 2015 and Quarter 4 2014/15	25/08/2015	212	
Mental Health and Learning Disabilities Statistics Monthly report: Final May 2015 and Provisional June 2015	25/08/2015	744	
Data on written complaints in the NHS 2014-15	26/08/2015	900	
Provisional Accident and Emergency Quality Indicators for England - May 2015, by provider	26/08/2015	213	

August 2015 Publications continued (2)

Publication	Date	Unique page views	Media units
Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2015 - May 2015; Special topic	26/08/2015	503	69
Dental Working Hours 2012/13 and 2013/14 Motivation Analysis: Experimental Statistics	27/08/2015	669	4

Actions Required of the Board

For information.

Board meeting – Public session

Title of paper:	Programme Definitions
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 07 (b)
Paper presented by:	Carl Vincent, Director of Finance and Corporate Services
Paper prepared by:	John Willshire, Portfolio Director
Paper approved by: (Sponsor Director)	Carl Vincent, Director of Finance and Corporate Services
Purpose of the paper:	To provide the Board with a summary of each programme listed on the programme dashboards.
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.
Actions required by the board:	For Reference Only

Portfolio Code	Portfolio Item name	Portfolio Item Desc
P0050/00	Spine 2	The provision of the existing Spine Services to be re-procured using the new Government ICT strategy framework, using internal and 3rd party resources.
P0238/00	NHS e-Referral Service Programme	The NHS e-Referral Service Programme will deliver an open, modern, electronic referral service, improving patient outcomes and delivering paperless referrals by 2015.
P0335/00	SUS Transition	Responsible for the delivery of interim tactical solutions to ensure business continuity from the end of the BT SUS contract. This will include system data and user transition.
P0208/00	GPSOC Replacement	To provide a contractual vehicle for the supply and development of GP clinical IT systems for all Practices in England, following expiry of the extended GPSOC call off agreements in March 2014.
P0325/00	Cyber Security Programme (CSP)	The HSCIC board commissioned an Interim Cyber Security Review (ICSR) to establish the readiness and capability of the HSCIC to proactively manage and respond to Cyber Security threats as part of a wider Information Assurance programme. The resulting report identified a significant number of high impacting risks that need to be addressed as a matter of urgency. This programme will address these risks. In addition there are some areas not covered by the report that may require additional effort such as threat analysis and specialist input from niche providers.
P0406/00	Data Services for Commissioners (DSIC)	This investment will build upon the existing HSCIC and Data Services for Commissioner Regional Office (DSRO) systems, processes, projects, programmes and services where appropriate to meet the strategic direction of the HSCIC and Data Services for Commissioners. The existing Data Service for Commissioner Programme P0265/00 will be closed down due to the fact that the timescales have slipped and the anticipated funding amounts were not allocated for the strategic solution. NHSE have now reprocured this programme of work and HSCIC will be responsible for continuing to provide the Business Service function (BAU) and will contribute to the Future State workstreams over the next 2 years, there this is a request for a new Data Services for Commissioners Programme to be initiated on the HSCIC Portfolio.
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.
P0031/00	CSC LSP Delivery Programme	The PSNH project will deliver a Public Services Network for Health, which will be aligned and accredited to PSN standards
P0196/00	NHSmail 2	LSP Delivery Programme: Increased patient safety and quality of healthcare and also greater clinical effectiveness and administration efficiency
P0022/00	BT LSP (London)	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.
P0047/00	BT LSP (South)	BT LSP (London) has overall responsibility for upgrading NHS information technology to make it possible for hospitals, community services and mental health trusts to implement Electronic Patient Record as per the LSP contract with BT. This will enable the NHS to provide better, safer care for patients wherever and whenever they need it.
P0026/00	NHS Choices	Ensuring patients detailed clinical information is available at the point of care. NHS Choices (www.nhs.uk) acts as the digital gateway and public front door to the NHS, transforming the delivery of health and social care to one that is patient-centred, personalised and accessible to all.
P0306/00	Care Data	The Care Data programme, this initiative will ensure that there is more rounded information available to citizens, patients, clinicians, researchers and the people that plan health and care services. Our aim is to ensure that the best possible evidence is available to improve the quality of care for all.
P0004/00	Child Protection - Information Sharing	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	NHS England fund HSCIC to deliver the CP-IS service through ministerial approved business cases signed off in Dec 12 and supports funding of the project through to April 2018. The project should be HSCIC cost neutral. 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 Delivery of the SCR which supports urgent and emergency care settings, providing information to authorised health care professionals to support care where no information is currently held about a patient, for example in out-of-hours settings, emergency departments, treating temporary residents and emergency admissions to secondary care. 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 ASC for the increased collection and sharing of client level data. The National Tariff System (NTS) programme will provide national solutions that implement the national payment system as defined by NHS England and Monitor. This will be achieved via implementation of a national system and enabling products which initially provide core Payment by Results (PbR) functionality for hospitals providing NHS care. Over the longer term it will deliver emerging national policy requirements and meet additional business requirements of users. 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 group's local requirements and include full integrated Electronic Health Records, Clinical Portal, Electronic Document Management (EDM) and ePrescribing solutions. It is anticipated that all of the groups will have signed contracts by the end of May 2015. To procure clinical solutions for the Southern Ambulance Trusts which do not currently have these solutions under the BT LSP solution. To procure clinical solutions for the Southern Community and Child Health Trusts which do not currently have these solutions under the BT LSP solution.
P0051/00	Summary Care Record	
P0341/00	Social Care Informatics Project (SCIP)	
P0294/00	National Tariff System (NTS)	
P0181/00	South Acute Programme	
P0182/00	South Ambulance Programme	
P0183/00	South Community and Child Health Programme	
P0033/00	PACS Exit Programme	Development and deployment of the PACS (Picture Archiving And Communication System). Overarching programme to manage the PACS sub-programmes.
P0070/00	Calculating Quality Reporting Service (CQRS)	The Calculating Quality Reporting Service (CQRS) is used to calculate, report and approve quality outcome-related achievement and payments to GP practices and NHS England Area Teams. CQRS has replaced the QMAS system which was previously responsible for calculating and reporting Quality Outcomes Framework (QOF) payments. A replacement system (for QMAS) was required to provide increased flexibility to meet the policy outlined in the Health and Social Care Act.
P0014/00	GP2GP	To deliver the national implementation and roll-out of a computerised system to manage the transfer of patient records between GP practices when patients change their GP, covering electronic records transfers between GP practices.
P0281/00	General Practice Extraction Service (GPES)	The General Practice Extraction Service (GPES) is a centrally managed service that extracts information from general practice IT clinical systems for a wide range of purposes. It also forms part of the new process for providing payments to GPs and clinical commissioning groups (CCGs).

P0207/00	Health & Justice Information Services	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	Offender Health IT	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 SystemOne, 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 – Data and Systems Business Case Development	The objective of this document is to define and authorise the work package to produce a feasibility study on information collection and sharing by the NHS on Female Genital Mutilation (FGM). The work package will 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 An assessment of feasibility will be formulated in a final document which will contain a study investigating multiple options for achieving the objective. The options will consider those requirements, risks and benefits relevant to the objectives, starting from a 'do nothing' state, to one which fully addresses the obligations on the NHS and health care professionals as outlined in the multi-agency practice guidelines on FGM. All the options together will identify a common set of requirements, against which each individual option will be assessed. Each option will also specify the estimated resources, in terms of time, cost and materials, required to realise the option.
P0055/00	Maternity and Childrens Datasets	To collect and report on data for maternity, child health and adolescent mental health services.
P0372/00	Information Service for Parents at Point of Care	The HSCIC Cross-Government Programmes team has been asked to initiate and subsequently manage the delivery of a project to develop information sharing between maternity systems and a central repository owned by PHE. The project will facilitate PHE in providing an information service (high quality digital advice) at point of care (maternity) for new and expectant parents. This work is being commissioned, and funded, by PHE and aligns with the PHE Marketing Strategy (addressing key public health issues, increasing quality and cost-effectiveness and being evidence based) as well as being a direct ministerial requirement. (Dan Poulter) to provide direct access to a coherent service at point of care for this patient group.
P0321/00	Pathfinders on DME (formerly Strategic Capability Platform (SCP) P1)	A public commitment has been made to extract primary care data from GP Systems in early 2014 and to link and disseminate that data in an anonymised form from July 2014. This, along with other short term commitments associated with programmes, including care data, results in a requirement for a new Interim Platform to meet the requirements of NHS England as Lead Commissioner ahead of any significant investment in the Strategic Capability Platform. The Strategic Capability is planned to be the platform that enables the HSCIC to carry out its statutory requirements for the processing and dissemination of data in a safe and secure environment.
P0010/00	Defence Medical Services (DMS)	Support Defence Medical Services to deliver the fully operating capability of their Personnel Care Record System Programme (DMCP). This includes integrating with the services and systems of the NHS, provision of relevant SME, skills and programme resource. In this context NHS systems include patient registration, staff authentication and patient choice together with activity related management information.

Board meeting – Public session

Title of paper:	Correspondence from the UK Statistics Authority
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 07 (c)
Paper presented by:	Martin Severs, Interim Director of Information and Analytics
Paper prepared by:	Julie Stroud, Interim Director and Head of Profession for Statistics
Paper approved by: (Sponsor Director)	Martin Severs, Interim Director of Information and Analytics
Purpose of the paper:	To inform the Board that the annual <i>Guardianship under the Mental Health Act, 1983, England</i> statistics have retained their National Statistics status following assessment by the UK Statistics Authority (UKSA).
Key risks and issues:	None
Patient/public interest:	Direct - The UK Statistics Authority has a statutory requirement to formally assess statistics released by public bodies. Their assessment provides assurance to users, that these statistics have been produced in compliance with the UKSA Code of Practice for Official Statistics.
Actions required by the board:	To note the outcome of the assessment and that the UKSA is particularly complimentary about the engagement of our statistical team especially the range of activities they have undertaken to investigate the quality of data provided by local authorities.

Director General for Regulation

Julie Stroud
Head of Profession for Statistics
Health and Social Care Information Centre
Trevelyan House
1 Trevelyan Square
Boar Lane
Leeds
LS1 6AE

4 August 2015

Dear Julie,

ASSESSMENT OF STATISTICS ON GUARDIANSHIP UNDER THE MENTAL HEALTH ACT, 1983

Thank you for the correspondence outlining the actions that have been taken to address the requirements for the remaining output in Assessment Report number 295 on Guardianship under the Mental Health Act, 1983.

On behalf of the Board of the Statistics Authority, I have reviewed these on the advice of the Assessment team and I am pleased to confirm the designation of *Guardianship under the Mental Health Act, 1983* as National Statistics. The Authority appreciates the very positive engagement between the statistical team in HSCIC and the Authority's Assessment team during the follow-up period. The range of activities undertaken to investigate the quality of the local authorities' data in the light of the Authority's guidance, *Quality Assurance of Administrative Data*, are commendable.

It is a requirement of the Statistics and Registration Service Act 2007 that compliance with the Code of Practice must be maintained. We would invite you to incorporate the attached text in publications containing the statistics. This text may only be used where National Statistics designation has been awarded following an Assessment Report. It is intended to convey a strong and independent endorsement for the statistical publication.

Please feel free to discuss any aspect of this with us at any time. I am copying this letter to John Pullinger, the National Statistician, and to Kingsley Manning.

Yours sincerely,



Ed Humpherson

Text that may only be used in publications that carry the National Statistics logo following assessment and designation:

NATIONAL STATISTICS STATUS

National Statistics status means that official statistics meet the highest standards of trustworthiness, quality and public value.

All official statistics should comply with all aspects of the *Code of Practice for Official Statistics*. They are awarded National Statistics status following an assessment by the Authority's regulatory arm.

The Authority considers whether the statistics meet the highest standards of Code compliance, including the value they add to public decisions and debate.

It is a producer's responsibility to maintain compliance with the standards expected of National Statistics, and to improve its statistics on a continuous basis. If a producer becomes concerned about whether its statistics are still meeting the appropriate standards, it should discuss its concerns with the Authority promptly. National Statistics status can be removed at any point when the highest standards are not maintained, and reinstated when standards are restored.



Board meeting – Public session

Title of paper:	Office for National Statistics Direction
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 07 (d)
Paper presented by:	n/a background paper for information
Paper prepared by:	Dawn Foster, Head of Information Governance
Paper approved by: (Sponsor Director)	Martin Severs, Interim Director of Information and Analytics and Lead Clinician (Caldicott Guardian)
Purpose of the paper:	For information
Key risks and issues:	<p>This Direction provides clarity on the basis for HSCIC to share data received from the Office for National Statistics (ONS) thereby resolving issues around inequality of access.</p> <p>It now provides a legal basis for ONS data to be provided to:</p> <ul style="list-style-type: none">• Trusts• Anyone who produces or analyses statistics on behalf of a body named in the Direction
Patient/public interest:	Indirect
Actions required by the board:	To note the Direction under the Statistics and Registration Service Act 2007 on the Office for National Statistics

D I R E C T I O N S

OFFICIAL STATISTICS

**The Statistics and Registration Service Act 2007 (Disclosure of
Health Service Information) Directions 2015**

The Secretary of State for Health, in exercise of the powers conferred by sections 42(4A) and (5B) of the Statistics and Registration Service Act 2007(a), gives the following Directions:

Citation, commencement and interpretation

1.—(1) These Directions may be cited as the Statistics and Registration Service Act 2007 (Disclosure of Health Service Information) Directions 2015.

(2) These Directions come into force on the day after the day on which they are signed.

(3) In these Directions—

“2006 Act” means the National Health Service Act 2006(b);

“NHS Foundation Trust” means a body corporate established under section 30 of the 2006 Act; and

“NHS Trust” means a body corporate established under section 25 of the 2006 Act.

Persons to whom information may be disclosed under section 42(4) of the Statistics and Registration Service Act 2007

2.—(1) The following persons are specified for the purpose of section 42(4A) of the Statistics and Registration Service Act 2007 (persons to whom information relating to births and deaths may be disclosed)—

(a) a NHS Foundation Trust;

(b) a NHS Trust; and

(c) a person who produces or analyses statistics for the purpose of assisting a person specified in paragraph (2) in the performance of functions exercisable by that person in relation to the health service.

(2) The following persons are specified for the purpose of paragraph (1)(c)—

(a) the Secretary of State;

(b) the National Health Service Commissioning Board;

(c) a clinical commissioning group;

(d) a local authority;

(e) the National Institute for Health and Care Excellence;

(f) the Health and Social Care Information Centre;

(g) a Special Health Authority;

(h) the Care Quality Commission;

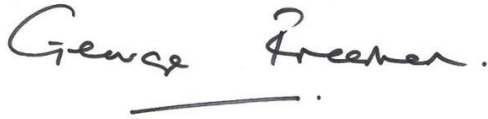
(a) 2007 c.18. Subsections (4) to (4B) were substituted for section 42(4) by section 287(2) of the Health and Social Care Act 2012 (c.7) and subsections (5A) to (5C) were inserted by section 287(3) of that Act.
(b) 2006 c.41.

(i) a NHS Foundation Trust; and

(j) a NHS Trust.

(3) For the purpose of paragraph (1)(c) "health service" means the health service continued under section 1(1) of the 2006 Act.

Signed by authority of the Secretary of State for Health

A handwritten signature in black ink that reads "George Freeman." Below the signature is a horizontal line.

Date: 28 July 2015

Member of the Senior Civil Service
Department of Health

Board meeting – Public session

Title of paper:	Request from NHS Scotland under section 255 of the Health and Social Care Act 2012
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 07 (e)
Paper presented by:	Chair
Paper prepared by :	Annabelle McGuire, Secretary to the Board
Paper approved by: (Sponsor Director)	N/A
Purpose of the paper:	<p>To share with the Board the request from NHS Scotland and the response from the HSCIC Chair.</p> <p>The Direction from NHS England for Genetic Testing Rates Information System was presented at the 15 July 2015 Board meeting.</p> <p>The UK Genetic Testing Network (UKGTN) collects information on the access and provision of genetic testing provided by UKGTN member laboratories for NHS patients for different healthcare populations (e.g. by NHS CCG in England and their equivalents in Scotland, Northern Ireland and Wales).</p> <p>The team carries out work on behalf of the UKGTN Clinical and Scientific Advisory Group (CSAG) and UKGTN membership. UKGTN is accountable to the Department of Health and is hosted by the North West London Commissioning Support Unit (NWLCSU). The data collection is mandatory for UKGTN member laboratories as part of their condition of UKGTN membership.</p> <p>The purpose of the data collection is to gain information on the access and provision to genetic testing provided by UKGTN member laboratories for NHS patients. The outputs from the data analysis supports commissioners in reviewing variation and taking action to improve access where required.</p>



Key risks and issues:

NHS National Services Scotland confirms that the information which will be obtained by carrying out this request to the HSCIC is information which it is necessary or expedient for it to have in relation to the exercise of its functions, as set out in The National Health Service (Functions of the Common Services Agency) (Scotland) Order 2008, or carrying out of activities, in connection with the provision of health care within Scotland.

Patient/public interest:

Transparency

Actions required by the board:

For information only

National Specialist and
Screening Directorate (NSD)

Gyle Square
1 South Gyle Crescent
Edinburgh EH12 9EB
Telephone 0131 275 7043
Fax 0131 275 7614
www.nsd.scot.nhs.uk



Mr Kingsley Manning
Chair of Health and Social Care Information
Centre (HSCIC)
Health and Social Care Information Centre
1 Trevelyan Square
Leeds
LS1 6AE

Date 28 August 2015
Your ref
Our ref K:07\Cttees\Policy Grps\UKGTN Advisory\Corres
Enquiries to Deirdre Evans
Direct line 0131 275 7043
Email Deirdre.Evans@nhs.net

Dear Mr Manning,

Request under section 255 Health and Social Care Act 2012

On behalf of NHS Scotland, NHS National Services Scotland requests the HSCIC to establish and operate the Genetic Testing Rates Information System to collect information from UKGTN member laboratories in **Scotland** in accordance with **Establishment of Information Systems for NHS Services: Genetic Testing Rates Information System Directions 2015** issued by the National Health Service Commissioning Board, and in particular to carry out the activities specified in paragraph 3(1) of the Directions in relation to the data specified in paragraph 3(2).

NHS National Services Scotland confirms that the information which will be obtained by carrying out this request to the HSCIC is information which it is necessary or expedient for it to have in relation to the exercise of its functions, as set out in **The National Health Service (Functions of the Common Services Agency) (Scotland) Order 2008**, or carrying out of activities, in connection with the provision of health care within **Scotland**.

Yours sincerely

A handwritten signature in black ink that reads 'Deirdre Evans'.

Mrs Deirdre Evans
Director

CC: Julie Henderson, Head of Analytical Services, HSCIC
Jane Deller, Programme Manager, UKGTN
Scott Heald, Associate Director, Public Health Information, NHS National Services Scotland



National Specialist and Screening Directorate (NSD)
Gyle Square, 1 South Gyle Crescent, Edinburgh EH12 9EB
Director Deirdre Evans

*NHS National Services Scotland is the common name of the
Common Services Agency for the Scottish Health Service.*

Board meeting – Public session

Title of paper:	Data Dissemination Service Review
Board meeting date:	23 September 2015
Agenda item no:	HSCIC 15 04 07 (f)
Paper presented by:	n/a background paper for information
Paper prepared by:	Terry Hill, Director of Data Dissemination and Simon Croker, Programme Manager
Paper approved by: (Sponsor Director)	Professor Martin Severs, Interim Director for Information and Analytics
Purpose of the paper:	Submitted to HSCIC Board Business Meeting on 2 nd September to provide information to support the Data Dissemination Service Review. Following this meeting, the Chair of the HSCIC requested that it be submitted to the public session of the HSCIC Board for information only.
Key risks and issues:	<p>5 organisations have yet to sign Data Sharing Framework Contracts (DSFC)</p> <p>28 open applications have breached their SLAs</p> <p>28 Historic applications (received between Aug 14 and Feb 15) remain in the system.</p> <p>There are currently 221 medical research studies suspended prior to 1st June that need to be resolved.</p>
Patient/public interest:	Indirect – This paper provides an overview of the service that disseminates data principally for secondary uses.
Actions required by the board:	Provided for information only

HSCIC Board Business Meeting

Data Dissemination Service Review

Author: Simon Croker

Date: 02/09/15

Purpose	3
Background	3
Data Release review	3
Data Deletions	3
Reducing the need to release data	5
Data Access	5
Current Developments	5
Data Sharing Framework Contracts	6
Progress on Data Applications	7
Medical Research suspended studies	11
DARS Process improvement	12
Issues	13
Wider Directorate	14

Purpose

The purpose of this paper is to provide the HSCIC Board with information to support the Data Dissemination service review.

Background

The Data Dissemination Directorate was formed in 2014 as a sub-directorate of Information and Analytics and comprises teams responsible for: the Data Access Request Service (DARS); Data Collections; Data Quality; the Data Management Environment (DME); and the National Back Office (NBO). Terry Hill has recently been appointed as the permanent Director for Data Dissemination.

Data Release review

In March 2014, the HSCIC undertook a review of Data Releases made by its predecessor organisation, the NHS Information Centre. The findings of this review were published on June 17th 2014.

In response to the review, and specifically to recommendations made by Sir Nick Partridge, the HSCIC Board introduced a series of steps to guarantee greater openness and reassurance to the public, stricter controls over data use and better clarity for data users. A programme of work was established to deliver these commitments with a target delivery date for the end of November.

Of the 9 recommendations made by Sir Nick, 7 were progressed sufficiently to be regarded as having been met in time for the meeting of the HSCIC Board in April 2015. This was evidenced by the findings from the external audit carried out as part of the Health Group Internal Audit programme for 2014/15.

2 of the recommendations, relating to data deletions and the requirement to reduce the need to release data externally are still ongoing, details of which are provided below.

Data Deletions

Partridge recommendation #1: That the HSCIC undertakes a programme of work to ensure that data has been deleted appropriately for all data releases referenced in the PwC report, where the agreement has ended.

The process for handling data deletions for recently expired agreements has been embedded into the Data Applications Team business as usual process.

Work is currently underway to uplift the CRM tool, the single system being used to manage data applications. As part of this uplift, a review of the automated alerting capability will be carried out. This will include triggers for notifying the team of deletion requirements.

Work to assure deletion of historic applications is ongoing. This work covers all releases made between April 2005 to July 2015 and applies to releases made by the NHS Information Centre and its successor organisation, the Health and Social Care information Centre. Owing to the age of the releases, the variable quality of the historic record keeping and the fact that there will now be organisations to whom data was released who no longer exist, have restructured or have no organisational memory of receiving the data, a project team was convened to carry out this task. This involved interrogating the available records to assemble the best possible information to follow up on every data sharing agreement.

This information gathering task is largely completed and deletion letters have been sent to the majority of data recipients who have not yet supplied a data deletion certificate. These are being followed up with a maximum of three chasing telephone calls at 1 week intervals. Failure to respond within this time frame will result in escalation and possible sanction. Sanctions will include notifying the HSCIC Board of non-compliance with a view to refusing access to future data applications unless the applicant can supply compelling narrative of extenuating circumstances on why they did not respond, and confirmation that they have now deleted the old data.

Given the issues identified above associated with the age of some of the releases, it is recognised that full compliance will not be possible. As such it has been agreed that the following conditions will be taken into account for determining that no further effort should be made to secure a certificate where:

- the data sharing is over 5 years old
- there has been no known data sharing breach
- the organisation no longer exists, and no obvious and clear successor
- the HSCIC has received written confirmation from the organisation that they have made reasonable effort to identify the data and have confirmed they are unable to locate it within their organisation

Reducing the need to release data

Partridge recommendation #8: That the HSCIC actively pursues a technical solution to allow access to data, without the need to release data out of the HSCIC to external organisations.

The programme of work established to pursue technical solutions to reduce the need for data to be released externally is ongoing.

An initial consultation exercise was carried out on a draft policy and potential technical solutions earlier in the year. This was followed by focussed stakeholder engagement using the care.data Expert Reference Group and users of the HES Data Interrogation System (HDIS) to understand their requirements and application of data received from the HSCIC.

This engagement identified that in the current landscape, many organisations will continue to have a legitimate need for direct data releases. However, insight gained from engagement activity has confirmed that we can “channel shift” organisations to other forms of secure access, with robust controls in place, to ensure that a higher volume of data can be analysed without the need for extract, or to limit extracts to aggregate data (with disclosure controls) only.

Work is ongoing to develop these alternative means for direct access.

A secure data facility was completed on 31 March 2015 and is ready for operation as required with options for secure access to data for purposes beyond direct care. The processes for approval and access to this facility are in place.

Data Access

Current Developments

- Recruitment to Data Access Request Service (DARS) permanent function complete. Permanent Director of Data Dissemination (Terry Hill) appointed.
- Project to enable online applications, application tracking and improved automation in progress. External user engagement planned for September
- Customer Services Improvement programme initiated in June 2015.

- Revised approach for landing new applications developed, with greater emphasis on customer service and involvement at the initial stages of the application. This includes early involvement from senior DARS staff and greater transparency around the criteria under which applications are accepted.
- Improved guidance being created to support the application process. This will be incorporated into functionality provided via the online application form.
- DARS webpages being reviewed and improved to make them easier to navigate.
- Engagement with the research community and wider health sector has been improved through an ongoing series of roadshows and masterclasses and the appointment of Strategic Relationship Managers.
- Quarterly Data Release Register has been made more timely to include all releases made up until 6 weeks prior to publication of the register. Previously there was a lag of 6 months.

Data Sharing Framework Contracts

The below table provides an update on the latest position regarding Data Sharing Framework Contracts:

As of 3rd September 2015

	May 15	Sep 15
No of organisations contacted	464 ¹	464
Not required (e.g. customer no longer wishes to receive data or the DSA was for a tabulation with small numbers suppressed)	228	272
Active contracts	179	187
Outstanding Contracts (e.g. with customer (to sign or respond with further information))	57	5

¹ *The above figures represent customers who already had live agreements with the HSCIC prior to the Data Sharing Framework Contracts being introduced. They do not include customers currently applying for data who require a Contract for the first time.*

The following organisations have yet to sign a contract:

- University of Westminster
- The Met Office
- University of Southampton
- City University, London
- Private Healthcare Information Network (PHIN)

The HSCIC is in active communication with the above organisations. Considerable effort has been undertaken to reach an agreed position that will enable each to sign the Data Sharing Framework Contract. Based on these communications, it is expected that the 3 academic institutions will return signed contracts and supporting security documentation by the end of September. Once the security arrangements have been assessed and approved, the HSCIC will issue the final contract.

Where satisfactory documentation is not provided within the required timescales, the HSCIC will issue deletion notices.

Progress on Data Applications

Overview

The below table provides an overview of activity since the publication of the Data Release Review in June 2014. The three periods identified represent the key stages in the development of the Data Access Request Service (DARS); the period prior to the publication of the Data Release review for which there remained outstanding applications as at June 30th 2014; the period between July 2014 and 31st Jan 2015 during which time DARS was being developed; and the period from February 1st 2015 to current from which point Service standards have been operational. There are no open applications (final column) that pre-date August 2014 as all applications up until this time were completed as part of the backlog clearance.

Summary of activity as at 8th September 2015

Applications received:	Cleansed	Rejected	Completed²	Total	Open
Prior Jul 2014	134	279	87	500	
Jul 1 st 2014 – Jan 31 st 2015		435	91	526	28
Feb 1 st 2015 – Sep 8 th 2015		109	77	186	190
Total	134	823	255	1212	218

Looking at this overview it is significant to note that the rate of rejection has reduced from 83% for applications received between July 14 and January 15; to 58% for those applications received between February 15 and Sep 15. The vast majority of these were rejected before being presented to DAAG as they were unsuitable to be progressed under the new legislation (e.g. the applicant did not have the appropriate legal basis to receive the data or had insufficient security controls in place). The declining rejection rate therefore can be attributed to the improved processes over this time which have resulted in a better quality of application being submitted. It is expected that as the processes continue to improve, particularly through the revised triage approach that has been introduced as of August 15, this rejection rate will continue to decline.

Applications under SLA (received since February 1st 2015)

The tables below provide a summary of applications received since Service Level Agreements were introduced for all data requests received since February 1st 2015.

The first table provides an overview of activity with a further breakdown by sector in the second table.

Summary of activity as at 8th September

Number of open applications	190
Of which have breached	28
Number of completed applications (closed or resolved)	186
Of which have breached	37
Total received since 1st Feb	376

Breakdown of applications by sector as at 8th September

² Completions represent access to data, facilitated by: a novel release of data; an extension to a Data Sharing Agreement to continue to hold data already received or a renewal of the Data Sharing Agreement to receive the same data but for different time frames.

Sector	Open	Rejection	Completed	Total
Academic	90	46	24	160
Research	19	11	8	38
Health	26	9	5	40
Agency / Public Body	29	14	25	68
Commercial	26	29	15	70
Total	190	109	77	376

Breaches to SLAs have occurred principally due to complexity of the application and specific case by case challenges. Additionally, whilst the SLAs continue to bed in, there remains learning to be done on the categorisation of applications which determines the SLA they are assigned too. Even where a case proves more complex than initially expected, the initial categorisation is retained and the customer expectations are managed as the application progresses.

In recognition of these challenges, the process for handling new applications has been amended with further review ongoing to develop a revised model. Under the amended process, there is now senior level involvement (via a Data Approvals Owner) at the initial triage stage to provide greater assurance that the complexity of an application is fully understood and that the correct SLA is assigned.

At triage, a named DAO will be assigned to the application ensuring there is senior level visibility from the outset. This will ensure that significant issues are picked up at the earliest possible opportunity whilst working with the customer on the application form.

Recruitment to the permanent structure is now a complete, with the Data Applications operations manager now in post supported by a management layer for the case officers. This permanent management structure will enable better control and monitoring of work flow, supporting delivery of the applications within their SLAs.

This revised approach has been applied to all new applications received since mid-July 2015 however there remain a significant number of applications in the system that were received prior to this time. Although every effort is being made to minimise the occurrence of breaches to the Service Standards, there remains a risk that further breaches may occur for the reasons identified above.

In recognition of this risk, the 'red team' approach that was successful in clearing the initial backlog of data requests has been instituted for all applications that have breached or at risk of breaching their SLAs. A Data Approvals Owner has been assigned to each case to ensure

they can be resolved as quickly as possible and progress of all at risk cases is reviewed daily by the Data Dissemination Senior Management Team. This approach has also been applied to the outstanding historic cases.

Historic Applications

There remain in the system a small number of applications that were received between 1st August 2013 and 31st January 2015. The table below provides a summary of progress against these applications:

Historic applications as at 8th September

Total applications received (01/08/14 – 31/01/15)	395
Applications closed or completed	367
Applications remaining	28
<i>Number of applications with customer for further information</i>	18
which are in the application stage ³	6
which are in the approval stage	5
which are awaiting customer to sign DSA / Contract	7
<i>Number of applications with HSCIC</i>	10
which are in the application stage	2
which are in the approval stage	6
which are in the access stage (i.e. data being prepared)	2

The outstanding cases are highly complex and remain open as there has been a change in emphasis to providing researchers with greater support if their applications are not suitable for approval (i.e. the legal basis for receipt of ONS data is not currently in place) rather than closing the applications as unapproved. Whilst this has had a beneficial impact on data applicants, it means the HSCIC has less control over how long an application remains open.

Additionally, there remain 3 applications from organisations that have yet to sign a Data Sharing Framework Contract (DSFC). Until an organisation signs a contract, it is not possible for the HSCIC to share data.

³ The DARS process is divided into 3 key stages. The applications stage, in which the DARS case officers work with the customer to bring their initial application up to standard to ensure it is ready for approval. The approvals stage, in which the application is managed through the appropriate approvals route (DAAG / IAO etc.) and the access stage, in which the data is prepared and processed for sending. During each of these stages, further information and clarification is usually required from the customer.

Medical Research suspended studies

Medical Research studies provide on-going data releases (typically quarterly) to researchers as cohorts are tracked over time. Many of these studies were approved prior to the HSCIC but all followed the appropriate legal basis in place at that time. Many were also on-going studies with no fixed end point.

Due to the changing legal position and increased level of scrutiny required of historic agreements, a large proportion of Medical research studies have been suspended (data dissemination is stopped) for one or more of the following reasons;

- External approvals expire (e.g.: Approved Researcher, s251)
- Data Sharing Agreement / Contract expires
- A critical amendment is required (e.g.: name of data recipient changes)
- Non-payment or non-responders

As at September 3rd 2015, there were 221 studies that were suspended prior to 1st June and handling plans for each of these have been developed. 33 studies have subsequently been suspended on or after 1st June 2015 and are being handled through the business as usual DARS process.

Of the 221 studies suspended prior to 1st June:

- 26 have been resolved, either unsuspending, closed or with a data sharing agreement in hand;
- 42 are resolved and are awaiting data destruction notices.

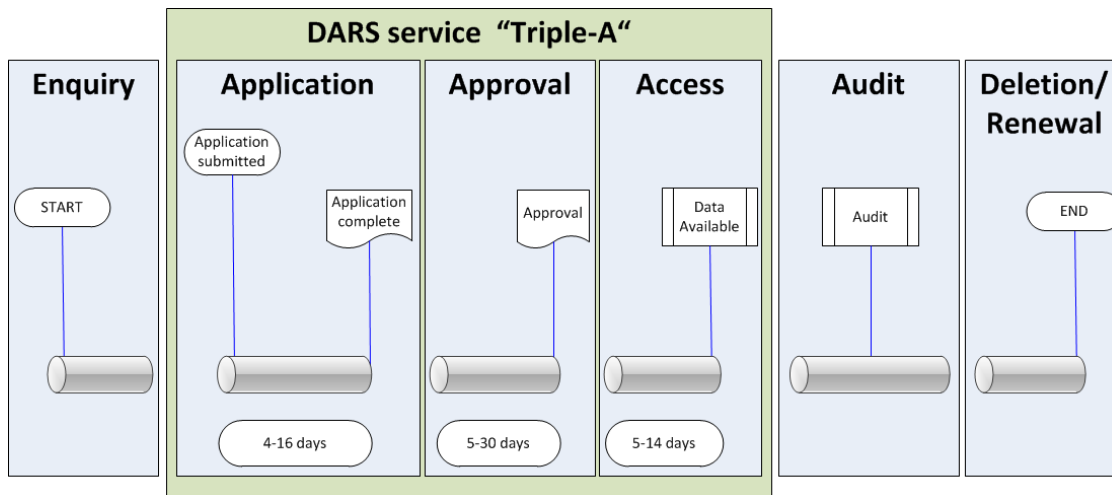
153 remain unresolved and fall into the following categories:

- A. 12 require Data Sharing Agreement (DSA) amendments
- B. 15 require section 251 renewals but have active DSAs
- C. 51 require a DSA renewal and may also require section 251 renewal
- D. 15 require approval since they were not covered under a class action s251 approval⁴
- E. 45 require additional approvals, and may fall into multiple other categories
- F. 15 are looking to move to using pseudo rather than identifiable data

This area is undergoing an intense period of activity and is a key priority for the interim Director of Information and Analytics. Work is underway to agree paths to resolution for each of the categories listed above.

⁴ Studies without sufficient levels of consent following the passing of the Health and Social Care Act 2001 were offered class action support under Section 60 of the HSCA (now re-enacted under Section 251 of the NHS Act 2006) subject to meeting certain conditions such as security standards. This class action support provided the legal gateway for the NHS Information Centre to be able to supply data to these studies and for the studies to hold identifiable data. Under the Health and Social Care Act 2012, the newly formed HSCIC no longer required support under Section 251 however the statutory powers did not extend to class action support for third parties who relied on Section 251 approval for their research studies. These studies were therefore advised to apply for their own Section 251 should they wish to continue to receive identifiable data. 15 studies did not receive the original communications following the change in legislation.

DARS Process improvement



The diagram above provides an overview of the current DARS process. Whilst these stages will remain at a high level, significant work is underway to improve the underlying processes and operating procedures as part of the project to deliver an online application form and through the customer services improvement project.

Process improvements will include:

- Revising the 'method of entry' for submitting an application. This includes making the criteria for submission transparent to data applicants to ensure they are aware of the evidence required for a successful application. This will improve the quality of applications and help to manage the expectations of the applicants (e.g. where data requests are submitted when the correct legal permissions are not yet in place).
- Ensuring applicants are engaged person to person at the beginning of the process to ensure they fully understand the requirements of the application process.
- Providing improved guidance for completing the application form.
- Automating the processes to ensure they are efficient as possible. This will include automating the production of Data Sharing Agreements, introducing electronic signatures to improve the administrative processes involved in approvals and minimising the number of manual hand offs within the internal process. Development of the online application form and these process improvements is currently underway, with migration from current systems and testing scheduled for October and November, with a projected go live, dependent upon the outcome of the testing,

scheduled for December 2015. Users will be fully engaged in this process via the customer forum (first meeting Sept 21st) and wider stakeholder engagement.

- Providing clarity of progress via an online progress tracker.

Customer Service Improvement project

The Customer Service Improvement Programme was initiated in June 2015 with the objective of reducing the number of complaints received from DARS customers by introducing a customer centric service to create a better customer experience.

The programme will focus on ensuring customer experience is central to any developments being initiated and that new products and processes are developed with the customer, not for them. To ensure the programme's deliverables are fit for purpose a Customer Working Group has been established to provide guidance and feedback on the changes being delivered. The group's membership reflects the various types of DARS customer with the first meeting to be held in September to assist with the online application development.

Issues

The principle issues facing regarding Data Access are summarised below:

Issue	Mitigation
1. Customers don't understand the current process.	<p>Customers are being engaged directly through upfront engagement with case officers and Data Approvals Owners regarding specific applications and via a series of roadshows / masterclasses which provide information around the application process and requirements.</p> <p>Going forward development of the online application form and progress tracker will greatly improve clarity of the processes for customers.</p> <p>Members of the HSCIC communications team have been engaged to develop a communications strategy to ensure customers are fully engaged with developments</p>
2. Applications continue to breach their SLAs.	A revised process has been introduced for new applications ensuring improved upfront engagement with experienced case officers and greater control of entry through transparent criteria and improved triage.

	The 'red team' approach has been initiated for existing applications to ensure they are resolved as swiftly as possible.
3. Poor quality applications are being accepted.	One of the principle issues to date has been the quality of applications allowed through the front door. Providing better education and guidance to applicants, tightening the controls on entry and improving customer engagement will raise the quality of initial submissions, reducing the overhead on bringing them to resolution.
4. Federated teams.	<p>The data access process continues to require input from multiple teams across the organisation. Workshops have been initiated to improve integration and understanding of requirements, cross directorate engagement is being promoted and the need to maintain a customer centric approach is being re-enforced through the customer improvement project.</p> <p>Automation of the processes will streamline the hand offs between these teams.</p>

Wider Directorate

The immediate focus is to ensure the improvements to data access and the customer experience outlined above are delivered. Over the next quarter a full review of all services provided by the Data Dissemination directorate will be carried out to identify areas of improvement and alignment. An overview of the data collections team is provided for information below.

Data Collections Team

The Data Collections team within the Data Dissemination directorate manage a number of data collections covering many aspects of health and social care and collected from a wide variety of NHS trusts, local authorities, and independent-sector organisations.

- Adult Social Care Finance Return (ASC-FR)
- Admissions, Changes in Status and Detentions under the Mental Health Act Collection (KP90)
- Assuring Transformation
- General Ophthalmic Services Activities Statistics Table 4

-
- General Practice (including Dental) Complaints Collection (KO41b)
 - Guardianship Collection (SSDA702)
 - Health Visitors Minimum Data Set
 - Hospital and Community Health Services Complaints Collection (KO41a)
 - Learning Disability Census
 - Mental Capacity Act Deprivation of Liberty Safeguards Collection (DoLS)
 - NHS Continuing Care and NHS Funded Nursing Care Collection
 - NHS Stop Smoking Services Collection
 - Percentage of People with Electronic Access to their Medical Records Return (PHF10)
 - PHS1 Pharmacy Collection
 - Safeguarding Adults Return
 - Sexual and Reproductive Health Activity Data Set (SRHAD) Collection
 - Short and Long Term Support (SALT)
 - Smoking Status at Time of Delivery Collection

The team also facilitate secure data transfer activities on behalf of teams across the HSCIC via Secure Electronic File Transfer (SEFT) systems.

ISO 9001 and SIAM are the Quality and Service Models that support and assure these collections. No issues are currently being raised by customers of this service.

