NHS Digital

Agenda: Part 1 (Public Session)

Tuesday 28 March 2017 10:00am to 12:30pm

Venue: Wellington House (Rooms LG19; LG20; LG21) 133-155 Waterloo Road, London SE1 8UG

Apologies:

- Rachael Allsop, Director of Workforce
- Sir John Chisholm, Non-Executive Director
- Professor Maria Goddard, Non-Executive Director
- Professor Keith McNeil, NHS Chief Clinical Information Officer (CCIO), NHS England
- Professor Martin Severs, Medical Director and Caldicott Guardian

Ref No	Agenda Item	Time	Presented By
NHSD 17 06 01	***Chair's Introduction and Apologies* (oral)**	10:00 – 10:10	Chair
NHSD 17 06 02	***Declaration of Interests and Minutes*** (a) NHS Digital Board Members Register of Interests (paper) – **for information** (b) Minutes of Board Meeting on 01 February 2017 (paper) – **to ratify** (c) Matters Arising (oral) – **for comment** (d) Progress on Action Points (paper) – **for information**		Chair
NHSD 17 06 03	***Strategy Delivery and Operational Performance***	10:10 – 11:00	
	(a) NHS Digital Board Performance Pack (paper) – **for information**		Interim CEO
	(b) NHS Digital Corporate Business Plan (paper) – **for approval**		Director of Finance and Corporate Services x 2
	(c) Update on the Production of the Annual Report and Accounts 2016-17 (paper) - **for information**		
NHSD 17 06 04	**Updates on Major Initiatives**	11.00 – 11.30	
	(a) National Back Office Tracing Review Report: (oral) – **for information**		Senior Independent Director
	(b) Progress Towards a Patient Centric Digital Health and Care System' (paper) – **for information**		Director of Programmes
NHSD 17 06 05	***Governance and Assurance*** (a) Directions - **for acceptance** i. Direction for Local Stop Smoking Services Data Collection (paper) ii. Direction from NHS England for the National Diabetes Audit Programme (paper) iii. Annual Uses of the Mental Health Act 1983 in English Acute Trusts Collection (paper) iv. PLICS (Patient Level Information and Costing Systems) Mandatory Request (paper) v. Direction from NHS England for 'General Practice Contract Data Collections' (paper)	11.30 – 12:00	Director of Programmes

	(b) Committee Reports – **for information**	12:00-12:15	
	i. Assurance and Risk Committee (ARC) Report: 15 March 2017 (oral)		Committee Chair
	ii. Information Assurance and Cyber Security Committee (IACSC): 15 March 2017 (oral)		Committee Chair
	(c) NHS Digital Board Forward Business Schedule 2017-18 (paper) – **for information**	12:15-12.30	Chair
NHSD 17 06 06	***Any other Business*** (subject to prior agreement with Chair)		Chair
	Close	12:30	

NHSD 17 06 07 ***Background Paper(s)*** (for information only)

(a) Forthcoming Statistical Publications (paper) – **for information**

(b) Streamlining the Independent Information Governance Advice to NHS Digital (paper) – **for information**

Date of next meeting: 03 May 2017, Hilton London Olympia, 380 Kensington High Street, London, W14 8NL

Board meeting – Public Session

Title of paper:	**NHS Digital Board Members Register of Interests**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 05 02 a
Paper presented by:	Chair
Paper prepared by:	Executive Office Secretariat
Paper approved by: (Sponsor Director)	Each Director is accountable for their declaration of interest
Purpose of the paper:	NHS Digital is required by its Standing Orders to maintain a publically available Register of Members' Interests. The Register contains, as they become available, the Declarations of Interest made by Board Members.
Key risks and issues:	N/A
Patient/public interest:	Corporate Governance Transparency and Openness
Actions required by the board:	For information

NHS Digital Board Register of Interests 2016-17

Name	Declared Interest
Non-Executive Directors	
Noel Gordon: Chair	• Non-Executive Director, NHS England • Non-Executive Director, PSR (Payments Services Regulator) • Chairman of Board of Trustees, Uservoice.org **Other Offices held:** • Member, Audit Committee, University of Warwick • Member, Development Board, Age UK **Shareholdings:** • Accenture **Other relevant interests:** • Senior Advisor, Aleron
Sir Ian Andrews: Non-Executive Director Senior Independent Director	• Partner in IMA Partners (formerly trading as IMA Partners Ltd until February 2016) providing legal and management consultancy services to government, academia (KCL[1]) and Transparency International UK. **Other Offices held:** • Conservator of Wimbledon and Putney Commons • Trustee Chatham Historic Dockyard • Member of UK Defence Academy Academic Advisory Board
Marko Balabanovic: Non-Executive Director	**Employment (other than with NHS Digital):** • Chief Technology Officer, Digital Catapult **Shareholdings:** • Equal Media Ltd
Daniel Benton: Non-Executive Director	**Directorships:** • Trustee, The Grange Festival **Other Offices held:** • Fundraising and Finance Committees , NSPCC **Shareholdings:**

[1] King's College London

Name	Declared Interest
	• Accenture • Supercarers
Dr Sarah Blackburn: Non-Executive Director	**Directorships:** • Director - The Wayside Network Limited • Board Director and Audit Committee member, RAC Pension Fund Trustee **Employment (other than with the NHS Digital):** • The Wayside Network Limited **Other Offices held:** None **Contracts held in last 2 years:** The Wayside Network Limited has: • a contract to supply GP and primary care nursing services to Avon and Wiltshire NHS Partnership • a zero hours contract with the Chartered Institute of Internal Auditors to provide an External Quality Assessment Reviewer and a viva voce examiner **Shareholdings:** • 50% of The Wayside Network Limited **Other relevant interests:** • Husband has the other 50% of The Wayside Network Limited shares • Daughter is a trainee orthopaedic surgeon in Bristol
Sir John Chisholm: Non-Executive Director	**Directorships:** • Executive Chair – Genomics England Ltd • Director – Historic Grand Prix Cars Association Ltd
Professor Soraya Dhillon MBE: Non-Executive Director	**Directorships:** • Non-Executive Director, The Hillingdon Hospital NHS Foundation Trust **Employment (other than with NHS Digital):** • Academic Manager, University of Hertfordshire **Other offices held:** • Senior Independent Sponsor Improvement Steering Group, Eastern

Name	Declared Interest
	Academic Health Science Network **Contracts held in last 2 years:** • Former Dean School of Life and Medical Sciences, University of Hertfordshire until 31 October 2016
Professor Sudhesh Kumar: Non-Executive Director	**Directorships:** • Institute of Digital Healthcare, Warwick Manufacturing Group **Employment (other than with NHS Digital):** • Dean, Warwick Medical School **Other offices held:** • Non-Executive Director, University Hospital of Coventry and Warwickshire (UHCW) NHS Trust • Honorary NHS Consultation Physician, (UHCW), Heart of England Foundation Trust and George Elliot Hospitals **Shareholdings:** • Medinova Research Limited **Other relevant interests:** • Member, Medical School Council
Professor Maria Goddard: Non-Executive Director	• Member of Board of Directors for the York Health Economics Consortium at the University of York • Professor of Health Economics at the University of York and head of department/director of the Centre for Health Economics at the University of York
Rob Tinlin: Non-Executive Director	**Directorships:** • Trustee, Southend Hospital Charity Foundation • Trustee, Southend Museum Development Trust **Employment (other than with the NHS Digital):** • Chief Executive, Southend-on-Sea Borough Council, until 31 03 2017 **Other Offices held:** • Member, Advisory Board, Queen Mary University of London Business

Name	Declared Interest
	School • Chairman and Board Member, Association of Local Authority Chief Executives, resigned 05 01 2017 • Member, Anglia Ruskin MedTech Board, until 31 03 2017 • Member, Southend Health & Well Being Board, until 31 03 2017
Executive Members of the Board	
Andy Williams: Chief Executive Officer (CEO)	• None
Rachael Allsop: Director of Workforce	• None
Beverley Bryant: Director of Digital Transformation	**Contracts held in last two years:** • Director of Digital Technology, NHS England (until 31 May 2015) **Other relevant interests:** • Silent Partner – Wildtrack Telemetry Systems Limited
Rob Shaw: Chief Operating Officer	• None
Carl Vincent: Executive Director of Finance and Corporate Services	• None
Ex Officio Board Members	
Professor Martin Severs: Medical Director and Caldicott Guardian	• Trustee of Dunhill Medical Trust, a research charity • Professor of Health Care for Older People with University of Portsmouth (Honorary) **Other Offices:** • Member of National Data Guardian's Panel **Other relevant interests:** • Member of Royal College of Physicians, British Geriatrics Society, the

Name	Declared Interest
	Faculty of Public Health Medicine and British Medical Association (BMA)
Tamara Finkelstein: Director General for Community Care, Department of Health	• Department of Health**,** Director General for Community Care **Directorships:** • New North London Synagogue (as Tamara Isaacs) • The Jewish Community Secondary School (as Tamara Isaacs)
Keith McNeill: Chief Clinical Information Officer, NHS England	Chief Clinical Information Officer, Health and Social Care **Directorships:** • Carers Queensland **Other Offices:** • Non-Executive Director Eastern Academic Health Science Network **Contracts held in last two years:** • Chief Executive, Addenbrookes Hospital Cambridge
Executive Management Team Directors	
Tom Denwood: Director for Provider Support and Integration	• British Computer Society (BCS) Health, Vice Chair Policy and Strategy (a voluntary role at this registered charity) • Senior Responsible Owner (SRO) for Local Service Provider (LSP) Programmes on behalf of Department of Health • Senior Responsible Owner (SRO) for the Health and Social Care Network (HSCN) Programme on behalf of Department of Health (DH)
James Hawkins: Director of Programmes	• Parent Governor at St Peters Church of England Primary School, Harrogate
David Hughes: Director of Information and Analytics	• None

NHS Digital

Minutes of Board Meetings

Wednesday 01 February 2017

Part 1 - Public Session

Present:	
Non-Executive Director (Chair)	Noel Gordon
Non-Executive Director (Vice Chair)	Dr Sarah Blackburn
Non-Executive Director (Senior Independent Director)	Sir Ian Andrews
Non-Executive Director	Marko Balabanovic
Non-Executive Director	Daniel Benton
Non-Executive Director	Soraya Dhillon, MBE
Non-Executive Director	Prof. Maria Goddard
Non-Executive Director	Sudhesh Kumar
Non-Executive Director	Rob Tinlin
Chief Executive Officer	Andy Williams
Director of Digital Transformation	Beverley Bryant
Chief Operating Officer	Rob Shaw
Director of Finance and Corporate Services	Carl Vincent
In attendance:	
Medical Director and Caldicott Guardian	Prof. Martin Severs
Executive Office Secretariat	Nicola Rhodes

1. Chair's Introduction and Apologies **NHSD 17 05 01 (P1)**

1.1 The Chair convened a meeting of the NHSD Digital Board.

1.2 The Chair reported that he had received apologies from Rachael Allsop, Director of Workforce, Sir John Chisholm, Non-Executive Director, Professor Keith McNeil, NHS Chief Clinical Information Officer (CCIO) and Tamara Finkelstein, Director General for Community Care, DH. The Chair confirmed that the meeting was quorate.

The Chair welcomed and introduced the newly appointed Non-Executive Directors NEDs to the NHS Digital Statutory Board Meeting.

The Chair noted that this was the final meeting for Professor Maria Goddard, Non-Executive Director. The Chair thanked her on behalf of the Board for her valuable contribution to the organisation whilst in post as a NED and wished her all the very best for the future.

2. Declaration of Interests and Minutes **NHSD 17 05 02 (P1)**

2.1 (a) Register of Interest (paper) NHSD 17 05 02 (a) (P1)

The Board agreed the register of interests was correct.

The Chair asked Board members to make declarations of interest for the Agenda items listed.

2.2 (b) Minutes of Board Meeting on 30 November 2016 (paper) NHSD 17 05 02 (b) (P1)

The Board ratified the minutes of the meeting held on 30 November 2016.

2.3 (c) Matters Arising (oral) NHSD 17 05 02 (c) (P1)

The Board were advised that Soraya Dhillon, Non-Executive Director was responsible for board oversight for clinical governance and safety, working with Martin Severs. Medical Director and Caldicott Guardian.

2.4 (d) Progress on Action Points (paper) NHSD 17 05 02 (d) (P1)

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

It was noted that the content of the action update was incomplete. A revised version of the action updates will be republished as soon as possible that fully reflects next steps.

3. Strategic Delivery and Operational Performance **NHSD 17 05 03 (P1)**

3.1 (a) Board Performance Pack (paper) NHSD 17 05 03 (a) (P1)

The Chief Executive Officer (CEO) presented this item. The purpose was to provide the Board with a summary of NHS Digital's performance in December 2016. The CEO updated the board as follows:

Programme Achievement during December was reported as Amber-Green. Across all reported programmes, overall delivery confidence for December was 65.7% - an increase from 64.8% in November 2016. It was noted that although the overall position is Amber-Green, delivery confidence across the Paperless 2020 portfolio of

programmes was Amber, which comprises of 30 Paperless 2020 programmes and 10 legacy programmes. There were no Paperless 2020 programmes reported as Red. However, seven were reported as Amber-Red. It was noted that these were complex programmes and some programmes were in early stages. It was felt that overall, the trend was positive.

Delivery confidence across the legacy programmes was Amber-Green and continues to improve. It was noted that one legacy programme, Child Protection Information Sharing, was reported as Red. The Board were assured that a root and branch review had been undertaken to understand the issues. It was found that a new approach was required and improved results are expected from April 2017. It was agreed that a more detailed paper outlining the issues, action taken and timelines for improvement would be brought back to the March Board for Information.

Action: Director of Digital Transformation

IT Service performance was reported as Green. All services met their service objectives for all the services reported on. The Board briefly discussed NHS Mail service issues and sought assurance that the NHS Mail platform remained stable and the issues resolved. The Board were advised that Accenture had made a number of modifications to the platform.

Organisational Health was reported Amber and is forecast to remain the same in the following months. The organisation continues to focus on recruitment campaigns by profession, the development of new employment pipelines, and on building on the success of the graduate scheme. It was noted that the lowest attrition rate within the organisation was with graduates.

It was highlighted that there are 178 posts at an unconditional offer / appointment stage which indicates that new starters joining the organisation is strengthening and reflects a big effort undertaken to attract talent within the organisation. Work continues to improve this further. The Board discussed the focused areas for recruitment which included Project and Programme management, digital and commercial. It was noted that the market was tight but that NHS Digital was seen as an attractive place to work. It was agreed that the NHS Digital rebrand had made a difference and the name itself has attracted further talent to the organisation. It was accepted that there are roles that won't be filled via recruitment; the board were assured that alternative solutions were being explored further. The importance of retaining talented staff was discussed at length.

It was noted that as organisation emerges from strategy and design into delivery and execution the board would need to focus on how the organisation links talent to delivery capability it was agreed that the outline of the talent map would be bought back to the March Board for further consideration.

Director of Workforce/ Director of Finance and Corporate Services

Data Quality was reported as Amber. It was noted that further improvement is required. There is a plan in place to address this.

Financial Management was reported as Red. The budget for the year has been materially restated at month nine to include the transfer of DH assets to NHS Digital, the transfer of Paperless 2020 revenue funding to NHS Digital and the realignment of some NHS England funding from external income. After making these adjustments to budgets, there is forecast underspend for the year of £11.3m. The Board noted the paper for information.

3.2 (b) NHSmail Incident Summary (paper) NHSD 17 05 03 (b) (P1)

The Director of Operations and Assurance presented this item. The purpose was to provide an overview of the NHSmail Incident and actions undertaken in response to the incident. Rob Shaw provided context to the issue advising that the 500 million emails were issued within one day due to one incident. The Board described the steps taken to prevent the recurrence of this, or of any similar issues. The Board debated the matters raised at length and discussed the importance of robust business continuity plans.

The Board discussed the lessons learned from NHS Mail incident and considered the impact of future relapses of functionality. The Board were assured that robust performance and scenario testing was undertaken routinely to ensure that everyone is aware of alternative plans in the event of service failure. It was agreed that any future relapses of functionality within the platform will be taken to either the ARC or Information Assurance and Cyber Security Committee (IACSC) for discussion.

The board noted the update observing that they were assured the way the incident had been resolved by NHS Digital and Accenture.

4 Strategy and Capability **NHSD 17 05 04 (P1)**

4.1 (a) Capability Review Update (paper) NHSD 17 05 04 (a) (P1)

The Director of Finance and Corporate Services presented this item. The purpose was to update the Board on progress to date within the Capability Review. Carl Vincent provided context advising the review was required to support delivery of the paperless 2020 portfolio of programmes. He spoke about the review being undertaken externally so that it would remain objective and allow the opportunity to benchmark against other organisations. Interim reports are in development and work continues on the production of the final report and implementation plan.

Carl Vincent provided a high level summary of the findings for consideration which the Board debated at length. It was observed that the organisation was going through a period of unprecedented change, where every part of the operating model has changed; the organisation must now change delivery of the programmes using agile delivery methods.

Assurance was sought that external stakeholders had been given the opportunity to critique and receive feedback particularly around client engagement. The Board were assured wider stakeholder groups had been given the opportunity to comment on the recommendations.

The final report and implementation plan will be submitted to the Statutory Board meeting for approval scheduled to take place on 28 March 2017. In the meantime a broadly agreed implementation plan will be developed. Where recommendations are non-contentious and can be developed within existing resources, the implementation will start in advance of Board approval.

Action: Director of Finance and Corporate Services

The Board noted the update.

4.2 (b) Implementing and Business Change Portfolio Proposal (paper) NHSD 17 05 04 (b) (P1)

The Director of Digital Transformation presented this item. The purpose of the paper was to present the final version of the Implementing and Business Change Portfolio Proposal to the Board for approval. Beverley Bryant summarised the issues encountered implementing business change on a programme by programme basis

and the impact of this on front line users. It was highlighted that there is currently no organisational ownership for business as usual products, moving into implementing business change following the end of their business case resulting in a lack of clarity for future developments and product direction. Beverley Bryant described the vision for the service and summarised the content of the proposal, the Board debated the proposal at length. There was consensus that the Business Change portfolio was required.

The Board debated the skill set required within team and future skills required to successfully embed the Business Change Portfolio. The Board were supportive of the proposal and approved the approach outlined within the paper noting that ongoing training requirements may require further consideration.

5 Governance and Assurance **NHSD 17 05 05 (P1)**

5.1 (a) Board and Sub-committee Appointments (paper) NHSD 17 05 05 (a) (P1)

The Chair presented this item. The purpose was to review and formally note the appointment of five new non-executive directors and to appoint members to the Board's sub-committees.

The Board, being satisfied with the information received, approved the Board and Sub-committee appointments.

5.2 (b) Directions for Acceptance NHSD 17 05 05 (b) (P1)

(i) Directions: Sexual Reproductive Health Attendance Data (paper) NHSD 17 05 05 (b)(i) (P1)

The Medical Director and Caldicott Guardian presented this item. The Board, being satisfied with the information and assurances provided, accepted the Direction.

5.3 (c) Committee Reports NHSD 17 05 05 (c) (P1)

(i) Assurance and Risk Committee (ARC) Report: 18 January 2017 (oral) NHSD 17 05 05 (c)(i) (P1)

Sarah Blackburn, Non-Executive Director and Chair of the Assurance and Risk Committee (ARC) presented this item. The purpose was to provide the Board with an update from the last committee meeting, which was held on 18 January 2017.

The Board were advised that no deep dives had been considered at the ARC. The discussion focused on the capability review and was attended by Deloitte. The draft recommendations of the Capability Review were presented to the Committee for consideration and comment. The implementation plan will be presented to the ARC on 15 March 2017 for approval.

Three Internal Audit reports were expected from Health Group Internal Audit Services (HGIAS) which were deferred. The three of the reports will now be discussed at the Information Assurance and Cyber Security Committee (IACSC) to ensure that each item has sufficient time for discussion.

The Anti-Fraud Audit Report was presented to the Committee for consideration. The report was moderate. HGIAS assured the Committee that they were on track to deliver the 2016/17 Audit plan by the end of the year as planned.

The Committee reviewed the first draft of the annual accounts commentary and also considered the financial report, issues and risks. The transfer of non-current fixed

assets that have been transferred from DH was discussed at length. The Assurance and Risk Committee were satisfied that the trajectory is going in the right direction. The Board noted the update.

5.4 (d) Board Forward Business Schedule 2016-17 NHSD 17 05 05 (d) (P1)

The Chair presented this item. The purpose was for The Board to note for information the NHS Digital Board forward business schedule for the financial year 2016-17. It was noted that this schedule is subject to frequent change. The Board noted the paper for information.

6 Any Other Business (subject to prior agreement with chair) NHSD 17 05 06 (P1)

6.1 The Board were advised that the Annual Review of Board Effectiveness would be deferred until April 2018. The Senior Independent Director advised this was due to the recent appointment of Non-Executive Directors. Furthermore, they did not believe there were any significant issues that may give rise to a different conclusion to previous years. The Chair advised that the routine 1:1 meetings were now established with Board members which will also support the review of the Board development.

The Board were advised that the National Back Office Tracing review will be published in due course.

7 Background Papers (for information) NHSD 17 05 07 (P1)

7.1 (a) Staff Survey Results 2016-17 (paper) NHSD 17 05 07 (a) (P1)

The Board noted this paper for information.

7.2 (b) Data Release Audit Status Report (paper) NHSD 17 05 07 (b) (P1)

The Board noted this paper for information.

7.3 (c) Forthcoming Statistical Publications (paper) NHSD 17 05 07 (c) (P1)

The Board noted this paper for information.

7.4 (d) Programme Definitions (paper) NHSD 17 05 07 (d) (P1)

The Board noted this paper for information.

8 **Date of Next Meeting**

8.1 The next statutory Board meeting will take place on Tuesday 28 March 2017.

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

Table of Actions:

Action	Action Owner
Child Protection Information Sharing It was agreed that a more detailed paper outlining the issues, action taken and timelines for improvement would be brought back to the March Board for Information.	**Director of Digital Transformation**
Talent Management It was noted that as organisation emerges from strategy and design into delivery and execution the board would need to focus on how the organisation links talent to delivery capability. It was agreed that the outline of the talent map would be bought back to the March Board for further consideration.	**Director of Workforce** **Director of Finance and Corporate Services**
Capability Review The final report and implementation plan will be submitted to the Statutory Board meeting for approval scheduled to take place on 28 March 2017. In the meantime a broadly agreed implementation plan will be developed. Where recommendations are non-contentious and can be developed within existing resources, the implementation will start in advance of Board approval.	**Director of Finance and Corporate Services**

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

Board meeting – Public Session

Title of paper:	**Progress on Action Points**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 02 d
Paper presented by:	Chair
Paper prepared by:	Executive Office Secretariat
Paper approved by: (Sponsor Director)	Each action update is submitted and approved by the relevant Executive Director
Purpose of the paper:	To share an update on open action points from previous meetings for information. To ensure the completion of Board business.
Key risks and issues:	As stated in the action and commentary
Patient/public interest:	Corporate Governance best practice
Actions required by the board:	To note for information

Progress against Board meeting actions

Green = completed
Amber = on-going
Red = overdue

Meeting Date	Status	Summary of Action	Responsible Director	Commentary	Next Steps	Target Completion Date
04/05/2016	Green	UK Statistics Authority Paper: Deriving Intelligence from Data: The interim Director of Information and Analytics, Medical Director and Caldicott Guardian said he would take this topic to the next scheduled Department of Health (DH)/NHS Digital Accountability meeting.	Interim Director of Information and Analytics, Medical Director and Caldicott Guardian	**Update 01 February 2017:** UK Statistics Authority Paper: Deriving Intelligence from Data: The interim Director of Information and Analytics, Medical Director and Caldicott Guardian said he would take this topic to the next scheduled Department of Health (DH)/NHS Digital Accountability meeting. **Update 28 March 2017:** Chris Roebuck attended a pre-meet to give a verbal brief on this topic referred to at the time as 'statistical publications'. Papers were provided for the main Accountability meeting on 21st June 2016. There are no outstanding actions or questions on this matter recorded in the minutes.	Action Complete	March 2017

Meeting Date	Status	Summary of Action	Responsible Director	Commentary	Next Steps	Target Completion Date
07/09/2017	Amber	The COO said that there was recognition that the Information Assurance and Cyber Security Committee terms of reference would need to evolve to reflect changes in the informatics governance landscape and across Whitehall, including the formation of the National Cyber Security Centre (NCSC). The Chair asked that the Board have sight of any proposed change to the Committee and its terms of reference prior to implementation.	Chief Operating Officer	**Update 28 March 2017:** Work with NCSC has begun to identify linkages and requirements on the IACSC Terms of Reference. However, the work is also looking to bring input from the recommendations within the NHS Digital Capability review which has not yet been approved.	Capability review to be approved within NHS Digital to be approved and released in March 2017. Once released, ToR to be update accordingly and circulated to the Board.	April 2017
30/11/2016	Amber	The Board discussed the requirement for a target workforce model as part of the next steps work and the Chair suggested that a joint paper should be submitted for the 28 March Board which encompasses the Capability Review, Refreshing the Strategy and the Target Workforce Model. He stated that the Target Workforce Model would bring together the Capability Plan and Strategy and the Strategy refresh and all three should converge in one paper.	Director of Workforce	**Update 01 February 2017:** Head of Workforce, Director of Strategy and Head of Capability Review to progress **Update 28 March 2017:** This action is being progressed within the context of the Capability Review paper, which will be available at the 28th March Board meeting.	To be discussed at March Board Meeting	March 2017

Meeting Date	Status	Summary of Action	Responsible Director	Commentary	Next Steps	Target Completion Date
30/11/2016	Green	Chair to confirm Non-Executive Director responsible for being sighted on Clinical Safety and Governance	Chair	**Update 01 February 2017:** Awaiting new NEDs to be appointed and Chair's discussion. **Update 28 March 2017:** Soraya Dhillon has been Confirmed at the Non-Executive Director responsible for being sighted on Clinical Safety and Governance.	Action Complete	February 2017
01/02/2017	Amber	Child Protection Information Sharing It was agreed that a more detailed paper outlining the issues, action taken and timelines for improvement would be brought back to the March Board for Information.	Director of Digital Transformation	**Update 28 March 2017:** With Noel's approval this paper has been deferred to the May public Board to allow approvals through CPIS programme board and NHS England prior to going to NHSD board.	Paper to go to the CPIS programme Board and NHS England for approval. Scheduled to return to NHS Digital Board in May.	May 2017
01/02/2017	Green	Talent Management It was noted that as organisation emerges from strategy and design into delivery and execution the board would need to focus on how the organisation links talent to delivery capability. It was agreed that the outline of the talent map would be bought back to the March Board for further consideration.	Director of Workforce/ Director of Finance and Corporate Services	**Update 28 March 2017:** To be covered as part of the Capability Review. This is scheduled for discussion on 28 March Board Agenda	Action Complete	March 2017

Meeting Date	Status	Summary of Action	Responsible Director	Commentary	Next Steps	Target Completion Date
01/02/2017	Green	The Capability Review final report and implementation plan will be submitted to the Statutory Board meeting for approval scheduled to take place on 28 March. In the meantime a broadly agreed implementation plan will be developed and will begin to be implemented and an Equality Impact Assessment will be been undertaken.	Director of Finance and Corporate Services	**Update 28 March 2017:** The Capability Review Implementation Plan based on the Final Report will cover issues that impact NHS Digital staff and services we deliver within health and social care. NHS Digital has a Diversity and Inclusion lead that has been engaged by the Capability Review and is supporting the team to provide a steer as we move into detailed planning to implement the recommendations. This will include the appropriate application of Equality Assessments, specifically around key areas such as workforce. The timescale for completion of these will be included within the plan for the implementation. A pilot Equality Impact Assessment (EIA) is being rolled out in NHS Digital in April/May and the Capability Review will utilise and learn lessons from this in developing the Capability Review EIA's. The EIA's are part of, rather than an addition to, the planning activity.	Action Complete	March 2017

Board Meeting – Public Session

Title of paper:	**NHS Digital Board Performance Pack (public)**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 03 a
Paper presented by:	Rob Shaw, Interim CEO
Paper prepared by:	David O'Brien, Head of Business Intelligence
Paper approved by: (Sponsor Director)	The Performance Pack is approved collectively by EMT in its corporate business management meeting held in advance of the Board papers being issued.
Purpose of the paper:	To provide the Board with a summary of NHS Digital's performance for February 2017.
Additional Documents and or Supporting Information:	No additional documents
Please specify the key risks and issues:	The corporate performance framework monitors NHS Digital performance including information governance and security.
Patient/public interest:	The public interest is in ensuring the NHS Digital manages its business in an effective way.
Supplementary papers:	N/A
Actions required by the Board:	**To Note**

Board Meeting – Public Session

Title of paper:	**NHS Digital Corporate Business Plan 2017/18**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 03 b
Paper presented by:	Carl Vincent Executive Director, Finance and Corporate Services
Paper prepared by:	David O'Brien Head of Business and Operational Delivery
Paper approved by: (Sponsor Director)	Carl Vincent Executive Director, Finance and Corporate Services
Purpose of the paper:	To seek the Board's approval for the NHS Digital Business Plan, pending any revisions that may be required. NHS Digital is required to produce and publish an annual business plan, setting out delivery commitments for 2017/18. As part of the new system wide-governance arrangements, our business plan must be approved by the Digital Delivery Board as part of the mechanism for releasing funding to NHS Digital. Partly in response to this, the business plan this year contains a greater focus on core services as well as the portfolio of major change programmes. Our business planning has identified affordability issues for 2017/18. These are addressed in an item to be taken in the private session of this Board meeting. Following its approval we will publish the business plan on the NHS Digital website. Prior to publication there will be an opportunity to amend the presentation of the document.
Additional Documents and or Supporting Information:	The final draft NHS Digital Business Plan 2017/18 is attached

Please specify the key risks and issues:	Three specific risks are outlined in the report: • Mobilisation to deliver the Personalised Health and Care 2020 portfolio • Implementation of the Capability Review recommendations • Financial Risks
Patient/public interest:	It is in the patient/public interest that this organisation plans it business well, with clear and achievable delivery commitments supported by sustainable financial plans.
Supplementary papers:	Appendix 1 - NHS Digital Business Plan 2017/18
Actions required by the Board:	(1) The Board approves the NHS Digital corporate business plan for 2017/18, pending any non-material revisions that may be required. (2) The Board authorises the CEO to enact any non-material revisions to the business plan as may be required prior to final approval.

Business Planning

NHS Digital Corporate Business Plan 2017/18

28 March 2017

Information and technology
for better health and care

Contents

Executive Summary

This paper presents the NHS Digital corporate business plan for 2017/18. The paper seeks the Board's approval for the corporate business plan, pending any non-material revisions that may be required. In addition, the paper outlines the key risks and issues facing NHS Digital regarding the delivery of its business plan commitments.

Background

Department of Health Arms-Length Bodies are required to prepare and publish an annual business plan. Such business plans are expected to set out delivery commitments for the year, high-level financial information, plus supporting information about the role, priorities, operations and governance of the organisation.

NHS Digital's corporate business plan must be approved by its Board. Moreover, under new system-wide governance arrangements the NHS Digital corporate business plan must also be approved by the Digital Delivery Board. Final approval of the business plan comes from the Department of Health on behalf of the Secretary of State.

Our 2017/18 business plan reflects the fact that NHS Digital's role has increased significantly as we have been tasked with delivering commitments set out in the National Information Board's strategy, *Personalised Health and Care 2020*. This represents a major shift in the scale and complexity of the requirements that fall on this organisation. The commitments in its 2017/18 corporate business plan will see NHS Digital accelerate the delivery of this ambitious portfolio of digital technology and data solutions.

Recommendation

(1) The Board approves the NHS Digital corporate business plan for 2017/18, pending any non-material revisions that may be required.

(2) The Board authorises the CEO to enact any non-material revisions to the business plan as may be required prior to final approval.

Implications

Strategy Implications

The corporate business plan directly supports implementation of NHS Digital's strategy for 2015-2020, *Information and Technology for Better Care*. It also represents NHS Digital's contribution to other strategies across the health and care system, notably:

- National Information Board, *Personalised Health and Care 2020*
- NHS England, *Five Year Forward View*
- Department of Health Shared Delivery Plan, *Our Health 2020*

Delivery of the *Personalised Health and Care 2020* commitments is so important to this organisation that we have structured our corporate business plan around its ten priority themes, or 'domains'.

Financial Implications

There are issues to resolve regarding funding for 2017/18. This will be the subject of an item to be taken in the private session of the Board meeting.

The Board should note that a recent process of 'funding realignment' has introduced new financial, governance and assurance arrangements to the health and care informatics system. With a few exceptions, all of the funding allocated to deliver the *Personalised Health and Care 2020* portfolio and other national health and care informatics work should transfer to NHS Digital as part of its core budget. The funding transferred to NHS Digital is not ring fenced: NHS Digital will determine how best to use this money effectively and efficiently to manage delivery. However, the Digital Delivery Board will hold NHS Digital to account for the use of this money and will set out the key commitments it expects NHS Digital to deliver.

Although the money sits within NHS Digital's budget, the Digital Delivery Board must approve actual expenditure. Services expenditure will be approved via the NHS Digital corporate business plan. Programme expenditure will be released via programme business cases approved by the Technology and Data Investment Board, a sub-group of the Digital Delivery Board.

Stakeholder Implications

Key stakeholder implications are:

- The National Information Board, whose strategy, *Personalised Health and Care 2020*, will be delivered through the commitments set out in the NHS Digital business plan.
- The Digital Delivery Board, which must approve the NHS Digital business plan. This is scheduled to happen at its meeting on 06 April. Digital Delivery Board partners include the Department of Health, NHS England, and the system-wide Chief Clinical Information Officer.
- The Department of Health, which must approve the NHS Digital corporate business plan on behalf of the Secretary of State. The Department of Health has issued a 'remit' document that sets out expectations about what NHS Digital should deliver in 2017/18. We believe the specific commitments and broader activities captured in the corporate business plan, combined with deliverables found in other operational plans below the corporate level, comply with these expectations.

Handling

In the interests of openness and transparency, Arms-Length Bodies such as NHS Digital are required to publish their annual business plan in the public domain. At some point after we have secured final agreement from the DH and our system wide partners on the Digital Delivery Board (DDB), we will publish on the NHS Digital website. At this point we will have options to revise some of the presentation of the document.

Risks and Issues

1. Delivery of Personalised Health and Care 2020

Delivery of the *Personalised Health and Care 2020* commitments presents NHS Digital with significant risks. These are captured in the organisation's strategic risk management framework. The scale and complexity involved in delivering more than thirty major programmes is challenging, especially as critical interdependencies exist between many of them. There are resource pressures: current plans and assumptions indicate that to deliver *Personalised Health and Care 2020* at the required pace requires the organisation to quickly attract and deploy more staff, especially in certain essential technical and digital professions.

To mitigate delivery risks, NHS Digital and the Digital Delivery Board have decided that all programmes should not proceed at the same time and at the same pace. While many programmes will proceed as planned, some higher priority programmes have been accelerated and other lower priority programmes slowed down. Programme plans have been recalibrated based on these prioritisation decisions. The commitments in this business plan reflect these recalibrated plans.

2. Capability Review

The business plan includes a commitment to implement the recommendations of our recent 'capability review'. The purpose of this review was to baseline our existing capabilities and to identify the steps needed to transform NHS Digital into a modern, agile organisation that is well placed to discharge its responsibilities and meet customer needs, particularly relating to the *Personalised Health and Care 2020* work. The review addressed four main themes:

- Modernising our delivery model
- Transforming the way we work with customers, stakeholders and partners
- Accountability, governance and decision-making
- Developing our workforce to respond to demand

We are committed to changing our organisation in the ways recommended by the review. However, we must find appropriate ways to invest sufficient time and resource in this work without it having a detrimental impact on our ability to deliver other business plan commitments, and especially our *Personalised Health and Care 2020* priorities.

3. Financial Risks

Financial pressures across the *Personalised Health and Care 2020* portfolio present risks to NHS Digital. As part of its budget process NHS Digital has found funding for programmes that had identified funding gaps, by moving from elsewhere some funds that are not expected to be required. This process highlighted that a number of other programmes are requesting revenue funding in excess of their agreed baselines. There is also an additional pressure for more funding to extend the scope of the Digital Child Health programme in order to include maternity. We do not expect that all of these pressures can be accommodated within the funding available.

The NHS Digital budget will be combined with budgets from NHS England and the Department of Health to form an overall budget / four year plan for the *Personalised Health and Care 2020* portfolio. At this point total affordability will need further review and some adjustments may be required. The Digital Delivery Board is due to approve the combined portfolio budget on 06 April.

Additional financial risks to NHS Digital include:

- Programme funding pressures in NHS England
- NHS England and NHS Digital have differing expectations and assumptions as to expenditure to be incurred by each organisation respectively. This applies to 2017/18 and to future years
- Pressures from new scope or additional requirements arising since baseline funding for programmes was agreed

Corporate Governance and Compliance

Following approval by the Board, the NHS Digital corporate business plan must be approved by the Digital Delivery Board and, subsequently, by the Department of Health on behalf of the Secretary of State. Approval by the Digital Delivery Board is scheduled to take place at its meeting on 06 April.

Delivery of our business plan commitments will be monitored by NHS Digital's internal governance bodies, including the Executive Management Team and the Operations Board. The NHS Digital Board will receive quarterly performance reports on business plan delivery. These reports will be presented in the public session of statutory Board meetings.

NHS Digital will report on its business plan delivery, and particularly the *Personalised Health and Care 2020* commitments, to the Digital Delivery Board and to the Department of Health via quarterly accountability meetings.

Management Responsibility

The responsible Executive Director for corporate business planning and budget-setting is Carl Vincent, Director of Finance and Corporate Services.

Actions Required of the Board

(1) The Board approves the NHS Digital corporate business plan for 2017/18, pending any non-material revisions that may be required.

(2) The Board authorises the CEO to enact any non-material revisions to the corporate business plan as may be required prior to final approval.

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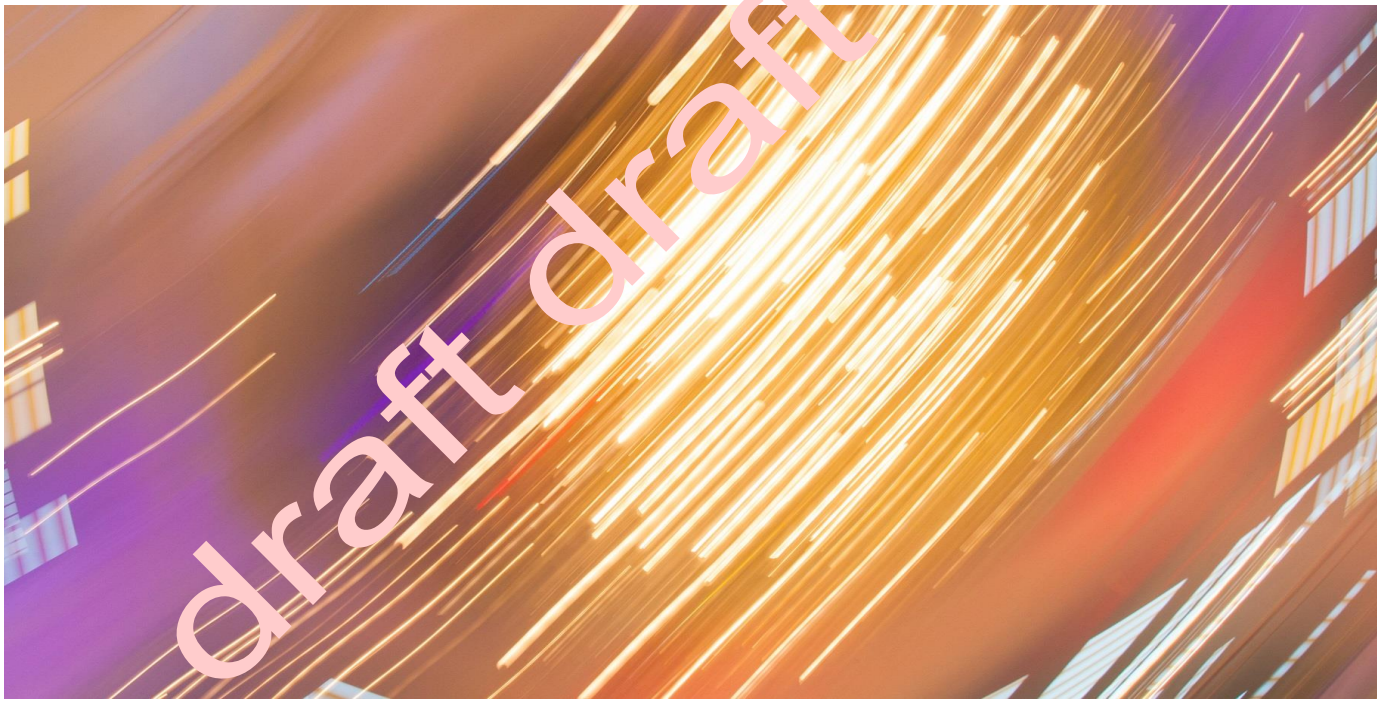
NHS Digital

2017/18 Business Plan



Information and technology
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Contents

1. Introduction

1.1 Who we are and what we do

NHS Digital is the national information and technology partner for the health and care system.

Our vision is to harness the power of information and technology to make health and care better for the professionals and people who deliver care services and for the people who receive them. Our teams of information analysis, technology and project management experts design, deliver and manage the essential technology infrastructure, data and digital services, products and standards that health and care professionals use every day to deliver services.

We have a unique statutory duty to help the health and care system drive greater value from the data and information it generates. The data and information we publish is used by commissioners to improve services, and by researchers to find new ways to prevent and treat disease. We must also ensure that the information we hold in trust for the public is always kept safe, secure and private. Our statutory duties, which we discharge on behalf of the health and care system, are summarised at Appendix 5.

We work in partnership with other national bodies and with those who use our data and services locally to deliver the quality and reliable technology of today while seeking to unlock the potential of the new, exciting and innovative technologies of our time.

Recently our role as the information and technology partner for the health and care system has increased significantly as we have been tasked with delivering commitments set out in the National Information Board's strategy, *Personalised Health and Care 2020*. This brings government investment of £4.2bn in technology to support more effective and efficient health services, and represents a major shift in the scale and complexity of the requirements that fall on NHS Digital. Following a period of careful planning, 2017/18 will see us accelerate the delivery of this ambitious portfolio of digital technology and data solutions.

2017/18 will also bring further changes to our organisation. We will welcome a new Chief Executive following the retirement of Andy Williams after three years at the helm. Last year we adopted a new internal operating model and re-branded as NHS Digital. This year, in response to a review of our organisational capabilities, we will further enhance our internal operations and governance arrangements, and we will strengthen how we engage with our many stakeholders. This will ensure that we are well placed to satisfy the needs of our customers and to drive digitally-enabled change across the health and care system.

1.2 Our partners and stakeholders

We work with a broad range of partners and stakeholders. These include government bodies such as:

Department of Health	Cabinet Office
NHS England	HM Treasury
Public Health England	Government Digital Services
Genomics England	Infrastructure and Projects Authority
National Institute for Clinical Excellence	Care Quality Commission
Health Education England	Medicines Healthcare Regulatory Authority
NHS Improvement	NHS Business Services Authority
Office of the Life Sciences	Other Departments, Devolved Administrations

Our partners and stakeholders include many other organisations, such as:

- The National Data Guardian, the Information Commissioner's Office, and the National Cyber Security Centre.
- Local authorities, including their social care and public health roles
- Local NHS organisations, including trusts, GP practices, pharmacies, community care providers, and local partnerships working on Sustainability and Transformation Plans
- Bodies such as the NHS Confederation, NHS Providers, NHS Clinical Commissioners, the Local Government Association, and the Association of Directors of Adult Social Services
- The Royal Colleges and professional groups such as the British Medical Association
- Policy organisations, including the Kings Fund, the Health Foundation, and the Nuffield Trust
- Research, academic, life science and business intelligence organisations
- Third sector organisations, including patient and public interest groups

1.3 The context for our business plan

NHS Digital is at the forefront of *Personalised Health and Care 2020*, the National Information Board's vision of digitally-enabled personalised health and care services. This business plan reflects our key role in delivering this work. Delivery of *Personalised Health and Care 2020* has been translated into a major portfolio of 33 programmes grouped into 10 'domains'. Appendix 1 summarises these domains.

The *Personalised Health and Care 2020* portfolio itself is a key enabler to support the strategic objectives set out in the Department of Health's *Shared Delivery Plan* and NHS England's *Five Year Forward View.* The *Five Year Forward View* sets out how technology and data can help the health and care system to:

- reconcile the growing demand for health and care services with finite resources
- focus on prevention, self-management and well-being in addition to treating ill-health
- increase the personalisation of care and support services to empower the citizen
- accelerate and extend the integration and devolution of services.

These aim to help the NHS bridge gaps relating to health and wellbeing, care and quality, and funding and efficiency.

NHS Digital contributes to the Department of Health's commitment, set out in its Single Departmental Plan, to "improve services through the use of digital technology, information and transparency." We deliver specific commissions for the Department of Health, other government departments, other arms-length bodies, and the devolved administrations.

Our business plan includes technology developments and core services that support these wider priorities for the health and care system.

2. Our strategy and priorities

2.1 Our strategic objectives

This business plan sets out our commitments for 2017/18. These are shaped around the five objectives set out in our 2015-2020 strategy, *Information and Technology for Better Care*:

Our strategic objectives are to:

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

These strategic objectives reflect our own ambitions for NHS Digital and address the needs of the wider health and care system. Appendix 2 summarises how these strategic objectives align with the *Personalised Health and Care 2020* domains.

Our strategy also contains a sixth organisational goal aimed at transforming how we engage with our stakeholders and how we deliver our work. Last year we undertook a 'capability review' to assess various aspects of how our organisation operates. This review has recommended actions to strengthen the organisation, and during 2017/18 we will implement many of these. More information about the capability review can be found later in this document.

2.2 Our priorities for 2017/18

Section 6 of this business plan presents our specific commitments for 2017/18. These include a mix of major change programmes and core 'business as usual' services that the support health and care system.

Our business plan commitments for 2017/18 mobilise delivery of *the Personalised Health and Care 2020* portfolio, take forward our strategy, fulfil our statutory duties, and progress our own transformation journey. The following pages set out the context of these commitments.

Domain A: Patient engagement, self-care and prevention

Help patients to take control of their own health and care and reduce the pressure on frontline services

Empowering Citizens: we are developing the next generation of digital services for people in need of health and care services and that promote patient engagement and support self-care and prevention. We will deliver solutions that allow people to interact confidently with health and care services, helping them to make informed decisions and choices. The NHS.uk platform, which will eventually replace NHS Choices, will provide a personalised and interactive way for people to access information and services.

Reduce Pressure on Services: frontline services are under pressure from rising demand during a period of financial constraints. We will develop digital technologies that offer new ways for professionals to deliver services and new ways for citizens to engage with them. This will help to relieve pressure on frontline services.

Wider Digital Participation: millions of citizens are not online, and millions more have low levels of digital literacy. We will support greater digital participation so that more people can benefit from digital health and care services.

Our 2017/18 business plan includes commitments relating to:

Citizen Identity: providing a single, secure identity for each member of the public, across all health and care services

NHS.uk: creating a single point of public access to online information and service interactions

Health Applications: recommending wearable technologies and digital applications that allow citizens to manage their health and clinicians to remotely monitor patients' health

Widening Digital Participation: providing 'hard to reach' communities with skills that help them benefit from digital health and care services.

Personal Health Record: developing technology to support digital / online clinical interactions

Wi-Fi: providing accessible digital infrastructure (e.g. Wi-Fi) for use by clinicians and patients, free at the point of care

Domain B: Urgent and emergency care

Improve telephone and online triage and provide better technology to support clinicians so that treatment is better targeted.

Better Triage: we aim to support more appropriate and better targeted care for patients. We will provide information and technology that help patients with urgent and emergency needs to receive quicker advice and more effective signposting to services. We will develop, improve and deliver up to-date clinical algorithms to strengthen triage, drive improved use of the NHS111 service, and enhance the patient experience of NHS111.

Better Support for Clinicians: we aim to provide better support for clinicians treating urgent and emergency cases. We will develop technology that safely and securely connects patient information to online clinical triage in order to give clinicians quick, direct and mobile access to critical information such as patient records and service availability. This will help clinicians to analyse symptoms more effectively and develop better informed options regarding patient care.

Our 2017/18 business plan includes commitments relating to:

Clinical Triage Platform: launching a new online channel – NHS111 online, integrated with NHS.UK – giving patient access advice for a limited number of low risk conditions

Access to Service Information: providing clinicians with full, real-time access to detailed patient records in order to inform and speed up diagnosis

Domain C: Transforming general practice

Use technology to free General Practice from time-consuming administrative tasks and provide patients with online services

Reduced GP burdens: we will provide technology and information that eases administrative burdens on general practice. We will help to reduce the burden of recording and reporting information to national bodies such as NHS England. We will help practices to optimise their use of existing technologies, deliver new models for General Practice information technology, and support practices to adopt new solutions.

New Online Services for Patients: we aim to increase the use of existing technology that allows patients to interact online with general practice services. New solutions will offer patients online consultations and give them access to key information such as test results, medication history, immunisation history, consultation details and letters.

Our 2017/18 business plan includes commitments relating to:

GP Operational Systems and Services: transitioning GP systems to the SNOMED clinical terminology to help minimise burden

Existing GP Technologies: increasing the uptake of online access to GP services such as appointments or prescriptions

Technology for GP Transformation: developing the next generation of digital solutions to support clinicians and give patients greater access to online services

GP Data for Uses other than Direct Care: •improving the availability of operational data for general practice performance management, commissioning and research, under appropriate governance.

Domain D: Integrated care and social care

Inform clinical decision-making across all health and care settings and improve the service user experience by enabling and enhancing flows of patient information

Joined-up health and social care: efficient and secure information flows between and within organisations are vital to unlocking the enormous potential of integrated, digitally-enabled health and care services. Different technology systems need to connect with each other and data must be able to flow seamlessly between them under appropriate governance and controls. This is essential to support the new services and care models being developed under the *Five Year Forward View* and *Personalised Health and Care 2020*. Local sustainability and transformation plans are already addressing ways of improving interoperability within local health economies. We will ensure that the right standards are in place at the national level and used well locally to provide consistent access to data and services, so that there is no 'postcode lottery' of variability in different parts of the country.

Improved clinical decisions: timely access to appropriate patient information supports improved clinical decision-making. We will enable clinicians to quickly request and share patient information securely with other clinicians and care providers.

Our 2017/18 business plan includes commitments relating to:

Interoperability and Architecture: enabling better digital information sharing mechanisms and providing common standards to support interoperability

Digital Interoperability Platform: developing information sharing capabilities and standards at national, local and patient level to improve access to patient records

Social Care Programme: enabling social care, mental health, community services and other settings to integrate with each other.

Domain E: Digital medicines

Give patients greater choice and added convenience by enabling them to choose where, when and how their medicines are delivered. Improve prescribing accuracy

Revolutionising medicine delivery: 22 million people are already able to use the Electronic Prescription Service, which manages 1.7 million prescriptions each day. Nearly 90% of GP practices and 99% of pharmacies provide this service. We will improve patients' experience of community pharmacy by enabling greater use of electronic prescribing and developing new digital services. This new technology will support home delivery and other more convenient ways for people to collect their medicines, offer patients online access to information about their prescriptions, and enable them to manage their own use of medicines.

Promoting new care models: we will give pharmacists technology that allows them to contribute more effectively to patient health and care. We will develop solutions that support pharmacists to engage in a patient's full care pathway, share information with other care settings, and direct patients to the services most appropriate for their condition.

Accurate and efficient prescribing: digital pharmacy solutions will support more accurate and efficient prescribing practice. We will provide technology that reduces the cost of pharmacy services by eliminating paper prescriptions, automating the checking of patients' exemption status, and facilitating a more efficient medicines supply chain. Digital pharmacy solutions will also generate data which can be used to identify poor prescribing practice and to provide a complete view of how medicines are used across the NHS.

Our 2017/18 business plan includes commitments relating to:

Digitising Community Pharmacy: accelerating digital maturity in the community pharmacy sector, including digital services for service users

Pharmacy Supply Chain and Secondary Uses: developing a fully digitised medicine supply chain and a complete view of medicines use across all health and care settings

Integrating Pharmacy Across Care Settings: maximising the opportunities for pharmacists to integrate with other professionals and contribute to patients' care pathways

Domain F: Elective care

Improve referral management and provide a better treatment choice for patients by automating referrals across the NHS.

Efficient referral management: last year we delivered the NHS Electronic Referral Service (eRS), which in its first year managed 10 million referrals and saved £10m for the NHS (eRS costs 60% less to run than its predecessor, 'Choose and Book'). *Personalised Health and Care 2020* commits us to provide greater electronic referrals functionality and to increase its use. We will deliver a single referral and booking platform and service for all elective care throughout the NHS and its partner organisations. This will reduce the time patients wait for appointments, diagnoses and treatments, and enable more effective and consistent referral and patient management by clinicians.

Patient choice: digital referrals technology will empower patients to make better care choices. We will provide solutions that give patients more control about when, where and by whom they are seen, and make it easier for them to understand and interact with the referrals process.

Our 2017/18 business plan includes commitments relating to:

Digital Referrals and Consultations: delivering the referral assessment service ('refer now, book later')

Domain G: Paper free at the point of care

Equip the NHS with technology that will transform care and ensure the workforce has the skills to get the most out of it

World-class technology and systems: we deliver a wide variety of systems and technology services that are critical to the day-to-day operation of the NHS, handling millions of interactions every day for patients and clinicians. *Personalised Health and Care 2020* commits us to deliver the next generation of systems and technology to help transform the way health and care organisations work.

As well as developing technology solutions we aim to help organisations get the most from them. We will do more to encourage health and care providers to take up digital solutions and to join-up local systems to maximise efficiency and impact. In particular, we must ensure that new capabilities delivered by *Personalised Health and Care 2020* are relevant to new models of care developed locally. We are putting in place new services to support organisations to adopt digital solutions. Our new Implementation and Business Change teams will help organisations to optimise the benefits of existing technology and support them to adopt new solutions.

Building a digital ready workforce: to optimise the use of technology the health and care workforce must have strong digital skills and the confidence to apply them. We will equip health and care workers with the skills and knowledge they need to make best use of information and technology. We will support the professional development of clinical digital leaders and other frontline professionals, including through a Digital Academy

Our 2017/18 business plan includes commitments relating to:

Digitising NHS Providers: supporting local and national organisations to adopt digital solutions that enable new care models

Digital Child Health: transforming the collection and sharing of children's health information

Digital Diagnostics: developing high quality and consistently applied diagnostic standards

Build A Digital Ready Workforce: equipping the health and care workforce with the skills, knowledge, values and behaviours to make best use of information and technology

Domain H: Data availability for outcomes, research and oversight

Improve the quality, availability and integrity of health data so that frontline staff, researchers and decision-makers are better informed.

We manage over 100 different data sets and collections. Our data supports frontline care and clinical decision-making, transparency and accountability, commissioning and policymaking, research, and the life sciences industry. Through our Data and Information Strategy we will develop new tools and services that support better use of data across the health and care system. For example, we will exploit developments in data science such as 'big data' and 'linked data', subject to appropriate governance and controls. In so doing we will collaborate with the best in class to ensure we develop and use the most up to date technology, innovate by providing thought leadership in the use of data, and stimulate the health and care system to improve through use of data and analytics. In addition, we will strengthen our role in supporting data quality across the health and care system.

Improved Care and New Treatments: we aim to empower the health and care system to be intelligent in the way it uses data. We want organisations and professionals to have all the data and information they need, provided in accessible and timely ways and under appropriate governance, to enable them to deliver the best possible care services and health outcomes. We will give professionals the data they need to plan and deliver care, to monitor how care is delivered across patient pathways, and to readily identify which treatments are safest and most effective. We will develop more flexible ways to access and analyse data, and provide richer source data to inform the development of new treatments and other research.

Better Policy and Commissioning: national and local organisations need help to improve decision-making, planning, policymaking and commissioning. We will provide robust and timely information about, for example, health and care needs, health and care activity, finance, workforce, service quality and health outcomes. We will develop person-level linked data sets, including patient outcomes, in a secure way from all core settings.

Our 2017/18 business plan includes commitments relating to:

National Data Services Development: establishing a national identifier to enable a patient's journey to be tracked across different geographic areas

Data Content and New Data Collections defining our strategic approach to data collection across the health and care system, and developing an implementation plan to deliver this

Innovative Uses of Data: developing new uses of data and analytics, including linked data to support Sustainability and Transformation Plans and vanguards

Domain I: Infrastructure

Enable information to move securely across all health and care settings by providing and maintaining robust, future-proofed national systems and networks

Resilient systems: we maintain the national infrastructure critical to the day-to-day operation of the NHS. This includes the Spine, which provides the technical backbone on which many services depend, connecting over 23,000 systems across more than 20,000 organisations. Throughout 2016/17 the national systems we managed achieved average availability rates of 99.97%. We aim to make better use of this infrastructure and open it up to a wider range of users, under appropriate governance. During 2017/18 we will start delivery of the Health and Social Care Network to replace the N3 network. This will provide better and more cost-effective digital connectivity for the health and care system.

Modern tools and services: we will enable clinicians to connect to and collaborate with colleagues in their own organisations and others, utilising audio, video and web conferencing and desktop sharing. The new NHSmail2 platform offers a secure and modern email exchange and new messaging and e-conferencing tools. We will make NHSmail2 available to a wider range of health and care settings.

Our 2017/18 business plan includes commitments relating to:

NHSMail2: using NHSmail to enable integrated email and digital collaboration for social care, optometrists, dentists and other health and care settings

Health and Social Care Network: commencing the delivery of the Health and Social Care Network to provide better and more cost-effective digital connectivity for health and care.

Domain J: Public Trust and Security

Support and respect the data sharing preferences of patients and keep their data secure in all settings.

Secure data: security of systems and data is a high priority for health and care organisations. We work closely with the National Cyber Security Centre to ensure we are fully aligned with national and international efforts to respond to the challenges posed by cyber threats. Cyber threats continue to increase and we will continue to develop our capabilities to help counter them. A key element of this work will be knowledge transfer across the health and care system. We have a structured engagement campaign and a knowledge service which gives organisations access to a library of health related cyber security threats with mitigations to improve understanding and promote best practices. It also provides a range of e-learning modules to prepare health and care professionals for managing threats to data confidentiality, integrity and availability.

Respect people's data sharing preferences: public trust is critical to harnessing the power of information and technology to make health and care better. We want citizens to have complete confidence that health and care data is secure, shared only when appropriate, and shared only for their benefit. We must empower citizens to choose how their personal data is held, shared and used. We will develop a new model for managing citizens' preferences regarding the sharing of their personal data.

Improving Information Governance: work to improve information governance across the health and care system underpins public trust and data security. Independent reviews led by Dame Fiona Caldicott, the National Data Guardian, and the Care Quality Commission have made recommendations on information governance and secure data sharing. We will support the implementation of these recommendations.

Our 2017/18 business plan includes commitments relating to:

Data and Cyber Security: providing national and local capabilities to further strengthen the security of data and systems across the health and care system

National Opt-Out Model: developing an end-to-end solution and delivery model for the national opt-out model for managing patients' data sharing preferences

Information Governance: supporting implementation of the National Data Guardian Review of data security and information sharing

3. Transforming NHS Digital

3.1 Our Transformation

Our transformation programme aims to enable the organisation to equip itself to embrace known present and future challenges. Our transformation is shaped by the following principles:

Professionalism To have an enriched workforce: the right size and right capabilities to deliver for our customers and ensure organisational longevity	**Agility** To be an agile and flexible organisation which delivers against our customers' future requirements
Efficiency To be a more efficient organisation with a better control on costs and staff utilisation	**Operational Impact** Transformation should have no detrimental impact on the delivery of core programmes / services.

During 2016/17 we made progress in implementing our transformation. We introduced a new way of working based on a professional services operating model. New approaches to resource management allow the organisation to deploy staff in ways that bring greater flexibility, in accordance with the priorities of our customers and stakeholders. Staff are aligned with professions and supported by career managers to ensure they have tailored opportunities for development. Throughout 2016/17 we have further developed this new operating model and other aspects of our organisation. During 2017/18 we will continue to develop and refine our internal ways of working.

3.2 Transformation next phase

This year we will take forward the next phase of our transformation. This will be informed by the findings of a review of our organisation which we conducted during 2016/17. The purpose of this review was to baseline our existing capabilities and to identify steps needed to make NHS Digital a more modern, agile organisation that is well placed to discharge its responsibilities and meet customer needs, particularly relating to the *Personalised Health and Care 2020* work. The review addressed four main themes:

- Modernising our delivery model
- Transforming the way we work with customers, stakeholders and partners
- Accountability, governance and decision-making
- Developing our workforce to respond to demand

To ensure objectivity and bring external expertise we employed independent advisors to help with the review. The advisors found evidence of good progress and development across our organisation– we have a sound foundation to build on. But they also gave us advice and direction to help improve our effectiveness. The following sections summarise our main areas of planned improvement.

Modernising Our Delivery Model

Our delivery model must produce technology solutions that work together to provide integrated and interoperable services across the health and care system. We must put in place a consistent and systematic approach to designing, planning and delivering our products and services. This will include deciding whether to develop products 'in house' or whether to use external partners. We must also strengthen our cyber capabilities, improve our information and analysis delivery model, and increase our commercial capabilities.

Enterprise Architecture: we will implement an enterprise architecture function that supports greater interoperability and meets national and local service needs.

Consolidate our service operations: we will enhance our capability and processes for managing the transfer of change programmes into live service operations.

Consolidate our software development teams: we will merge our two Leeds-based digital delivery teams and draw up plans to establish a single digital delivery centre.

Our delivery methods: we will define our development and programme management methods and tools, and ensure they are applied consistently across the organisation.

Our build / buy decisions: we will adopt a single organisation-wide approach to the 'build or buy' decision, and ensure this becomes a major checkpoint in programme oversight.

Strengthen our cyber capabilities: we will implement a single security operating model, establish a National Security Operations Centre, and incorporate new Data Security Standards as recommended by the National Data Guardian.

Improve our information and analysis offer: we will enable a wider range of users to access the data we hold, make data available more quickly, and implement the Data Services Platform to revolutionise how we collect, store and release data.

Increase our commercial capabilities: we will implement our commercial strategy and a model for managing effective relationships with suppliers and stakeholders.

Transforming the ways we work with customers, stakeholders and partners

We need to help local organisations make better use of existing data and technology capabilities and we must respond effectively to their future needs. We must raise our profile by becoming innovative 'thought leaders' on health and care technology and data. Our aspiration is to become the 'go to' organisation for advice on emerging technologies and be a centre of innovation for effective use of data and technology.

Work more closely with our stakeholders: we will support our customers to define their requirements for new services and embed stronger customer-focussed behaviours.

Accelerate implementation and adoption: we will support provider organisations to accelerate their adoption of our information and technology products and services.

Foster innovation: we will develop our 'thought leadership' to stimulate new thinking on data and technology, and create a community of innovation and collaboration.

Use technology to improve our effectiveness: we will digitise all customer-facing interactions on our website, and determine the optimal customer contact model.

Accountability, governance and decision-making

We must have transparent and robust governance and assurance arrangements to support our modernised delivery model and to cover our other technology and data services, cyber security and information governance functions, and new and existing programmes/services. We have identified ways to improve our internal governance, assurance and controls, and to better meet the assurance requirements of external bodies, particularly the Digital Delivery Board, the Department of Health, and HM Treasury.

Internal assurance: we will embed an integrated assurance process across all of our programme work, based on the three lines of defence model. We will introduce a new investment sub-committee of the NHS Digital Board.

System-level governance: we will improve alignment of assurance and risk controls across new governance structures, based on the 'assure once, satisfy all' principle. We will lead the development of new forms of assurance for digital services.

Developing our workforce to respond to demand

We currently employ around 2700 people. We expect some growth in order to deliver the *Personalised Health and Care 2020 work*, but at this stage we do not expect our workforce to exceed 3000 between now and 2020. We used the review of our organisation to inform our next steps in developing workforce capacity and capabilities. These fall into two areas:

Workforce planning: we will determine the optimal size and skills mix for our workforce. We will set up a workforce planning centre of expertise and adopt advanced planning models to respond to changing patterns of supply and demand.

Workforce development: we will extend our graduate and apprenticeship schemes, digitise our recruitment processes, and implement talent interventions for critical workforce capabilities. We will produce a new locations strategy for NHS Digital.

In 2017/18 we will enhance our workforce planning capability in order to secure for the organisation the right people with the right talent at the right time and in the most efficient way. This includes the following key action areas:

Alternative sourcing: using new recruitment channels, including deployment of temporary labour in certain circumstances

Recruitment at scale: attracting sufficient numbers of staff to fill our identified skills gaps

Digital culture and leadership: developing strong leadership and the right culture and behaviours to support successful delivery in an agile, digital organisation.

Segmentation and bespoking: recognising that our approaches to recruitment, retention and staff development will not be the same for all parts of the workforce

Prioritisation of critical professions: we cannot address every skills gap at the same time

Alternative futures: not all of our professions currently have the skills and expertise we will need in future, and so they will need to adapt and develop.

Retention and development: we must retain and develop our most critical and skilled staff

What this means for NHS Digital

These actions have significant implications for how we work. We must become more responsive to our stakeholders and customers. We must reduce lead times for developing new capabilities, and adopt agile methodologies more pervasively. We must make better use of technology and information to improve and our own processes.

Making the change happen

The details of these actions and their implementation are set out in a separate report. Most of the actions will be completed during 2017/18. Some will start during 2017/18 and continue into future years. Others will not start until later.

We will take care to invest sufficient resource in this work without impeding the delivery of our products and services. We will appoint a senior programme director responsible for ensuring that the review recommendations are implemented effectively. A Non-Executive Director will oversee the implementation plan and provide additional expertise.

4. Financial Information

4.1 The financial context and how we are funded

Our primary source of funding is an annually agreed allocation received from the Government. However, the funding associated with *Personalised Health and Care 2020* has changed both how we are funded and how much money we receive.

The *Personalised Health and Care 2020* portfolio represents government investment of £4.2bn over five years, 2015-2020. The figure of £4.2bn represents a combination of new money and existing funding for health and care informatics held by the Department of Health, NHS England and NHS Digital. It covers both revenue and capital funding.

Funding arrangements across the health and care technology sector are being 'realigned' to support more efficient and effective management of this money. As a result, most of the funding allocated to the *Personalised Health and Care 2020* portfolio should transfer to NHS Digital as part of our core funding. The funding realignment exercise has been informed by the following principles:

With a few exceptions, all of the funding allocated to delivery of the *Personalised Health and Care 2020* portfolio and other national health and care informatics work should transfer to NHS Digital.

The funding transferred to NHS Digital is not ring fenced. NHS Digital will determine how best to use this money effectively and efficiently to manage delivery. The Digital Delivery Board will hold NHS Digital to account for the use of this money.

Priorities and deliverables for are given to NHS Digital by the Digital Delivery Board.

Although the money sits with NHS Digital, the Digital Delivery Board must approve actual expenditure. Services expenditure will be approved in the NHS Digital business plan. Programme expenditure will be approved by the Technology and Data Investment Board.

NHS Digital will adopt an open book approach with the Digital Delivery Board.

The actual realignment of funding flows commenced in December last year. This saw money transfer to NHS Digital from both NHS England and the Department of Health, generating an in-year increase in our revenue budget of £57m.

4.2 Financial governance arrangements

With this additional funding for NHS Digital comes greater accountability. New system-wide arrangements are being put in place to strengthen the assurance, controls and accountability requirements that govern how we spend our money. Under these new arrangements our overall expenditure and business plan must be approved by the Digital Delivery Board, which includes representation from the Department of Health, NHS England, and the system-wide Chief Clinical Information Officer. The Digital Delivery Board also sets out priority commitments that it expects NHS Digital to deliver each year.

Funding for many of our individual programmes will only be released when a robust business case is approved by the Technology and Data Investment Board, a sub-group of the Digital Delivery Board.

4.3 Our budget for 2017/18

The following table sets out our budget for 2017/18.

Please note that this budget is still draft and is not yet finalised or approved

NHS Digital 2017/18 Budget – Draft as at 21/03/2017	**Revenue £'m**	**Capital £'m**
Domain A - Patient Engagement: Self Care and Prevention	34.4	12.8
Domain B - Urgent and Emergency Care	16.0	8.6
Domain C - Transforming General Practice	15.2	7.5
Domain D - Integrated Care and Social Care	22.7	9.0
Domain E - Digital Medicines	7.6	3.5
Domain F - Elective Care	23.0	7.4
Domain G – Paper Free at Point of Care	10.2	0.5
Domain H - Data Availability for Outcomes, Research and Oversight	57.0	12.0
Domain I - Infrastructure	97.0	13.5
Domain J - Public Trust and Security	22.8	6.0
Outside Domains	27.5	14.4
TOTAL	**333.4**	**95.2**

4.4 Making best use of our resources

We are committed to providing good value from the public monies entrusted to us. The ongoing focus on cost savings across the public sector, and the findings from our recent capability review, are good reasons for continuing to make our operations more efficient and cost-effective. We will use funding realignment, and the fact that more money is now held in one place, to identify and drive efficiency, particularly across our data and technology services. In addition, we will look at other opportunities for efficiency savings in a number of areas, including:

Staff costs: our workforce strategy aims to create a more flexible and dynamic organisation that is more effective and more efficient. We have also reduced our expenditure on contingent workers.

Buildings costs: we have numerous locations across the country and operate from four separate sites in central Leeds alone. We have undertaken some short-term rationalisation. We are developing a longer-term locations strategy to ensure our estate represents good value and is used in the most efficient way.

Technical and allocative efficiency: our new operating model will help us to deploy resources more flexibly across our programmes and services. This will improve our efficiency for our customers. We will also examine further opportunities to insource some services where appropriate, building on the substantial savings released through the insourcing of the Spine.

Improving productivity and efficiency during 2016/17 we took forward a cost improvement progamme that identified savings of around £3.5m. We believe there are further opportunities for rationalisation, cost reduction or improved productivity across our operations. During 2017/18 we will progress a set of strategic efficiency activities, either within existing commitments or as discrete projects. These will focus on two main areas:

- Opportunities for NHS Digital to deliver systems and services which will realise cost savings for the wider health and social care service
- Opportunities for NHS Digital to become more effective and efficient in the ways it delivers programmes and services

Where possible we have factored potential cost reductions into our 2017/18 plans, but in a number of areas it is not yet possible to estimate the amounts to be saved.

5. How NHS Digital Operates

5.1 Our organisation

Last year we redesigned our organisational structure so that it is more appropriate for a customer-facing, demand-and-supply operating model. Our programmes, services and other functions are grouped together into executive portfolios:

Health Digital Services: patient-facing and citizen-facing services.

Provider Support and Integration: services supporting health and care organisations and their staff.

Information and Analytics: the collection, quality assurance, storage, analysis and dissemination of health and care data.

Operations and Assurance: the live operations of all national services.

Digital Transformation: digital strategy, customer engagement, innovation, benefits realisation, uptake and implementation.

Clinical: clinical governance and assurance, information governance, clinical input into programmes

Workforce: resource management, professions, human resources

Finance and Corporate Services: services to support delivery, including financial management, commercial, procurement, legal, estates and portfolio management.

5.2 Our governance

NHS Digital is an executive non-departmental public body. Our Chief Executive is accountable to the Secretary of State for Health for discharging our functions, duties and powers effectively and efficiently. The Department of Health is our sponsoring body and oversees the governance processes which hold this organisation to account.

Our most senior decision-making body is our Board, which meets in public at least six times per year. Our Board is accountable to the public, Parliament and the Secretary of State for Health. The Board is led by our Chairman and comprises nine Non-Executive Directors, our Chief Executive and some of our Executive Directors, plus two ex-officio members who represent NHS England and the Department of Health.

The Board is supported by committees, each chaired by a Non-Executive Director:

The **Assurance and Risk Committee** ensures appropriate arrangements are in place to identify, evaluate and report on the effectiveness of risk management, other internal audit and assurance controls, and the efficient use of resources.

The **Information Assurance and Cyber Security Committee** ensures that arrangements are in place to manage information assurance and cyber security risks and threats across the organisation. This committee also works in support of the wider health and social care sector.

The **Remuneration Committee** reviews, approves and advises on matters relating to pay, including remuneration packages, performance related pay awards and redundancy.

During 2017/18 we intend to establish a new investment sub-committee of the Board.

Our main Board meetings take place in public. More details of our governance arrangements, including information about our Board and its members, can be found on our website.

We are also held to account through new governance arrangements that apply across the health and care informatics system, notably the Digital Delivery Board and its supporting bodies which govern finance and investment approvals, technical architecture, and data design and standards.

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

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

5.3 Performance management and reporting

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

Appendix 4 lists our corporate key performance indicators. These are reviewed routinely and some changes will come on stream during 2017/18. Additional performance information is reported to internal governance bodies, including our Operations Board and our Management Board.

5.4 Risk management and assurance

Risk management practice within NHS Digital is supported by a comprehensive governance framework, including policy, strategy and guidance. Our risk management model is organised around a set of strategic risk themes, each owned by an Executive Director. These risk themes are supported by a more granular set of risks managed at the level of portfolios, programmes, services and corporate functions. Appendix 5 lists our strategic risk areas.

We work with the Department of Health and arms-length bodies to identify and manage risks and dependencies across the health and care informatics system.

During 2017/18 we will implement the recommendations of the review of our organisation to further strengthen our risk and assurance arrangements.

5.5 Inclusion and diversity

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

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

Workforce objectives

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

Service objectives

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

6. Delivery Commitments for 2017/18

6.1 Programmes

DOMAIN A: Patient Engagement: Self-Care and Prevention

Ref	Commitment		NHS Digital Lead	Target Date
Personalised Health and Care 2020 Programmes: implement the following programmes in accordance with agreed delivery plans and milestones				
A1	PHC2020 Programme 1: **Citizen Identity**	We will agree a solution for Citizen Identify and go live for selected *Personalised Health and Care 2020* programmes	James Hawkins	30/09/2017
A2	PHC2020 Programme 2: **NHS.uk**	We will launch the NHS.uk platform for public use	James Hawkins	30/09/2017
A3	PHC2020 Programme 3: **Health Applications Assessment and Uptake**	We will provide developers with guidance about how applications can access national systems and data.	James Hawkins	30/09/2017
A4	PHC2020 Programme 4: **Widening Digital Participation**	We will support digitally excluded citizens to engage with digital health and care services	James Hawkins	31/03/2018
A5	PHC2020 Programme 16: **Personal Health Record**	We will ensure GPs are able to provide their patients with access to their GP record	James Hawkins	30/09/2017
A6	PHC2020 Programme 31: **Wi-Fi**	We will support the delivery of Wi-Fi functionality to all GP surgeries	James Hawkins	31/12/2017

DOMAIN B: Urgent and Emergency Care

Ref	Commitment		NHS Digital Lead	Target Date
Personalised Health and Care 2020 Programmes: implement the following programmes in accordance with agreed delivery plans and milestones				
B1	PHC2020 Programme 5: **Clinical Triage Platform**	We will fully launch the NHS 111 digital online service	James Hawkins	31/12/2017
B2	PHC2020 Programme 7: **Access to Service Information**	We will ensure that all integrated urgent care hubs are able to utilise the Directory of Service open Application Programme Interface (API)	James Hawkins	31/08/2017

DOMAIN C: Digital Transformation in General Practice

Ref	Commitment		NHS Digital Lead	Target Date
Personalised Health and Care 2020 Programmes: implement the following programmes in accordance with agreed delivery plans and milestones				
C1	PHC2020 Programme 9: **General Practice Operational Systems and Services**	We will transition GP systems to the SNOMED clinical terminology system	James Hawkins	31/03/2018
C2	PHC2020 Programme 10 **Adopting Existing Technologies in General Practice**	We will deliver an operational and maturing regionally structured Implementation and Business Change function	Beverley Bryant	30/09/2017
C3	PHC2020 Programme 11: **Technology for General Practice Transformation**	We will publish the operating model and guidance for Primary Care IT, 2018-2020	James Hawkins	28/02/2018
C4	PHC2020 Programme 12: **General Practice Data for Secondary Uses**	We will secure Cabinet Office approval for the full business case	James Hawkins	22/12/2017

DOMAIN D: Integrated Care and Social Care

Ref		Commitment	NHS Digital Lead	Target Date
Personalised Health and Care 2020 Programmes: implement the following programmes in accordance with agreed delivery plans and milestones				
D1	PHC2020 Programme 13: **Interoperability and Architecture**	We will develop standards and functionality to support delivery of inpatient based episode discharge summaries	Tom Denwood	31/03/2018
D2	PHC2020 Programme 14: **Digital Interoperability Platform**	We will develop and deliver information sharing capabilities and standards at national, local and patient level giving better access to patient records with appropriate controls and safeguarding	Tom Denwood	31/08/2017
D3	PHC2020 Programme 15: **Social Care Programme**	We will implement standards for local health and care organisations to use to support the secure exchange of information, starting with admissions, discharges and withdrawals.	Tom Denwood	31/10/2017
Other Developments: implement the following development activities in accordance with agreed delivery plans and milestones				
D4	Standards Implementation and Maintenance	We will provide new releases of, and implementation support for, a series of standards including: Pathology, Digital Imaging Dataset, Clinical Classifications, SNOMED CT, and the Dictionary of Medicines	Tom Denwood	31/03/2018

DOMAIN E: Digital Medicines

Ref	Commitment		NHS Digital Lead	Target Date
Personalised Health and Care 2020 Programmes: implement the following programmes in accordance with agreed delivery plans and milestones				
E1	PHC2020 Programme 17: **Digitising Community Pharmacy**	We will agree first stage dispensing system supplier process	James Hawkins	31/03/2018
E2	PHC2020 Programme 18: **Pharmacy Supply Chain and Secondary Uses**	We will upgrade hospital pharmacy systems to meet the dictionary of medications and devices standard	James Hawkins	31/03/2018
E3	PHC2020 Programme 19: **Integrating Pharmacy Across Care Settings**	We will deliver functionality that allows (a) clinicians to record activity regarding their patients' care and (b) patients calling NHS 11 to speak with clinicians who can access the Electronic Prescriptions Service tracker	James Hawkins	31/03/2018

DOMAIN F: Elective Care

Ref	Commitment		NHS Digital Lead	Target Date
Personalised Health and Care 2020 Programmes: implement the following programmes in accordance with agreed delivery plans and milestones				
F1	PHC2020 Programme 20: **Digital Referrals and Consultations**	We will deliver the 'refer now, book later' service that allows a hospital or clinic to receive a referral without an appointment booking.	James Hawkins	30/11/2017

DOMAIN G: Paper Free at the Point of Care

Ref	Commitment		NHS Digital Lead	Target Date
Personalised Health and Care 2020 Programmes: implement the following programmes in accordance with agreed delivery plans and milestones				
G1	PHC2020 Programme 21: **Digitising NHS Providers**	We will work with partner organisations to establish the provider digitisation programme, ensuring that funding and support mechanisms align with local Sustainability and Transformation Plans	Tom Denwood	31/08/2017
G2	PHC2020 Programme 22: **Digital Child Health**	We will work with the Professional Records Standards Body to define sets of information that can be captured about planned care activities for children performed by care professionals in a variety of settings	Tom Denwood	31/08/2017
G3	PHC2020 Programme 23: **Digital Diagnostics**	We will provide support for NHS England's Personalised Medicine national informatics strategy, defining the information blueprint for the clinical sharing of digital diagnostics data	Tom Denwood	31/10/2017
G4	PHC2020 Programme 24: **Building A "Digital Ready" Workforce**	We will deliver the 'Building A Digital Ready Workforce' programme, including establishment of the NHS Digital Academy, the Faculty of Clinical Informatics and the Federation of Informatics Professionals	Tom Denwood	31/03/2018
Other Developments: implement the following development activities in accordance with agreed delivery plans and milestones				
G5	Digitising NHS acute providers: we will support all organisations required to exit the Local Service Provider contract in 2017/18 to do so		Tom Denwood	tbc
G6	With partner organisations including NHS England and the Ministry of Justice, we will launch the new Health and Justice Information Service for prisons, immigration removal centres, youth institutes and secure children's homes.		Tom Denwood	tbc

DOMAIN H: Data Availability for Outcomes, Research and Oversight

Ref	Commitment		NHS Digital Lead	Target Date
Personalised Health and Care 2020 Programmes: implement the following programmes in accordance with agreed delivery plans and milestones				
H1	PHC2020 Programme 25: **National Data Services Development**	We will establish a national de-identification / re-identification service to enable a patient's journey to be monitored across different areas	David Hughes	31/01/2018
H2	PHC2020 Programme 26: **Data Content and New Data Collections**	We will define NHS Digital's strategic approach to data collection across the health and care system, and develop an implementation plan to deliver this	David Hughes	20/04/2017
H3	PHC2020 Programme 27: **Innovative Uses of Data**	We will establish the Innovation and Virtual Data Science Centre	David Hughes	tbc
H4	PHC2020 Programme 27: **Innovative Uses of Data**	We will develop the use of linked data to support Sustainability and Transformation Plans and vanguards, and the developing national strategy for life sciences.	David Hughes	30/09/2017
Other Developments: implement the following development activities in accordance with agreed delivery plans and milestones				
H5	We will expand and enhance the Data Access Request Service		David Hughes	30/09/2017
H6	We will develop and deliver a secure remote data access environment		David Hughes	31/12/2017
H7	We will develop prescribing and medicines data to support national and local needs		David Hughes	30/06/2017

H8	We will implement the Data Management Service	David Hughes	30/06/2017
H9	We improve our data quality function and implement a framework of data quality levers and sanctions	David Hughes	31/03/2018
H10	We will provide a service model to support the government's Troubled Families policy initiative	David Hughes	31/012018
H11	We will assure health and care indicators for NHS Digital and other organisations across the health and care system.	David Hughes	31/03/2018
H12	We will deliver a national library and repository of quality assured indicators	David Hughes	31/03/2018
H13	We will progress the transformation of the NHS Digital Information and Analytics functions to deliver our Data and Information Strategy and to meet customer requirements.	David Hughes	31/03/2018
H14	We will reduce the turnaround time for making data about hospital activity available from SUS+	Sean Walsh	31/12/2017

DOMAIN I: Infrastructure

Ref	Commitment		NHS Digital Lead	Target Date
Personalised Health and Care 2020 Programmes: implement the following programmes in accordance with agreed delivery plans and milestones				
I 1	PHC2020 Programme 29: **NHSmail2**	We will complete NHSmail rollout across Community Pharmacies and deliver to Social Care, Optometrists, Dental and other health and care settings	James Hawkins	31/03/2018
I 2	PHC2020 Programme 30: **Health and Social Care Network**	We will continue the phased delivery of the Health and Social Care Network and commence migration from existing networking arrangements	Tom Denwood	14/08/2017
Other Developments: implement the following development activities in accordance with agreed delivery plans and milestones				
I 3	We will implement a new communications tool for the delivery of Service Notifications across the NHS.		Sean Walsh	30/09/2017
I 4	We will deliver customer facing communication tools to enable real time IT security advice and information		Sean Walsh	28/02/2018
I 5	We will establish a service to manage and migrate Unify data collections, reducing burden on organisations submitting data to national bodies		Sean Walsh	31/03/2018
I 6	We will introduce and embed a new process for the transition of programmes to live service		Sean Walsh	30/09/2017
I 7	We will embed the new Business Continuity Management System (BCMS)		Sean Walsh	30/06/2017
I 8	We will deliver Spine Demographics Reporting Service (SDRS), with data feeds delivered to support cervical screening, GP payments, breast screening, bowel cancer screening, and the abdominal aortic aneurysm service		Sean Walsh	31/03/2018
I 9	We will create a collaborative assurance and service acceptance framework that provides clear direction to suppliers on the requirements when connecting to NHS Digital systems and services.		Sean Walsh	30/09/2017
I 10	We will deliver an Enterprise Architecture programme and service for the health and care system, including NHS Digital's own functions		Sean Walsh	tbc

DOMAIN J: Public Trust and Security

Ref	Commitment		NHS Digital Lead	Target Date
Personalised Health and Care 2020 Programmes: implement the following programmes in accordance with agreed delivery plans and milestones				
J1	PHC2020 Programme 32: **Data and Cyber Security**	We will deliver the IG Toolkit replacement 'CareCERT Assurance'	Sean Walsh	31/03/2018
J2	PHC2020 Programme 32: **Data and Cyber Security**	We will support the national implementation of the recommendations from the National Data Guardian Review	Sean Walsh	30/06/2017
J3	PHC2020 Programme 33: **National Opt-Out Model**	We will develop an end-to-end solution and implementation model to support delivery of the national opt-out model to manage patient preferences about the sharing of their data	Tom Denwood	30/09/2017
Other Developments: implement the following development activities in accordance with agreed delivery plans and milestones				
J4	We will improve our assurance and appraisal process that is informed by and contributes to system wide standards, burden, and training and technology governance		Martin Severs	31/03/2018
J5	We will deliver comprehensive advice on reducing the burden of data collections.		Martin Severs	31/03/2018
J6	We will expand and enhance the Data Security Centre's capability to protect citizen data and build public trust.		Sean Walsh	30/06/2017
J7	We will develop and publish information governance standards and provide supporting advice and guidance.		Martin Severs	31/03/2018
J8	We will enable 40,000 health and care organisations to self-assess their performance against information governance standards		Martin Severs	31/03/2018
J9	We will design, develop and implement the ICO Anonymisation Code of Practice in the health and social care system		Martin Severs	31/03/2018
J10	We will implement the Clinical Governance improvement Plan		Martin Severs	31/03/2018
J11	We will implement the Patient Safety Improvement Plan		Martin Severs	31/03/2018

6.2 National Services and Infrastructure

Deliver national services and infrastructure in accordance with service level agreements and performance targets, including the following:		
Service	**Example key service standards**	**NHS Digital Lead**
NHS Pathways	We will deliver infrastructure service availability rates of 99.9% We will respond to at least 90% of service desk calls within 60 seconds of connection We will diagnose and fix at least 98% of Category 1 to 4 incidents within the time specified	Sean Walsh
Screening Programme Services	We will deliver total service availability of at least 98% during hours of service operation We will ensure there is a maximum planned downtime of 5 working days per annum We will diagnose and resolve 90% of incidents within the target timescale	Sean Walsh
Contact Centre	We will answer at least 90% of telephone calls within 20 seconds of connection We will respond to at least 95% of National Back Office Urgent Death Fixes within 45 minutes We will respond to at least 90% of Email contacts within 4 hours	Sean Walsh
Other Smaller Services Delivered by Systems Support and Development	We ensure infrastructure service availability rates of at least 95% We will ensure there is a maximum planned downtime of 12 working days per annum We will diagnose and resolve 90% of incidents within the target timescale	Sean Walsh
NHS Blood and Transplant Services	We will transmit data files to the NHSBT PULSE system at 13:00 and 17:00hrs daily. We will respond to at least 95% of reported support calls within the target time We will resolve at least 90% of reported support calls within the target time	Sean Walsh
Primary Care Services (IT Systems)	We will respond to at least 98% of reported support calls within the target time We will resolve at least 90% of reported support calls within the target time	Sean Walsh

Deliver national services and infrastructure in accordance with service level agreements and performance targets, including the following:		
Service	**Example key service standards**	**NHS Digital Lead**
Cancer Waiting Times	We will respond to at least 95% of incident calls within the target time We will diagnose and ix at least 90% of incidents within the target time We will work to a Recovery Point Objective of 8 hours We will work to a Recovery Time Objective of 2 hours	Sean Walsh
Repeat Caller Service	We will ensure infrastructure service availability rates of at least 99.90% We will respond to at least 90% of service desk calls within 60 seconds of connection We will diagnose and fix at least 98% of Category 1 to 4 incidents within the time specified	Sean Walsh
eContract	We will ensure total service availability rates of at least 98% We will diagnose and resolve at least 90% of incidents within the target timescale We will ensure restoration of full production service to failover infrastructure within one business day	Sean Walsh
NHS Choices	We will ensure average service availability of at least 99.70%.	Sean Walsh
GP Systems Managed Service	We will ensure average service availability of at least 99.90% We will resolve Severity Level 1 incidents within a fix time target of 2 hours We will resolve Severity Level 2 incidents within a fix time target of 4 hours	Sean Walsh
GP Systems Data Collections Service (GPET-Q service only)	We will ensure average service availability of at least 99.99% We will resolve Severity Level 1 incidents within a fix time target of 2 hours We will resolve Severity Level 2 incidents within a fix time target of 4 hours	Sean Walsh
GP Payments Service	We will ensure average service availability of at least 99.70% We will resolve Severity Level 1 incidents within a fix time target of 2 hours We will resolve Severity Level 2 incidents within a fix time target of 4 hours	Sean Walsh

Deliver national services and infrastructure in accordance with service level agreements and performance targets, including the following:		
Service	**Example key service standards**	**NHS Digital Lead**
GP2GP Live Service	To be confirmed	
Electronic Prescriptions Live Service	Elements of the Electronic Prescription Service are covered within other measures (for example, GP Systems Managed Service and Spine Core Services)	Sean Walsh
NHS e-Referral Live Service	We will ensure average service availability of at least 99.99% We will resolve Severity Level 1 incidents within a fix time target of 4 hours We will resolve Severity Level 2 incidents within a fix time target of 8 hours	Sean Walsh
Summary Care Record	We will ensure average service availability of at least 99.90% We will resolve Severity Level 1 incidents within a fix time target of 2 hours We will resolve Severity Level 2 incidents within a fix time target of 4 hours	Sean Walsh
Secondary Uses Service	We will ensure average service availability of at least 99.50% We will resolve Severity Level 1 incidents within a fix time target of 2 hours We will resolve Severity Level 2 incidents within a fix time target of 4 hours	Sean Walsh
Spine Core Services	We will ensure average service availability of at least 99.90% We will resolve Severity Level 1 incidents within a fix time target of 2 hours We will resolve Severity Level 2 incidents within a fix time target of 4 hours	Sean Walsh
Care Identity Services	We will ensure average service availability of at least 99.90% We will resolve Severity Level 1 incidents within a fix time target of 4 hours We will resolve Severity Level 2 incidents within a fix time target of 8 hours	Sean Walsh

Deliver national services and infrastructure in accordance with service level agreements and performance targets, including the following:		
Service	**Example key service standards**	**NHS Digital Lead**
NHSmail2 Service	We will ensure average service availability of at least 99.90% We will resolve Severity Level 1 incidents within a fix time target of 2 hours We will resolve Severity Level 2 incidents within a fix time target of 4 hours	Sean Walsh
Telephone Appointments Line	We will ensure average service availability of at least 99.90% We will resolve Severity Level 1 incidents within a fix time target of 12 hours We will resolve Severity Level 2 incidents within a fix time target of 12 hours	Sean Walsh

6.3 Data and Information Services

Deliver data and information services in accordance with service level agreements and performance targets, including the following:		
Service	**Example key service standards**	**NHS Digital Lead**
Casemix Services	We will produce 100% of Grouper products and tools in line with agreed final annual policy delivery dates We will respond to 50% of helpdesk queries within 5 working days and 90% within 10 working days, maintain an average response time of no more than 7 working days. We will facilitate at least 10 external policy / Casemix educational events per annum	David Hughes
Secondary Care (HES) Services	We will produce at least 95% of publications on the date announced We will respond to all generic mailbox queries within 2 working days of the query being received We will load the Diagnostic Imaging Data the iView portal on the third Thursday of every month	David Hughes
Community Data Analysis	We will publish at least 95% of maternity monthly report on time. We will publish at least 95% of children's monthly reports on time.	David Hughes
Mental Health Data Analysis	We will publish at least 95% of mental health monthly reports on time. We will publish at least 95% of IAPT monthly reports on time	David Hughes
Population Health Data and Information Services	We will deliver the Health Survey for England in line with the contractually agreed timetable and achieve a response rate of at least 65% We will deliver the National Child Measurement Programme, dataset and publications in line with the contractually agreed timetable and standards	David Hughes
Primary Care Domain Analysis Service	We will respond to all customer enquiries within 48 hours We will deliver an interim set of code clusters to support the roll-out of SNOMED-CT by the end of September 2017, and a full release by July 2018	David Hughes

Deliver data and information services in accordance with service level agreements and performance targets, including the following:			
Service	**Example key service standards**		**NHS Digital Lead**
Analytical Services	During 2017/18 we will develop a formal Service Level Agreement that includes service standards and performance targets		David Hughes
Statistical Services	We will release every statistical publication by 09:30 on the publication date We will ensure every statistical publication has an approved disclosure risk assessment		David Hughes
Data Dissemination Services	We will deliver requests received through the Data Access Request Service to the following timescales:	Standard applications: 14 days Medium complexity applications: 30 days High complexity applications: 60 days	David Hughes
Indicator and Methodology Assurance Services	We will complete all initial reviews of indicator assurance application within 5 working days of receiving the application form. We will send the outputs of Methodology Review Group (MRG) meetings to applicants within 5 working days of the MRG meeting		David Hughes
Corporate Data Quality Assurance Services	We will respond to all customer enquiries within 72 hours or within standards set out in an agreed contact centre service level agreement		David Hughes
Data Services for Commissioners and SUS Live Services	We will complete set-ups (subject to receiving a request signed by CCG Caldicott Guardian) within 15 working days We will resolve general DSfC enquiries within 10 working days We will resolve general enquiries related to SUS within 10 working days		David Hughes
Clinical Audit Services	During 2017/18 we will develop a formal Service Level Agreement that includes service standards and performance targets **(includes: Breast and Cosmetic Implant Registry and Out of Area Placements)**		David Hughes

Deliver data and information services in accordance with service level agreements and performance targets, including the following:		
Service	**Example key service standards**	**NHS Digital Lead**
Workforce and Estates	During 2017/18 we will develop a formal Service Level Agreement that includes service standards and performance targets	David Hughes
Clinical Indicators	During 2017/18 we will develop a formal Service Level Agreement that includes service standards and performance targets	David Hughes
Social Care Statistics	During 2017/18 we will develop a formal Service Level Agreement that includes service standards and performance targets	David Hughes
Prescribing Analytical Services	During 2017/18 we will develop a formal Service Level Agreement that includes service standards and performance targets **(Includes publication of the Innovation Scorecard)**	David Hughes

6.4 Uptake Targets for Existing Services

Our new Implementation and Business Change teams will support local health providers to adopt technology services already provided by NHS Digital. The table below shows the uptake targets we have set for 2017/18.

Existing Products and Services: the Implementation and Business Change teams aim to deliver these uptake targets			
Service	**Target**		**Target Date**
Child Protection – Information Sharing (CP-IS)	80% of local authority sites and 80% of NHS sites are live		31/03/2018
Electronic Prescription Service (EPS)	80% of repeat prescriptions are delivered through EPS Of those repeat prescriptions, 10% to be converted to Electronic Repeat Dispensing		31/03/2018 31/03/2018
EPS tracker available in NHS111 (IPaCS programme)	100% of NHS 111 sites have access to the EPS tracker		31/03/2018
Electronic Referrals Service (eRS)	80% of GP to 1st outpatient referrals are delivered through NHS e-RS.		30/09/2017
Patient Preferences / National Opt-out model	Citizens are able to record their data sharing preferences using the new national opt-out solution		31/12/2017
Summary Care Record (SCR)	100% of GP Practices are live (Summary Care Records created for patients)		tbc
GP2GP	The percentage of patients who move GP who have their Electronic Health Record fully transferred	60%	tbc
		80%	tbc
		100%	tbc
Summary Care Record in Community Pharmacy	The percentage of community pharmacies live and able to view Summary Care Records:	50%	tbc
		75%	tbc
		100%	tbc

6.5 Transforming how we engage and work

Ref	Commitment	NHS Digital Lead	Date
Implement the following development activities in accordance with agreed delivery plans and milestones			
T1	Strategy and Account Management: we will design and implement a new client engagement model which moves beyond a function-by-function view to an organisation-based focus on coordinated activities and aligned behaviours	Beverley Bryant	tbc
T2	Strategy and Account Management: We will put in place internal infrastructure to support the client engagement activities and deliver corporate insight and intelligence to inform future delivery	Beverley Bryant	tbc
T3	We will implement the recommendations from the NHS Digital Capability Review	Rachael Allsop	31/03/2018
T4	We will provide a high performing and efficient workforce service to enable delivery of NHS Digital corporate delivery priorities.	Rachael Allsop	31/03/2018
T5	We will develop and deliver strategic, operational and tactical approaches to resourcing to ensure that the right people are in the right place at the right time to meet organisational resource requirements.	Rachael Allsop	31/03/2018
T6	We will develop and deliver optimum organisational capability to enable delivery of corporate priorities.	Rachael Allsop	31/03/2018
T7	We will operate and assure the organisation's funding mechanisms and the new system-wide financial governance arrangements	Carl Vincent	31/03/2018
T8	We will deliver a Commercial change programme: new frameworks, toolsets, systems and processes especially in the areas of strategic sourcing, category management, supplier relationship management, and contract management.	Carl Vincent	31/03/2018
T9	We will establish and embed consistent planning, reporting, governance and assurance arrangements for all programmes, including development and support for system-wide governance and approvals arrangements	Carl Vincent	31/03/2018
T10	We will plan and progress tactical estates initiatives to support immediate and short term organisational needs whilst also planning and preparing for longer term strategic estate solutions.	Carl Vincent	31/03/2018

Appendices

Appendix 1: Personalised Health and Care 2020: Domains and Programmes

Domain				Programme		Lead
A		**Patient Engagement: Self-Care and Prevention**	Help patients to take control of their own health and care and reduce the pressure on frontline services	1	Citizen Identity	HDS
				2	NHS.uk	HDS
				3	Health Applications Assessment and Uptake	HDS
				4	Widening Digital Participation	HDS
				16	Personal Health Record	HDS
				31	Wi-Fi	HDS
B		**Urgent and Emergency Care**	Improve telephone and online triage and provide better technology to support clinicians so that treatment is better targeted	5	Clinical Triage Platform	HDS
				6	Patient Relationship Management	HDS
				7	Access to Service Information	HDS
				8	Out of Hospital Care	HDS
C		**Digital Transformation in General Practice**	Use technology to free GPs from time consuming administrative tasks and provide patients with online services.	9	General Practice Operational Systems and Services	HDS
				10	Adopting Existing Technologies in General Practice	DT
				11	Technology for General Practice Transformation	HDS
				12	General Practice Data for Secondary Uses	HDS
D		**Integrated Care and Social Care**	Inform clinical decisions across all health and care settings and improve the experience of service users by enabling and enhancing the flow of patient information.	13	Interoperability and Architecture	PSI
				14	Digital Interoperability Platform	PSI
				15	Social Care Programme	PSI
E		**Digital Medicines**	Give patients greater choice and added convenience by enabling them to choose where, when and how their medicines are delivered. Improve prescribing accuracy.	17	Digitising Community Pharmacy	HDS
				18	Pharmacy Supply Chain and Secondary Uses	HDS
				19	Integrating Pharmacy Across Care Settings	HDS

Personalised Health Care 2020: Domains and Programmes (continued)

Domain				Programme		Lead
F		**Elective Care**	Improve referral management and provide a better treatment choice for patients by automating referrals across the NHS	20	Digital Referrals and Consultations	HDS
G		**Paper Free at the Point of Care**	Equip the NHS with technology that will transform care and ensure the workforce has the skills to get the most out of it.	21	Provider Digitisation	PSI
				22	Digital Child Health and Maternity	PSI
				23	Digital Diagnostics	PSI
				24	Building a Digital Ready Workforce	PSI
H		**Data Availability for Outcomes, Research and Oversight**	Improve the quality, availability and integrity of health data so that frontline staff, researchers and decision makers are better informed.	25	National Data Services Development	I&A
				26	Data Content and New Data Collections	I&A
				27	Innovative Uses of Data	I&A
I		**Infrastructure**	Enable information to move securely across all health and care settings by providing and maintaining robust and future-proofed national systems and networks.	29	NHSmail2	HDS
				30	Health and Social Care Network	PSI
J		**Public Trust and Security**	Respect the data sharing preferences for patients and keep their data secure in all setting.	32	Data and Cyber Security	OAS
				33	National Opt-Out Model	PSI

Appendix 2: How our strategy aligns with the Personalised Health and Care 2020 domains

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

Appendix 3: Our Corporate Key Performance Indicators

Performance indicator		Description	Owner
1	Programmes Achievement	This indicator provides a consolidated view of the delivery status of our portfolio of programmes, focussing on the overall delivery confidence, and including aggregated findings from gateway reviews.	Director of Programmes
2	IT Service Performance	This indicator reports on the performance of information technology services for health and care providers, looking at service availability, incident response times, and high severity service incidents.	Director of Operations and Assurance Services
3	Organisational Health	This indicator includes workforce planning and recruitment, staff turnover, staff engagement, training and development, personal development reviews, and sickness absence rates.	Director of Workforce
4	Data Quality	This indicator looks at the quality of data received by NHS Digital from health and care providers and the effectiveness of our data quality processes.	Director of Information and Analytics
5	Stakeholder Reputation	This indicator gives a composite view of reputation, including outcomes of stakeholder and staff surveys, media coverage, social media sentiment, and complaints handling.	Director of Digital Transformation
6	Financial Management	This indicator covers the management of our organisational finances and other significant funding streams we manage. The performance reports also include the organisation's management accounts.	Director of Finance and Corporate Services
7	Risk Management	This indicator covers management of the organisations strategic risk themes, providing for each an assessment of the current risk exposure and the status of mitigation actions.	Director of Finance and Corporate Services
8	Security Incidents	This indicator gives a composite view of information security incidents.	Director of Operations and Assurance Services

Appendix 4: Our Strategic Risk Framework

	NHS Digital Strategic Risk Theme	Owner
1	Deliver the required levels of clinical quality, safety and utility in NHS Digital programmes and services	Medical Director
2	Mobilise in a sufficiently timely manner to deliver NHS Digital's Paperless 2020 commitments	Director of Programmes
3	Deliver on our statutory, legal and financial obligations	Director of Finance and Corporate Services
4	Guard against IT/cyber security threats, to protect citizen data	Senior Information Risk Owner
5	Safely collect, analyse and disseminate high quality and timely data/information and maintain public trust	Director of Information and Analytics
6	Support the realisation of demonstrable system wide benefits from Paperless 2020 and other programmes and services	Director of Digital Transformation
7	Transform the organisation so that it secures, develops and deploys its workforce effectively and efficiently to deliver its future vision	Director of Workforce
8	Maintain operational continuity of systems and infrastructure, to protect patient safety and critical services	Chief Operating Officer
9	Secure a positive, responsive and trustworthy reputation and maintain effective relationships with key customers/stakeholders	Director of Digital Transformation
10	Design and deliver interoperable systems that work as anticipated to meet user needs	Director of Provider Support and Integration

Appendix 5: Our Statutory Obligations: Health and Social Care Act 2012

Reference		Statutory Obligation	Owner
1	Health and Social Care Act 2012 (HSCA 2012)	The HSCIC (NHS Digital) must meet its statutory obligations as set out in the Health and Social Care Act 2012	Director of Finance and Corporate Services
2	HSCA 2012: Section 253	The HSCIC (NHS Digital) must exercise its functions effectively, efficiently and economically	Director of Finance and Corporate Services
3	HSCA 2012: Section 253	The HSCIC (NHS Digital) must seek to minimise the burden it imposes on others	Medical Director
4	HSCA 2012: Section 253	The HSCIC (NHS Digital) must have regard to information standards published by or guidance issued by the Secretary of State for Health or the NHS Commissioning Board (NHS England)	Director of Information and Analytics
5	HSCA 2012: Section 257	The HSCIC (NHS Digital) must publish procedures for making requests for the collection or analysis of information and for reconsidering any requests that are refused	Director of Information and Analytics
6	HSCA 2012: Section 257	The HSCIC (NHS Digital) must publish details of all requests (including mandatory requests) for information which it is required to or decides to collect.	Director of Information and Analytics
7	HSCA 2012: Section 258	The HSCIC (NHS Digital) has a duty to consult prior to establishing a new system for collecting or analysing information	Medical Director
8	HSCA 2012: Section 260	The HSCIC (NHS Digital) must generally publish the information it collects or may derive from a collection	Director of Information and Analytics

Reference		Statutory Obligation	Owner
9	HSCA 2012: Section 263	The HSCIC (NHS Digital) must publish a Code of Practice for health and social care bodies on how to handle person-identifiable or other confidential information.	Medical Director
10	HSCA 2012: Section 265	The HSCIC (NHS Digital) must maintain and publish a register containing descriptions of the information which has been obtained by virtue of this Chapter.	Medical Director
11	HSCA 2012: Section 265	The HSCIC (NHS Digital) is required to provide advice or guidance to any person or body if it is requested to advise by the Secretary of State or the NHS Commissioning Board (NHS England)	Director of Information and Analytics
12	HSCA 2012: Section 265	The HSCIC (NHS Digital) must, at least once when requested in any 3 year review period, provide advice to the Secretary of State on ways in which burden relating to the collection of information imposed on health or social care public bodies and service providers may be minimised.	Medical Director
13	HSCA 2012: Section 266	The HSCIC (NHS Digital) must publish periodic reports on the extent to which the information it collects meets published information standards.	Director of Information and Analytics
14	HSCA 2012: Section 268	The HSCIC (NHS Digital) must maintain and publish a database of quality indicators.	Director of Information and Analytics
15	HSCA 2012: Section 269	The HSCIC (NHS Digital) must issue GPs with doctor index numbers.	Director of Information and Analytics
16	HSCA 2012: Section 252, and Schedule 18	The HSCIC (NHS Digital) is required to publish an annual report and accounts a copy of which must be laid before Parliament and a copy sent to the Secretary of State for Health	Director of Finance and Corporate Services

Board Meeting – Public Session

Title of paper:	**Update on the Production of the Annual Report and Accounts 2016-17**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 03 c
Paper presented by:	Carl Vincent Director of Finance and Corporate Services
Paper prepared by:	Chris Bunting Senior Communications Manager
Paper approved by: (Sponsor Director)	Carl Vincent Director of Finance and Corporate Services
Purpose of the paper:	Update the board on the production of the Annual Report and Accounts
Additional Documents and or Supporting Information:	None
Please specify the key risks and issues:	The annual report and accounts is a key public documents. Its content is subject to statutory requirements.
Patient/public interest:	Indirect
Supplementary papers:	None
Actions required by the Board:	None – for information.

Update on the production of the Annual Report and Accounts 2016/17

Information and technology
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Contents

1. Purpose

To provide an update on the production of the 2016/17 Annual Report and Accounts and the schedule for production.

2. Introduction

The 2016/17 Annual Report and Accounts will be the first under our new NHS Digital identity.

The communications team have consulted within the organisation on the presentation and content of last year's report and received feedback that this year's document should put greater stress on the technological focus of the organisation. There has also been a demand for a more succinct, harder hitting performance review that explains NHS Digital's role as the lead delivery organisation for the National Information Board's 'Paperless 2020' domains and underlines the benefits our programmes deliver for citizens, health and care professionals, and system leaders.

3. Content and document structure

The Annual Report and Accounts will include a foreword by the Chairman followed by two longer sections, the Management Commentary and the Accounts. The Performance review will be structured around a review of delivery for key beneficiary groups, with sections focusing on achievements for citizens, frontline professionals and system leaders. In place of the photographic case studies included in last year's report, we will feature succinct text-based case studies and infographics explaining delivery for the user groups.

A detailed breakdown of the planned content is:

1. Chairman's Foreword (750 words): Explaining our role in the digital transformation of health and care and our vital contribution to a sustainable NHS and social care system

2. Performance report

Explaining our activities, achievements for key user groups and our new role in the system.

- Chief Executive's introduction (750 words): An overview of our activities, achievements and key challenges in 2016-17.
- NHS Digital's role – Our role in the health and care system changed significantly in 16-17. This section will explain our part in delivering digital transformation.
- Delivering for patients – A summary of key achievements in 16-17 that improved the experience of patients
- Delivering for frontline professionals -- A summary of key achievements in 16-17 that improved services for doctors, nurses, social workers etc.
- Delivering for system leaders -- A summary of key achievements in 16-17 that delivered for system leaders and policy makers
- Our performance in 2016/17: A summary of our delivery in 2016-17 against commitments made in the 2015/16 report and performance against our KPIs

- Concise items on managing our risks and the preparation of our accounts, included in line with statutory requirements

There is no proposal for major changes to content of the Management commentary and Account sections of the annual report and these will be similar to the content of the 2015/16 document, because to a large extent this content is mandatory. There has been feedback that the biographical information about board members and the executive management team included in 2015/16 occupied was too lengthy. The proposal is to shorten this content.

4. Design brief

The communications team has put out a design brief to external agencies for a new look and feel for the 2016/17 report and will receive initial responses from agencies by March 17. In line with the feedback received on the 2016/17 report, the brief is to develop a new look and feel that complies with NHS Digital's visual identity guidelines while reflecting the technological nature of the organisation's work and our critical role in a major area of technological innovation.

5. Production schedule

Date	Event
17.03.17	Deadline for agency tenders
22.03.17	Tender response assessment and agency appointment
27.03.17	Project meeting in Leeds between NHS Digital communications team and agency
06.04.17	Draft content for the Foreword and performance review sections reviewed by EMT and chairman
20.04.17	Delivery of concepts for design of NHS Digital annual report and accounts (including front cover, graphical elements, case study and graphical elements and charts and tables).
30.04.17	Business review of draft front end completed and final draft produced and first draft of Management Commentary and the Accounts sections produced.
10.05.17	ARC reviews content of first draft of report
12.05.17	Agency sends designed draft of the full report document to NHS Digital.
19.05.17	Document incorporating NAO comments to date sent to agency.
26.05.17	Final report document produced
31.05.17	Board and ARC approve final version of report
14.06.17	Final editing and proof reading completed and final version of report submitted to the NAO
30.06.17	Target completion date.

Board Meeting – Public Session

Title of paper:	**Progress towards a patient – centric Digital Health and Care System**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 04 b
Paper presented by:	James Hawkins, Director of Programmes
Paper prepared by:	Rachel Murphy, Domain A Programme Director
Paper approved by:	James Hawkins, Director of Programmes
Purpose of the paper:	To inform the board of the progress on key deliverables for 2017/18.
Additional Documents and or Supporting Information:	No additional documents
Please specify the key risks and issues:	The need to recruit and retain the digital skills to design digital services for the public remains the key risk for successful delivery. Risks continue to be identified and mitigated through appropriate programme governance and are raised as appropriate to the NHS Digital Assurance and Risk Committee.
Patient/public interest:	Direct (services that will be used by patients or the public)
Supplementary papers:	No supplementary papers
Actions required by the Board:	For information

NHS Digital

Progress towards a Patient-Centric Digital Health and Care System

28 March 2017

Information and technology
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Contents

Executive Summary

Personalised Health and Care 2020: A Framework for Action[1], published in 2014, sets out an ambitious strategy to transform heath and care through technology.

As the strategy moves into implementation, NHS Digital is the system partner charged with delivering a portfolio of programmes that will give patients more control over their health and well-being.

Over the next two years the NHS Digital will work with NHS England to increase the number of services that can be accessed on line, whilst remembering that healthcare is about people and that many people want the reassurance of a real person to talk to.

This paper provides the Board with an update on progress with some of these programmes, particularly the transformation of the NHS Choices website. The paper also provides an overview of the breadth of the partnerships and syndicated content provided through the site and public health campaigning delivered in partnership with Public Health England.

In addition, the paper provides a brief summary on the current status and progress on key programmes such as NHS 111 online and the development of Personal Health Records.

The NHS Digital Board is invited to note the ambitious delivery programmes underway and anticipated delivery through 2017.

Introduction

Personalised Health and Care 2020 was developed into a set of requirements and eight workstream roadmaps[2] established by the National Information Board.

This set of requirements was developed into a delivery portfolio that was used to inform the health and care submission to the Government Spending Review in autumn 2015.

The financial settlement from the Spending Review meant that the Department of Health was able to announce a new portfolio of work organised into 10 business domains. This portfolio translates the ambition and objectives of Personalised Health and Care 2020 into a set of business led delivery programmes (see diagram on next page).

[1] https://www.gov.uk/government/publications/personalised-health-and-care-2020
[2] https://www.gov.uk/government/publications/national-information-boards-workstreams

These programmes present a real opportunity to transform health and social care. They recognise that better use of data and technology can give patients more control over their health and well-being, empower carers, reduce the administrative burden for care professionals and support the development of new medicines and treatments.

In particular for patients, they aim to:

- Enable citizens to make the right health and care choices;
- Give care professionals and carers access to all the data, information and knowledge they need;
- Make the quality of care transparent;
- Build and sustain public trust; and
- Assure best value for taxpayers.

These deliverables link to the NHS England 5 Year Forward View[3], published in October 2014, which set out a positive vision for the future based around seven new models of care. The proposed delivery for patient-centric elements will deliver against the following objectives:

- Focus on prevention and patient empowerment;
- Larger focus on out-of-hospital care;
- Services integrated around the patient;
- Exploiting the information revolution;
- Accelerate useful health innovation;
- Support people to manage their own health; and
- National key system 'electronic glue'.

[3] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

This paper summarises an update on the progress of a number of the programmes in meeting those aims. The timeline for planned deliverables are outlined in **Appendix A**.

Transformation of NHS Choices

The NHS Choices website was established in 2007 and is the leading online source of health and care information in England with over 40,000 pages of managed content and averaging 50 million user visits per month (see **Appendix B**).

Recognising the increasing demand on the site and the need to respond to changing public expectations, a programme was launched in April 2016 to investigate user needs, scope the required service and service approach to develop transactional services to test with the public.

Through this programme, the NHS Choices website will be transformed into NHS.UK, a service through which people will be able to access digital tools and services that help them to control and manage their health and wellbeing. Online information will help people to understand more about their conditions so that they can make better, more informed choices about their care and help reduce the pressure on frontline NHS services by directing people to the care that they need faster and more directly.

User research has demonstrated that:

- Patients require and expect digital channels;
- The patient experience is a journey around which it is possible to design services;
- People want fast, practical, real-life information and services;
- Personalised information can be motivating;
- Providing digital services will reduce pressure on care services; and
- Digital services will improve the efficiency of care.

Research also found that users:

- Want content that is relevant and practical;
- Like action-based content;
- Want to use smart phones to transact with health and care services; and
- Do not want to work hard to find information.

Key highlights from the NHS.UK programme are set out below.

1. Connecting to services

The programme is currently exploring user needs around General Practice (GP) services, and building new pages to meet those needs.

By March 2017, the programme will provide clearer signposting to existing GP online services from the NHS.UK website, to see if this has a positive effect on the uptake of digital services such as booking appointments and ordering repeat prescriptions. The programme will also provide better information on local pharmacy services, and capture feedback on usage (see image in **Appendix C**).

Research has also identified a couple of key barriers to the uptake of online GP booking. This is being explored further to see how this can be addressed.

By Autumn 2017 the programme will:

- Improve the pages for individual GP pages to make it easier for patients to find their GP Practice; and
- Deliver a pilot for booking GP booking from NHS.UK.

In addition, research in the past year has identified a lack of understanding and awareness around service alternative to GPs, such as pharmacies, walk-in centres, and sexual health clinics. During this period, more investigation will be conducted with the aim of guiding more people to appropriate primary care services.

The further rollout of free wifi to the remainder of the GP estate will be a key enabler in encouraging the uptake of online health services.

Finally in the summer 2017 and updated online patient appointment system will be launched, providing patients with the ability to book their first outpatient appointment with access to waiting time information on a smartphone or computer.

2. Register with a GP

The programme will make finding and registering with a new GP easier and more consistent for everyone. There is currently a range of approaches to registration reflecting the size of the GP market with around seven and a half thousand practices in England. This inconsistency presents challenges for both patients and practices.

By working closely with practices and patients to understand what is needed from the registration process, the programme will provide a clearer, more consistent service.

The benefits of such a service will include:

- Making it easier to find a new GP, provide the information needed to register with a GP and to help the practice meet care needs;
- Enabling more practices to offer new patients the option of submitting registration applications online - thereby reducing demand on services; and
- Providing practices with clearer and more consistent information about patients who wish to register with them that will improve the registration process.

By March 2017, the programme will launch a small-scale (private beta) trial of an early registration service with circa six GP practices. If this trial validates potential benefits, by September 2017, it will be expanded to a larger set of GP practices and include enhanced features (e.g. understanding the catchment area for your chosen practice).

3. Digital Tools Library

There is a growing use of health-related digital tools in everyday life (including fitness and exercise). Estimates range between 150,000 and 300,000 digital tools already, however, there is no consistent mechanism for measuring their suitability or effectiveness, and no reliable, published figures on significant national uptake or utilisation.

The programme therefore aims to improve the health and well being of citizens and patients through the increased use of healthcare mobile digital tools, making them an essential part of health and care provision and public health behaviour change. Increased use will help patients manage their own health needs, their health information and their relevant NHS healthcare interactions.

It is challenging for citizens, patients and healthcare professionals to identify the most relevant, appropriate and effective digital tools and there is no guarantee that tools ranked top in the various 'app' stores are suitable. The programme has therefore worked with Public Health England (PHE) and the National Institute for Clinical Excellence to develop a healthcare digital tool assessment process.

It is proposed that there will be various categories of assessment including, 'NHS Approved' apps which have a published evidence base demonstrating that they can help a person manage and improve their health and 'NHS Connected' digital tools which means that they have been tested and approved for connection to NHS systems, allowing you to download information into the tool.

A pilot of this assessment took place last year and provided valuable insight on the experiences for developers and subject matter experts in assessing digital tools.

As a result, the programme team will be launching a Digital Tools Library hosted on NHS.UK. This will be a Beta launch aimed at enabling patients to find good health digital tools that can help them manage and support their health and care better. It is anticipated that there will be a small number of digital tools in the library at launch and patient feedback on this service will help develop and improve the service.

NHS Digital is also working with the mobile healthcare market to help them integrate their products into existing and new healthcare information technology, data and systems. In particular, we are working with a series of developers to evidence the capabilities that can be made available to citizens and patients to improve their health and well-being.

4. Technology Platform

NHS Choices is cloud hosted which has helped with flexibility and stability over the past few years. Availability, security and stability are key parameters for the development of the site and the approach will adapt as the transformation continues.

This approach is consistent across NHS Digital, where we seek to leverage existing investment by using resources across multiple programmes. Later this year the site will be moved to a new content platform, whilst ensuring that service availability is maintained throughout this transition.

Working with Partners

1. Sharing Content

The success of a site like NHS Choices is dependent on sharing content with other organisations and people, for example:

- The majority of the content on NHS Choices is available for use through syndication. Currently 794 organisations use NHS Choices content, and it is anticipated this number will continue to grow. Current partners are from a wide variety of sectors, including organisations such as Johnston Press, Babylon Health, YourMD, patient.co.uk, Which? and Netmums as well as other NHS organisations and Local Government. This syndication results in around 6.5m additional visits each month. As the NHS.UK programme delivers, this syndication will also be developed further.
- Over the last year, NHS Choices has also collaborated with search provider Bing to provide users with a comprehensive GP and Hospital search experience; enabling

better connection with people to the information and services they need. A Bing search of 'GP in' followed by a location now delivers a summary of each local service, including location, opening times and NHS user reviews – all taken from NHS Choices but without needing to leave the Bing page.

- In addition to providing content via the NHS Choices website, the programme has a considerable presence on social media, providing an alternative channel for people to navigate towards the health information they need. In 2016 there were over 138 million social media impressions. Users of the site can also sign up to regular email services, such as The Dementia Information Service and NHS Weight Loss plans.

2. Public Health Campaigns

NHS Choices have been delivering and managing digital products and services for PHE for the last five years, including high profile behaviour change campaigns such as OneYou, Change4Life, Start4Life, Schools Zone, Rise Above, Be Clear on Cancer, Stoptober, 10 Minute Shake Up with Disney, Heart Tool, Stroke, Alcohol Checker and many more.

Campaigns planned over the next six months include:

- Start4Life – Content refinement and delivery of better breastfeeding section (**April**); content refinement for smoking in pregnancy (**May**);
- Change4Life – Physical activity campaign focus for summer, alongside redesign of the campaign homepage and associated sections, Get Going and Eat Well (**June**); Lunchboxes phase 2 (**September**);
- Be Clear on Cancer – Respiratory campaign update (**June**); regional generic campaign (**September**);
- School Zone – physical activity support (**June)**; iteration of Our Healthy Year food support campaign (**August)**; and
- Stay Well This Winter – website rebuild, phased delivery (**September**).

3. Personal Health Records

The programme vision is to provide citizen access to online health services, so that they are able to access and contribute to their health information, and to interact and transact with those that care for them.

Personal Health Records (PHRs) will become an essential enabler of health and care provision and public health behaviour change. Delivering this will involve understanding and addressing the barriers to use and the commissioning of PHRs by the health and care system: citizens, patients, commissioners, healthcare professionals and developers.

To deliver this, it is key that:

- The new NHS.UK site provides a channel for citizens to link securely to local PHRs or PHR apps which patients can interact with;
- The supplier market is supported in their development of PHR solutions through the provision of clear standards and best practice guidance; and
- Work continues to encourage citizens to become proactive in self-care by driving the adoption of digital tools and reducing burden on front line services.

By the end of April 2017 new patient journeys will be available through NHS.UK to link to the existing services provided by the principal GP System Providers in England. The aim of this initiative is to encourage citizen digital uptake and continue the journey of giving the citizen

free and accountable access to their own data. In the future, it will be the citizen who determines who has access to their data.

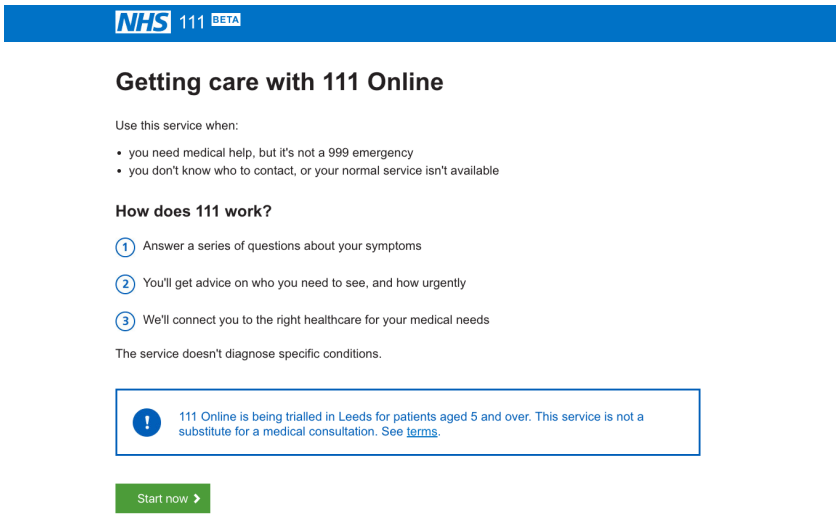
NHS 111 Online

We are working to design online triage services that enable patients to enter their symptoms and received tailored advice or a call back from a healthcare professional.

NHS 111 Online core objective is to allow a patient to self-serve and assess their symptoms online and, if needed, be connected directly with local NHS services.

The programme is currently testing apps, web tools and interactive avatar in local areas such as the West Midlands and West Yorkshire. The pilots will include testing a digital version of NHS Pathways developed by NHS Digital, as well as other online triage services such as Babylon. We will assess the most efficient and accurate system of triage available to inform commissioning decisions that will be made at the end of this phase.

An example of what the start page of the journey looks like for is shown below.



Patient Preferences

The National Data Guardian Review[4] has recommended that a patient should be able to opt out from personal confidential data being used beyond their own direct care.

A Government response is awaited on the review that will set out how the recommendations will be taken forward. In readiness, NHS Digital is evaluating how a simpler approach to enabling people who want to opt-out can do so either online or through other face to face channels.

[4] https://www.gov.uk/government/publications/review-of-data-security-consent-and-opt-outs

Risks

The need to recruit and retain the digital skills to design digital services for the public remains the key risk for successful delivery. This skills shortage is shared across government and government agencies.

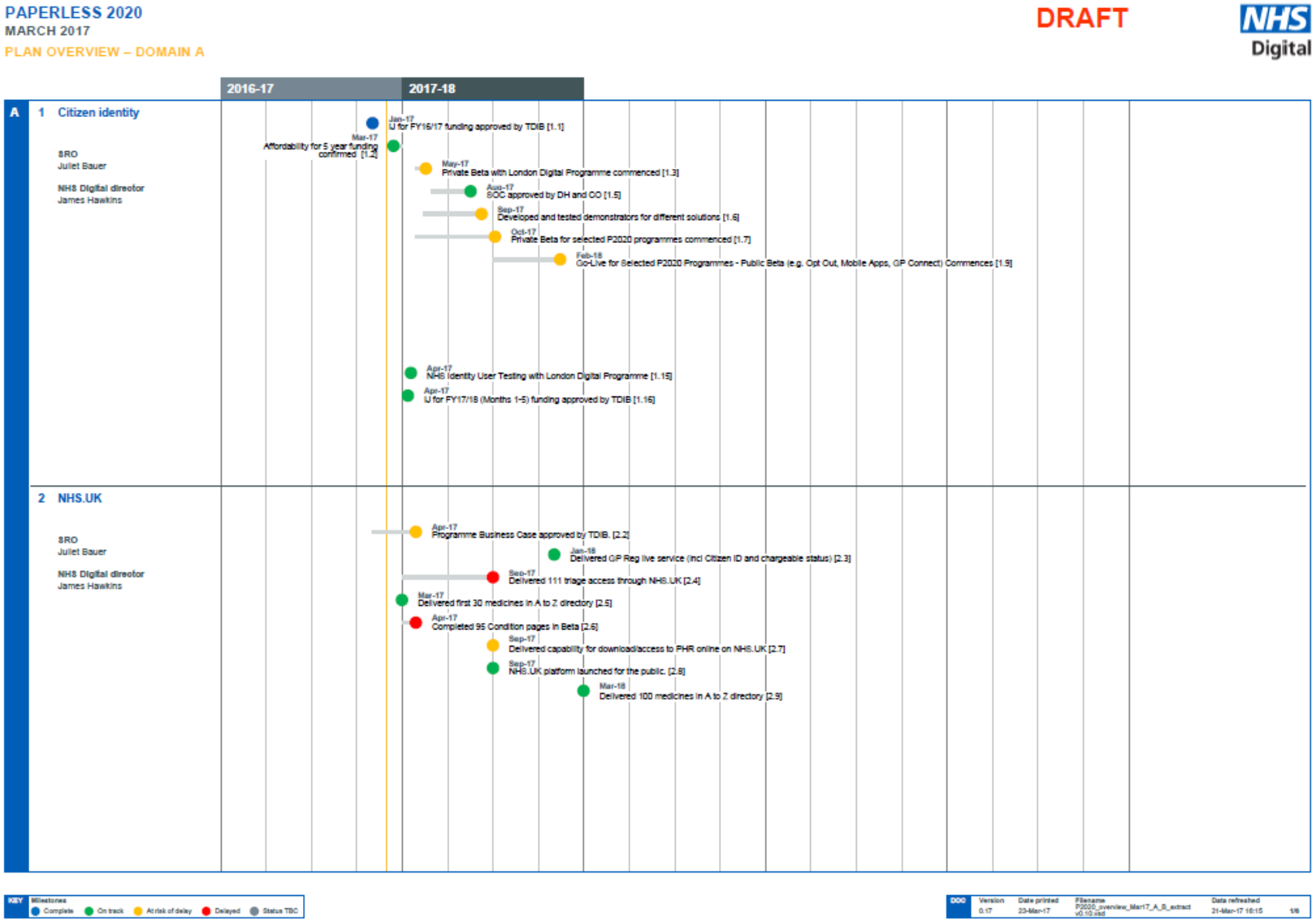
To mitigate this we will investigate options to utilise development partners to deliver the required capability to fill the capacity shortfalls.

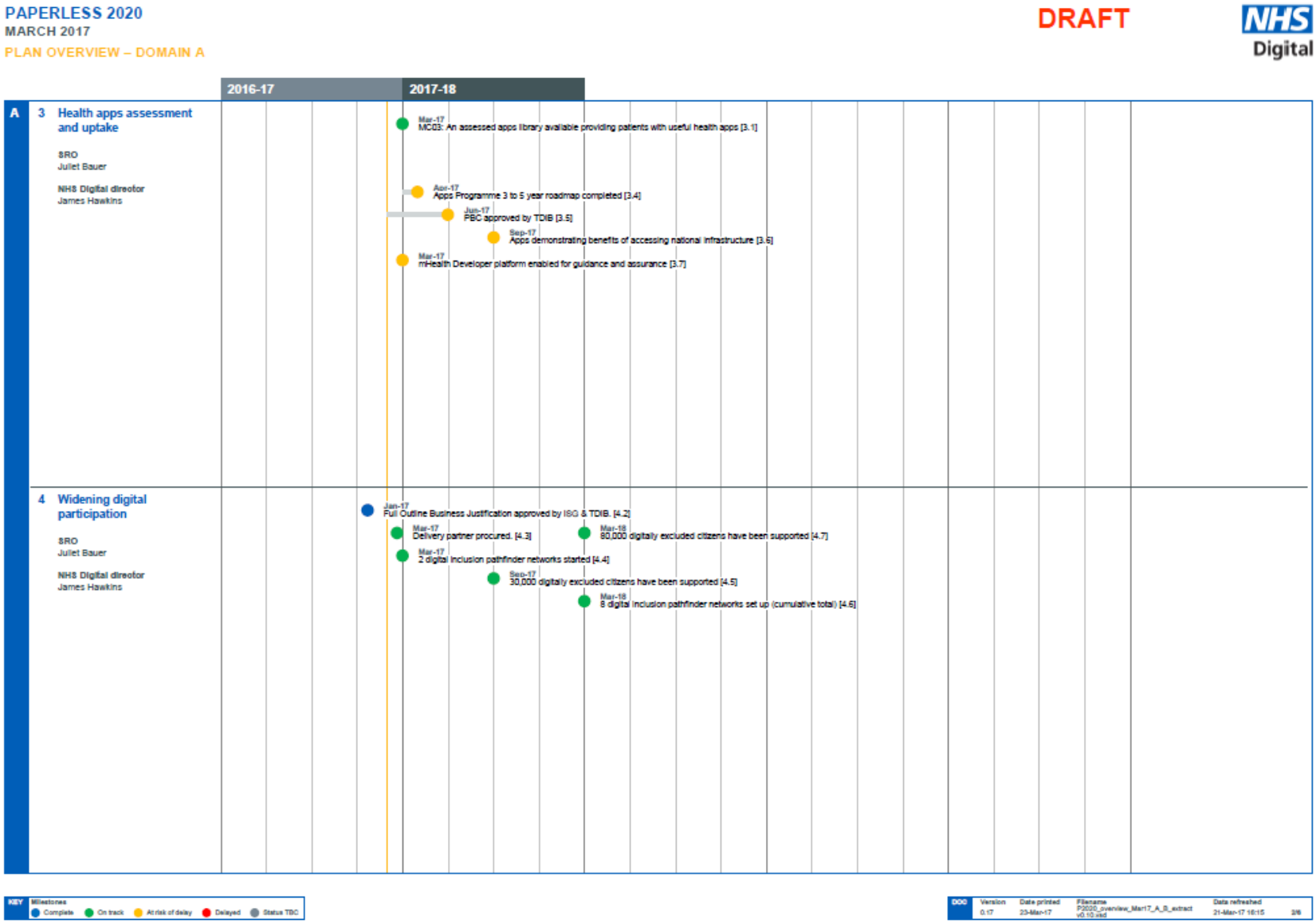
Risks within each programme are actively managed by the relevant Programme Boards. The delivery confidence of the programmes that contribute to progress towards a patient centric NHS are included in in Appendix D.

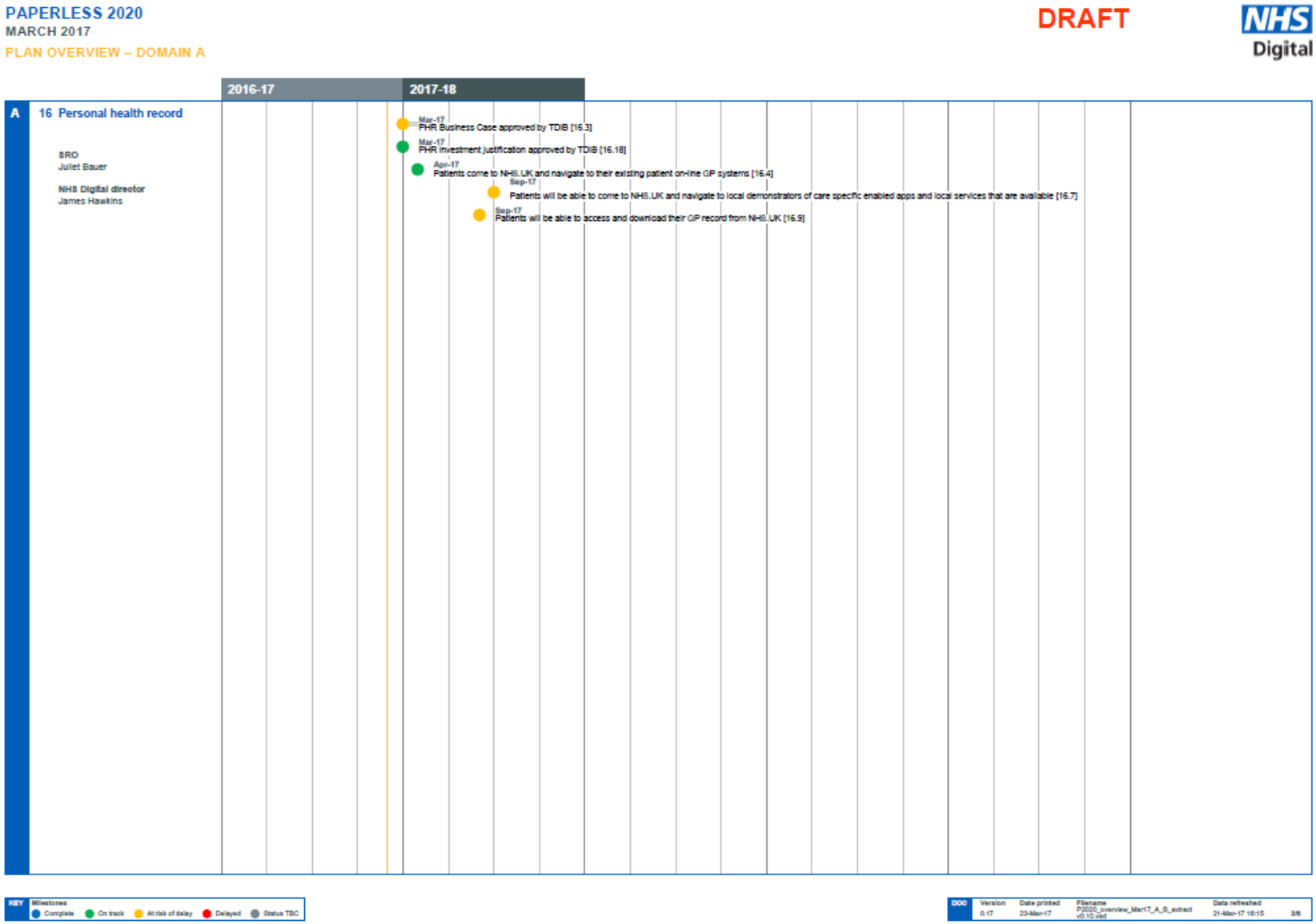
Actions Required of the Board

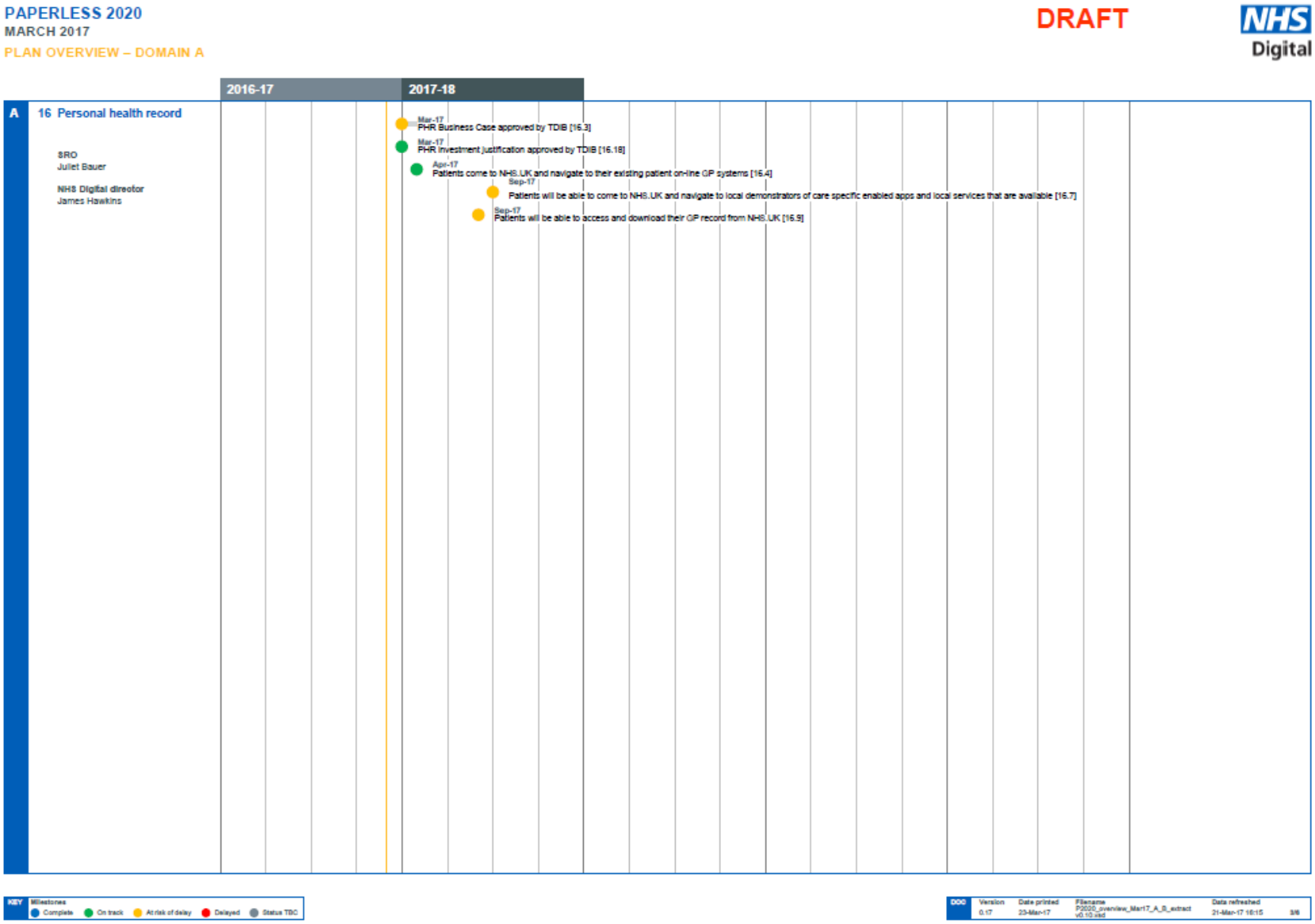
The Board is asked to note this paper for information.

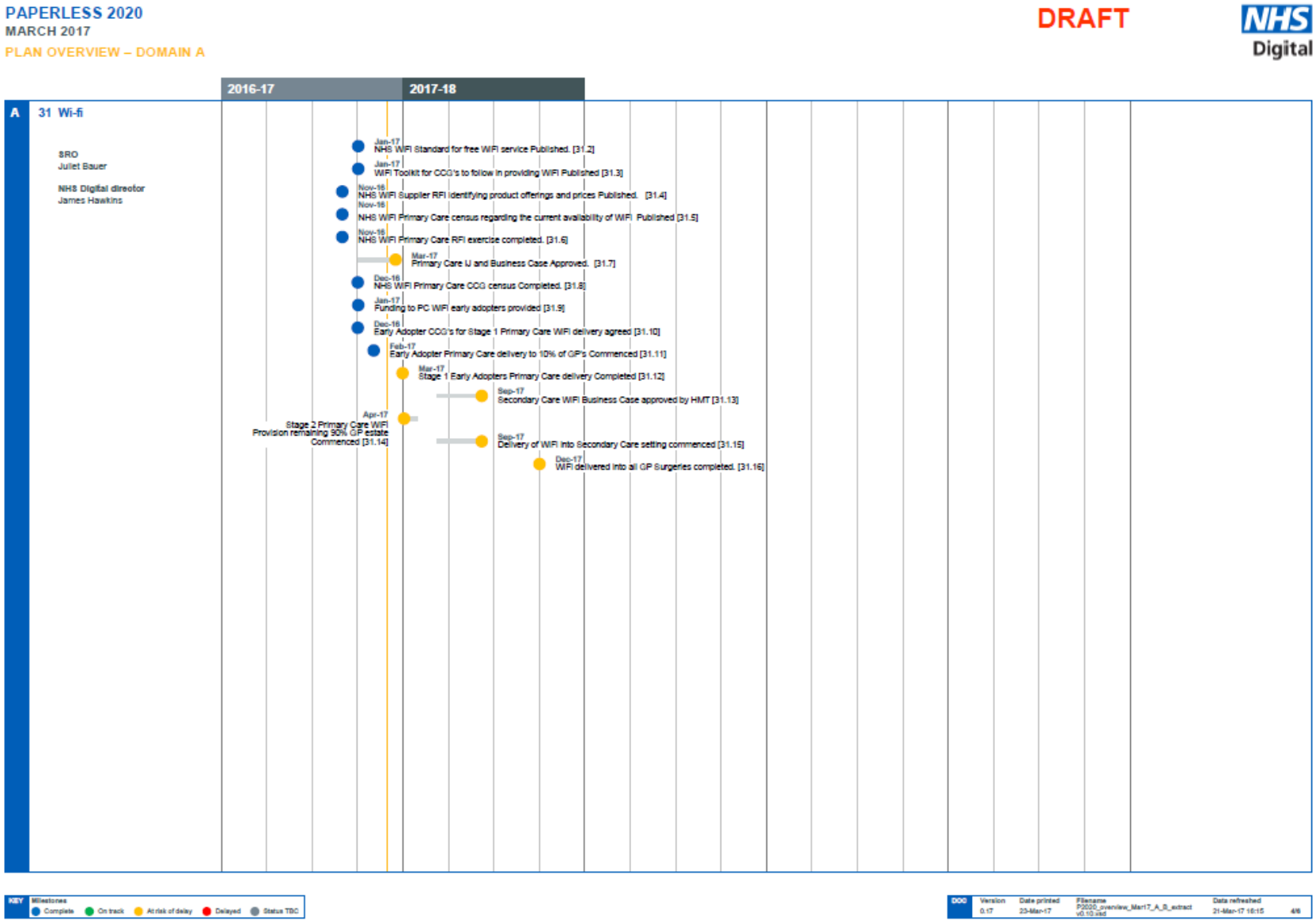
Appendix A – Plan Overviews

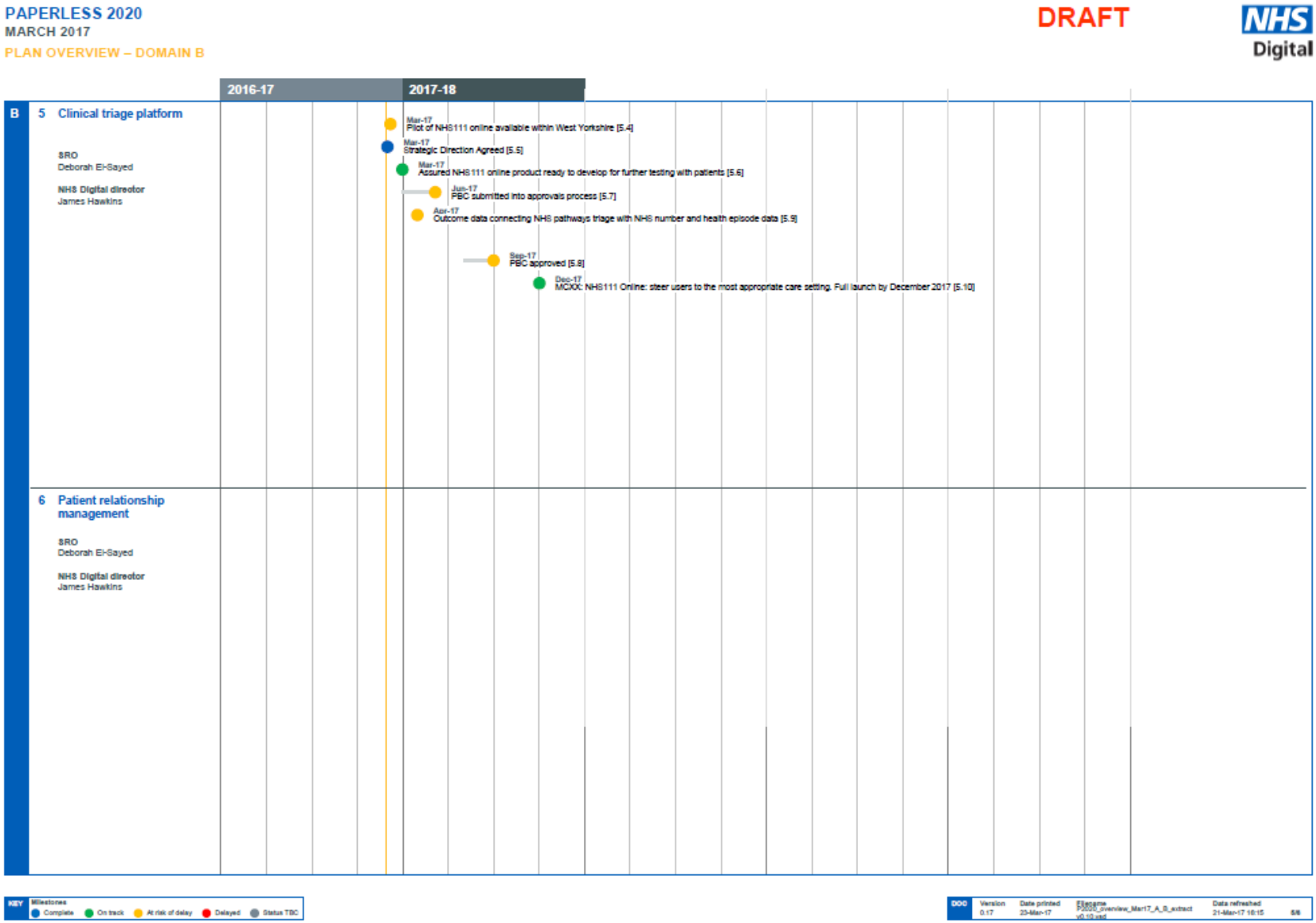


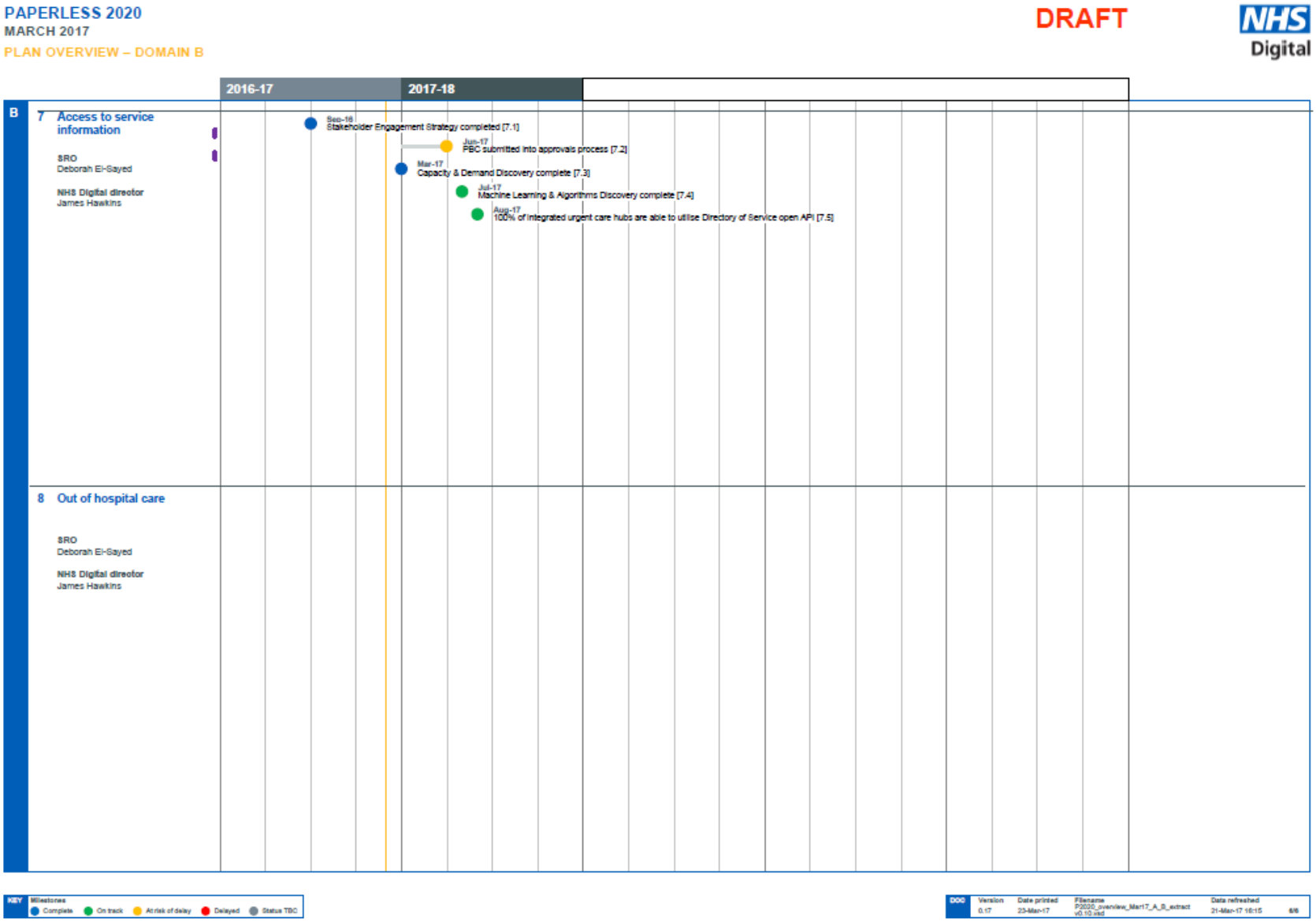










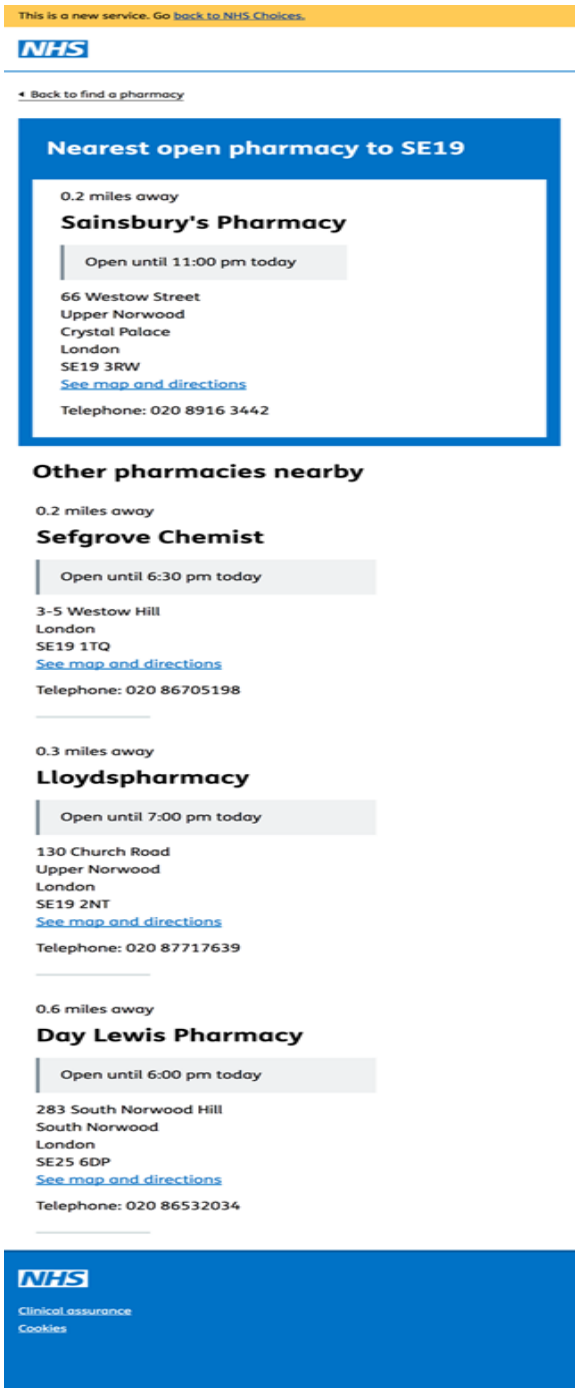


Appendix B – Headline Figures about NHS Choices

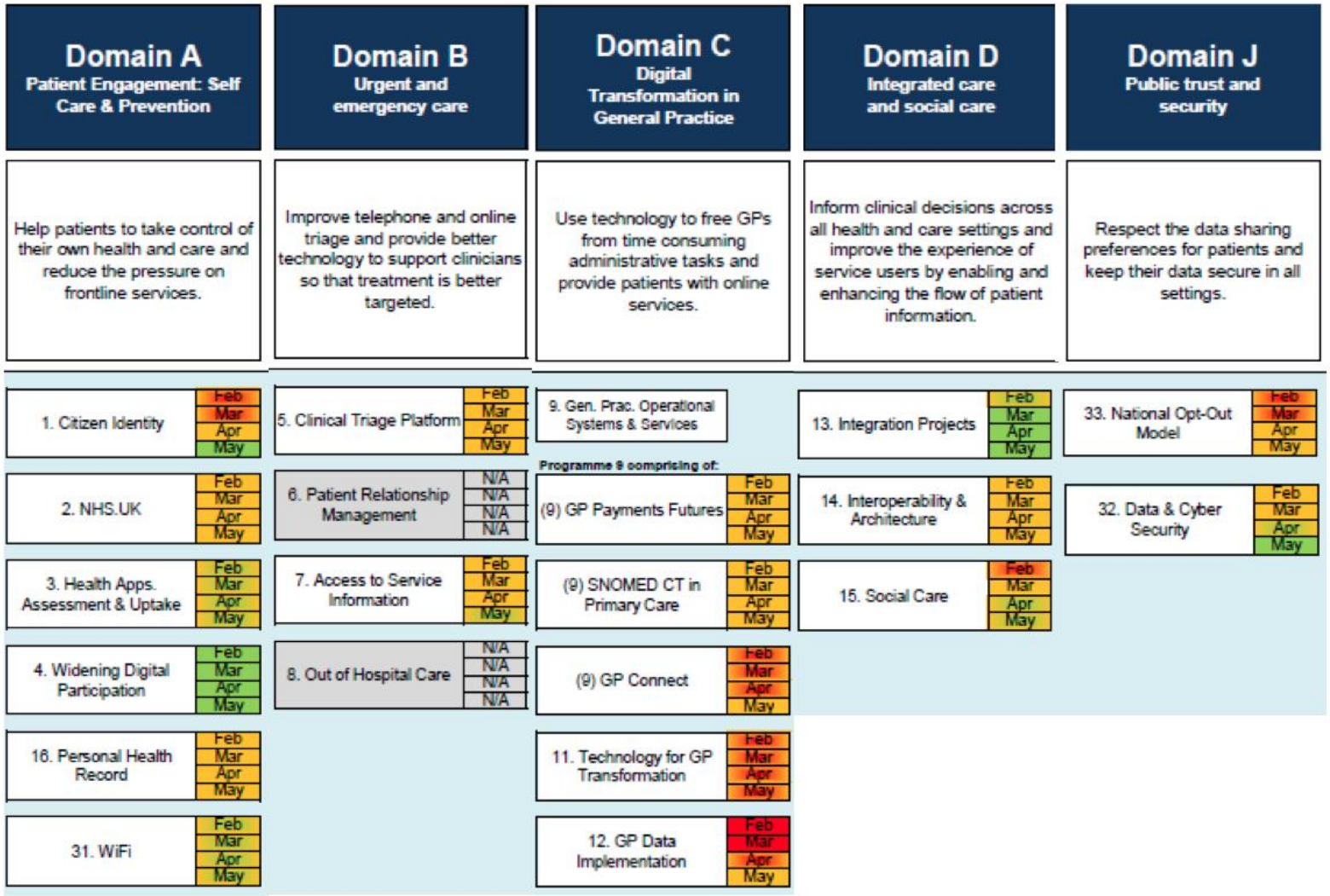
NHS Choices continues to be one of the most popular health websites in the world.

Time Period	Sessions	Users	Average users per day
Sep-16	46,997,184	28,965,852	1,371,631
Oct-16	48,137,582	28,946,174	1,355,094
Nov-16	47,191,487	28,497,756	1,371,322
Dec-16	44,898,269	27,430,580	1,260,440
Jan-17	55,221,008	32,234,984	1,544,348
Feb-17	47,450,654	28,223,424	1,470,819

Appendix C – Example of new NHS.UK website



Appendix D – Programme Delivery Confidence Status



Board Meeting – Public Session

Title of paper:	**Direction for Local Stop Smoking Services Data Collection**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 05 a i
Paper presented by:	James Hawkins Director of Programmes
Paper prepared by:	Paul Niblett Lifestyles Section Head
Paper approved by: (Sponsor Director)	Professor David Hughes Director of Information and Analytics
Purpose of the paper:	To accept the Direction
Additional Documents and or Supporting Information:	Appendix 1 – DH Direction for Stop Smoking Services Data Collection
Please specify the key risks and issues:	There is reputational risk to NHS Digital; both with DH, PHE and the wider general public if NHS Digital are unable to continue collecting the data.
Patient/public interest:	Indirect – relates to dataset created from patient attendances at Stop Smoking Services.
Supplementary papers:	Appendix 1 – DH Direction for Stop Smoking Services Data Collection
Actions required by the Board:	To accept the Direction

Direction for Local Stop Smoking Services Data Collection

Published 28 March 2017

Information and technology
for better health and care

Contents

Executive Summary

This paper requests acceptance of a Direction from the Department of Health (DH) which will allow NHS Digital to continue to collect the Local Stop Smoking Services data (SSS).

The Direction is included at appendix 1.

Background

NHS Digital (under its predecessor organisation NHS Information Centre) inherited the task of collecting and disseminating data from SSS when it was formed as part of the Health and Social Care Act 2012.

Since then there have been some changes to the dataset which require an updated Direction from DH for NHS Digital to continue have a legal basis in place to collect the data.

Recommendation

To accept the Direction.

Implications

Strategy Implications

This proposal falls within “Making better use of health and care information” in the NHS Digital strategy for 2015-2020 and is part of our statutory duty to “Manage the collection, storage, processing and publication of national health and care information, as directed by the Secretary of State and NHS England”.

Financial Implications

As the data is already being collected there are no additional financial applications.

Stakeholder Implications

Both DH and Public Health England (PHE) are users of this dataset and the Official Statistics report produced from the dataset is used by the media and general public.

Therefore if NHS Digital were to stop collecting the data it is likely to have adverse implications both for our immediate stakeholders and may result in reputational damage from the wider general public.

Handling

The Direction has been approved by Information Governance.

Media team have confirmed there are no communication implications.

Risks and Issues

Risks / Issues	Mitigation plans / actions
There is reputational risk to NHS Digital; both with DH, PHE and the wider general public if NHS Digital are unable to continue collecting the data.	Request the NHS Digital Executive Management Team and Board, accept the DH Direction to continue to collect and disseminate SSS Data.

Corporate Governance and Compliance

As part of the consultation process, this Direction was reviewed at EMT on 9 March 2017 date and all Directions should be referred to the NHS Digital Board for consideration and acceptance.

The Official Statistics report generated from the dataset will be published in line with the Code of Practice for Official Statistics.

The data collection is aggregated at local authority level so there is very little chance of any individuals being identified, and any dissemination of the data will be compliant with the ICO Guide on Anonymisation.

Management Responsibility

Chris Roebuck (Director of Publications and Head of Profession for Statistics)
Professor David Hughes (Executive Director of Information and Analytics)

Actions Required of the Board

The Board is requested to accept the Direction.

Department of Health

Andy Williams
Chief Executive,
NHS Digital
1 Trevelyan Square, Boar Lane
Leeds
LS1 6AE

DRAFT

Dear Andy

I am writing to provide a Direction to NHS Digital, formerly known as the Health and Social Care Information Centre (HSCIC) and hereafter referred to as NHS Digital, to establish and operate an informatics system for the collection of data from local stop smoking services.

This Direction is given in exercise of the powers conferred by sections 254(1) and (6), 260, 261, and 304(9), (10) and (12) of the Health and Social Care Act 2012 (the Act)[1].

In accordance with section 254(2)(a) of the Act, the information which could be obtained by complying with the direction is information which it is necessary or expedient for the Secretary of State to have in relation to the exercise by the Secretary of State of the Secretary of State's functions in connection with the provision of health services or of adult social care in England.

This Direction is to be known as the Local Stop Smoking Services Dataset Direction, and comes into force on [***date TBC***]. The Direction will cover the collection of data from upper tier local authorities in respect of their stop smoking services.

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

- Collect aggregate data from local authority stop smoking services on a quarterly basis. (See Annex 1 for full list of data items to be collected)
- Validate and analyse the data, and publish an Official Statistics report.

Please accept this letter as a direction given under subsection (1) of section 254 of the 2012 Act to the NHS Digital to exercise the functions in relation to the informatics system for the collection of data from local authority stop smoking services. The purpose of the data collection is to support the Secretary of State for Health's commitment to reduce smoking and to demonstrate the success of local stop smoking services, and to populate local and regional tobacco datasets. NHS Digital will have regard to and comply with the Directions to NHS Digital to process Type 2 objections.

In accordance with section 254(5) of the Act, NHS Digital has been consulted before this Direction has been given.

[1] 2012 c.7

Yours sincerely

Director name

Director title

..Ends

Annex 1 – List of Data Items to be Collected

Number setting a quit date by gender and ethnic group

Number successively quit by gender and ethnic group

Number setting a quit date by gender and age group

Number successively quit by gender and age group

Number who had not quit by gender and age group

Number not known or lost to follow up by gender and age group

Number successfully quit where non-smoking status confirmed by CO validation by gender and age group

Number of pregnant women setting a quit date

Number of pregnant women successively quit

Number of pregnant women who had not quit

Number of pregnant women not known or lost to follow up

Number of pregnant women successfully quit where non-smoking status confirmed by CO validation

Number setting a quit date on free prescriptions

Number successively quit on free prescriptions

Number setting a quit date by socio-economic classification

Number successively quit by socio-economic classification

Number setting a quit date by pharmacotherapy treatment received

Number successively quit by pharmacotherapy treatment received

Number setting a quit date by intervention type

Number successively quit by intervention type

Number setting a quit date by socio-economic classification

Number successively quit by socio-economic classification

Allocation for smoking cessation for year excluding pharmacotherapies

Cumulative spend on delivery of stop smoking services to the end of the quarter

Total cost of pharmacotherapies issued as part of this service for the year to the end of the quarter

Other monies allocated to smoking cessation to the end of the quarter

Board Meeting – Public Session

Title of paper:	**Direction from NHS England for the National Diabetes Audit Programme**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 05 a ii
Paper presented by:	James Hawkins Director of Programmes
Paper prepared by:	Alyson Whitmarsh Information Analysis Lead Manager, Clinical Audit Services Portfolio
Paper approved by: (Sponsor Director)	Professor David Hughes Director of Information and Analytics
Purpose of the paper:	To enable the views of the Board to be considered as part of the formal consultation on the Direction prior to it being signed by NHS England. This consultation is in line with our agreed process.
Additional Documents and or Supporting Information:	Appendix 1 – NDA directions v0.5 Appendix 2 – National Diabetes Audit programme requirement specification v0.6 Appendix 3 –Technical Specification NDA programme v1.0 Appendix 4 – Communication Plan for Establishing NDA Directions 05
Please specify the key risks and issues:	Data Access - In the event that NHS Digital governance processes will not support linkage to other NHS Digital owned datasets in a timely manner there is a risk that NHS Digital will not deliver reports and publications on time. This will result in NHS Digital not meeting deliverables, and realising one of the main benefits of a directed approach. This may result in changes to payments, and future implications for the Clinical Audit Programme and Directions.
Patient/public interest:	Indirect
Supplementary papers:	Appendix 1 – NDA directions v0.5 Appendix 2 – National Diabetes Audit programme requirement specification v0.6 Appendix 3 –Technical Specification NDA programme v1.0 Appendix 4 – Communication Plan for Establishing NDA Directions 05

Actions required by the Board:	Consider the draft Direction and to identify any issues or concerns as part of the formal consultation process.

Direction from NHS England for the National Diabetes Audit Programme

Formal consultation with the NHS Digital Board

Published 28 March 2017

Information and technology
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Contents

Executive Summary

The National Diabetes Audit (NDA) audit is currently delivered under contract with the Healthcare Quality Improvement Partnership (HQIP) and has been delivered by NHS Digital under this agreement since 2011. The audit is continuing, and moving to a Directed approach using our powers under the Health and Social Care Act 2012. A Direction from NHS England is needed to provide the legal basis for the data to flow. The draft Direction, and associated documentation have been approved by Information Governance and are included as Appendices.

This is the first audit NHSE have approved to be operated through a Directed approach from their national clinical audit programme, although we have a Direction in place already for the Pulmonary Hypertension audit through NHSE Specialised Commissioning. NHSE wishes HQIP to continue with operational oversight on their behalf. A Work package outlining the delivery, governance and funding/payments terms under the POSA will be developed between NHS England and NHS Digital. HQIP will act as a payment agent for NHS England, it is expected that a Collateral Contract will be in place between HQIP and NHS Digital to support the payment. This approach is supported by the NHS Digital finance and legal teams.

Background

The NDA is a major national clinical audit programme and NHS Digital's largest, consisting of a suite of individual audits, which measure the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales, and provides data and information to support the improvement of patient care. National Clinical Audits (currently around 30) are largely competitively tendered by NHSE through HQIP, leading to a plethora of audit providers. NHS Digital, in its role as National Data Repository could provide the informatics component to all audits, using powers in the HSCA 2012 to do this. Successful delivery of this NDA audit may take the organisation in this direction. Benefits would include greater efficiency and more stringent governance around patient data.

NHS Digital provide and will continue to provide, audit delivery management, stakeholder engagement, dataset design and development, data collection system, processes and support, data analysis and report development of publications and outputs.

The audit is currently being reviewed by SCII services and after Impact Assessment is to progress to SCCI as a single stage collection for acceptance at the board meeting on 29th March 2017.

Recommendation

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

Implications

Strategy Implications

The NDA supports the 'Making better use of health and care information' element of the NHS Digital strategy and in particular supports allowing citizens to make informed choices about their own care and helping care professionals make better and safer decisions, support policymakers, and facilitate better commissioning of health and care services.

The successful move to Directions is a specific line in the Information and Analytics business plan for 2017/18. Furthermore a significant amount of discussion and influence to move this audit into a Direction has taken place with both NHSE and HQIP.

Commissioning NHS Digital to provide informatics expertise has the potential to realise significant benefits for the audit commissioner, audit participants, statutory bodies and other users of audit information. These would include efficiencies in the programme and audits:

- reduction of burden relating to audit participation and improved user experience
- consistency in audit design, development and delivery
- flexibility in the commissioning and decommissioning of audits in the programme
- cost savings
- greater consistency and economies of scale
- improved quality, robustness and reliability of services
- improved data availability for statutory functions and additional purposes
- a strengthened approach to data management and information governance
- would fit with the concordat for reducing the administrative burden arising from national requests for information

Financial Implications

Funding for NHS Digital has been identified by NHSE and is anticipated to flow through HQIP for a total of £3,490,745 over three years as follows:

June 17 to June 18	June 18 to June 19	June 19 to June 20	Total
1,240,366	£1,113,084	£1,137,295	£3,490,745

The NHSE business case to support this work has been approved.

Expenditure is summarised in the table below. This comprises staff costs, some external work packages such as contracting an engagement partner to work with people with diabetes and the various clinical communities and the provision of primary care extract specifications; and costs associated with accessing other datasets to meet the needs of the audits.

Expenditure	**WP Year 1**	**WP Year 2**	**WP Year 3**
NHS Digital Staff (inc corporate overheads)	799,366	720,817	713,921
Workpackages/Consultancy	376,002	289,594	320,422
Meetings/Travel Expenses (external)	6,000	6,060	6,120
Design – Patient Material/Posters/leaflets etc	11,500	11,562	11,730
Access to other datasets	42,500	80,000	80,000

Postage	5,000	5,050	5,101
SubTotal	**1,240,368**	**1,113,083**	**1,137,294**
Grand total	**3,490,745**		

Stakeholder Implications

Stakeholders of the audit are aware of the planned use of a Direction to provide the legal basis for the collection of data for the audit; many have been included in its development. These include NHSE, HQIP, the clinicians who advise and lead the audit, the audit's existing Advisory Groups which consist of healthcare professionals and people with diabetes and the audit's Partnership Board which has representation from the wider diabetes care community.

The Directions development process requires evidence of consultation which is included in the communications plan attached at Appendix 4. Two tri-partite groups (NHS Digital, NHSE and HQIP) have met regularly throughout the development process of these Directions:

- NDA Directions development working group
- NDA Directions oversight group – also includes the National Clinical Director for obesity and diabetes.

Handling

Communications plan is attached at Appendix 4 and has been developed in conjunction with the NHS Digital communications team.

Risks and Issues

Risk description and impact	Mitigation
Working arrangements and funding pathways between NHSE, NHS Digital and HQIP are not agreed in line with the project plan. Risk that the agreements will not be developed on time. Result in the agreements not being issued within the timescales needed and the audit delayed.	Strong, regular engagement between all 3 parties including fortnightly delivery group meetings. Early engagement with legal and commercial teams in respective organisations. Steps to complete POSA work package and other agreements required identified and tracked through project plan.
SCCI approval not received in time for the planned data collection start dates..	Regular engagement with SCCI colleagues. Steps to achieve approval identified & tracked through project plan.
Data Access - In the event that NHS Digital governance processes will not support linkage to other NHS Digital owned datasets in a timely manner there is a risk that NHS Digital will not deliver reports and publications on time. This will result in NHS Digital not meeting deliverables, and	Working closely with DARS team and other I&A teams to develop a process for accessing HES and ONS data in line with the current project plan.

realising one of the main benefits of a directed approach. This may result in changes to payments, and future implications for the Clinical Audit Programme and Directions.	
Resources needed to deliver the NDA Programme cannot be secured and/or retained. Risk that NHS Digital will not deliver the NDA work programme as specified in the direction and contract. Result in changes to payments and future implications for the Clinical Audit Programme and Directions.	Ensure resource requests submitted in timely manner.

Corporate Governance and Compliance

The NDA will be delivered under a signed POSA work package between NHS Digital and NHS England, with a supporting Collateral Contract between NHS Digital and HQIP to support payment flow. Information Governance has approved the draft Direction.

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

Management Responsibility

- Alyson Whitmarsh, Information Analysis Lead Manager, Information & Analytics Portfolio
- Julie Henderson, Head of Analytical Services, Information & Analytics Portfolio
- Daniel Ray, Director of Data Science, Information and Analytics Portfolio
- David Hughes, Executive Director of Information and Analytics

Actions Required of the Board

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

D I R E C T I O N S

NATIONAL HEALTH SERVICE, ENGLAND

The Health and Social Care Information Centre (Establishment of Information Systems for NHS Services: National Diabetes Audit) Directions 2017

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

In accordance with section 254(5) of the Health and Social Care Act 2012, the National Health Service Commissioning Board has consulted the Health and Social Care Information Centre before giving these Directions[1].

Citation, commencement and interpretation

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

2. In these Directions–

"The 2012 Act"	means the Health and Social Care Act 2012[2];
"The Board"	means the National Health Service Commissioning Board[3];
"HSCIC"	means the Health and Social Care Information Centre[4];

[1] S.I. 2013/259
[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.
[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

"Relevant Organisation"	means the organisations that deliver the services that are listed in the Inclusion Criteria paragraphs respectively for each audit described in the Specification;
"Specification"	means the means the National Diabetes Audit Programme Requirement Specification version 0.6 dated 07/02/2017 (Document ID: NDA_Prog_Req_Spec) and annexed to these Directions at Annex A or any subsequent amended version of the same document approved by the Board which supersedes version 0.6;
"Technical Output Specification"	means National Diabetes Audit Programme Technical Specification version 1.0 dated [date] and annexed to these Directions at Annex A or any subsequent amended version of the same document approved by the Board which supersedes version 1.0.

Establishing and Operating the National Diabetes Audit Information System

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

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

   (3) The Board directs HSCIC to carry out the activities described in sub-paragraph (1) in accordance with the Specification and generally in such a way as to enable and facilitate the purposes that are described in the Specification.

S254(3) - Requirement for these Directions

4. In accordance with section 254(3) of the 2012 Act, the Board confirms that it is necessary or expedient for it to have the information which will be obtained through the HSCIC complying with these Directions in relation to the Board's functions in connection with the provision of NHS Services.

Fees and Accounts

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

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

Review of these Directions

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

Signed by authority of the NHS Commissioning Board

Sir Bruce Keogh
Caldicott Guardian

[INSERT DATE]

Annex A – Specification
(This document has been removed and can be found in the Shared Documents Folder)

Annex B – Technical Output Specification
(This document has been removed and can be found in the Shared documents Folder)

Document filename:	**National Diabetes Audit Programme Requirement Specification**		
Project / Programme	**CARMS**	Project	**NDA**
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Author	**Cher Cartwright**	Version issue date	**07/02/2017**

National Diabetes Audit Programme Requirement Specification

Document management

Revision History

Version	Date	Summary of Changes
0.3	17/01/17	First complete draft
0.4	18/01/17	NADIA changes made
0.5	31/1/17	Update to data linkages, spotlight audits, DPP, QI activities
0.6	07/02/17	Update to change management

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version

Glossary of Terms

Term / Abbreviation	What it stands for

Document Control:

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

Contents

Introduction

The National Diabetes Audit was established in 2004, initially as a combined adult and paediatric audit, and delivered by NHS Digital (formerly the Health and Social Care Information Centre (HSCIC). It was developed as part of the diabetes National Service Framework (NSF) implementation plan to drive service improvement and monitor the impact of the NSF. In 2011 the adult and paediatric components were tendered separately, the national paediatric diabetes audit (NPDA) was awarded to the Royal College of Paediatric Child Health (RCPCH), whilst the NDA continued to be delivered by the HSCIC (then the Information Centre) as prime contractor and Diabetes UK (DUK) as the subcontractor leading on clinical and patient engagement.

From 2010 new elements were incorporated to include specialised care pathways. Pregnancy in women with diabetes (NPiD), foot ulcer management in people with diabetes (NDFA), and Continuous Subcutaneous Insulin Infusion in people with Type 1 Diabetes were the subjects of new NICE guidelines and care of in-patients with diabetes (NaDIA) arose from a request by the Diabetes National Clinical Director and Department of Health due to concern about the management of people with diabetes admitted to hospital e.g. the post-admission DKA sustained by the index patient in the Mid Staffs enquiry. Transitional care has become a national priority and the NDA has been working with the NPDA to develop measurements relevant to supporting people with diabetes through childhood to adulthood.

The NDA is part of the National Clinical Audit (NCA) Programme, which is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England. National comparative clinical audit is a data driven improvement approach used to determine if healthcare is being provided in line with nationally agreed standards. It informs care providers and patients of where their service is doing well, and where there could be improvements.

The prevalence of diabetes and associated secondary complications continue to rise nationally, bringing with it a high burden of disease. As such diabetes has been prioritised nationally, forming part of the Department of Health's 2016/17 mandate to NHS England. In 2015, the NHS England Domain directors, the Welsh Government, HQIP and NAGCAE undertook a prioritisation exercise to review the current NCA Programme to understand their value and benefit and whether they should be re-commissioned. This was to ensure that the NCA programme is current and provides value for money. The decision was made that the NDA Programme should continue.

NHSE and HQIP invited various stakeholders to discuss priorities for the NDA at a Specification Development Meeting in June 2016. Attendees of the meeting included relevant national clinical directors, clinicians and healthcare professionals, representatives of patient bodies, people with diabetes, academia and the Welsh Government. The meeting discussed each of the current audit work-streams and how these could be developed further and any future developments for the audit programme. Based on feedback from the meeting a proposal document was drafted; proposals were prioritised with NHS England and HQIP and the resulting programme of work is detailed within this requirement specification.

From April 2017 NHS England will use their powers under Section 254 of the Health and Social Care Act to direct NHS Digital (formerly the Health and Social Care Information Centre) to collect, analyse and disseminate the NDA Programme of work.

Purpose of Document

This document sets out the requirements for the National Diabetes Audit Programme and should be read alongside the NDA Programme Technical Specification and the Direction issued by NHS England.

Aims of Clinical Audit

The role of a national clinical audit is to support improvement in the quality and outcomes of patient care by benchmarked reporting against national guidance and standards, for example by utilising standards from the National Institute for Clinical Excellence (NICE), and those from other established professional and patient sources. Successful national audits are those where the individuals providing the data are also in a position to improve the system, and there is a shared understanding of what good care looks like.

The overarching aim of the NDA is the collection, analysis and effective reporting of robust comparative data on the quality of diabetes care delivered to people with diabetes to drive improvements in services and outcomes. The audit should at its core be a mechanism to drive improvement within the NHS for the benefit of patients and those working to deliver care. Engagement with clinicians, patients and commissioners (both local and national) and regional networks is essential in order to support improvements and lever change.

This audit programme is expected to:

a. develop a robust, high quality audit designed around key quality indicators likely to best support local and national quality improvement.

b. Achieve, articulate and maintain close alignment with relevant NICE national guidelines and quality standards throughout the audit, as appropriate;

c. enable improvements through the provision of timely, high quality data that explores variation by comparing providers of healthcare, and comprises an integrated mixture of named Trust or Health Board, commissioner, MDT, general practitioner, possibly consultant or clinical team level and other levels of reporting;

d. engage patients, carers and families in a meaningful way, achieving a strong patient voice which informs and contributes to the design, functioning, outputs and direction of the audit;

e. consider the value and feasibility of linking data at an individual patient level to other relevant national datasets

f. ensure robust methodological and statistical input at all stages of the audit;

g. identify full range of audiences for the reports and other audit outputs, and plan and tailor them accordingly

h. provide data in a timely, accessible and meaningful manner to support quality improvements, minimising the reporting delay and providing continual access to each unit for their own data

i. utilise strong and effective project and programme management to deliver audit outputs on time and within budget

j. close engagement with the National Paediatric Diabetes Clinical Audit and to seek opportunities to align scope, methodology and outputs to optimise a whole pathway analysis of diabetes care and outcomes from pregnancy and childhood through to adulthood; and

k. develop and maintain strong engagement with local clinicians, networks, commissioners, patients and their families and carers and charity and community support groups in order to drive improvements in services for patients

National Diabetes Audit Programme Governance

The governance structure should be robust and transparent and the structure should allow for joint working with the NPDA to ensure opportunities for alignment are maximised.

Clinical Leadership

Effective clinical leadership is integral to the audit delivery. In this context, clinical leadership means that individual(s) with relevant clinical expertise, appropriate experience with national project delivery and demonstrably high professional peer respect and authority are integral to the audit's governance structure and lead the project. It is essential that clinical leaders represent the specialties responsible for delivery of the care that is being audited as these are the clinicians who will need to accept the findings and lead service improvements.

Strong, effective clinical leadership is a core component, which should help to drive:

a. effective operational delivery of the audit and;
b. successful engagement and influence at local and national levels to maximise the quality improvement impact of the audit (e.g. leading on engagement with local clinicians, commissioners, and networks, patients and carers, whilst aligning and working at a national strategic level in partnership with national clinical directors, clinical reference groups and the equivalent groups in Wales).

Meaningful engagement is integral to the success and utility of the audit. It is essential that the audit continues to successfully engage with primary care, secondary care, CCGs (in England) and Health Boards (in Wales) to promote ownership and drive quality improvement at a local level. It is therefore essential that clinical leadership, engagement and governance continue to be provided effectively and transparently as essential functions either by NHS Digital or subcontracted to a specialist organisation.

Statistical Involvement

Appropriate statistical input is integral to the successful delivery of the audit. Statistician input will be essential to the drafting and delivery of a comprehensive analysis plan which should be developed jointly with the clinical lead(s), the methodologist(s) and other experts on the team. The analysis plan must be designed to support the specific improvement goals and anticipated published comparisons which have been identified for the audit during development.

Methodologist Involvement

Appropriate methodological input must be integral to the planning and delivery from the outset. Audits pose various challenges related to the definition of the patient inclusion criteria, the definition of the dataset and the robust collection of the data, including the linkage of audit data to information from other databases. Methodological input is also required during the analysis and interpretation of the audit findings. These individuals will have a key role in the design of the audit, ensuring that it meets the requirements of the audit aims and objectives.

Patient and Public Involvement

There are seven principles of patient and public involvement (PPI) that should be integrated into the NDA Programme:-

- Representation
- Early and continuous involvement
- Clarity of purpose
- Inclusivity
- Transparency
- Cost-effectiveness
- Feedback

Effective and meaningful PPI in the governance structure is required and the above principles should be integrated appropriately throughout every stage of the design and delivery of the work.

Examples that relate to these principles may include:

a. There is appropriate PPI representation on relevant governance groups including the project board
b. Patients are involved when defining specific project improvement goals and audit measures to ensure that they will address issues of importance to patients
c. Patients are clear about their continuing role and purpose in contributing to different stages of the project
d. Information is accessible to facilitate patient engagement with the project throughout its lifetime
e. Patients are included in the development of the National clinical audit report and actively influence the format of the reporting. Patients are involved in developing plain English/patient friendly reports
f. There is transparency about how patient involvement will influence project activity, eg, there is clear evidence of a collaborative approach to the development of tools and resources that will support the project.

Audit Governance Structure

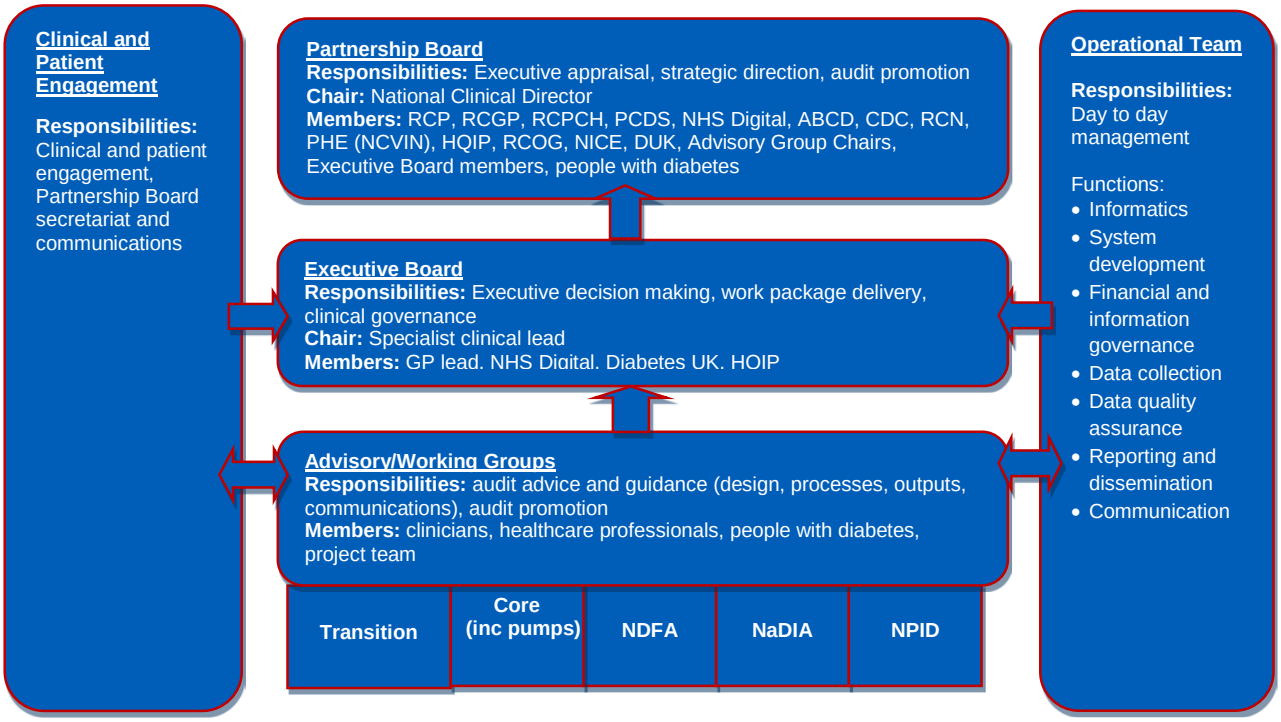
The audit must be governed by a robust management structure with clearly-defined governance groups, designed to maximise effectiveness. The proposed NDA governance structure is defined in Figure 1. Membership should be reviewed at least on an annual basis and as needed throughout the life cycle of the audit.

Adopting the current approach, each work-stream should have its own Advisory or Working Group that is comprised of a multi-disciplinary team with experience and specialist knowledge of the relevant audit, this should include healthcare professionals, people with diabetes, analysts, and representatives from governing bodies. The Advisory Group will oversee the development of the audit collection and outputs, along with quality improvement initiatives.

In addition to the governance for the individual audits, the NDA should have a governance structure in place that provides responsibility for the delivery of the audits and making executive decisions, along with strategic direction and promotion of the audit. Under the current governance structure this is two governance groups. The NDA Executive Board is responsible for executive decision making and the delivery of the audit against the pre-defined deliverables. The NDA Partnership Board provides Strategic Direction and promotion of the Audit. The group(s) membership should be comprised of relevant professionals e.g. Specialist Clinical Lead, GP Lead, NHS Digital, HQIP, NPDA, NHS England, Welsh Government, Public Health England, people with diabetes.

In addition, annually the NDA Oversight Group (consisting of HQIP, NHSE and NHS Digital membership) will review the Direction requirement specification and the work package.

Figure 1: NDA Governance structure



National Diabetes Audit - Core

The National Diabetes Audit (NDA) started in 2003-4 as part of the Diabetes National Service Framework (NSF) implementation plan to provide reliable measurements for service improvement and monitor the impact of the NSF. The core components of the NDA were designed to align with the Diabetes NSF, NICE guidelines and Quality Standards in respect of achievement rates for annual care process, and treatment targets and disease measure including premature mortality. It integrates data reflecting contributions from all primary and secondary care providers and captures data on over 2 million people with diabetes each year.

The core NDA is designed to answer four key questions based:

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

Inclusion criteria

Services

- NHS funded General Practices in Primary Care.
- Secondary Care Diabetes Services delivering routine Diabetes Care.
- Secondary care diabetes services delivering insulin pump clinics

Geographical coverage:

- England and Wales

Patient/population characteristics:

a. There is no age limits for patient inclusion
b. Patients with diabetes mellitus (Type 1 and Type 2, Maturity Onset Diabetes of the Young (MODY) and other rare forms)
c. Patients with non-diabetic hyperglycaemia and potentially women with previous gestational diabetes, as guided by the NHS England Diabetes Prevention Programme inclusion criteria See DPP section).
d. Diabetic patients with learning disability and/or mental health diagnosis.

Dataset design

The NDA dataset should be comprehensive enough to support quality improvement and assurance, allow for adequate risk adjustment, while balancing the need to minimise local burden. To achieve this aim, the existing dataset of the NDA should undergo annual review to ensure all data items collected from providers are directly aligned with the quality improvement questions, and that data linkage opportunities with national data sources (e.g. Hospital episode statistics (HES); Patient Episode Database for Wales (PEDW); Office for National Statistics (ONS)) are maximised. This review should take account of data items that are a priority for stakeholders that are currently not included in the dataset but could become part of the core audit dataset. The review should also be responsive to changes if the dataset requires revision, such as removing data items that are no longer clinically relevant. Any changes to the dataset should go through the appropriate change management process as detailed in this document.

The NDA will be expected to engage in appropriate stakeholder consultations during dataset development and review, including (but not limited to):

a. service users and carers;
b. commissioners (local and national);
c. clinicians (including General Practitioners);
d. third sector organisations; and
e. organisations setting professional standards/users of the data for quality improvement and benchmarking, e.g. National Institute for Clinical Excellence (NICE); Care Quality Commission (CQC).

The dataset should align with current and, where possible, forthcoming national guidance and quality standards of best practice. It is expected that data are collected which directly reflect relevant NICE guidance and quality standards.

Items that should be included in the Core dataset are:-

a. measurement of the delivery of NICE recommended care processes;
b. incidence of diabetic complications and mortality using data linkage on an individual patient level with HES, PEDW and Mortality data
c. measurement of NICE recommended treatment target achievement and other meaningful and measurable outcomes at the appropriate care levels, these should align with national

best practice and, where possible, be adaptive to advancements in individualised treatment targets (e.g. collecting drug data);

d. analysis and reporting for learning disability and mental health patient sub groups to support initiatives to reduces health inequalities and support parity of care
e. measurement of the uptake and attendance at structured education programmes
f. The scope of the core dataset should be expanded to include Type 2 diabetes prevention and measure variations by primary care practice and CCG/Health Board in non-diabetic hyperglycaemia, capture uptake and effectiveness of the English Diabetes Prevention Programme lifestyle interventions (utilising specific primary care 'read codes', shortly to be replaced by SNOMED codes). Where appropriate it is expected that the NDA explore linkage to the Welsh equivalent cardiovascular prevention programme.

Participation and case ascertainment

It is expected that the audit strives for 100% participation in primary care and the audit engages with key stakeholders, such as clinicians, commissioners and system providers, to influence and enable an increase in participation within secondary care. Case ascertainment should be evaluated and reported, where appropriate this should make use of other national data sources (e.g. hospital episode statistics (HES), Quality Outcomes Framework (QOF) and Patient Episode Database for Wales (PEDW)).

Data collection

The NDA primary care extraction currently takes place annually. Primary Care Extraction will continue as an annual extraction for the 2016-17 and 2017-18 audit collections, but from the 2018-19 audit onwards the primary care extraction will move to a 6 monthly collection. This will give more timely reporting to help support local quality improvement.

For secondary care data collection should be continuous whereby service can enter data throughout the year. The online system will be secure, provide data quality checks and completeness functions and validations to help submitters and decrease the burden on services. As part of the continuous collection meaningful information should be able to be extracted by providers, for purposes of local quality improvement, quality assurance and benchmarking. This includes the provision of online reports that present results, in graphical, tabular or other usable format.

Data linkage

The audit should identify and define any potential data linkages which would enhance the data quality, or the impact of the audit or reduce data burden. It is expected that the NDA Core dataset is linked to PDS (Patient demographic service) HES (Hospital Episode Statistics), PEDW (Patient Episode database for Wales) and mortality (Office for National Statistics datasets) on an individual patient level and these data linkages are utilised to best effect, such as collecting data on diabetic complications, admissions or service provision.

Is is expected that the NDA Core dataset is linked to the National Paediatric Diabetes Audit (NPDA) dataset to explore the transition of care from paediatric to adult services. The data flow and information governance criteria should be explored and NHS Digital should work with NPDA and HQIP to address so that data linkage can be undertaken (See Transition Section).

Other data linkages that would benefit the impact of the audit are linkages with other NCAPOP audits (e.g. national vascular registry, national ophthalmology audit and national cardiac audit programme), these should be explored. It is expected that the audit explores the mechanism for linkage with the National Diabetic Eye Screening Programme (DES) in England (https://www.gov.uk/guidance/diabetic-eye-screening-programme-overview) and Diabetic Eye Screening Wales (DESW) (http://www.eyecare.wales.nhs.uk/drssw).

These linkages would reduce the overall collection burden on participating trusts and would improve data completeness and quality, helping to produce a complete picture of diabetes care and comparison of patient outcomes.

Learning Disability and Mental Health

The NDA should capture and report meaningful information about the care and outcomes of patients with diabetes who also have a learning disability or a mental health disorder, seeking to answer the following questions:

a. What is the prevalence of learning disability/mental health disorders in people with diabetes and how does this compare with available national prevalence figures?
b. What are the characteristics of diabetic patients with a learning disability/mental health disorder (including BMI index and ethnicity)?
c. How does this reflect on outcomes (e.g. blood sugar control / HbA1C) and complications?
d. Where possible, What proportion of service providers make reasonable adjustments for diabetics with learning disabilities, for instance in relation to structured education programmes, education and awareness for blood sugar control in pregnancy?

People on Insulin Pumps

The NDA should capture and report meaningful information about the care of Type 1 patients that are on insulin pumps to help inform services about the care they deliver. The audit should aim to understand the following:

a. The reasons why people are put on pumps
b. How long people have been on pumps
c. Whether their care has improved since they started on a pump
d. Any differences in care process and treatment target achievement for people on pump compared to their peers not on pumps.
e. Whether individual treatment targets are being achieved for those people on pumps

The analysis and data items collected should be considered with relevant stakeholders e.g. Advisory Group, Insulin Pump network. The collection and reporting of data items should be in line with the NDA Core schedule.

Analysis and audit outputs

The analysis and audit outputs should be as specified in the Analysis and Audit Output Section of this requirement document. In addition:-

a. For the 2016-17, 2017-18 audit collections care processes and treatment targets should be reported annually. For the 2018-19 audit onwards an annual report should be produced along with a progress report.
b. The annual report should provide details of annual care process completion and treatment target achievement, along with patient demographic information and information for offered and attendance at structured education places. This will help users to identify areas for quality improvement.
c. The progress report should provide an update for how services are performing at meeting the end of audit year annual care processes and treatment targets to help services with local improvements to help improve the variation in completion rates.

d. The content of both the annual report and progress report should be agreed with stakeholders.
e. The data should be linked to PDS data to help improve the quality and data completeness
f. The data should be linked to HES, PEDW and mortality data and a report for diabetic complications produced every two years. The content of the report should be agreed with stakeholders.
g. The data should be linked to the NPDA dataset, along with linkage to HES and PEDW. A report should be produced as detailed in the Transition section of this requirement.
h. A supplementary annual report for learning disability and mental health should be published that includes information about how well they are performing for care processes and treatment target achievement compared to their peers.
i. A supplementary annual report for insulin pump findings should be reported annually.

National Pregnancy in Diabetes Audit

The National Pregnancy in Diabetes Audit (NPID) launched in March 2013, it is a continuous audit of the care and outcomes of women with diabetes who become pregnant, conducted in secondary care maternity units with a joint maternity and diabetes service.

NPID seeks to answer three key questions:

1. Were women adequately prepared for pregnancy?
2. Were adverse maternal outcomes minimised?
3. Were adverse foetal/infant outcomes minimised?

Inclusion criteria

Services:

- Secondary care maternity units with a joint diabetes and maternity service

Geographical coverage:

- England, Wales and the Isle of Man

Patient/population characteristics:

- Women with pre-existing diabetes who become pregnant
- There is no upper or lower age limit for inclusion

Exclusion criteria

- Gestational diabetes

Dataset design

The dataset should align to current and where possible, forthcoming national guidance (including NICE) and quality standards of best practice. The dataset should consider maternal and foetal process and outcome measures, including:

Process:

a. Diabetes treatment prior to pregnancy
b. Treatment and medications before pregnancy

c. Folic acid supplementation
d. Onset of labour and method of delivery
e. Gestation at first contact with specialist antenatal diabetes team

Maternal outcome:
f. Diabetes control and complications before pregnancy
g. HbA1C control before, during and where possible extend to post-partum
h. Pregnancy outcomes
i. Adverse outcomes

Foetal outcome:
j. special care baby unit/neonatal intensive care unit requirement
k. Gestation length
l. Adverse outcomes

Participation and case ascertainment

It is expected that the audit aims to achieve 100% participation of eligible providers and 100% case ascertainment.

Data collection

The audit should be a continuous data collection where services can capture pregnancy outcomes throughout the year. The mechanism for data collection should be secure and facilitate data quality and completeness, e.g. built in validations, data completeness reporting.

Data Linkage

The NPID dataset should link with other modules of the NDA Programme, particularly the NDA core dataset, to reduce the data collection burden upon participating organisations and maximise opportunities for examination of long term outcomes. It is expected that the audit links to HES and PEDW data for pregnancy and adverse outcome data to decrease burden on services. The audit should explore the opportunity to link with the diabetic eye screening programme to collect the required process and outcome measures.

Analysis and audit outputs

The analysis and audit outputs should be as specified in the Analysis and Audit Output Section of this requirement document. In addition:-

a. As part of the continuous collection improvements meaningful information should be able to be extracted by providers, for purposes of local quality improvement, quality assurance and benchmarking. This includes the provision of online reports that present real time results, in graphical, tabular or other usable format. Services should have input into the design of these reports.
b. National reporting for the NPID audit should occur every two years.

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National Diabetes Foot Care Audit

The National Diabetes Foot Care Audit (NDFA) is a continuous prospective audit of diabetic foot disease in England and Wales. The audit aims to examine the care and outcomes of patients with diabetes who develop diabetic foot disease.

The NDFA seeks to address the following key questions:

1. Are the nationally recommended care structures in place for the management of diabetic foot disease?
2. Does the treatment of active diabetic foot disease comply with nationally recommended guidance?
3. Are the outcomes of diabetic foot disease optimised?

Inclusion Criteria

Services:

a. Diabetes specialist foot care services within secondary care, primary care and community care.
b. Inpatient and outpatient services.
c. Commissioners (Clinical Commissioning Groups (CCG) and Local Health Boards (LHB)).

Geographical coverage:

a. England and Wales.

Patient/population characteristics:

a. Health care professional training programme to undertake annual foot checks
b. Referral pathway of those at increased risk to foot protection service (FPS)
c. Referral pathway of those with new foot disease for urgent multidisciplinary foot team (MDFT) assessment
d. All patients with diabetes presenting with a foot ulcer
e. There is no upper or lower age limit for inclusion

Dataset design

The dataset should align to current and where possible, forthcoming national guidance (including NICE) and quality standards of best practice. The dataset should include the following:

Structures Survey:

a. Health care professional training programme to undertake annual foot checks
b. Referral pathway to foot protection service (FPS) and for urgent assessment

Process:

a. Ulcer features and severity at presentation (including SINBAD score)
b. Referral and assessment

Outcome:

a. Foot ulcer status
b. Mortality
c. Hospital admissions and length of stay

Participation and case ascertainment
It is expected that the audit aims to achieve 100% participation of eligible providers and achieves 100% case ascertainment.

Data collection
The audit should be a continuous data collection where services can capture data on foot ulcers throughout the year. The mechanism for data collection should be secure and facilitate data quality and completeness, e.g. built in validations, data completeness reporting.

Data Linkage
It is expected that data linkage (to HES, PEDW, ONS, all relevant modules of the NDA and the national vascular registry) on an individual patient level is utilised to best effect to reduce the data collection burden upon participating care providers and enhance impact.

Analysis and audit outputs
The analysis and audit outputs should be as specified in the Analysis and Audit Output Section of this requirement document. In addition:-

a. As part of the continuous collection improvements meaningful information should be able to be extracted by providers, for purposes of local quality improvement, quality assurance and benchmarking. This includes the provision of online reports that present real time results, in graphical, tabular or other usable format. Services should have input into the design of these reports.
b. National reporting for the NDFA audit should occur every two years.

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National Diabetes Inpatient Audit (NaDIA)

Currently the National Diabetes Inpatient Audit (NaDIA) is a bedside 'snapshot' audit conducted annually during a specified one week period. The audit measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital, by answering the following questions:

a. Did diabetes management minimise the risk of avoidable complications?
b. Did harm result from the inpatient stay?
c. Was patient experience of the inpatient stay favourable?
d. Has the quality of care and patient feedback changed since the previous audit years?

Modernised approach to NADIA
It is expected that the audit methodology be adapted to support parity of esteem and reduction in health inequalities between mental and physical health through rotating between secondary care, community care and mental health settings. This should initially be explored through a feasibility study for the ability of community and mental health settings to take part and also case ascertainment for these settings before full implementation.

The approach to all elements of NADIA should be reviewed and modernised where possible. This may include the move to more use of electronic data capture, development of a continuous harms audit and review of the patient experience element.

It is expected that hospital characteristics are collected annually and two full NADIA audits are collected during the initial three year period. Work to modernise the audit to be implemented following review and consultation. It is expected that, following review and consultation, a continuous harms collection is developed; this is to be rolled out to all eligible services (including community and mental health setting if appropriate). Following review any electronic data capture for the NaDIA audit week is to be piloted with a subset of hospitals before it is rolled out nationally

Inclusion criteria

Services:

a. Hospitals that admit people who have diabetes (either for a diabetes related issue or where diabetes is a co-morbidity)
b. Community Hospitals
c. Mental health inpatient facilities

Geographical coverage:

a. England and Wales

Patient/population characteristics:

a. Adults of 18 years and over
b. There is no upper age limit for patient inclusion.
c. Patients with diabetes as a primary diagnosis or comorbidity
d. All patients meeting the eligibility criteria should be included

Dataset Design

The dataset should align with current and forthcoming national guidance and quality standards of best practice, it is expected that relevant NICE guidance and quality standards are incorporated to the dataset. The dataset should also include the following:

Hospital level structures:

a. Staffing
b. Training

Process measures:

a. Blood glucose monitoring
b. Pharmacological treatment
c. Involvement of diabetes specialist teams
d. Using data linkage to reduce the data collection burden and increase the quality of the core dataset

Outcome measures:

a. Recommended treatment target attainment
b. Harms: inpatient onset of DKA/HHS, Severe Hypoglycaemia, new foot ulcer
c. Diabetic complications and mortality

NADIA has a patient experience component this may be retained subject to regular evaluation to ensure it is fit for purpose and meets quality expectations.

Participation and case ascertainment

It is expected that the audit achieves 100% participation of eligible providers and achieves 100% case ascertainment.

Data collection

The data collection should endeavour to move away from a snapshot audit to a continuous collection following review. The mechanism for data collection should be reviewed as part of this development.

Data Linkage

Opportunities for data linkage should be explored as part of the review process. Currently as the audit does not contain identifiable data there is no opportunity for data linkage.

Analysis and audit outputs

The analysis and audit outputs should be as specified in the Analysis and Audit Output Section of this requirement document. In addition:-

1. Detailed national reporting for the NADIA audit week should occur every two years.
2. Reporting should also be provided at a hospital level to ensure meaningful information is available to providers, for purposes of local quality improvement, quality assurance and benchmarking.
3. Hospital characteristics should be reported annually

c. On development of a continuous harms collection meaningful information should be able to be extracted by providers, for purposes of local quality improvement, quality assurance and benchmarking. This includes the provision of online reports that present real time results, in graphical, tabular or other usable format. Services should have input into the design of this data collection and outputs.

Transition

This is a joint enterprise linking datasets from the adult and paediatric national diabetes audits to evaluate the quality and outcomes of transition care from paediatric to adult diabetes services. Following the completion of the first transition report any lessons learned will be incorporated into the design of future reports.

The audit seeks to investigate if there are changes in the achievement of care standards as children in paediatric diabetes services move to adult diabetes services. It will do this by specifically answering the following questions:

a. Is the transition from paediatric to adult care associated with changes in care process completion rates?
b. Is the transition from paediatric to adult care associated with a change in achievement of treatment targets (specifically HbA1c)?
c. Is the transition from paediatric to adult care associated with changes in episodes of diabetic ketoacidosis (DKA)?
d. Is the transition from paediatric to adult care associated with changes in attendance at clinics?

The NDA will align with the NPDA to capture and share data on processes and outcomes to ensure continuity of excellent care when young people transition into adult diabetes care.

The audit should provide services, commissioners and policy makers with reliable measurements of changes in the achievement of annual care checks and treatment targets along with changes in the experience of outcomes such as DKA and hypoglycaemia. The audit should provide measurements for the number of patients lost to follow up from paediatric to adult care (i.e. patients who were engaged and participating in paediatric review and care but then fail to do so when under adult services).

Audit results should stimulate and support quality improvements to help improve transitional care particularly for those patients who are lost to follow up (especially to eye, foot and kidney surveillance) and improvements to care outcomes (such as blood glucose control).

Inclusion criteria:

Services:

a. Paediatric diabetes units
b. Primary care
c. Specialist secondary care

Geographical coverage:

a. England and Wales

Patient/population characteristics:

a. patients with a diagnosis of diabetes mellitus from childhood
b. patients 24 years or under

Data collection

No additional data is needed for collection for the transition audit. The audit is a data linkage exercise, between the NDA Core dataset and the National Paediatric Diabetes Audit (NPDA). The NDA audit will work with the providers of the NPDA to link the two datasets under the appropriate data sharing agreement. The first transition report linked data for 2003-04 to 2013-14. The Transition audit will add to this linkage by including data for 2014-15 and 2015-16.

Data Linkage

The NDA and NPDA linked dataset should be linked to HES and PEDW data to understand complications during the period before, during and after transition. NHS Digital will work with HQIP and the NPDA to understand data flows and provide the correct information governance framework for the data linkage of these datasets.

Analysis and audit outputs

The analysis and audit outputs should be as specified in the Analysis and Audit Output Section of this requirement document. In addition:-

- Quality improvement activity will be proposed in conjunction with NPDA following on from the reporting.

Diabetes Prevention Programme

- There are currently over 5 million people in England at high risk of developing Type 2 diabetes and if current trends persist, by 2035 one in ten people will develop Type 2 diabetes. People with non-diabetic hyperglycaemia, and therefore at high risk of developing Type 2 diabetes, are being offered an educational Prevention Programme. Following the diabetes prevention programme pilot being run by NHS Digital in 2017 the scope of the NDA collection should be updated to include people with non-diabetic hyperglycaemia, impaired glucose tolerance or a pre-diabetes. The aim will be to understand the care that these patients are receiving and to measure over time whether they go on to develop Type 2 diabetes. The audit will also measure whether attending a prevention programme helped to stop/delay the onset of diabetes and any diabetes associated complications.
- The audit will use the findings of the pilot study to understand the best way to update the NDA collection to include the required data, and to work with stakeholders to address the key questions that should be answered as part of the collection. The audit will also consider the best process for data linkages to the Clinical Support Unit data collected from education providers supplying the National Prevention Programme and HES and mortality data. The audit will also work with stakeholders, including Public Health England and NHS England to understand roles and responsibilities for analysis and reporting along with mechanisms for any data sharing requirements. Following this work the requirements and technical specification will be updated to allow for inclusion of non-diabetic hyperglycaemic patients and recording of prevention programme data along with reporting plans. The specifications will be updated in line with the change management process outlined in this document and the direction.

Inclusion criteria:

Services:

a. NHS funded General Practices in Primary Care

Geographical coverage:

a. England

Patient/population characteristics:

a. patients with a diagnosis of pre-diabetes, non-diabetic hyperglycaemia or impaired glucose tolerance
b. There is no upper or lower age limit for inclusion

Data collection

Following the DPP pilot study in 2017 a lessons learned exercise will be undertaken to understand the best way of updating the current NDA core dataset to include the collection of DPP nationally. It is expected that the DPP dataset will be collected alongside the NDA core dataset.

Data Linkage

The DPP dataset should be linked to HES and ONS datasets to understand complications associated with pre-diabetes. The DPP dataset should also be linked to the Clinical Support Unit dataset collected from intervention programme providers, this will provide data completeness for the prevention programme. NHS Digital will work to understand data flows and provide the appropriate information governance framework for the data linkage of these datasets.

Analysis and audit outputs

- The audit will use the findings of the pilot study to understand the best way to update the NDA collection to include the required data, and to work with stakeholders to address the key questions that should be answered as part of the collection. The audit will also work with stakeholders, including Public Health England and NHS England to understand roles and responsibilities for analysis and reporting along with mechanisms for any data sharing requirements.
- Following this work the requirements and technical specification will be updated to allow for inclusion of non-diabetic hyperglycaemic patients and recording of prevention programme data along with reporting plans. The specifications will be updated in line with the change management process outlined in this document and the direction.

Spotlight Audits

A) Provision, attendance, quality and outcomes of structured education for patients and carers

The CCG IAF will measure attendance at structured education programmes for newly diagnosed people within 12 months of diagnosis. Currently the NDA Core collection has highlighted that there are data quality concerns around the recording of attendance at education in primary care clinical systems. The NDA has been working with Diabetes UK, Clinical Networks, CCGs and education providers to highlight a process to help improve data recording. This process has been shared nationally with CCGs and Clinical Networks. The audit will help facilitate the improvement of attendance recording by the following activity during the three years:

- Continue to work with CNs, CCGs, GPs, Specialist services and education providers to support improved data recording for attendance.
- Use results for 17-18 audit to review current approach to data recording, produce case studies for CCGs where improvement shown, publish case studies, and target CCGs where recording still an issue.
- In the 2018-19 annual report 1, if the data supports, include additional analysis for education
- In future years of report 2 measure the impact of attendance on hospital admissions and complications this will need linkage to HES, PEDW and ONS data
- Publicise approach to education recording at Diabetes UK conferences during the 3 year contract, including improvements and case studies, along with results from 18-19 report.

Inclusion criteria:

Services:

a. NHS funded General Practices in Primary Care
b. Clinical Commissioning Groups (CCGs)

Geographical coverage:

a. England and Wales

Patient/population characteristics:

a. There is no age limits for patient inclusion
b. Patients with diabetes mellitus (Type 1 and Type 2, Maturity Onset Diabetes of the Young (MODY) and other rare forms)
c. Diabetic patients with learning disability and/or mental health diagnosis.

Data collection

No additional data collection is needed. This data is already collected as part of the NDA Core dataset. This project is about facilitating the improvement of data recording within GP practices and once improved more in depth analysis that cannot be currently done due the lack of data completeness.

Data Linkage

In future years of the audit (not within this 3 year contract) it is expected that the audit will link the NDA Core dataset to HES, ONS and PEDW data to look at whether attendance at education helps to reduce the risk of complications.

Analysis and audit outputs

The analysis and audit outputs should be as specified in the Analysis and Audit Output Section of this requirement document. In addition:-

- Case studies will be published and disseminated to CCGs, LHBs and CNs to help facilitate improvements in local data recording for attendance at education programmes
- In the 2018-19 annual NDA Core report 1, if the data supports, include additional analysis for education
    - Measure variation in offering/attendance by practice, specialist service and CCG by type of diabetes, age, sex, ethnicity and IMD
    - Measure the impact of attendance initially on care process completion and treatment target attainment
    - Measure improvement in BMI, blood pressure, blood glucose, cholesterol for before and after the education programme

B) Accessibility and outcomes of treatment using an insulin pump and continuous glucose monitoring

During discussions about the specification for NDA 2017-20 stakeholders articulated the need to measure compliance with NICE TA 151 (Continuous subcutaneous insulin infusion for the treatment of diabetes) and NICE DG21 (Integrated sensor-augmented pump therapy systems for managing blood glucose levels in type 1 diabetes)

Specifically they were concerned to know:

1. Are the recommended services available?
2. Is the infrastructure commissioned to deliver them?
3. Are patients achieving the intended treatment objectives?

To support this, activity will comprise of the following:

- Develop a working group for this spotlight audit collaborating with NPDA (subject to them having resource to do so, and this spotlight being included in their specification) and the Insulin Pump Network.
- Design a ‘structures’ survey to answer questions 1 & 2 and develop a question to add to the insulin pump audit to capture the results for question 3. Alignment would be needed with the NPDA so that the same insulin pump questions are asked from both audits. The methodology for analysis would need to be aligned between the audits so that results are comparable, we will do this through the working group and regular communications.

- Link the insulin pump data collected in Core with the NPID data, to understand if it is feasible to see if insulin pumps helped women with diabetes to achieve target glucose control and also avoid admission with hypoglycaemia.

Inclusion criteria:

Services:

a. Secondary care diabetes services delivering insulin pump clinics

Geographical coverage:

a. England and Wales

Patient/population characteristics:

a. There is no age limits for patient inclusion
b. Patients with diabetes mellitus (Type 1 and Type 2, Maturity Onset Diabetes of the Young (MODY) and other rare forms) that are on an insulin pump

Data collection

Data is currently collected for insulin pump patients as part of the NDA Core dataset for specialist services. Following the establishment of the Working Group with NPDA and the Insulin Pump Network the group will establish a set of questions for the structures survey that will answer questions 1 and 2. It is expected that this will be developed as an online survey for insulin pump clinics to complete. The working group will also develop additional questions to answer question 3, these will be added to the NDA Core dataset for the 17-18 collection. Whilst designing the questions for the spotlight audit the working group will consider the burden on services and ensure that only the minimum amount of questions are asked to be able to answer the proposed questions to the required amount of detail. Once the questions have been developed the technical specification will be updated as per the Change Management process outlined in this document.

It is expected that the structures survey will only be collected once during the 3 year contract, this will form part of the 17-18 NDA Core collection.

Analysis and audit outputs

The analysis and audit outputs should be as specified in the Analysis and Audit Output Section of this requirement document. In addition:-

- The current insulin pump report that is published as part of the NDA Core dataset will be updated to include the findings from the structures survey for 17-18

Other Activities

The National Diabetes Audit Programme of work also includes a number of other programmes for the 2017-2020 period that will not involve data collection from all services but will form part of either scoping exercises or quality improvement activities. These activities are documented here so that the NDA programme in its' entirety can be seen.

Patient Experience Audit

Patient Experience is not currently carried out throughout the NDA programme of audits, apart from as part of the inpatient audit. A scoping exercise should be carried out in year 1 which will inform any future work.

The scoping exercise will look at:-

- Review the findings from the Pilot study carried out previously
- Review the questions to understand if still relevant and whether new questions need adding, including individualised care planning and dietary advice
- Review feedback from CSQM workshops with people with diabetes
- Review literature and other surveys for questions, uptake, and methodology
- Patient involvement in developing the survey questions and methodology
- Methodology for how we promote to people with diabetes
- Methodology for how we engage GP practices and Specialist Services
- Consideration of the current NaDIA patient experience survey
- Consideration of NPDA approach and whether any joint learning/activity would be possible
- Investigate the use of mobile apps for surveys, how to commission, costs and formats

Following the scoping exercise we will produce a report for NHS England and HQIP to review and to decide if we proceed.

Quality Improvement

The audit should support a quality improvement programme of work for specialist services. This programme of work should cover NPID, NDFA and NaDIA audits. The programme should be led by an independent person that has relevant experience of quality improvement activities within a healthcare setting. The works should take place between 2017 and 2020, and should use the audit outputs for each audit to help services identify local areas for improvement. The work should capture how services have used the audit outputs, what changes they have identified and any improvements or findings from the processes they have put in place. A report for of the findings should be published for each audit.

Overarching Requirements

Analysis

Strong methodological statistical analysis must be a core component of the audit design and delivery. The analysis should take note of the following:-

a. The aim should be to produce data interpretable by all relevant stakeholders, particularly clinicians, commissioners, and service users and carers, to improve the quality of clinical services.
b. The management of missing data or variability in the quality of data submitted to the audit will be explicit
c. A person or group with appropriate statistical expertise will carry out and supervise the analysis of data.
d. Data will be analysed and presented at general practice, hospital/NHS Trust, Clinical Commissioning Group level subject to NHS Digital disclosure policy and taking into account the views of stakeholders for level of granularity.
e. The interpretation and presentation of the analyses will be a joint enterprise decided by the Advisory Group

Outlier analyses

a. Outliers will be determined in line with national guidance. Outlier analyses should be applied to measures which are robust and have an evidence based link to patient outcomes.
b. The audit will determine with stakeholders, including national commissioners (e.g. NHSE, Welsh Government and HQIP) which measures will be included in the outlier analyses.

Audit outputs

The audit outputs should be developed in such a way that they could be used locally to drive quality improvement e.g. making performance against NICE guidance clear for providers, commissioners and patients; use of interactive tools; bespoke reporting tailored to different audiences (including patient outputs); regional workshops and supporting peer review processes.

The audit is expected to demonstrate an understanding of the audiences for the audit data and tailor the outputs to meet different stakeholder needs and better support local and regional quality improvement. The audit should improve the accessibility of the data, for example through infographics, interactive web tools, run charts.

The level of granularity for reporting should be agreed with stakeholders and in line with NHS Digital disclosure policy, e.g. general practice, trust/health board, clinical commissioning group, local health board.

The audit findings should include a breakdown of analysis by ethnicity and socioeconomic deprivation to support local and national initiatives to reduce health inequalities and promote parity of care.

All reports produced are to be made available in the public domain, at named provider level, excluding any information that might make individual patients identifiable. Data at the level of granularity available in the reports will be made available in .csv format to data.gov.

The audit should engage with other departments to maximise the impact of the audit outputs, this includes working with Public Health England, NHS Choices and MyNHS. Where possible data should be made available on public facing domains to support the transparency agenda.

National and local reports are expected to be made available in a timely manner as soon as possible after data collection and analysis

Dissemination

The audit should report the findings for each work-stream in line with the audit output sections detailed in this document and as agreed with NHS England. The audit should facilitate the need for sharing of audit data with researchers and other organisations. This will follow established NHS Digital governance processes.

Joint working between NDA and NPDA

Integral to the success of the national diabetes audit programme is the successful joint working between the NDA and NPDA to optimise a whole pathway analysis of diabetes from pregnancy, to childhood, to adulthood and the complications which can result. It is expected that the NDA proactively seeks opportunities for alignment with the NPDA in governance, scope, methodology and outputs across all elements of the audit such as, but not limited to:

a. Transition from children's to adult services
b. Spotlight audits
c. The NDA extracts primary care diabetes records for all ages, it is therefore expected that the NDA collect paediatric and adolescent primary care data and through the transition work explores case ascertainment for the NPDA.
d. Reduce duplication of data for CCG level outcomes reporting (CCG OIS and CCG IAF) by working together and alignment.

Synergies between the audits and other national initiatives

During dataset design/review and at key milestones, it is expected that scoping be undertaken to ensure that the audit continues to align and support other national initiatives and priorities. In addition to national clinical guidance and quality standards, it is expected that the national clinical audit design and dataset align with, are responsive to, and can work synergistically with other national policy initiatives and levers to support improvements in services, including (but not limited to):

a. Clinical Outcomes Publication (COP), previously Consultant Outcomes Publication (http://www.hqip.org.uk/national-programmes/clinical-outcomes-publication/)
b. NHS England Seven Day Hospital Services (https://www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week/)
c. NHS Diabetes Prevention Programme (https://www.england.nhs.uk/ourwork/qual-clin-lead/diabetes-prevention/)
d. CCG Improvement and Assessment Framework (CCG IAF) (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/ccg-iaf-mar16.pdf)
e. CCG Outcome Indicator Set (CCG OIS) (https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/)
f. The NHS Outcomes Framework in England (https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/)
g. The NHS Outcomes Framework in Wales (http://llyw.cymru/topics/health/nhswales/circulars/performance-delivery/?skip=1&lang=en)

h. NHS Quality Outcomes Framework (QOF) in England (http://www.hscic.gov.uk/qof) and Wales (http://llyw.cymru/topics/health/nhswales/circulars/performance-delivery/?skip=1&lang=en)
i. Welsh Diabetes Delivery Plan (http://gov.wales/topics/health/nhswales/plans/diabetes/?lang=en)
j. NHS Rightcare and the Atlas of Variation (http://www.rightcare.nhs.uk/)
k. National Cardiovascular Intelligence Network (http://www.yhpho.org.uk/default.aspx?RID=182342)
l. National Child and Maternal Health Intelligence Network (ChiMat) (http://www.chimat.org.uk/)
m. The model NHS hospital (Carter Review of productivity in NHS hospitals) (https://www.gov.uk/government/publications/productivity-in-nhs-hospitals)
n. NHS England's Clinical Service Quality Measures (CSQMs) Programme (https://www.england.nhs.uk/ourwork/tsd/data-info/open-data/clinical-services-quality-measures/)
o. Best Practice Tariff in England (https://improvement.nhs.uk/resources/developing-201718-national-tariff/)

Alignment with Health Policy Direction

The NDA Programme is part of the National Clinical Audit Programme and therefore the audit design, tools and data items should remain aligned with and responsive to contemporary health policy directives. In particular, the audit must evolve in response to updated NICE guidance and quality standards and should remain responsive to and aligned with other national initiatives (Clinical Outcomes Publication, BPT, seven day hospital services, the Rightcare atlas of variation, QOF, NCVIN, ChiMat, Welsh Diabetes Delivery Plan, CSQM and the model hospital).

The audit is also expected to align where appropriate with the NHS Outcomes Framework including the CCG Outcome Indicator Set and Improvement and Assessment Framework. The audit should also contribute to the development of new indicators if required.

Linkage to other Databases

The audit will consider linkages to other national databases including HES, PEDW, ONS, Patient Demographic Service, NPDA, and other national audits, registries and databases to support enhancements of the audits and decrease burden for services. The audit will aim to identify any existing databases for linkages to avoid unnecessary duplication for services, including duplication of data collection platforms. The NDA will work with stakeholders to identify the required information governance frameworks to be able to perform data linkages.

Data Security

As part of data collection development and maintenance measures will be developed to mitigate the risk of loss of data. The NDA will ensure a full understanding of the Data Protection Act along with other relevant security policies and legislation. The NDA will follow NHS Digital policies for data protection, information security and confidentiality.

Local Contributor Requirements

The audit design must take into account the workload anticipated locally during participation in the audit and minimise this wherever possible. The dataset size should be the minimum required to effectively meet the requirements of the audit.

The platform supplied for data entry must provide a fast, secure and user-friendly interface, with real-time data entry facilitated wherever possible. Data inputted by each service should be extractible locally and supported by appropriate tools to facilitate its use in relevant local activities such as for presentations or for comparisons with other local data sources. The platform should also supply real-time relevant information such as data completeness

Communications Plan

Comprehensive information about the audit including the commissioning body, audit aims and objectives, design, geographical cover, timelines, and audit tools / data set (including terms and conditions of their use) must be publically accessible via a dedicated section of the NHS Digital website, with links wherever possible from relevant stakeholders' websites.

A comprehensive communications plan will form part of the audit delivery. Dissemination of audit results are expected to be to the full range of interested parties including clinical service providers; service commissioners; patients, carers and the public; policymakers and regulators. Dissemination should take place through a variety of formats and activities appropriate to the needs of the target audience. The interpretation of the audit results for all reports must reflect the same integral clinical leadership, methodological/statistical input and patient and public involvement as other stages of the audit to ensure the data can be used by the clinical community for quality improvement and remains grounded in the needs of the patients.

All reports must be publically accessible. Adaptations may be required to remove the risk of patients being individually identifiable and should be aligned to NHS Digital policy for disclosure control.

Change Management

Any changes to the NDA Direction either in terms of requirements and/or in terms of data items will need to be supported by the individual Advisory Groups for the audit. Once agreed the Advisory Group will recommend the proposed changes to the NDA Executive Board and NHS England. If supported, the NDA Executive Board will recommend the changes to the NHS England Data Co-ordination Board (DCB). Following DCB approval the requirements and/or technical specification will be updated, with appropriate consideration of whether the direction itself needs to be updated. Once changes have been approved these will be communicated with stakeholders.

Standards and Guidelines

The following tables capture some of the key relevant documents which are likely to underpin the audit, Table 1 relates to NICE publications and Table 2 to other guideline sources and references. It is expected that these and any other relevant standards and guidelines be reviewed at regular intervals during the life cycle of the audits so that the audit's datasets can be adapted and updated if and when appropriate.

Table 1. NICE guidance, standards and recommendations to inform the National Clinical Audit of Diabetes.

Guidelines	Title
NICE diagnostics guidance [DG21] https://www.nice.org.uk/Guidance/DG21	Integrated sensor-augmented pump therapy systems for managing blood glucose levels in type 1 diabetes (the MiniMed Paradigm Veo system and the Vibe and G4 PLATINUM CGM system)
NICE Guidelines (NG17), August 2015 https://www.nice.org.uk/Guidance/NG17	Type 1 diabetes in adults: diagnosis and management
NICE Guidelines (NG19), August 2015 https://www.nice.org.uk/Guidance/NG19	Diabetic foot problems: prevention and management
NICE Guidelines (NG28), December 2015 https://www.nice.org.uk/Guidance/NG28	Type 2 diabetes in adults: management
NICE Guidelines (NG3), February 2015 https://www.nice.org.uk/Guidance/NG3	Diabetes in pregnancy: management from preconception to the postnatal period
NICE in development [GID-NG10023] Expected publication TBC https://www.nice.org.uk/guidance/indevelopment/gid-ng10023	Type 2 diabetes management. Standing committee C update. To update NG28
NICE in development [GID-NG10024] Expected publication date: March 2017 https://www.nice.org.uk/guidance/indevelopment/gid-ng10024	Type 2 diabetes prevention. Standing committee C update. To update PH38
NICE guidelines [PH35] Published date: May 2011 https://www.nice.org.uk/guidance/PH35	Type 2 diabetes prevention: population and community-level interventions
NICE guidelines [PH38] Published date: July 2012 https://www.nice.org.uk/guidance/PH38	Type 2 diabetes: prevention in people at high risk
Standards	**Title**
NICE quality standard [QS6] Published date: March 2011 https://www.nice.org.uk/Guidance/QS6	Diabetes in adults

NICE quality standard [QS109] Published date: January 2016 https://www.nice.org.uk/guidance/qs109	Diabetes in pregnancy
NICE in development [GID-QSD133] Expected publication date: August 2016 https://www.nice.org.uk/guidance/indevelopment/gid-qsd133	Diabetes in adult (update)
Technical guidance appraisal	**Title**
NICE medical technology guidance [MTG22] Published date: December 2014 https://www.nice.org.uk/Guidance/MTG22	VibraTip for testing vibration perception to detect diabetic peripheral neuropathy
NICE technology appraisal guidance [TA151] Published date: 23 July 2008 https://www.nice.org.uk/Guidance/TA151	Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus
NICE technology appraisal guidance [TA274] Published date: 27 February 2013 https://www.nice.org.uk/Guidance/TA274	Ranibizumab for treating diabetic macular oedema
NICE technology appraisal guidance [TA288] Published date: 26 June 2013 https://www.nice.org.uk/Guidance/TA288	Dapagliflozin in combination therapy for treating type 2 diabetes
NICE technology appraisal guidance [TA301] Published date: 27 November 2013 https://www.nice.org.uk/Guidance/TA301	Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema after an inadequate response to prior therapy
NICE technology appraisal guidance [TA315] Published date: 25 June 2014 https://www.nice.org.uk/Guidance/TA315	Canagliflozin in combination therapy for treating type 2 diabetes
NICE technology appraisal guidance [TA336] Published date: 25 March 2015 https://www.nice.org.uk/guidance/TA336	Empagliflozin in combination therapy for treating type 2 diabetes
NICE technology appraisal guidance [TA346] Published date: 22 July 2015 https://www.nice.org.uk/guidance/TA346	Aflibercept for treating diabetic macular oedema
NICE technology appraisal guidance [TA349] Published date: 22 July 2015	Dexamethasone intravitreal implant for treating diabetic macular oedema

https://www.nice.org.uk/guidance/TA349	
NICE technology appraisal guidance [TA390] Published date: 25 May 2016 https://www.nice.org.uk/guidance/TA390	Canagliflozin, dapagliflozin and empagliflozin as monotherapies for treating type 2 diabetes
NICE in development [GID-TA10025] Expected publication date: January 2017 https://www.nice.org.uk/guidance/indevelopment/gid-ta10025	Dapagliflozin in triple therapy regimens for treating type 2 diabetes [ID962]
NICE in development [GID-TAG244] Expected publication date: TBC https://www.nice.org.uk/guidance/indevelopment/gid-tag244	Diabetes - buccal insulin [ID311]
NICE in development [GID-TAG386] Expected publication date: TBC https://www.nice.org.uk/guidance/indevelopment/gid-tag386	Diabetic retinopathy - ruboxistaurin [ID382]
NICE in development [GID-TAG280] Expected publication date: TBC https://www.nice.org.uk/guidance/indevelopment/gid-tag280	Macular oedema (diabetic) - pegaptanib sodium [ID452]

Table 2. Other Standards, Guidelines, and Useful References

Title (hyperlinked if possible)	Reference
Action for Diabetes	NHS England
Management of Diabetes	Scottish Intercollegiate Guidelines Network (SIGN)
National Service Framework for Diabetes: Standards (NSF)	Department of Health
Together for Health – A Diabetes Delivery Plan	Welsh Government
2016/17 National Tariff Payment System	NHS England
Lost in transition : moving young people between child and adult health services	Royal College of Nursing - RCN
Diabetes transition service specification	NHS England
ABCD position statement on standards of care for management of adults with type 1	Association of British Clinical Diabetologists

diabetes	
Admissions avoidance and diabetes: guidance for clinical commissioning groups and clinical teams	Association of British Clinical Diabetologists
Difference intensities of glycaemic control for pregnant women with pre-existing diabetes	Cochrane Database of Systematic Reviews
Continuous subcutaneous insulin infusion versus multiple daily injections of insulin for pregnant women with diabetes	Cochrane Database of Systematic Reviews
Computer-based diabetes self-management interventions for adults with type 2 diabetes mellitus	Cochrane Database of Systematic Reviews
Self management interventions for type 2 diabetes in adult people with severe mental illness	Cochrane Database of Systematic Reviews
Improving management of type 2 diabetes in South Asian patients: a systematic review of intervention studies	British Medical Journal (BMJ) Open
Diabetes Eye Health	International Diabetes Federation (IDF)
Hospital management of hypoglycaemia in adults with diabetes	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Hospital management of hypoglycaemia in adults with diabetes (revised second edition 2013)	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
The management of diabetic ketoacidosis (DKA) in adults	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
The management of diabetic ketoacidosis (DKA) in adults (revised second edition 2013)	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Adult diabetic ketoacidosis emergency care pathway to use in the case notes - accompanies the DKA revised guideline 2013	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Management of adults with diabetes undergoing surgery	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Management of adults with diabetes undergoing surgery – full document	Association of British Clinical Diabetologists. Joint British Diabetes

	Societies (JBDS) for Inpatient Care Group
Management of adults with diabetes undergoing surgery - summary	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Management of adults with diabetes undergoing surgery – changes to 2011 guideline	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Self management of diabetes in hospital	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Glycaemic management during enteral feeding in stroke	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Management of Hyperosmolar Hyperglycaemic State (HHS)	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Admissions avoidance in diabetes	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Steroid use for inpatients with diabetes	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Variable rate insulin infusion (VRII) for medical inpatients with diabetes	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Discharge planning for people with diabetes	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group
Management of adults with diabetes on the haemodialysis unit	Association of British Clinical Diabetologists. Joint British Diabetes Societies (JBDS) for Inpatient Care Group

National Diabetes Audit Programme Technical Specification v 1.0

Summary
This document details the technical specification for the National Diabetes Audit Programme.
This specification includes the National Diabetes Audit (NDA) Core Collection, the National Pregnancy in Diabetes Audit (NPID) collection, the National Diabetes Footcare Audit (NDFA) Collection and the National Inpatient Diabetes Audit. There are also holding tabs for the Insulin Pump Spotlight Audit and the Diabetes Prevention Programme, which will be added as per the requirement specificaiton once data items agreed.

The **Model tabs** show the structure for the MiQuest queries for the NDA primary care collection and the structure within the clinical audit platform for NPID and NDFA.
The **Data tabs** shows individual data items for each of the audits including the allowed values, business rules and validations.
The R**eference List tab** shows the values that should be used for the NDA specialist services and insulin pumps.

Summary of Changes to collection and data tables

Audit Name	Data Tab	Change	Date	Document Version

Document Change Log

Date	Description	Version
	First Published version	1.0

National Diabetes Audit Programme Technical Specification v 1.0

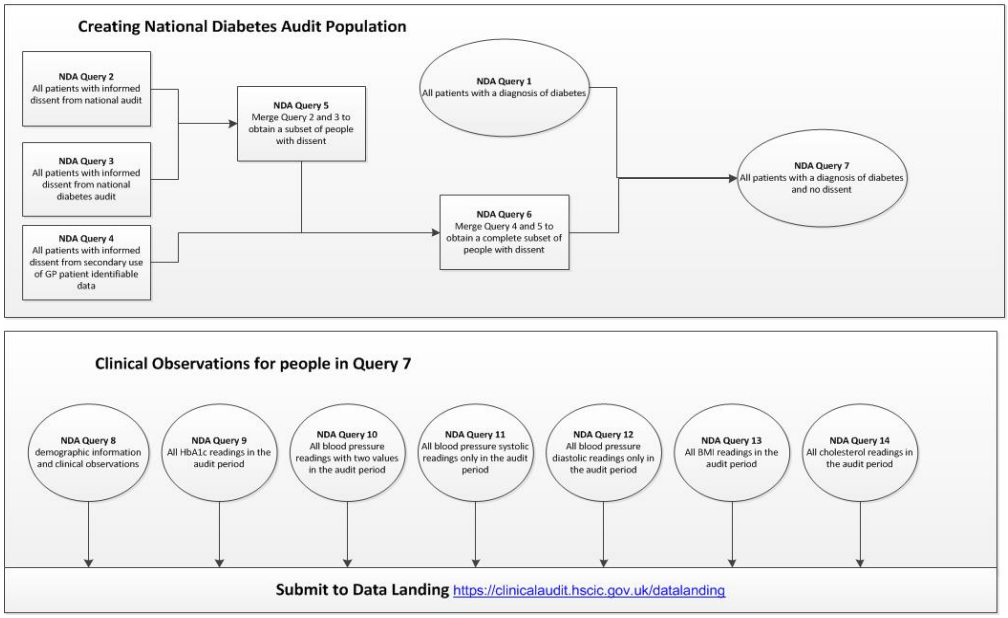
Table of individual audits and data items

Name of Worksheet	description
NDA Primary Model	Structure of the Miquest queries for NDA Core primary care collection
NDA Data primary care	Data items collected as part of the NDA Core primary care collection
NDA data specialist pump	Data items collected as part of the NDA Core specialist service and insulin pump collection
NDA Reference List	Reference tables used for the NDA Core specialist service and insulin pump collection
DPP data items	Data items collected as part of the DPP data collection
IP spotlight data	Data items collected as part of the insulin pump spotlight audit
NPID model	Structure of the NPID data collection within the clinical audit platform
NPID data	Data items collected as part of the NPID data collection
NDFA model	Structure of the NDFA data collection within the clinical audit platform
NDFA data	Data items collected as part of the NDFA data collection
NaDIA HC data	Data items collected as part of the hospital characteristics survey for the NaDIA collection
NaDIA BA data	Data items collected as part of the bedside audit for the NaDIA collection
NaDIA PE Data	Data items collected as part of the patient experience survey for the NaDIA collection

The National Diabetes Audit primary care specification is based on the data items collected in the NDA Priamry Care Tab

The query structure below is based on the MiQuest queries that are developed for practices so that they can extract their diabetes data and participate in the audit
Clinical system suppliers use this strucure as a basis for building their own queries for practices to submit

National Diabetes Audit Miquest Query Structure



Structure Querv 8

CONCEPT	MIQUEST CLAUSE	FIELD NO.	FIELD CONTENTS
Patient Details	1	1	NHS_NUMBER
		2	DATE_OF_BIRTH
		3	POSTCODE
		4	SEX
Ethnicity	2	5	CODE
Dissent from disclosing personal data by HSCIC	3	6	CODE
		7	DATE
Practice	4	8	PRACTICE
Earliest diabetes diagnosis	5	9	DATE
Latest Type 1/Type 2 diabetes diagnosis	6	10	CODE
Serum Creatinine	7	11	VALUE1
		12	DATE
Urine Albumin	8	13	VALUE1
		14	DATE
		15	CODE
Persistent proteinuria	9	16	CODE
Retinal Screen	10	17	CODE
		18	DATE
Feet Examination	11	19	CODE
		20	DATE
Smoking Status	12	21	CODE
		22	DATE
Diabetes Education Review	13	23	CODE
		24	DATE
Referral to structured education programme	14	25	CODE
		26	DATE
Attended structured education programme	15	27	CODE
		28	DATE
Earliest IHD diagnosis	16	29	CODE
		30	DATE
Latest learning disabilities diagnosis	17	31	CODE
		32	DATE
Mental Health diagnoses	18	33	CODE
		34	DATE

National Diabetes Audit Core - data items for Primary Care

The primary care specification is developed with system suppliers and based on the below data items
The read codes for the data items are provided in the primary care specification which is updated each year to take account of any updates to the latest version of read.
The audit will be transitioning to SNOMED as part of the 2017-18 collection
The latest version of the primary care specification can be found on the NDA webpage **http://content.digital.nhs.uk/nda**

Field No.	Data item name	Record	Format	Validation rules
1	NHS number	Patient	10 digit numeric	must be a valid NHS number
2	Date of Birth	Patient	YYYY-MM-DD	
3	Postcode of usual address	Patient	Format Example AA9A 9AA EC1A 1BB A9A 9AA W1A 0AX A9 9AA M1 1AE A99 9AA B33 8TH AA9 9AA CR2 6XH AA99 9AA DN55 1PT	must be <= 7 characters
4	Sex	Patient		
5	Ethnic category	Patient		must be a valid read code as specified in the primary care specification
6	dissent from disclosure of personal confidential data by HSCIC	Patient		must be a valid read code as specified in the primary care specification
7	GP Practice Code	Organisation	X99999	where X can be A-H, J-N, P, W, Y
8	Date of Diagnosis (Diabetes)	Diagnosis	earliest diagnosis of diabetes YYYY-MM-DD	must be > date of birth
9	Diabetes Type	Diagnosis	latest diagnosis code for diabetes for Type 1, Type 2, MODY or Other	must be a valid read code as specified in the primary care specification
10	Person observation (BMI)	Observation	Format 99.9	Expected range 16-70 all readings within the audit period must be a valid read code as specified in the primary care specification
11	Observation Date (BMI)	Observation	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period
12	Systolic Blood Pressure	Observation	maximum 3 digit numeric	Expected range 80 - 250 all readings within the audit period must be a valid read code as specified in the primary care specification
13	Observation Date (Blood pressure)	Observation	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period
14	Diastolic Blood Pressure	Observation	maximum 3 digit numeric	Expected range 30 - 150 all readings within the audit period must be a valid read code as specified in the primary care specification
15	Observation Date (Blood pressure)	Observation	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period
16	Person observation (HbA1c Level)	Observation	Format 999.9	Values in mmol/mol all readings within the audit period must be a valid read code as specified in the primary care specification
17	Observation Date (HbA1c level)	Observation	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period
18	Person observation (Serum Creatinine Level)	Observation	maximum 4 digit numeric	Expected range 20-1000 must be a valid read code as specified in the primary care specification
19	Observation Date (Serum creatinine level)	Observation	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period
20	Person observation (Urinary Albumin Level)	Observation	Format 9999.9	must be a valid read code as specified in the primary care specification
21	Observation Date (Urinary Albumin level)	Observation	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period
21	The first persistent proteinuria diagnosis ever	Observation		must be a valid read code as specified in the primary care specification
23	Person observation (Total Serum Cholesterol Level)	Observation	Format 99.9	all readings within the audit period must be a valid read code as specified in the primary care specification
24	Observation Date (Cholesterol level)	Observation	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period
25	Diabetes routine review (eye)	Observation		must be a valid read code as specified in the primary care specification
26	Observation Date (Eye examination)	Observation	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period
27	Diabetes routine review (foot)	Observation		must be a valid read code as specified in the primary care specification
28	Observation Date (Foot examination)	Observation	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period
29	Smoking Status	Observation		must be a valid read code as specified in the primary care specification
30	Observation Date (Smoking status)	Observation	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period
31	Patient education review	Observation		must be a valid read code as specified in the primary care specification
32	Observation Date (patient education review)	Observation	YYYY-MM-DD	Must be > date of diagnosis
33	Diabetes Structured Education programme offered	Observation		must be a valid read code as specified in the primary care specification
34	Observation date (Diabetes Structured Education programme offered)	Observation	YYYY-MM-DD	Must be > date of diagnosis
35	Diabetes Structured Education programme attended	Observation		must be a valid read code as specified in the primary care specification
36	Observation date (Diabetes Structured Education programme attended)	Observation	YYYY-MM-DD	Must be > date of diagnosis
37	The earliest ischaemic heart disease diagnosis	Observation		must be a valid read code as specified in the primary care specification
38	Observation date earliest ischaemic heart disease	Observation	YYYY-MM-DD	
39	The latest learning disability diagnosis	Observation		must be a valid read code as specified in the primary care specification
40	Observation date learning disability	Observation	YYYY-MM-DD	
41	The latest mental health diagnosis code	Observation		must be a valid read code as specified in the primary care specification
42	Observation date mental health	Observation	YYYY-MM-DD	

National Diabetes Audit Core - data items for Specialist Services and insulin pump clinics

Below are the data items for collection as part of the NDA Specialist Service collection including insulin pump.
For more information about how to submit your data please visit the NDA webpage http://content.digital.nhs.uk/nda

Field No.	Data item name	Record	Type	Mandatory / Optional	Format	Validation rules
1	NHS number	Patient	Long	M	10 digit numeric	must be a valid NHS number
2	Type of data	Internal	Integer	M	1	1 is used identify the record as demographic/ observation data in the NDA system
3	Date of Birth	Patient	Date	M	YYYY-MM-DD	
4	Postcode of usual address	Patient	String	M	Format Example AA9A 9AA EC1A 1BB A9A 9AA W1A 0AX A9 9AA M1 1AE A99 9AA B33 8TH AA9 9AA CR2 6XH AA99 9AA DN55 1PT	must be <= 7 characters
5	Sex	Patient	List	M		reference list Sex
6	Ethnic category	Patient	List	O		reference list ethnicity
7	GP Practice Code	Organisation	String	M	X99999	where X can be A-H, J-N, P, W, Y
8	NHS organisation code (provider code)	Organisation	String	M	RXX RXXXX	RXX – Acute trust code RXXXX – Acute hospital code
9	Source Unit	Internal	blank	O		leave this field empty
10	Date of Diagnosis (Diabetes)	Diagnosis	Date	M	YYYY-MM-DD	must be > date of birth must be > 1905 If date is not known set to 9999-99-99
11	Diabetes Type	Diagnosis	List	M		Reference Diabetes Type Organisations should determine the type of diabetes from local coding systems. Where Type 1 or Type 2 cannot be derived e.g. a coding of NIDDM or IDDM is used the Type should be coded as 08 Other specified. Where diabetes type is not known code as 99 Not Specified. Do not include records for gestational diabetes.
12	Person observation (BMI)	Observation	Integer	O	Format 99.9	Expected range 16-70 return all readings in the audit period
13	Observation Date (BMI)	Observation	Date	M if observation value entered	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period Mandatory if observation value provided
14	Systolic Blood Pressure	Observation	Integer	O	maximum 3 digit numeric	Expected range 80 - 250 return all readings in the audit period
15	Observation Date (Blood pressure)	Observation	Date	M if observation value entered	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period Mandatory if observation value provided
16	Diastolic Blood Pressure	Observation	Integer	O	maximum 3 digit numeric	Expected range 30 - 150 return all readings in the audit period
17	Observation Date (Blood pressure)	Observation	Date	M if observation value entered	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period Mandatory if observation value provided
18	Person observation (HbA1c Level)	Observation	Decimal	O	Format 999.9	Values in mmol/mol return all readings in the audit period
19	Observation Date (HbA1c level)	Observation	Date	M if observation value entered	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period Mandatory if observation value provided
20	Person observation (Serum Creatinine Level)	Observation	Integer	O	maximum 4 digit numeric	Expected range 20-1000
21	Observation Date (Serum creatinine level)	Observation	Date	M if observation value entered	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period Mandatory if observation value provided
22	Person observation (Urinary Albumin Level)	Observation	Decimal	O	Format 9999.9	
23	Urinary Albumin Level Testing Method	Observation	List	O		reference UA Testing Method
24	Albuminuria Stage	Observation	List	O		reference UA Stage
25	Observation Date (Urinary Albumin level)	Observation	Date	M if observation value entered	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period Mandatory if observation value provided
26	Person observation (Total Serum Cholesterol Level)	Observation	Decimal	O	Format 99.9	Expected range return all readings in the audit period
27	Observation Date (Cholesterol level)	Observation	Date	M if observation value entered	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period Mandatory if observation value provided
28	Diabetes routine review (eye)	Observation	List	O		reference eye review
29	Observation Date (Eye examination)	Observation	Date	M if eye review 01	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period Mandatory if observation value provided
30	Diabetes routine review (foot)	Observation	List	O		reference foot review
31	Observation Date (Foot examination)	Observation	Date	M if foot review 01	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period Mandatory if observation value provided
32	Smoking Status	Observation	List	O		reference smoking
33	Observation Date (Smoking status)	Observation	Date	M if observation value entered	YYYY-MM-DD	Must be > date of diagnosis must be within current audit period Mandatory if observation value provided
34	Patient education review	Observation	List	O		reference education review
35	Observation Date (patient education review)	Observation	Date	M if education review 01	YYYY-MM-DD	Mandatory if observation value = 01 Must be > date of diagnosis must be <= end of audit period
36	Diabetes Structured Education programme offered	Observation	List	O		reference education offered
37	Observation date (Diabetes Structured Education programme offered)	Observation	Date	M if education offered 01	YYYY-MM-DD	Mandatory if observation value = 01 Must be > date of diagnosis must be <= end of audit period
38	Diabetes Structured Education programme attended	Observation	List	O		Reference education attended
39	Observation date (Diabetes Structured Education programme attended)	Observation	Date	M if education attended 01	YYYY-MM-DD	Mandatory if observation value = 01 Must be > date of diagnosis must be <= end of audit period
40	Is the patient on an insulin pump?	insulin pump	List	O		Reference on pump Records returned as all 01 will be rejected submission must include information for all diabetes patients.
41	Reason on pump hypoglycaemia reduction	insulin pump	List	M if on pump = 01		Reference reason hypo Mandatory if observation value for on pump = 01
42	Reason on pump glucose control	insulin pump	List	M if on pump = 01		Reference reason glucose Mandatory if observation value for on pump = 01
43	Reason on pump Other	insulin pump	List	M if on pump = 01		Reference reason Other Mandatory if observation value for on pump = 01
44	Reason on pump Unknown	insulin pump	List	M if on pump = 01		reference reason unknown Mandatory if observation value for on pump = 01
45	Treatment Goals achieved for Hypos	insulin pump	List	O		reference goals hypos
46	Treatment Goals achieved for Glucose Control	insulin pump	List	O		reference goals glucose
47	Year started Using Pump	insulin pump	Date	M if on pump = 01	YYYY	Mandatory if observation value for on pump = 01

National Diabetes Audit Core - reference data for specialist services and insulin pump services

ListName	Coding	Description	Notes
Type of data	1	demographic/observation data	1 is used identify the record as demographic/ observation data in the NDA system
Sex	0	Unknown	
	1	Male	
	2	Female	
	9	Not specified	
Ethnic category	A	White - British	
	B	White - Irish	
	C	White - Any other White background	
	D	Mixed - White and Black Caribbean	
	E	Mixed - White and Black African	
	F	Mixed - White and Asian	
	G	Mixed - Any other Mixed Background	
	H	Asian - Indian	
	J	Asian - Pakistani	
	K	Asian - Bangladeshi	
	L	Asian - Any other Asian background	
	M	Black - Caribbean	
	N	Black - African	
	P	Black - Any other Black background	
	R	Other - Chinese	
	S	Other - Any other ethnic group	
	Z	Not stated	
Diabetes Type	01	Type 1	Organisations should determine the type of diabetes from local coding systems. Where Type 1 or Type 2 cannot be derived e.g. a coding of NIDDM or IDDM is used the Type should be coded as 08 Other specified. Where diabetes type is not known code as 99 Not Specified. Do not include records for gestational diabetes.
	02	Type 2	
	06	MODY	
	08	Other specified	
	99	Not Specified	
Urinary Albumin Level Testing Method	01	Albumin concentration (mg/L)	
	02	Albumin creatinine ratio (mg/mmol)	
	03	Timed overnight albumin (ug/min)	
	04	24hr albumin excretion (mg/24hr)	
Albuminuria Stage	01	Normoalbuminuria	
	02	Microalbuminuria	
	03	Macroalbuminuria	
Diabetes routine review (eye)	01	Carried out	
	02	Not done	
	03	Not necessary	
Diabetes routine review (foot)	01	Carried out	
	02	Not done	
	03	Not necessary	
Smoking Status	1	Current smoker	
	2	Ex-smoker	
	3	Non-smoke history unknown	
	4	Never smoked	
	9	Unknown	
Patient education review	01	Carried out	
	02	Not done	
Diabetes Structured Education programme	01	Carried out	
	02	Not done	
Diabetes Structured Education programme	01	Carried out	
	02	Not done	
Is the patient on an insulin pump?	01	Yes	Records returned as all 01 will be rejected. Include information for all diabetes patients.
	02	No	
Reason on pump hypoglycaemia reduction	01	Yes	Mandatory if observation value for on pump is 01
	02	No	
Reason on pump glucose control	01	Yes	Mandatory if observation value for on pump is 01
	02	No	
Reason on pump Other	01	Yes	Mandatory if observation value for on pump is 01
	02	No	
Reason on pump Unknown	01	Yes	Mandatory if observation value for on pump is 01
	02	No	
Treatment Goals achieved for Hypos	01	Yes	
	02	No	
	03	Not Applicable	
	04	Unknown	
Treatment Goals achieved for Glucose Control	01	Yes	
	02	No	
	03	Not Applicable	
	04	Unknown	

National Diabetes Audit - Diabetes Prevention Programme

This page will be updated to include information on the data items collected as part of the diabetes prevention programm

National Diabetes Audit - Insulin Pump Spotlight Audit

As part of the NDA Core data collection information is collected for patients that are also on an insulin pump
During the 2017-18 collection a structures survey will take place with insulin pump clinics.
This page will be updated to include information on the data items collected as part of the insulin pump spotlight audit

The model below shows the structure of the records for NPID within the Clinical Audit Platform

National Pregnancy in Diabetes Audit - data items

The below table details the data items collected as part of the National Pregnancy in Diabetes Audit.
Data is entered for mother and baby into the clinical audit platform **https://clinicalaudit.hscic.gov.uk/**
The structure of the data items with the clinical audit platform is shown within the NPID model tab

Data Item	Definition	Mandatory	Options and validations	Record within CAP
Section A: Participant and pre-pregnancy details				
Mother's NHS Number	This is a unique 10-digit number. It is essential for data linkage with other related datasets such as Hospital Episode Statistics (HES) and Patient Episode Data for Wales (PEDW).	Yes	Must be 10 digits	Mother
Height (cm)	Record the height of the patient at time of booking.	Yes	This must be recorded in cm (no decimal places).	Mother
Weight (kg)	Record the weight of the patient at time of booking.	Yes	This must be recorded in kg (to one decimal place)	Mother
Date of birth	Record the date of birth of the mother. This is required to check that the details of the correct patient are identified. It is also used to calculate the mother's age.	Yes	DDMMYY	Mother
Booking Hospital	Record the hospital name. If your hospital does not appear in the drop down list on the online tool then please contact the NPID Team.	Yes	Select from drop down list	Mother
Diabetes Type	Mother's type of diabetes as diagnosed prior to pregnancy	Yes	· Type 1 · Type 2 · MODY · Other · Not Specified	Mother
First contact with specialist antenatal diabetes team after LMP:	Record the date of the first contact with specialist antenatal diabetes team after last menstrual period (LMP) (i.e. excluding any pre-conception clinic contact).	Yes	DDMMYY Date must be after date of birth	Pre-pregnancy
Estimated delivery date	Record the earliest estimated delivery date following 7-12/40 scan	Yes	DDMMYY Date must be after first contact	Pre-pregnancy
Folic acid used prior to LMP	Whether Folic Acid has been used before pregnancy, prior to LMP only include if given as a specific supplement not as part of multivitamin preparation	Yes	· Yes · No · Not Known	Pre-pregnancy
Folic acid dose prior to LMP	Record the highest dose given prior to LMP.	Conditional: If folic acid used prior to LMP = Yes	· 400mcg · 5mg · Not Known	Pre-pregnancy
Folic acid used since LMP	Whether Folic Acid has been used since LMP only include if given as a specific supplement not as part of multivitamin preparation	Yes	· Yes · No · Not Known	Pre-pregnancy
Folic acid dose since LMP	Record the highest dose given within the first 12 weeks after conception.	Conditional: If folic acid used since LMP = Yes	· 400mcg · 5mg · Not Known	Pre-pregnancy
Diabetes treatment regimen at 1st day of LMP	Record the diabetes treatment regimen on the first day of LMP. Please tick all that apply. Oral agents: metformin, sulphonylurea or glitinide, gliptin, pioglitazone (BNF sections 6.1.2.1 – 6.1.2.3). GLP-1 analogues: e.g. Exenatide, Liraglutide (BNF section 6.1.2.3). Basal bolus insulin regimen: Any regimen involving a combination of background insulin (BNF section 6.1.1.2) either once or twice daily in combination with a prandial (meal time) short acting insulin (BNF section 6.1.1.1). Mixed insulin or basal insulin only regimes: Any regimen using biphasic insulins and/or background insulin exclusively (i.e. without additional prandial insulin) as listed in BNF section	Yes	· Metformin · Sulphonylurea or glitinide · Gliptin · GLP-1 analogue · Basal Bolus Insulin Regimen · Mixed Insulin or Basal insulin only · Insulin pump therapy · Pioglitazone · Other · Diet only	Pre-pregnancy
Treated hypertension prior to 1st day of LMP	Record whether the patient has a history of treated hypertension prior to the first day of LMP. Please tick one box only.	Yes	· No known hypertension · Treated hypertension · Not known	Pre-pregnancy
ACE inhibitor/ARB at 1st day of LMP	Record whether the patient is on ACE inhibitor/ARB at first day of LMP. Please tick one box only. ACE inhibitor: Angiotensin Convertase Inhibitor treatment –treatments listed in	Yes	· Not on ACE inhibitor/ARB · On ACE inhibitor/ARB · Not known	Pre-pregnancy
Statins on 1st day of LMP	Record whether the patient is on statins at first day of LMP. Please tick one box only. Statin: All HMGCoA reductase inhibitor agents (BNF section 2.12).	Yes	· Not on Statins · On Statins · Not known	Pre-pregnancy
Ischaemic heart disease prior to 1st day of LMP	Record whether the patient has a history of ischaemic heart disease (IHD) prior to the first day of LMP. Please tick one box only.	Yes	· No known IHD · Known IHD · Not known	Pre-pregnancy
Section B: Pregnancy details				
First HbA1c in pregnancy	Record the first HbA1c reading taken during the pregnancy		mmol/mol	Pregnancy
Date of first HbA1c	Date of first reading	Conditional: If value for first HbA1c in pregnancy entered	DDMMYY	Pregnancy
Last HbA1c in pregnancy	Record the last HbA1c reading taken during the pregnancy		mmol/mol	Pregnancy
Date of last HbA1c	Date of last reading	Conditional: If value for last HbA1c in pregnancy entered	DDMMYY	Pregnancy
Retinal screening grade in first trimester retinopathy grade	Retinal screening is recorded and reported in the same way by all UK accredited digital retinal photography eye screening programmes. For specific information refer to http://diabeticeye.screening.nhs.uk/. Please record highest reported grade for R and M (worst eye) in first and last trimester		· R0 No retinopathy · R1 Background retinopathy · R2 Pre-proliferative retinopathy · R3 Proliferative retinopathy · R3A Active proliferative retinopathy · R3S Stable proliferative · retinopathy · Not known · Not done	Pregnancy
Retinal screening grade in first trimester maculopathy grade	As Above		· M0 No maculopathy · M1 Maculopathy · Not known · Not done	Pregnancy
Retinal screening grade in last trimester - retinopathy grade	As Above		· R0 No retinopathy · R1 Background retinopathy · R2 Pre-proliferative retinopathy · R3 Proliferative retinopathy · R3A Active proliferative retinopathy · R3S Stable proliferative · retinopathy · Not known · Not done	Pregnancy
Retinal screening grade in last trimester - maculopathy grade	As Above		· M0 No maculopathy · M1 Maculopathy · Not known · Not done	Pregnancy
Section C: Pregnancy outcome				
Baby NHS number	For live and stillbirths, record the NHS number of the baby (forms for live births and stillbirths cannot be submitted without this information.)	Conditional: If pregnancy outcome = live birth or stillbirth	Must be 10 digits	Baby
Date pregnancy ended	Record the date the pregnancy ended.	Yes	MMDDYY Must be after first contact	Baby
Pregnancy outcome	Record the outcome of the pregnancy. Please tick one box only.	Yes	· Live birth · Stillbirth · Termination of Pregnancy · Miscarriage	Baby
Congenital malformation	Record whether any congenital malformation was present and if there was one or more congenital malformation, provide a description.	Yes	· Yes · No · Not known	Baby
Congenital malformation code	Please refer to ICD-10 Chapter XVII or your local clinical coding specialist for further assistance. http://apps.who.int/classifications/icd10/browse/2010/en#/XVII	Conditional: If congenital malformation = Yes		Baby
Delivery hospital	If the hospital does not appear on the drop down list on the web data entry system then please contact the NPID Team.	Conditional: If pregnancy outcome = live birth or stillbirth	Select from drop down list	Baby
Sex	Sex of the baby	Conditional: If pregnancy outcome = live birth or stillbirth	· Male · Female · Indeterminate	Baby
Neonatal care	Special Care Admission = Level 2: special care new-born nursery Intensive Care Admission = Level 3: Intensive neonatal care For further information please refer to	Conditional: If pregnancy outcome = live birth	· Normal · Special Care Admission · Intensive Care Admission	Baby
Weight	Record the birth weight of the baby. This must be recorded in kg (to three decimal places).	Conditional: If pregnancy outcor	Kg	Baby
Baby alive at 28 days	Please note that for a live birth, the record will only be treated as complete and included in the analysis once this question has been answered. Cannot be completed before 28 days after pregnancy end date	Conditional: If pregnancy outcor	· Yes · No · Not Known	Baby

The model below shows the structure of the records for NDFA within the Clinical Audit Platform

Patient [NHS Number] Edit Record Delete Record

Episode Add Record

Episode [Date of first assessment] Edit Record Delete Record

National Diabetes Footcare Audit - data items

The below table details the data items collected as part of the National Diabetes Footcare Audit.
Data is entered into the clinical audit platform **https://clinicalaudit.hscic.gov.uk/**
The structure of the data items with the clinical audit platform (CAP) is shown within the NDFA model tab

Data Item	Definition	Mandatory	Options and validations	Record within CAP
Section A: Patient and presenting details				
NHS Number	unique 10 digit number	Yes	must be 10 digits	Patient
Date of birth	record the date of birth of the patient	Yes	DDMMYY	Patient
Date of first assessment by your team			DDMMYY	Patient
Time to MDT assessment			· self presenting · less than or equal to 2 days · between 3 to 13 days · between 14days to 2 months · over 2 months	Patient
Section A: Presenting Features				
Location of index (most severe) ulcer	please tick all that apply		· index ulcer right foot · index ulcer left foot · multiple ulcers (either foot)	Episode
Current/previous Charcot	please tick all that apply		· No charcot · possible charcot foot · definite charcot foot involving · right foot and still active · right foot and now inactive · left foot and still active · left foot and now inactive	Episode
SINBAD score for index ulcer	**Index Ulcer =** Most Severe Ulcer with highest SINBAD score			Episode
Site = index ulcer hindfoot	**Hindfoot** = includes the tarso-metatarsal joints and everything proximal to them below the ankle		Yes No	Episode
Ischaemia = clinical PAD	**Ischaemia** = absent pulses +/-other suggestive clinical signs		Yes No	Episode
Neuropathy = sensory loss	**Neuropathy** = impaired sensation using monofilament or touch or vibration or other stimulus used in routine clinical practice **NOTE:** If you score Neuropathy Yes, it means that the person has LOST SENSATION and CANNOT FEEL the stimulus on the foot of the index ulcer		Yes No	Episode
Bacterial infection = clinical	**Bacterial Infection** = clinical signs of infection		Yes No	Episode
Area >1sq cm or more	**Area** = product of greatest diameters or other method		Yes No	Episode
Depth: to tendon or bone	**Depth** = assessment by eye +/- sterile probe		Yes No	Episode
Section B: Outcome				
Alive 12 wk after presentation	can not be completed until 12 weeks after the first assessment		Yes No	Episode
active ulcer 12 wk after presentation	can not be completed until 12 weeks after the first assessment		Yes No	Episode
date of 12 week assessment	can not be completed until 12 weeks after the first assessment		DDMMYY	Episode
Alive 24 wk after presentation	can not be completed until 24 weeks after the first assessment		Yes No	Episode
active ulcer 24 wk after presentation	can not be completed until 24 weeks after the first assessment		Yes No	Episode
date of 24 week assessment	can not be completed until 24 weeks after the first assessment		DDMMYY	Episode
Lost to follow up	Please tick for patients that are no longer in your care at week 12 or week 24		12 wk 24 wk	Episode

Below are the data items collected as part of the Hospital Characteristics Survey for NaDIA

2016 Questions		
Data Item No.	**Data Item**	**Description**
HOSPITALS CHARACTERISTICS FORM DATASET		
1	Unique Code	Unique and anonymous identifier for hospital characteristics response. Equates to barcode/ref pre-printed on the hospital characterisitcs questionnaire or the file ref of the scanned hospital characteristics questionnaire
2	Audit Year Identifier	Audit Year for the data. Third party supplier should hard code "2016" into field for the 2016 audit
3	Hospital Identifier	Identifying code of the centre where the questionnaire was completed. Code should be present on the bedside audit questionnaire and be entered by third party supplier
Hospital Details		
A	On the day of the audit how many occupied beds were there in your hospital? (Minus the excluded wards)	Free text
Hospital Details		
B	For how many occupied beds in the hospital were you able to check whether the patient had diabetes or not?	Free text
C	How many of these beds had patients with diabetes **that had been admitted as an inpatient for 24 hours or more**? (this is the number of bedside audit forms that would be expected to be submitted by your hospital)	Free text
	Total team hours spent on **inpatient** care.	
Q1_1a	DISN	Free text (Numerical Hours)
Q1_1b	DSN	Free text (Numerical Hours)
Q1_1c	Specialist Diabetes Dietitian	Free text (Numerical Hours)
Q1_1d	Non-specialist Dietitian	Free text (Numerical Hours)
Q1_1e	Podiatrist	Free text (Numerical Hours)
Q1_1f	Diabetes Specialist Pharmacist	Free text (Numerical Hours)
	Total team hours spent on **outpatient** care*:*	
Q1_2a	DISN	Free text (Numerical Hours)
Q1_2b	DSN	Free text (Numerical Hours)
Q1_2c	Specialist Diabetes Dietitian	Free text (Numerical Hours)
Q1_2d	Non-specialist Dietitian	Free text (Numerical Hours)
Q1_2e	Podiatrist	Free text (Numerical Hours)
Q1_2f	Diabetes Specialist Pharmacist	Free text (Numerical Hours)

	Total team hours spent on **General admin/ Meetings**	
Q1_3a	DISN	Free text (Numerical Hours)
Q1_3b	DSN	Free text (Numerical Hours)
Q1_3c	Specialist Diabetes Dietitian	Free text (Numerical Hours)
Q1_3d	Non-specialist Dietitian	Free text (Numerical Hours)
Q1_3e	Podiatrist	Free text (Numerical Hours)
Q1_3f	Diabetes Specialist Pharmacist	Free text (Numerical Hours)
	Total team hours spent on **Strategic innovation/management re inpatient care**	
Q1_4a	DISN	Free text (Numerical Hours)
Q1_4b	DSN	Free text (Numerical Hours)
Q1_4c	Specialist Diabetes Dietitian	Free text (Numerical Hours)
Q1_4d	Non-specialist Dietitian	Free text (Numerical Hours)
Q1_4e	Podiatrist	Free text (Numerical Hours)
Q1_4f	Diabetes Specialist Pharmacist	Free text (Numerical Hours)
Q2a	Total consultant employed hours (general medicine, diabetes endocrinology, etc) per week	Free text (Numerical Hours)
Q2b	Total weekly consultant hours spent on **inpatient** care per week	Free text (Numerical Hours)
Q2c	Total weekly consultant hours spent on **outpatient** care per week	Free text (Numerical Hours)
Q2d	Total weekly consultant hours spent on **General admin/ Meetings**	Free text (Numerical Hours)
Q2e	Total weekly consultant hours spent on **Strategic innovation/ management re inpatient care**	Free text (Numerical Hours)
	Does your hospital use any of the following;	
Q3a	Electronic patient record	1 = yes
		2 = no
		3 = partial
		-8 = No response
		-9 = Invalid response
Q3b	Electronic prescribing	1 = yes
		2 = no
		3 = partial
		-8 = No response
		-9 = Invalid response
Q3c	Remote blood glucose monitoring	1 = yes
		2 = no
		3 = partial
		-8 = No response
		-9 = Invalid response

Q4a	Does your hospital have an agreed lower glucose target below which action should be taken?	-8 = No response
		1 = Yes
		2 = No
		3 = Don't know
		-9 = Invalid response
Q4b	What is that target value for the majority of patients?	Free text (mmol/l)
Q5a	Does your hospital have an agreed upper glucose target above which action should be taken?	-8 = No response
		1 = Yes
		2 = No
		3 = Don't know
		-9 = Invalid response
Q5b	What is that target value for the majority of patients?	Free text (mmol/l)
Q6	Does your hospital have a policy for self-management of diabetes?	-8 = No response
		1 = yes
		2 = no
		-9 = Invalid response
	Do you allow your patients to do the following?	
Q7a	Monitor their own blood glucose concentrations?	-8 = No response
		1 = yes
		2 = no
		-9 = Invalid response
Q7b	Adjust the dose of their insulin?	-8 = No response
		1 = yes
		2 = no
		-9 = Invalid response
Q7c	Self-administer insulin?	-8 = No response
		1 = yes
		2 = no
		-9 = Invalid response
Q7d	Treat their own hypoglycaemia?	-8 = No response
		1 = yes
		2 = no
		-9 = Invalid response
Q8	What percentage of wards in your hospital follow the self-administration of insulin policy?	1 = <10%
		2 = 10-50%
		3 = 50-90%
		4 = >90%
		-8 = No response
		-9 = Invalid response
Q9	Does your hospital have a checklist to determine whether the patient is capable of self- managing their diabetes?	-8 = No response
		1 = yes
		2 = no
		-9 = Invalid response
Q10a	Does your hospital utilise a pressure ulcer risk scoring system for all hospital admissions?	-8 = No response
		1 = Yes
		2 = No
		3 = Don't know
		-9 = Invalid response

Q10b	Please indicate which system is used.	-8 = No response
		1 = Waterlow
		2 = Braden
		3 = Norton
		4 = Other
		-9 = Invalid response
Q11	In your hospital have any tools or systems been put into place to increase the number of inpatients with diabetes who have a foot examination?	-8 = No response
		1 = Yes
		2 = No
		3 = Don't know
		-9 = Invalid response
Q12	Is there an established multi-disciplinary diabetic foot team as defined above?	-8 = No response
		1 = yes
		2 = no
		-9 = Invalid response
Q13	Is there a foot care pathway to ensure MDT input within 24 hours (e.g. 'Putting Feet First')?	-8 = No response
		1 = yes
		2 = no
		-9 = Invalid response
Q14	Do you have easy access within an appropriate time to the following specialists?	
Q14a	Vascular surgeon	-8 = No response
		1 = Foot team member
		2 = not member but accessible
		3 = no access
		-9 = Invalid response
Q14b	Diabetologist	-8 = No response
		1 = Foot team member
		2 = not member but accessible
		3 = no access
		-9 = Invalid response
Q14c	Specialist podiatrist	-8 = No response
		1 = Foot team member
		2 = not member but accessible
		3 = no access
		-9 = Invalid response
Q14d	Diabetes specialist nurse	-8 = No response
		1 = Foot team member
		2 = not member but accessible
		3 = no access
		-9 = Invalid response
Q14e	Interventional radiologist	-8 = No response
		1 = Foot team member
		2 = not member but accessible
		3 = no access
		-9 = Invalid response

Q14f	Orthopaedic surgeon	-8 = No response
		1 = Foot team member
		2 = not member but accessible
		3 = no access
		-9 = Invalid response
Q14g	Tissue Viability Nurse	-8 = No response
		1 = Foot team member
		2 = not member but accessible
		3 = no access
		-9 = Invalid response
Q14h	Microbiologist	-8 = No response
		1 = Foot team member
		2 = not member but accessible
		3 = no access
		-9 = Invalid response
Q14i	Orthotist	-8 = No response
		1 = Foot team member
		2 = not member but accessible
		3 = no access
		-9 = Invalid response
Q15	Does your hospital provide Diabetes Inpatient Specialist Nursing (DISN) care 7 days a week (this could include partial cover at the weekends)?	-8 = No response
		1 = yes
		2 = no
		-9 = Invalid response
Q16	Does your hospital provide access to a Diabetes physician every Saturday and Sunday (this could be partial cover)?	-8 = No response
Q17	Does your hospital have suitable Wi-Fi access available in all applicable wards which could be used to support the completion	-8 = No response
		1 = yes
		2 = no
		-9 = Invalid response
Q18	Since the previous NaDIA, has there been an increase in referrals/patient contacts?	-8 = No response
		1 = yes
		2 = no
		-9 = Invalid response

Q19	Have any of the following been introduced in your hospital? Please tick all which apply.	
Q19_1	DKA and hypoglycaemia guidance (2013)	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_2	Hypoglycaemia management in hospital (2013)	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_3	Management of adults with diabetes undergoing surgery (2011)	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_4	Self-management of diabetes in hospital (2012)	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		3 = No
		4 = Not sure
		5 = Locally adapted
		-9 = Invalid response
Q19_5	Hyperosmolar Hyperglycaemia State (2012)	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_6	Glycaemic management of enteral-fed stroke patients (2012)	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_7	Admission Avoidance (front door/AMU protocols) (2013)	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		3 = No
		4 = Not sure
		5 = Locally adapted
		-9 = Invalid response

Q19_8	Steroid use for inpatients with diabetes (2014)	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		3 = No
		4 = Not sure
		5 = Locally adapted
		-9 = Invalid response
Q19_9	Discharge planning (2014)	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		3 = No
		4 = Not sure
		5 = Locally adapted
		-9 = Invalid response
Q19_10	Variable rate insulin infusion (VRIII) for medical inpatients (2014)	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		3 = No
		4 = Not sure
		5 = Locally adapted
		-9 = Invalid response
Q19_11	Regular ward nurse diabetes training	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_12	NHS Diabetes e-learning on safe insulin use	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_13	NHS Diabetes e-learning on other diabetes topics	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		3 = No
		4 = Not sure
		5 = Locally adapted
		-9 = Invalid response

Q19_14	NHS Institute for Innovation Think Glucose	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_15	End of Life Care Clinical Care Recommendations	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_16	NICE inpatient foot guidance	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_17	'Putting Feet First'	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response

Q19_18	Best Practice Tariff for DKA	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		3 = No
		4 = Not sure
		5 = Locally adapted
		-9 = Invalid response
Q19_19	Hypoglycaemia boxes	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_20	Insulin passport	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_21	Combined glucose monitoring/diabetes drug charts	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_22	Combined glucose monitoring/ insulin infusion chart	-8 = No response
		1 = Yes wthin last 12 months
		2 = Yes before the last 12 months
		5 = Locally adapted
		3 = No
		4 = Not sure
		-9 = Invalid response
Q19_23	Other	Free text
Q20	Does your hospital hold Diabetes Mortality and Morbidity meetings which aim to identify the root causes of inpatient	-8 = No response
		1 = yes
		2 = no
		-9 = Invalid response
Q21	Your views are important to us, if you have any comments about the audit, please record them below	Free text

Below are the data items collected as part of the Bedside Audit for NaDIA

2016 Questions		
Data Item No.	**Data Item**	**Description**
2016 BEDSIDE AUDIT QUESTIONNAIRE DATASET		
1	Unique Code	Unique and anonymous identifier for bedside audit response. Equates to barcode/ref pre-printed on the bedside audit questionnaire or the file ref of the scanned bedside audit questionnaire
2	Audit Year Identifier	Audit Year for the data. Third party supplier should hard code "2016" into field for the 2016 audit
Hospital Details		
3	Hospital Identifier	Identifying code of the centre where the questionnaire was completed. Code should be present on the bedside audit questionnaire and be entered by third party supplier
Audit responses		
Q1	Specialty of Ward and Primary Consultant providing care	
Q1a	Specialty of ward	1 = General Medicine
		2 = Cardiology
		4 = Stroke
		5 = Respiratory
		6 = Oncology
		7 = Care of the elderly
		8 = Renal
		9 = Haemotology
		10 = Gastroenterology
		11 = Acute Medicine
		12 = Diabetes and endocrinology
		13 = Other - Medical
		14 = General Surgery
		15 = Cardiothoracic Surgery
		16 = Orthopaedic
		17 = Vascular Surgery
		18 = Ear Nose and Throat
		19 = Gynaecology
		20 = Other - Non Medical
		-8 = No response
		-9 = Invalid response
Q1b	Specialty of consultant	1 = General Medicine
		2 = Cardiology
		4 = Stroke
		5 = Respiratory
		6 = Oncology
		7 = Care of the elderly
		8 = Renal
		9 = Haemotology
		10 = Gastroenterology
		11 = Acute Medicine
		12 = Diabetes and endocrinology
		13 = Other - Medical
		14 = General Surgery
		15 = Cardiothoracic Surgery
		16 = Orthopaedic
		17 = Vascular Surgery
		18 = Ear Nose and Throat
		19 = Gynaecology
		20 = Other - Non Medical
		-8 = No response
		-9 = Invalid response
Q2	Patients Age	Age of patient at time of completion of questionnaire
		[Free text]
		-8 = No response
		-9 = Invalid response
Q3	Sex	Patients Sex
		1 = Male
		2 = Female
		-8 = No response
		-9 = Invalid response

Q4	Ethnicity	Patients ethnicity group
		1 = White - British
		2 = White - Irish
		3 = White - Any other White Background
		5 = Mixed - White and Black Caribbean
		4 = Mixed - White and Black African
		6 = Mixed - White and Asian
		7 = Mixed - Other mixed background
		8 = Asian or Asian British - Indian
		9 = Asian or Asian British - Pakistani
		10 = Asian or Asian British - Bangladeshi
		11 = Asian or Asian British - Any Other Asian background
		12 = Black or Black British - Caribbean
		13 = Black or Black British - African
		14 = Black or Black British - Other Black background
		15 = Other - Chinese
		16 = Other - Any other
		17 = Prefer not to say
		18 = Don't Know
		-8 = No response
		-9 = Invalid response
Q5	Diabetes type on admission	Patients diabetes type
		1 = Type 1
		2 = Type 2
		7 = Other e.g. pancreatitis, monogenic diabetes, ketosis-prone diabetes
		-8 = No response
		-9 = Invalid response
Q6	Patient diabetes treatment regimen on admission	Treatment Regimen
Q6a	Insulin	1 = Yes
		-8 = No response
		-9 = Invalid response
Q6b	Tablets	1 = Yes
		-8 = No response
		-9 = Invalid response
Q6c	Non-insulin injectables	1 = Yes
		-8 = No response
		-9 = Invalid response
Q6d	Diet only	1 = Yes
		-8 = No response
		-9 = Invalid response
Q7	All that formed part of the patient's diabetes treatment regimen on admission.	Treatment Regimen - Medication
Q7a	Basal insulin	1 = Yes
		-8 = No response
		-9 = Invalid response
Q7b	Prandial insulin	1 = Yes
		-8 = No response
		-9 = Invalid response
Q7c	Pre-mixed insulin	1 = Yes
		-8 = No response
		-9 = Invalid response
Q7d	Insulin pump	1 = Yes
		-8 = No response
		-9 = Invalid response
Q7e	Acarbose	1 = Yes
		-8 = No response
		-9 = Invalid response
Q7f	Metformin	1 = Yes
		-8 = No response
		-9 = Invalid response
Q7g	Glitazones	1 = Yes
		-8 = No response
		-9 = Invalid response
Q7h	Sulphonylureas	1 = Yes
		-8 = No response
		-9 = Invalid response
Q7i	DPP4 – inhibitors	1 = Yes
		-8 = No response
		-9 = Invalid response
Q7j	SGLT-2 inhibitors	1 = Yes
		-8 = No response
		-9 = Invalid response
Q7k	Fixed dose combination tablet	1 = Yes
		-8 = No response
		-9 = Invalid response
Q7l	GLP-1 analogues	1 = Yes
		-8 = No response
		-9 = Invalid response

Q8	Is the patient having enteral (tube) feeding?	1 = Yes
		2 = No
		-8 = No response
		-9 = Invalid response
Q9	How long has the patient had diabetes?	1 = < 5 years
		2 = 5-9 years
		3 = 10-14 years
		4 = 15-29 years
		5 = > 30 years
		6 = Diabetes diagnosed during this admission
		7 = Unknown
		-8 = No response
		-9 = Invalid response
Q10	Number of nights in hospital?	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q11	Type of admission?	1 = elective
		2 = emergency
		3 = transfer from another hospital
		-8 = No response
		-9 = Invalid response
Q12	Main reason for admission	6 = Non-diabetes related medical (e.g. resp., CoE, gastro. etc)
		1 = DKA
		2 = HHS (HONK)
		3 = Active diabetic foot disease
		4 = Hypoglycaemia
		5 = Hyperglycaemia with established diabetes
		7 = non medical (general surgery, orthopaedics, ENT, etc.)
		-8 = No response
		-9 = Invalid response
Q13	Receiving renal replacement therapy? (haemodialysis or peritoneal dialysis and transplantation)	1 = yes
		2 = no
		3 = unsure
		-8 = No response
		-9 = Invalid response
Q14	Foot disease? (previous ulcer, amputation, Charcot's arthropathy)	1 = yes
		2 = no
		3 = unsure
		-8 = No response
		-9 = Invalid response
Q15	Is the glucose chart available for review?	1 = yes
		2 = no
		-8 = No response
		-9 = Invalid response
Q16	Patient currently on intravenous insulin infusion?	1 = yes
		2 = no
		-8 = No response
		-9 = Invalid response
Q17	Was the patient doing any of the following at any time in the last 7 days	Activity
Q17a	Self-testing glucose	1 = Yes
		2 = No
		3 = Unsure
		4 = N/A
		-8 = No response
		-9 = Invalid response
Q17b	Self-administering insulin	1 = Yes
		2 = No
		3 = Unsure
		4 = N/A
		-8 = No response
		-9 = Invalid response
Q17c	Self-adjusting insulin dosage	1 = Yes
		2 = No
		3 = Unsure
		4 = N/A
		-8 = No response
		-9 = Invalid response
Q18	Looking at the **previous 7 days,** on how many days has blood glucose monitoring been carried out?	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q19	For patients on subcutaneous insulin on how many of these 7 days was the frequency of monitoring appropriate?	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response

Q20	No. of glucose readings between 3 - 3.9 mmol/L	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q21	Was the treatment of all episodes of hypoglycaemia documented?	1 = yes
		2 = no
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q22	Was the treatment of all episodes in accordance with local guidelines?	1 = yes
		2 = no
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q23	No. of glucose readings < 3 mmol/L	[Free text]
		-8 = No response
		-9 = Invalid response
Q24	Was the treatment of all episodes of hypoglycaemia documented?	1 = yes
		2 = no
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q25	Was the treatment of all episodes in accordance with local guidelines?	1 = yes
		2 = no
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q26	No. of episodes of hypoglycaemia requiring injectable treatment (glucagon or IV glucose)?	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q27_1	If there has been hypoglycaemia (any glucose below 4mmol/l in a 4 hour period) during the last 7 days please indicate the number of episodes in each of the following time periods	**Number of readings between 3-3.9 mmol/L**
Q27_1a	09:00-12:59	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q27_1b	13:00-16:59	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q27_1c	17:00-20:59	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q27_1d	21:00-00:59	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q27_1e	01:00-04:59	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q27_1f	05:00-08:59	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q27_2	If there has been hypoglycaemia (any glucose below 4mmol/l in a 4 hour period) during the last 7 days please indicate the number of episodes in each of the following time periods	**Number of readings between <3 mmol/L**
Q27_2a	09:00-12:59	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q27_2b	13:00-16:59	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q27_2c	17:00-20:59	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q27_2d	21:00-00:59	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q27_2e	01:00-04:59	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response

Q27_2f	05:00-08:59	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q28	What level of control is appropriate for this patient?	1 = Good control as described (i.e. between 4 and 11 mmol/L)
		2 = Symptomatic control (e.g terminal/palliative care, frailty, cognitive impairment)
		-8 = No response
		-9 = Invalid response
Q29	Number of 'good diabetes days' in the last 7 days, defined as days in which the frequency of tests is appropriate (Q19) and there is no more than one reading more than 11 mmol/L and none less than	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q30a	Did the patient develop **DKA** at any time after their admission?	1 = yes
		-8 = No response
		-9 = Invalid response
Q30b	Did the patient develop DKA or **HHS** at any time after their admission?	1 = yes
		-8 = No response
		-9 = Invalid response
Q30c	Did the patient develop **DKA or HHS** at any time after their admission?	1 = neither
		-8 = No response
		-9 = Invalid response
Q31	Was the drug chart available for review?	1 = yes
		2 = no
		-8 = No response
		-9 = Invalid response
Q32	Did the patient receive insulin at any time during the last 7 days?	1 = yes
		2 = no
		-8 = No response
		-9 = Invalid response
Q33	Insulin prescription errors *(Please tick all that apply)*	
Q33a	Insulin not written up	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q33b	Name of insulin incorrect (eg Humalog)	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q33c	Number (dose) unclear	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q33d	Unit abbreviated to 'u' or written unclearly	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q33e	Insulin or prescription chart not signed by prescriber	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q33f	Insulin not signed as given	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q33g	Insulin given/prescribed at the wrong time	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q34	Insulin management errors *(Please tick all that apply)*	
Q34a	Insulin not increased when persistent BG >**15** mmol/L and better glycaemic control appropriate for this patient	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response

Q34b	Insulin not increased when persistent BG >11 mmol/L and <=15 mmol/L and better glycaemic control appropriate for this patient	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q34c	Insulin not reduced if unexplained BG <4mmol/L	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q34d	Inappropriate omission of insulin after episode of hypoglycaemia	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q35	Oral Hypoglycaemic Agent (OHA) prescription errors	
Q35a	OHA not signed as given	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q35b	OHA given/prescribed at the wrong time	1 = at least once
		2 = not at all
		3 = not applicable
		-8 = No response
		-9 = Invalid response
Q35c	Wrong dose	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q35d	OHA not written up	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q36	OHA management errors	
Q36a	No action taken when persistent BG >**15** mmol/L and better glycaemic control appropriate	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q36b	No action taken when persistent BG >11 mmol/L and <=15 mmol/L and better glycaemic control appropriate	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q36c	OHA not reduced if unexplained BG <4mmol/L	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q36d	Inappropriate omission of OHA after episode of hypoglycaemia	1 = at least once
		2 = not at all
		3 = Not Applicable
		-8 = No response
		-9 = Invalid response
Q37	Has the patient been on an insulin infusion during the last 7 days?	1 = yes
		2 = no
		-8 = No response
		-9 = Invalid response
Q38	Duration on insulin infusion *(please tick)*	1 = < 1 day
		2 = 1 to < 2 days
		3 = 2 to < 4 days
		4 = 4 to < 7 dayd
		5 = ≥ 7days
		-8 = No response
		-9 = Invalid response
Q39	Was the use of the insulin infusion deemed appropriate (e.g. not eating or drinking, or on a DIGAMI protocol)?	1 = yes
		2 = no
		-8 = No response
		-9 = Invalid response

Q40	Was the duration of the infusion appropriate (e.g. duration appropriate on infusion only while patient not eating or drinking and not beyond)?	1 = yes
		2 = no
		-8 = No response
		-9 = Invalid response
Q41	If "no" to **Q40**, what was the approximate number of excess days on infusion?	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q42	If discontinued, has the transfer to s.c. insulin been managed appropriately *(e.g*. s.c. insulin or oral therapy introduced before infusion stopped)?	1 = yes
		2 = no
		3 = not sure
		-8 = No response
		-9 = Invalid response
Q43	What was the total number of glucose readings in the last 24 hours on infusion?	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q44	Total number of glucose readings > 11 mmol/L in the last 24 hours on infusion?	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q45	Total number of glucose readings >=3 and <4 mmol/L in the last 24 hours on infusion?	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q46	Total number of glucose readings < 3 mmol/L in the last 24 hours on infusion?	[Free text] Whole Number
		-8 = No response
		-9 = Invalid response
Q47	Is there documented evidence of the patient being seen by a member of the diabetes team?	1 = yes
		2 = no
		-8 = No response
		-9 = Invalid response
Q48	Should the patient have been referred to the diabetes team? (for example, see 'Think Glucose' referral criteria below).	1 = yes
		2 = no
		3 = unsure
		-8 = No response
		-9 = Invalid response
Q49	Was there any documentation of a specific diabetic foot risk (for ulceration) examination in the **FIRST** 24 hours of admission? (does not include Waterlow score, Norton score and similar general pressure sore checks)	1 = yes
		2 = no
		3 = unsure
		-8 = No response
		-9 = Invalid response
Q50	Was there any documentation of a specific diabetic foot risk (for ulceration) examination **AFTER** the first 24 hours of admission? (does not include Waterlow score, Norton score and similar general pressure sore checks)	1 = yes
		2 = no
		3 = unsure
		-8 = No response
		-9 = Invalid response
Q51	Was the patient admitted with active foot disease?	1 = yes
		2 = no
		3 = unsure
		-8 = No response
		-9 = Invalid response
Q52	Did a foot lesion (e.g. heel ulcer) arise during this admission?	1 = yes
		2 = no
		3 = unsure
		-8 = No response
		-9 = Invalid response
Q53	Was the patient seen by a member of the foot MDT within 24 hours?	1 = yes
		2 = no
		3 = unsure
		-8 = No response
		-9 = Invalid response
Q54	Has there been input from the foot MDT in the last 7 days?	1 = yes
		2 = no
		3 = unsure
		-8 = No response
		-9 = Invalid response

Q55	Nature of surgery?	1 = Elective
		2 = Emergency
		3 = Don't Know
		-8 = No response
		-9 = Invalid response
Q56	Pre-operative assessment record available for review?	1 = Yes
		2 = No
		-8 = No response
		-9 = Invalid response
Q57	Does the pre-operative assessment note that the patient has diabetes?	1 = Yes
		2 = No
		3 = N/A - Diabetes diagnosed during this admission
		-8 = No response
		-9 = Invalid response
Q58	Was there evidence of a plan for the management of the patient's diabetes in the perioperative period?	1 = Yes
		2 = No
		-8 = No response
		-9 = Invalid response

Below are the data items collected as part of the patient Experience Audit for NaDIA

2016 Questions		
Data Item No.	**Data Item**	**Description**
2016 PATIENT EXPERIENCE QUESTIONNAIRE DATASET		
1	Unique code	Unique and anonymous identifier for patient response. Equates to barcode/ref pre-printed on the patient questionnaire or the file ref of the scanned patient questionnaire
2	Audit Year Identifier	Audit Year for the data. Third party supplier should hard code "2016" into field for the 2016 audit
Hospital Details		
3	Hospital Identifier	Identifying code of the centre where the patient has completed the questionnaire. Code should be present on the patient questionnaire and be entered by third party supplier
About the Patient		
Q1	Are you aware that the diabetes staff within the hospital are available to provide support to you and advice to ward staff?	Aware of staff for support
		1 = Yes
		2 = No
		6 = Not sure
		-8 = No Response
		-9 = Invalid response
Q2	Were you involved in the planning of your diabetes treatment, whilst in hospital, as much as you would have liked?	Involvement in care plan
		1 = Yes
		2 = No - I would have liked to be more involved
		3 = No - I would have liked to be less involved
		6 = Can't remember / Not sure
		-8 = No Response
		-9 = Invalid response
Q3	Have you been able to take control of your own diabetes care while in hospital to the extent you would like?	Own diabetes control
		1 = Yes, as much as was possible
		2 = No
		6 = Can't remember / Not sure
		-8 = No Response
		-9 = Invalid response
Q4	Have hospital staff taken your treatment preferences for your diabetes treatment into account when caring for you?	Treatment Preferences
		1 = Yes, definitely
		2 = Yes to some degree
		3 = No
		-8 = No Response
		-9 = Invalid response
Q5	Do you take insulin for your diabetes?	Insulin use
		1 = Yes
		2 = No
		3 = Not sure
		-8 = No Response
		-9 = Invalid response
Q6	Are you allowed to administer insulin yourself while in hospital?	Insulin self administration
		1 = Yes
		2 = No - but I would like to
		3 = No - but I do not want to
		6 = Not sure
		-8 = No Response
		-9 = Invalid response
Q7	Are you able to test your own blood sugar level while in hospital?	Test own blood sugar
		1 = Yes
		2 = No - but I would like to
		3 = No - but I do not want to
		4 = I do not need to test my blood sugar
		6 = Not sure
		-8 = No Response
		-9 = Invalid response
Q8	During this hospital stay, how often was the choice of meal suitable for your diabetes?	Frequency of suitable meal choice
		1 = Always or almost always
		2 = Sometimes
		3 = Rarely or never
		6 = Don't know / Can't remember
		-8 = No Response
		-9 = Invalid response

Q9	During this hospital stay, how often was the timing of meals suitable for your diabetes?	Meal timing
		1 = Always or almost always
		2 = Sometimes
		3 = Rarely or never
		6 = Don't know / Can't remember
		-8 = No Response
		-9 = Invalid response
Q10	Do you think that the hospital staff caring for you are aware that you have diabetes?	Diabetes awareness
		1 = Yes, all or most are aware
		2 = No, few or no staff are aware
		3 = Don't know
		-8 = No Response
		-9 = Invalid response
Q11	Do you feel that the hospital staff who look after you know enough about diabetes to meet your needs while in hospital?	Staff meet needs
		1 = Yes, all or most staff know enough
		2 = Yes, some staff know enough
		3 = No
		-8 = No Response
		-9 = Invalid response
Q12	If you have had questions about your diabetes, were staff able to answer these in a way you could understand?	Understandable information
		1 = Yes, definitely
		2 = Yes, to some extent
		3 = No
		4 = I did not have any questions
		6 = Don't know / Not sure
		-8 = No Response
		-9 = Invalid response
Q13	How satisfied are you with the overall care of **your diabetes** while you were in hospital?	Overall satisfaction
		1 = Very satisfied
		2 = Satisfied
		3 = Neither satisfied nor dissatisfied
		4 = Dissatisfied
		5 = Very dissatisfied
		-8 = No Response
		-9 = Invalid response
Q14	Please tick **One** box from the list below to tell us which of these areas of diabetes care you feel is most important for the hospital to improve.	Area for hospital to improve
		1 = Having staff who know enough about diabetes to meet your needs
		2 = Offering a choice of meal suitable for your diabetes
		3 = Serving meals at times suitable for your diabetes
		4 = Allowing you to administer insulin yourself while in hospital
		5 = Offering the ability to test your own blood sugar level while in hospital
		6 = None of these areas need improvement
		-8 = No Response
		-9 = Invalid response

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Communication Plan for establishing NDA Directions

Document management

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Version	Date	Summary of Changes
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0.2	20/10/16	Updated following review by CARMS
0.3	16/11/16	Updated following review by Directions Delivery Group
0.4	28/11/16	Updated following review by Oversight Group
0.5	9/3/17	Updated following review by NHS Digital communications team

Reviewers

This document must be reviewed by the following people:

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Approved by

This document must be approved by the following people/groups:

Name	Signature	Title	Date	Version
Oversight Group			21/11/16	0.3

Glossary of Terms

Term / Abbreviation	What it stands for

Document Control:

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Contents

1. Introduction

The National Diabetes Audit (NDA) is part of the National Clinical Audit Programme which is funded by NHS England (NHSE) and the Welsh Government. The Healthcare Quality Improvement Partnership (HQIP) holds the contract to manage the National Clinical Audits. NHS Digital has delivered the NDA on behalf of HQIP since the start of the audit in 2003.

In 2015, the NHS England Domain directors, the Welsh Government, HQIP and NAGCAE undertook a prioritisation exercise to review the current NCA Programme to understand their value and benefit and whether they should be re-commissioned. This was to ensure that the NCA programme is current and provides value for money. The decision was made that the NDA programme should continue.

The legal basis for the collection of patient identifiable data for the NDA Core Audit has previously been through Section 251 approval via the Confidentiality Advisory Group (CAG). In 2012, NHS Digital were granted powers under the Health and Social Care Act (section 254) to be directed to collect, analyse and disseminate data. CAG have previously questioned why NHS Digital do not use their powers to collect the data rather than using Section 251. They have only continued to support the collection of patient identifiable data under the assumption that NHS Digital investigates alternative methods for data collection.

It has been agreed that from June 2017, the NDA will not be commissioned by HQIP. Instead, the delivery of the audit - including data collection, processing, analysis and outputs - will be directed by NHSE to NHS Digital. Details of the management arrangements between HQIP, NHS Digital and NHSE are being negotiated. The implementation must start at the end of the contract for the current NDA and ideally, in advance of the current contract end to ensure continuity of the work. The end date for the current contract is June 2017.

1.1. Purpose of this Document

This document details the consultation and communication plans with agreed stakeholders to ensure that the move to Directions is smooth and that the reputation of the NDA is upheld.

2. Key Stakeholders

The following groups (table 1) have been identified as key stakeholders for the National Diabetes Audit Programme.

Table 1: NDA Programme Stakeholders

Stakeholder	Role	Which data sources	Reason for interest in NDA
NHS England Policy Teams	User	NDA Core, NaDIA, NPID, Footcare, Transition	Track national figures, regions for concerns, guide policy
Welsh Government Policy Teams	User	NDA Core, NaDIA, NPID, Footcare, Transition	Track national figures, regions for concerns, guide policy
Isle of Man policy teams?	User	NPID	Track national figures, guide policy
Department of Health Policy teams	User	NDA Core, NaDIA, NPID, Footcare, Transition	Track national figures, guide policy
Attendees at PAC, NCDs	User	NDA Core, NaDIA, NPID, Footcare, Transition	Track national figures, guide policy. Respond to questions raised by PAC
Public Health England/NCVIN	User	NDA Core, NaDIA, NPID, Footcare, Transition	Track national figures, link to other data sources
Charities	User	NDA Core, NaDIA, NPID, Footcare, Transition	Target areas for concern at national, regional level
Researchers	User	NDA Core, NaDIA, NPID, Footcare, Transition	Guide future studies into cause/prevention/treatment of Diabetes
RCPCH	User	Transition, NDA Core	National results for young adults and alignment of audits
Clinical Networks	User	NDA Core, NaDIA, NPID, Footcare, Transition	National and local results for benchmarking
NICE	User	NDA Core, NaDIA, NPID, Footcare, Transition	Guide national standards
CQC	User	NDA Core, NaDIA, NPID, Footcare, Transition	National and local results for benchmarking
RCGP/BMA	User	NDA Core, NPID, Transition	National figures, guide approaches to care
Other Royal Colleges	User	NDA Core, NaDIA, NPID, Footcare, Transition	National figures, guide approaches to care
Clinical Audit Networks	User	NDA Core, NaDIA, NPID, Footcare, Transition	National and local results for benchmarking
Patients	User and Supplier	NDA Core, NaDIA, NPID, Footcare, Transition	Make informed choices about care
CCGs/LHBs	User and Supplier	NDA Core, NaDIA, NPID, Footcare, Transition	National and local results for benchmarking
Midwifes, gynaecologists, maternity units	User and Supplier	NPID	National and local results for benchmarking

Footcare services	User and Supplier	NDA Core, Footcare	National and local results for benchmarking
GP practices	User and Supplier	NDA Core, transition, NPID	National and local results for benchmarking
Specialist Services, hospitals, acute trusts	User and Supplier	NDA Core, NaDIA, NPID, Footcare, Transition	National and local results for benchmarking
Clinical Audit Teams	User and Supplier	NDA Core, NaDIA, NPID, Footcare, Transition	National and local results for benchmarking
CEOs and Medical Directors for Acute Trusts	User and Supplier	NDA Core, NaDIA, NPID, Footcare, Transition	National and local results for benchmarking
NDA Partnership Board	Development Team	NDA Core, NaDIA, NPID, Footcare, Transition	Strategic direction of the NDA Programme
NDA Advisory Group	Development Team	NDA Core, NaDIA, NPID, Footcare, Transition	Future development of the audits, collection, analysis and dissemination
CAG	Legal Guidance	NDA Core, Transition	Legal basis for future collections and linkage
NHS DARS Team	Dissemination of data, linkage	NDA Core, NaDIA, NPID, Footcare, Transition	Future linkage dissemination of NDA data

3. Consultation to establish Direction

This section describes the approach adopted to ensure that appropriate consultation takes place regarding the development of a Direction for the NDA.

NHS England (NHSE) will be directing NHS Digital to carry out the NDA, under section 254 of the Health and Social Care Act 2012 (H&SC Act 2012). Section 258 of the Act states that:

(1) Before establishing an information system pursuant to a direction under section 254 or a request under section 255 the Information Centre must consult:

(a) The person who gave the direction or made the request,

(b) Representatives of other persons who the Centre considers are likely to use the information, to which the direction or request relates,

(c) Representatives of persons from whom any information will be collected and

(d) Such other persons as the Centre considers appropriate.

3.1. Consultation approach – defining audiences

The method for consulting these audiences and what the content of that consultation will be is the focus of this next section.

3.1.1. The person who gave the direction

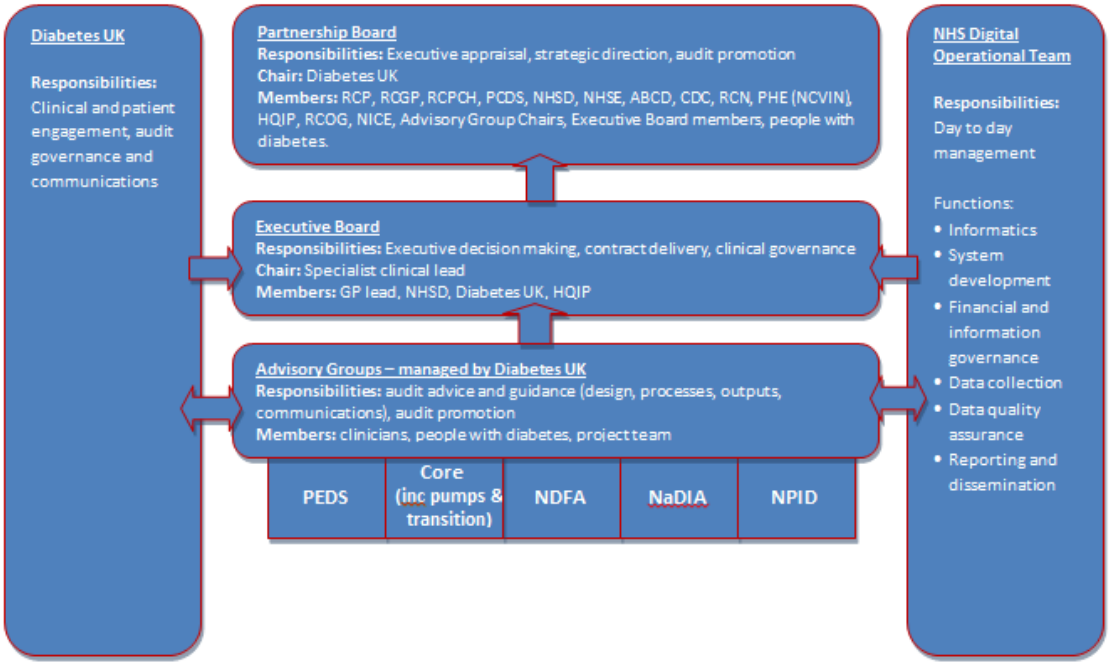
A series of meetings have been established with NHSE, HQIP and NHS Digital to work through the detail of the Direction and management arrangements. The Delivery Group, which identifies, agrees and takes forward operational requirements, meets every 2 weeks with the first meeting taking place in August 2016. The Oversight Group meets on a quarterly basis with the first meeting in October 2016 and has a strategic remit.

3.1.2. Representatives of other persons who the Centre considers are likely to use the information to which the direction refers

NHSE and HQIP invited various stakeholders to discuss priorities for the NDA programme of audits at the Specification Development Meeting in June 2016. Attendees of the meeting included relevant national clinical directors, clinicians, healthcare professionals, representatives of patient bodies, people with diabetes, academics and the Welsh Government. A full attendee list can be found in Appendix A. The resulting specification for the audit was based on the feedback collected from the specification meeting and was circulated to all attendees for comment in September 2016.

The final specification was circulated to NHS Digital in October 2016. NHS Digital produced a response to the specification which detailed proposals for deliverables and costings based upon the final specification. In formulating the response, NHS Digital liaised with members of the current NDA governance structure for their input into the future structure of the NDA Programme. The current NDA governance structure is detailed in Figure 1. NHSE, HQIP and NHS Digital discussed the proposals, and agreed the overall deliverables and costings for the 3 years.

Figure 1: Current Governance Structure for the NDA Programme



In addition, the BMA and RCGP were consulted separately through the joint GPIT committee. A discussion paper was written for review at the meeting. The GPIT committee supported the move.

National Cardio-Vascular Intelligence Network will be utilised. The NDA already supports monthly workshops through which progress on Directions can be presented. Attendees at these workshops include NHS England, Public Health England, CCG representatives, Clinical Network representatives, Acute Trust representatives, Clinical Audit representatives.

Researchers will also be targeted. The NHS Digital team send out quarterly bulletins to the research community (the list is generated from the DARS application team). An article will be written for the bulletin in the Summer 2017 detailing how the move to directions will benefit the research community.

Consult with Professor Kamlesh Khunti, Diabetes Research Centre, University of Leicester, about which other research networks to target and how.

3.1.3. Representatives of persons from whom any information will be collected

There is much overlap between those providing the data to support the audit and those utilising the information from the audit. In addition to stakeholders already considered above:

NHS Digital (CARMS) will be consulting with the NHS Digital BAAS team as part of developing the direction and assessing the burden on providers. This will mean that providers of information will be consulted.

- Welsh Government will be consulted specifically on how a request can be used to allow for collection of data from Welsh general practices. If agreed as the way forward, joint communications will be sent to Welsh GP Practices.
- Diabetes UK are currently sub-contracted to provide the patient engagement for the NDA and as such will be utilising their methods of communication through regional representatives and patient groups.
- The RCGP have a newsletter and blog that goes to all GP Practices. An article will be written for this.
- NHS England have a monthly bulletin that goes to GP practices and CCGs, an article will be written for this
- NHS Digital send out a monthly bulletin to GP Practices, an article will be written for this.
- The NDA has many contacts in CCGs and Clinical Networks. Communication through these contacts will also be utilised.
- The NDA also has contacts for Acute Trusts, Specialist Services, Maternity Units, Footcare Services, Clinical Audit teams. Communications through these contacts will also be utilised.
- The NDA team also hold a list of CEOs within Acute Trusts, a letter from the NDA Partnership Board will be sent to CEOs.

3.1.4. Such other persons as the Centre considers appropriate

From the stakeholders identified in section 2.0, the below are not covered in the above communication plans.

- RCPCH will be kept up to date through regular engagement through the Transition work. An agenda item will be added to the transition working group meetings to cover directions updates and the implications for data linkage for future transition reports.
- As part of the annual review for S251 permissions, CAG were updated in August 2016 that Directions were being pursued as the mechanism for future audits. CAG will need

to be kept up to date with how this is progressing and when Directions are in place, and the outcome for Wales once a request has been considered.

- There is a possibility to approach NHS Confed to help strengthen the message with providers; however the method for accessing them has not been confirmed.

The following are not covered:-

- CQC
- NICE
- NHS Digital DARS team
- Clinical Audit Networks
- Department of Health Policy Teams

3.2. Consultation approach – content of communications

Consultation will be tailored to the requirements of the audience, where appropriate. A summary sheet will be used as the basis for each communication. The summary sheet will be developed by the NDA Direction Delivery Group in partnership with patient representatives and the NDA Partnership Board. The summary sheet will be converted into a fact sheet for the NDA Webpage that other communications can link to to provide more information.

Broadly the content will consist of:

- An explanation of what a direction is and the benefits of this approach
- An explanation of the mandated requirement and reassurance around upholding patient choice and the link to Quality Accounts
- An explanation of the use of a Data Provision Notice
- What the audit programme will/is likely to consist of.

4. Privacy Impact Assessment

As part of the SCCI process, a document of how patient information will be kept safe will be produced. This will involve undertaking a privacy impact assessment.

The purpose of privacy impact assessments are to:

- Explain and justify in law, how personal data about individuals are used
- Identify and assess privacy risks
- Propose actions to mitigate or avoid those risks.

Privacy impact assessments aim to provide transparency over the processing of personal data.

5. Users of the Diabetes Standard

There is currently an ISBN standard for Diabetes Care. As there will be a move from being a “Standard” to a “Data Collection” users may need to be consulted, in order to understand any implications of retiring the ISBN Standard. SCCI will lead on this consultation process if the SCCI Board decide that this is the correct way forward.

6. Timeline for communications

The Table below outlines the key dates for communicating with the different audiences

Date	Audience	Method of communication	Reason for communication
September 2015	NHS England/NAGCAE	Prioritisation meeting	Decision made to re-procure the NDA programme
June 2016	NHS England, PHE, Clinicians, Specialist Nurses, Diabetes UK, RCPCH, HQIP, Patients, Clinical Networks, NCD, NAGCAE, NICE, Royal Colleges, Welsh Government	Specification Development Meeting	Input into what the NDA Programme specification should include
August 2016	CAG	Annual review application	Update for S251 renewal to cover until Directions in place. Informed that Directions being pursued.
October 2016 onwards	Welsh Government	Telephone conference	Future direction of collection in Wales, discuss options (Request or S251) and subsequent meetings until a decision made
October 2016	NDA Partnership Board	Partnership Board meeting	Update on directions. Input into what should be prioritised in response to the specification.
October 2016	NDA Advisory Group Patient Representatives	Email/Partnership board Meeting	Input into the draft for the one page summary
October - November 2016	NDA Advisory groups	Advisory group meetings	Input into the response from NHS Digital to the specification. What do they envisage as the future direction for the relevant audits.
December 2016	patients	Privacy Impact Assessment	Develop Privacy Impact Assessment
January – February 2017	Suppliers (GP Practices, Acute Trusts, Hospitals, Maternity Units, Footcare Services)	BAAS team	Contacted to input into burden assessment for collecting NDA information.
November 2016	GPIT Chair	Email/telephone	Plans for informing GPIT committee
February 2017	GPIT Committee	Briefing Paper	Inform GPIT of plans at February meeting

March 2017	CCG, Clinical Networks	Email contacts	Provisional dates for 16-17 announced
March 2017	CCGs/CNs/GPs/Patients	Fact Sheet - website	Develop communication summary into a fact sheet for the web page
March 2017	GP Practices/ specialist services	NDA team email list. Leaflet	Fair Processing, updated patient information leaflet and poster announce provisional collection dates
April 2017	GP practices	NHS England bulletin	Inform of move to Directions what will this mean
April 2017	GPs, CCG, Clinical Networks	Email contacts	Inform of move to Directions what will this mean. Confirm dates for collection
April 2017	RCGP	Blog/newsletter	Inform of move to Directions what will this mean for data collection
April 2017	Public	Update webpage	Update NDA webpage once direction confirmed
April 2017	GP practices	NHS Digital GP email contact list	Data Provision Notice
April 2017	GP practices	NHS Digital GP bulletin	Inform of future collection dates and method for collection
April 2017	CEOs, Medical Directors, Insulin Pump Networks	Letter from Partnership Board	Inform of future collection dates
April 2017	Acute Trusts, Hospitals	NaDIA email contacts	Inform of future collection and any changes
May 2017	Maternity Units	NPID contacts	Inform of and move to directions and move away from consent
May 2017	Footcare Services	NDA team email list	Inform of data collection cut-off date, update on impacts on consent model
TBC	Researchers	NHS Digital Bulletin	Inform of move to Directions what will this mean for data dissemination future linkages

Appendix A – Attendees Specification Meeting

Attendees at the NDA and NPDA Specification Meeting June 2016

Attendees	
Jonathan Valabhji (chair) (JV) *national clinical director for obesity and diabetes, NHS England* Jackie Cornish (co-chair) (JC) *national clinical director for children, young people and transition to adulthood, NHS England* Cathy Hassell (CH)*deputy director, quality programmes, NHS England* *Matthew Fagg (MF)* *deputy director, reducing premature mortality, NHS England* Claire Lemer (CL) *associate national clinical director, children and young people, NHS England* Richard Arnold (RA) *clinical programme lead, national medical directorate, NHS England* Robert Grant (RG) *senior lecturer, health and social care statistics, NAGCAE* David Cromwell (DC) *director, clinical effectiveness unit, Royal College of Surgeons of England* Amanda Adler (AAd) *consultant diabetologist, Addenbrookes Hospital* Andrew Askey (AA) *lead GP, Walsall for Diabetes, St Johns Medical Centre* Val Bailey (VB) *West Midlands Effectiveness & Audit Network (MEAN), NQICAN* Lorraine Oldridge (LO) *national lead, National Cardiovascular Intelligence Network (NCVIN)*	John Barton (JB) *consultant endocrinologist, Bristol Royal Hospital for Children* Leighton Coombs (LC) *senior programme analyst, NICE* Anthony Davies (AD) *policy lead, Welsh Government* Kate Fazakerley (KF) *patient representative (paediatric)* Julian Hamilton-Shield (JHS) *professor of diabetes and metabolic endocrinology, University of Bristol* Mark Hannigan (MH) *programme manager, RCPCH* Carol Jairam (CJ) *diabetes specialist nurse, Imperial College Healthcare NHS Trust* Nick Lewis-Barned (NLB) *endocrinologist & diabetes specialist physician, Northumbria Healthcare NHS Foundation Trust* Maureen McGinn (MMc) *patient representative (adult)* Ben McGough (BMc) *DPP programme manage, Public Health England* Carol Metcalfe (CM) *lead paediatric diabetes specialist nurse, Macclesfield District General Hospital* Sean Newton (SN) *Welsh Government representative*

Sian Rilstone (SR) *specialist diabetes dietician, St Mary's Hospital* Holly Robinson (HR) *NPDA project manager, RCPCH* Bridget Turner (BT) *director of policy and care improvement, Diabetes UK* Paul Twigg (PT) *pricing development manager, NHS England* Justin Warner (JW) *clinical lead, National Paediatric Diabetes Audit, RCPCH*	**HQIP** Sasha Hewitt (SH) *associate director, NCAPOP* Kirsten Windfuhr (KW) *associate director, NCAPOP* Jill Stoddard (JS) *director of operations NCAPOP* Sophia Olatunde (SO) *Project Manager, NCAPOP* Judith Hughes (JH) *interim head of procurement, HQIP* Eleanor Mitchell-Heggs (EHM) *programme support officer, NCAPOP*

Board Meeting – Public Session

Title of paper:	**'Annual Uses of the Mental Health Act 1983 in English Acute Trusts' Collection**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 05 a iii
Paper presented by:	James Hawkins Director of Programmes
Paper prepared by:	Kate Croft Information Lead Manager, Mental Health, Psychological Therapies and Learning Disabilities
Paper approved by: (Sponsor Director)	Professor David Hughes Director of Information and Analytics
Purpose of the paper:	To enable the views of the Board to be considered as part of the formal consultation on the draft Direction. This consultation is in line with our agreed process.
Please specify the key risks and issues:	None
Patient/public interest:	Indirect
Supplementary papers:	Appendix 1 – Annual uses of the Mental Health Act 1983 in English Acute Trusts Draft Direction
Actions required by the Board:	Consider the draft Direction and to identify any issues or concerns as part of the formal consultation process.

Annual uses of the Mental Health Act 1983 in English acute trusts' collection

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Contents

Executive Summary

This paper provides the NHS Digital Board with the information necessary to consider the Direction that is required to support 'Annual uses of the Mental Health Act 1983 in English acute trusts' collection.

Background

Information about uses of the Mental Health Act in hospitals was previously collected in the KP90 collection, used for the last time in 2015/16. In line with the SoS Fundamental Review of Returns recommendations (2013) the KP90 collection has now been retired and the data source for official statistics about uses of the Mental Health Act, from 01/04/2016, is the Mental Health Services Dataset (MHSDS). All organisations that returned the KP90 are now in scope for the MHSDS, except acute hospital trusts. The proposed new collection is a reduced aggregate collection (very few uses of the Act occur in acute hospital trusts) to ensure that full information about uses of the Act is available for annual official statistics published by NHS Digital since 2006. It is possible that the introduction of the Emergency Care Dataset, which will include information about the Act, will remove the need for this collection in future.

Recommendation

EMT approved the Draft Direction for the Annual uses of the Mental Health Act 1983 in acute hospital trusts collection on 9 March 2017 and recommended it be submitted to NHS Digital Board for acceptance at the earliest opportunity.

This proposal for a new, aggregate collection, has been assessed by Standardisation Committee for Care Information (SCCI) Impact Assessment Panel as low risk, low impact.

Implications

Strategy Implications

The retirement of the KP90 represents a significant reduction in burden on the NHS. This is in line with the goal of collecting once and using many times. MHSDS is an administrative dataset that is used for a wide range of purposes by commissioners, policy leads, providers and academics. It also now provides data for monitoring uses of the Act in mental health, learning disability and autism services.

The introduction of this limited new collection is designed to ensure that we maintain credibility in our official statistics about the Mental Health Act by ensuring that the annual publication includes all settings, including those not in scope for MHSDS, whilst minimising the burden of data collection.

Financial Implications

The KP90 collection was funded by GIA. This new reduced collection should also be funded by GIA but will be a much smaller task. Within the Data Collections team and the Mental

health analysis team the work involved is approximately one week in each team (est 5 days X Band 7 X 2). The majority of the work will take place in 2017/18.

Stakeholder Implications

The collection has been discussed and agreed with DH Mental Health Act lead.

Handling

The NHS Digital Media team have collaborated with us over a Transition Plan, including communications, around the changes to the way we collect and publish information about uses of the Mental Health Act. These were described to users in a special report 'Mental Health Act Statistics: Improved reporting to support better care' which was published alongside the annual statistics about the Act for 2015/16. The CQC, DH and UK Statistics Authority have been working with us to communicate and manage the transition. There is a page on the NHS Digital website which talks about the changes (http://content.digital.nhs.uk/datacollections/kp90). This will be updated with details of this new collection once approved.

Risks and Issues

This has been assessed by SCCI Impact Assessment Panel as low risk, low impact.

Risk of issue	Mitigation
Reputational risk if these data are not collected and NHS Digital is perceived to underestimate the importance of a complete national collection.	The introduction of this collection, which is designed as an interim measure until uses of the Act in Emergency Departments can be included in ECDS, is designed to mitigate this risk. Alternatively we would need to manage the impact on existing users of our annual statistics.
Risk that data cannot be collected in time if approval of the collection is delayed.	Timing of publication of annual statistics might be delayed.

Corporate Governance and Compliance

As part of the consultation process, this Direction was reviewed at EMT on 9 March 2017 and all Directions should be referred to the NHS Digital Board for consideration and acceptance.

The legal basis for the collection is described in the Direction. The resulting analysis will be published in line with the Code of Practice for Official Statistics.

Management Responsibility

Kate Croft, Information Lead Manager – Mental Health, Psychological Therapies and Learning Disabilities

John Varlow, Director of Analysis.

Professor David Hughes, Executive Director of Information and Analytics

Actions Required of the Board

The Board is asked to accept the Direction that is required to support the 'Annual uses of the Mental Health Act 1983 in English acute trusts' collection.

Department of Health

Andy Williams
Chief Executive,
NHS Digital
1 Trevelyan Square, Boar Lane
Leeds
LS1 6AE

DRAFT

Dear Andy

I am writing to provide a Direction to NHS Digital, formerly known as the Health and Social Care Information Centre (HSCIC) and hereafter referred to as NHS Digital, to establish and operate an informatics system for the collection and analysis of data from acute hospital trusts that make use of the Mental Health Act 1983.

This Direction is given in exercise of the powers conferred by sections 254(1) and (6), 260 and 304(9), (10) and (12) of the Health and Social Care Act 2012 (the Act)[1].

In accordance with section 254(2)(b) of the Act, the Secretary of State for Health considers it to be in the interests of the health service in England or of the recipients or providers of adult social care in England for the direction to be given.

This Direction is to be known as the 'Annual uses of the Mental Health Act 1983 in English acute trusts' Direction, and comes into force on 1 ***April*** 2017. The collection will have a short name 'MHA_Acute'. The Direction will cover the collection of annual data from acute hospital trusts in respect of their use of the Mental Health Act 1983 from 01/04/2016. This collection replaces the former annual KP90 collection which was retired after the 2015/16 collection in line with the recommendations of the SoS Fundamental Review of Returns. (Mental Health Act information is now collected in the Mental Health Services Dataset by all relevant organisations, except acute hospital trusts)

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

- Collect on an annual basis **aggregate** data from acute hospital trusts in relation to their use of the Mental Health Act 1983. (See Annex 1 for full list of data items to be collected.
- Validate and analyse the data, and publish a National Statistics report.

Please accept this letter as a direction given under subsection (1) of section 254 of the 2012 Act to the NHS Digital to exercise the functions in relation to the informatics system for the collection of data from acute hospital trusts that make use of the Mental Health Act 1983. The purpose of the data collection is to support the Secretary of State for Health's commitment to monitor the use of the Mental Health Act 1983 to ensure the provision of fair and effective health services and

[1] 2012 c.7

compliance with the requirements of the Human Rights Act 1998. NHS Digital will have regard to and comply with the Directions to NHS Digital to process Type 2 objections.

In accordance with section 254(5) of the Act, NHS Digital has been consulted before this Direction has been given.

Yours sincerely

Director name

Director title

..Ends

Annex 1– Data collection template

Annual uses of the Mental Health Act 1983 in English acute trusts

Please see related guidance below for cross references to the former KP90 collection with location

All data items were previously included in the annual KP90 collection by HSCIC (see references below)

This collection is for a much reduced set of data in keeping with non mental health acute trust settings

1. Formal admissions to hospital

Number of admissions during the year by legal status on admission:

	Legal status	Number of formal admissions
1.1	Section 2	
1.2	Section 3	
1.3	Section 136	
1.4	Any other formal admissions (see guidance)	

2. Changes in legal status under the Mental Health Act

Number of changes during the year:

	Type of change in status	Number of changes in legal status
2.1	Informal to 5(4)	
2.2	Informal to 5(2)	
2.3	Informal to 2	
2.4	Section 136 to 2	
2.5	Section 5(2) to 2	
2.6	Informal to 3	
2.7	Section 5(2) to 3	
2.8	Section 136 to 3	

3. Number of Patients detained in hospital at 31 March 2017

		Number of people detained
3	Patients detained/resident under the Mental Health Act 1983 or other	

4. Number of patients transferred in and out

Patient transfers on section during year:

		Number of people transferred
4.1	Transfers in	
4.2	Transfers out	

Board Meeting – Public Session

Title of paper:	**PLICS (Patient Level Information and Costing Systems) Mandatory Request**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 05 a iv
Paper presented by:	James Hawkins Director of Programmes
Paper prepared by:	John Winter Programme Manager Data Content/New Data Collections
Paper approved by:	Professor David Hughes Director of Information and Analytics
Purpose of the paper:	This paper provides an update on the final draft Mandatory Request received from NHS Improvement. Approval is sought to establish and operate a system for the collection and analysis of PLICS data by acceptance of the Mandatory Request.
Additional Documents and or Supporting Information:	NHSI's Mandatory Request to NHS Digital
Please specify the key risks and issues:	The risk of implementing a solution which is not fit for purpose. Risks associated with lack of appropriate resources.
Patient/public interest:	Indirect – relates to a new data collection which enables improvement in cost management and efficiencies.
Supplementary papers:	Appendix 1 - NHSI's Mandatory Request to NHS Digital
Actions required by the Board:	The Board is asked to consider the draft Mandatory Request and accept it at the earliest opportunity.

PLICS (Patient Level Information and Costing Systems) Mandatory Request

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Contents

Executive Summary

This paper provides an update to the NHS Digital Board on the Mandatory Request received from NHS Improvement in final draft on 09 March 2017 for submission to the Board.

Approval is sought to establish and operate a system for the collection and analysis of PLICS data by acceptance of the Mandatory Request.

Background

PLICS data is an enabler for the overall sector Costing Transformation Programme to deliver productivity and efficiency savings identified in the Five Year Forward View, through a step change in the quality of costing information.

It will enable improvements in cost management and efficiency; cost benchmarking, sector development and price system efficiency.

A Mandatory Request for a small scale PLICS pilot was previously accepted by the NHS Digital Board and implemented by NHS Digital between June and October 2016.

Following the success of this pilot, NHS Improvement has requested NHS Digital to further develop a PLICS system on a larger scale in 2017.

This will involve live person identifiable data collection, data linkage, data quality and validation and data supply, to provide pseudonymised PLICS data to NHS Improvement for onward processing and analysis.

The data would be collected and processed by NHS Digital via existing tools. These systems will be further developed where necessary, to enable the large data volumes required by PLICS data and the required data validations and processing.

The Board is asked to note that:

- NHS Digital has been consulted on this request.
- The Mandatory Request has been reviewed by NHS Improvement's and NHS Digital's lawyers, with amendments subsequently reflected in the version received on 09 March 2017.
- Plans are in place for NHS Digital to consult with representatives of persons from whom any information will be collected.
- There was a late amendment to the scope of the mandatory request received one month ago. As there has been limited time to scope and cost the implications of this amendment, rather than delay the wording has been carefully agreed with lawyers to enable:
    - Satisfactory completion of scoping and funding exercises to be a pre-requisite of complying with the amendment.
    - NHS Digital sole discretion remains the guiding principle in carrying out the amendment, to ensure Information Governance and Data Dissemination concerns can be entirely satisfied before complying with the request.

Recommendation

Do Nothing - Not preferred due to the timescales for delivery of the data needed and the reputational risk associated.

Recommendation 1 – Accept the Mandatory Request, and establish and operate a PLICS system from May 2017 to have the following functionality:

- Data collection - ability for providers to submit PLICS data direct to NHS Digital;
- Potential to link PLICS data with Hospital Episode Statics (HES) data
- Data Quality and validation; and
- Data Supply – the functionality to provide pseudonymised PLICS data to NHS Improvement for onward processing and analysis.

Recommendation 2 - Accept the Mandatory Request and with respect to the below wording in the Mandatory Request:

> "In making this mandatory request, NHS Improvement also requests that, pursuant to section 262(4) and (5) of the HSCA:
>
> 1. NHS Digital exercises in its sole discretion the powers it has to disseminate the information which it obtains by complying with this request, so as to provide information to a Volunteer Provider Trust to enable it to re-identify the individuals who were the subject of the PLICS data which that Volunteer Provider Trust had submitted."

Then, explore the feasibility of implementing this request, subject to relevant data dissemination/information governance clearance, funding agreement and/or determination of suitable cost recovery charging model.

Implications

Strategy Implications

The information gathered from the Costing Transformation Programme will be used to enable NHS Improvement to perform its pricing and licensing functions under the HSCA more effectively.

Within NHS Digital, this work fits with our strategy and purpose to be the organisation that collects and disseminates health and care data. NHS Improvement is a key partner for NHS Digital.

It is beneficial for the system overall to use existing NHS Digital tools, technology and knowledge to collect this data.

Continued NHS Digital involvement in collecting PLICS data on a larger scale will help in understanding the dataset further, in preparation for the proposed national collection of PLICS data in subsequent years as part of the Costing Transformation Programme.

Financial Implications

For Recommendation 1:
Funding for implementation of this Mandatory Request to the end of the current financial year is budgeted for and covered by an approved Investment Justification.

Funding for the next financial year has been included within the internal business planning process and is included within a draft Business Case for the Data Content/New Data Collections Programme within NIB Domain H.

For Recommendation 2:
This expenditure is, at this stage, unbudgeted. Additional funding would be needed via a suitable funding agreement and/or determination of suitable cost recovery charging model.

Stakeholder Implications

Work is on-going with NHS Improvement as part of implementing the systems required.

NHS Digital will consult with representatives of persons from whom any information will be collected.

Handling

No media implications are anticipated because those Trusts involved have volunteered for the data collection.

NHS Improvement is managing the communications with these Trusts, as part of the wider Costing Transformation Programme.

NHS Digital will:

1) Provide technical expertise as an input to the NHS Improvement communications where required, in order to implement the required systems and de-risk the data collection process.
2) Issue some complementary communications where required by NHS Digital processes and operational emails to Trusts to enable the data collection process.

Risks and Issues

The risk of implementing a solution which is not fit for purpose is being mitigated by NHS Digital and NHS Improvement working closely together in implementing the necessary systems; this includes agreeing business requirements, analysis of likely PLICS file sizes against the capacity of the NHS Digital technical solution and iterative impact assessment and refinement of the data set specification. This approach proved successful in the initial pilot covering data from 6 trusts, and current arrangements are significantly informed by the learning from that initial pilot process.

Risks associated with lack of appropriate resources have been escalated within I&A to enable prioritisation and deployment on an as needs basis.

Corporate Governance and Compliance

A milestone for PLICS data collection for Acute Trusts (PO code 26.14) is included in the "P2020 Ministerial Commitments, Key Outcomes and Key Milestones." As such progress will be tracked via this mechanism.

Reporting of progress and assurance is also undertaken via the Data Content and New Data Collections Programme Board (NIB Domain H).

Day to day progress of this request will be managed through an established weekly project call between project teams at NHS Digital and NHS Improvement.

Management Responsibility

The Executive Director who will have accountability for this work is the Executive Director for Information and Analytics Portfolio, Professor David Hughes.

The senior manager who will have overall responsibility and will deal with the matter on a day to day basis is Jackie Shears – Programme Director, Data Content/New Data Collections.

Actions Required of the Board

Accept the Mandatory Request of 09 March 2017 and further establish and operate a PLICS system from May 2017 to have the following functionality:

- Data collection - ability for providers to submit PLICS data direct to NHS Digital;
- Potential to link PLICS data with Hospital Episode Statics (HES) data
- Data Quality and validation; and
- Data Supply – the functionality to provide pseudonymised PLICS data to NHS Improvement for onward processing and analysis.

Endorse Recommendation 2.

NHSI
Wellington House,
133-155 Waterloo Road,
London,
SE1 8UG

Health and Social Care Information Centre
1 Trevelyan Square
Boar Lane
Leeds
West Yorkshire
LS1 6AE

[9 March] 2017

Dear Andy Williams

NHSI's Mandatory Request to NHS Digital

I am writing to the Health and Social Care Information Centre (now known as and referred to in this letter as "NHS Digital") on behalf of Monitor (referred to in the rest of this letter as "NHS Improvement"). Further to the initial pilot collection of Patient Level Costing Information Systems data ('PLICS') carried out by NHS Digital pursuant to NHS Improvement's mandatory request dated 6 July 2016 ("Pilot System Request"), we are writing to make a further mandatory request under section 255 of the Health and Social Care Act 2012 ("HSCA") that NHS Digital continue to establish and operate a system for the collection and analysis of PLICS. I've set out below full details of the relevant functions of NHS Improvement and the data collection required.

NHS Improvement's functions

Under Chapter 4, Part 3 of the HSCA, NHS Improvement, working with NHS England, is responsible for developing, publicising and enforcing the national tariff, which sets out the price payable by commissioners for NHS services.

NHS Improvement is also responsible for licensing providers of NHS services under Chapter 3, Part 3 of the HSCA. The licence includes a set of standard licence conditions, including:

- conditions applicable to foundation trusts relating to governance arrangements (e.g. there is a requirement for licensees to establish and implement systems and/or processes to ensure compliance with licensee's duty to operate efficiently, economically and effectively); and

- conditions that enable us to fulfil our duties in partnership with NHS England to set prices for NHS care by requiring providers to collect costing information.

Three licence conditions relate to costing:

Pricing condition 1: Recording of information. Under this licence condition, we can require licence holders to record information, including cost information, in line with our published guidance. Such information must be recorded using our 'approved reporting currencies' and in accordance with our *Approved costing guidance*.

Pricing condition 2: Provision of information. Having recorded the information in line with pricing condition 1, licence holders can be required to submit this information to us, as well as other information and reports we may require for our pricing functions.

Pricing condition 3: Assurance report on submissions to NHS Improvement. It is important for price setting that the information submitted is accurate. This condition allows us to require licence holders to submit an assurance report confirming that the information they have provided is accurate.

Although NHS trusts do not have to hold a provider licence, they too must comply with the requirements of these licence conditions under the NHS Trust Development Authority's regime for NHS trusts.

NHS Improvement has a general power under paragraph 15 of Schedule 8 to the HSCA to do anything which appears to it to be necessary or expedient for the purposes of, or in connection with, the exercise of our function.

Costing Transformation Programme

Understanding how providers spend money is essential in tackling short-term deficits; supporting the development of new models of care and reducing the variation in resource utilisation.

Benchmarking using current Reference Cost data cannot identify precisely where there is potential for efficiency gains. Such data is limited in its ability to reflect the complexity of patient care and identifying cost variation between individual patients. By introducing a standardised method of reporting cost information at patient level this can be rectified. This is known as Patient Level Costing Information Systems (PLICS).

NHS Improvement's Costing Transformation Programme (CTP), was established to implement PLICS across Acute, Mental Health, Ambulance and Community providers. The programme entails:

- Introducing and implementing new standards for patient level costing;

- Developing and implementing one single national cost collection to replace current multiple collections;

- Establishing the minimum required standards for costing software and promoting its adoption; and

- Driving and encouraging sector support to adopt Patient Level Costing methodology and technology.

The information gathered from this programme will be used to enable NHS Improvement to perform its pricing and licensing functions under the HSCA more effectively. It will:

- inform new methods of pricing NHS services;
- inform new approaches and other changes to the design of the currencies used to price NHS services;
- inform the relationship between provider characteristics and cost;
- help trusts to maximise use of their resources and improve efficiencies, as required by the provider licence;
- identify the relationship between patient characteristics and cost; and
- support an approach to benchmarking for regulatory purposes.

Mandatory request

Under section 255 of the HSCA, we hereby request that NHS Digital continues to establish and operate a system for the collection and analysis of PLICS data. This system will build on the Pilot System Request undertaken by NHS Digital from June 2016 that concluded in October 2016.

The system to be further established and operated under this request will need to have the following functionality:

- Data collection - ability for providers to submit PLICS data direct to NHS Digital;

- Potential to link PLICS data with Hospital Episode Statics (HES) data (NIC- 15814 - C6W9R);

- Data Quality and validation; and

- Data Supply – the functionality to provide pseudonymised PLICS data to NHS Improvement for onward processing and analysis.

There are four ‘levels’ of data requiring collection by NHS Digital as part of the Costing Transformation programme, collectively these will form the data extract requested by NHS Improvement.

The four levels referred to above are:

- Reconciliation tables[1]
- Message Header Information
- Activity Records; and
- Activity Costs Records

Detailed data levels can be found at Annex A.

To build on the system established by the Pilot System Request, NHS Improvement would like to increase the number of trusts from which data are to be collected and analysed. Volunteer provider trusts who have agreed to participate in this second data collection exercise expected to take place over the period of May to December 2017 (inclusive) are listed at Annex B ("Volunteer Provider Trusts"). In the event any of the Volunteer Provider Trusts are not able to participate in this data collection, then NHS Improvement shall provide an updated Annex B to NHS Digital.

The Costing Transformation Programme: 2016/17 PLICS cost collection guidance (Acute) sets out the collection period.

The collection year begins on 1 April 2016 and ends on 31 March 2017. All episodes and attendances completed within the collection year or episodes still open at the end of the collection year are in scope of this collection.

Only resources used and activities undertaken within the collection year should be included, regardless of when the episode started or ended.

Unless it is deemed by the NHSI Costing Director that the system for the collection and analysis of PLICS data established and operated pursuant to this request is deemed ineffective at any point during this programme of works, NHS Improvement shall continue to request NHS Digital to collect and analyse PLICS data from any of those Volunteer Provider Trusts in accordance with this request.

We have set out above how the collection of PLICS data is relevant to our pricing functions. We consider that the information which could be obtained by complying with the request is information which it is necessary or expedient for NHS Improvement to have in relation to its discharge of its duties:

(a) in relation to the pricing of health care services provided for the purposes of the NHS; in particular, its duty to prepare and publish the national tariff (section 116 and 118 of the HSCA);
(b) in relation to the licensing of providers of NHS services; in particular, its duty to oversee and enforce the licence (see Part 3 of Chapter 3 of the HSCA); and

[1] These tables are not final and are subject to change. Any changes shall be notified to NHS Digital and updated tables provided to NHS Digital as soon as practicable.

(c) generally in relation to the exercise of its functions, in particular its duty under section 62(1) of HSCA in exercising its functions to protect and promote the interests of people who use health care services by promoting provision of health care services which is economic, efficient and effective, and maintains or improves the quality of the services.

"Monitor" is listed as a "principal body" under section 255(9) of the HSCA. This request therefore meets the requirements for a mandatory request under section 255(4) of the HSCA and is a confidential collection request in accordance with section 256(2)(a) of the HSCA. Prior to making this request, NHS Improvement has liaised and worked with NHS Digital as required by 257(4) of the HSCA and recognises this request must go through an established system of approvals within NHS Digital.

In making this mandatory request, NHS Improvement also requests that, pursuant to section 262(4) and (5) of the HSCA:

1. NHS Digital exercises in its sole discretion the powers it has to disseminate the information which it obtains by complying with this request, so as to provide information to a Volunteer Provider Trust to enable it to re-identify the individuals who were the subject of the PLICS data which that Volunteer Provider Trust had submitted.

2. NHS Digital does not exercise the power conferred by section 261(4) of the HSCA in relation to the information which it obtains by complying with this request, other than to disseminate information to such persons, for such purposes and at such times as may be agreed between NHS Digital and NHS Improvement including but not limited to the circumstances for dissemination described at point 1 above.

NHS Improvement hereby recognises that in submitting this request under section 255 of the HSCA, NHS Digital is entitled to charge a reasonable fee pursuant to section 257 (3) in respect of the cost of complying with this request from NHS Improvement.

Yours sincerely

(Costing Director to sign)

Annex A

Costing Transformation Programme Data Extract Requirements

NHS Digital is being asked to collect information on four levels, which collectively form the extract requested by NHS Improvement:

- Reconciliation tables
- The message header
- The activity records
- The activity cost records

Reconciliation tables

Final audited accounts table

Field Name	Description
Final audit accounts ID	Identifier which describes the financial transactions charged to the statement of comprehensive income
Cost or Income value	Financial transaction value

Cost group main table

Field Name	Description
Cost group ID	Identifier to report costed activities
Total Cost	The unit costs on a full absorption basis, which should equal the sum of patient facing and support costs (department and organisation) for each resource reported
Other operating income	Income from non-patient-care services

Cost group sub table

Field Name	Description
Cost group ID	Identifier to report costed activities
Service ID	Identifier to report services within a cost group
Total Cost	The unit costs on a full absorption basis, which should equal the sum of patient facing and support costs (department and organisation) for each resource reported
Other operating income	Income from non-patient-care services
Activity	The number of episodes or attendances undertaken in the financial year for a service

Message Header

Field Name	Description
Organisation Identifier (code of submitting organisation)	The organisation code of the health care provider, acting as the physical sender of the data extract
Reporting Period Start	The start of the reporting period the extract covers (i.e. the period the Finished Consultant Episodes end)
Reporting Period End	The end of the reporting period the extract covers. (i.e. the period the Finished Consultant Episodes end)
Extract Creation Date Time	The date and time the extract was created
Feed Type	The data set the extract covers
Number of Activity Records	The total number of activity records included in the extract
Total Costs	The total sum of the costs within the extract

Activity Information – Admitted patient care

Field Name	Description
Organisation Identifier (Code of Provider)	The organisation code of the health care provider, providing the service

CDS Unique Identifier	A Commissioning Data Set data element providing a unique identity for the life-time of an episode carried in a Commissioning Data Set message.
NHS Number	The primary identifier of a person within the NHS in England and Wales
NHS number status indicator	Codes in this field indicate whether the patients' NHS Number is present, and if it is verified. If the NHS Number is absent, the indicator gives the reason why.
Postcode	Post code of usual address
Date of Birth	Date of Birth is the date of birth of the patient
Person Stated Gender Code	The gender of a PERSON.
Patient Classification Code	Classification of patients who have been admitted. The field is derived from the Admission Method, Intended Management and the duration of stay within the provider.
Admission Method Code	The method of admission the hospital provider spell
Hospital Provider Spell Number	A number to provide a unique identifier for each Hospital Provider Spell for a Health Care Provider.
Episode Number	Field used to uniquely identify episodes, and is the sequence number for each consultant episode within a Hospital Provider Spell
Episode Type	A field to indicate whether the inpatient consultant episode completed within the financial year
Start Date (Episode)	The date and time the episode started. Use in CDS types: 120,130,140,170,180,190,200
End Date (Episode)	The date the episode ended. Use in CDS types: 120,130,140,170,180,190,200
FCE HRG	FCE HRG based on the 16/17 Reference Cost HRG grouper

Spell HRG	Spell HRG based on the 16/17 Reference Cost HRG grouper
Unbundled HRGs	Unbundled HRGs based on the 16/17 Reference Cost HRG grouper
Adjusted Length of Stay	Difference between the End Date (Episode) and Start Date (Episode) adjusted to remove critical care days, rehabilitation days and specialist palliative care days
Contracted out Indicator	Flag indicating whether patient activity was contracted out.
Consultant	The CONSULTANT CODE is derived from either the GENERAL MEDICAL COUNCIL REFERENCE NUMBER for GENERAL MEDICAL PRACTITIONERS, or the GENERAL DENTAL COUNCIL REGISTRATION NUMBER for GENERAL DENTAL PRACTITIONERS (where the dentist doesn't have a GENERAL MEDICAL COUNCIL REFERENCE NUMBER).
Local Patient Identifier (Mother)	A number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's case note number and may be assigned automatically by the computer system. LOCAL PATIENT IDENTIFIER (MOTHER) uniquely identifies the mother, where the baby's identity is recorded by use of LOCAL PATIENT IDENTIFIER.
Patient Pathway Identifier	The field together with the ORGANISATION CODE of the issuer uniquely identifies a PATIENT PATHWAY.
Activity Treatment Function Code	TREATMENT FUNCTION CODE is a unique identifier for a TREATMENT FUNCTION. TREATMENT FUNCTION CODE is recorded to report the specialised service within which the PATIENT is treated. Has the same attributes as Activity Treatment Function Code
Organisation Identifier (Patient Pathway Issuer)	The Organisation code of the organisation issuing the Patient Pathway identifier

Activity Information – Outpatients

Field Name	Description
Organisation Identifier (Code of Provider)	The organisation code of the health care provider, providing the service
CDS Unique Identifier	A Commissioning Data Set data element providing a unique identity for the life-time of an episode carried in a Commissioning Data Set message.
NHS Number	The primary identifier of a person within the NHS in England and Wales
NHS number status indicator	Codes in this field indicate whether the patients' NHS Number is present, and if it is verified. If the NHS Number is absent, the indicator gives the reason why.
Postcode	Post code of usual address
Date of Birth	Date of Birth is the date of birth of the patient
Person Stated Gender Code	The gender of a PERSON.
Attendance Identifier	A sequential number or time of day, assigned locally, that is unique to only one activity for a patient within an organisation. As this field is often locally generated, the data in this field are not currently unique within a dataset. However, as the NHS moves towards central systems this should change.
HRG	HRG based on the 16/17 Reference Cost HRG grouper
Unbundled HRGs	Unbundled HRGs based on the 16/17 Reference Cost HRG grouper
Appointment Start Date and Time	An Out-Patient Appointment is an APPOINTMENT for a PATIENT to see or have contact with a CARE PROFESSIONAL at an Out-Patient Clinic.

Consultant led or non consultant led	Is the lead care professional a consultant
Activity Treatment Function Code	TREATMENT FUNCTION CODE is a unique identifier for a TREATMENT FUNCTION. TREATMENT FUNCTION CODE is recorded to report the specialised service within which the PATIENT is treated. Has the same attributes as Activity Treatment Function Code
Consultant	The CONSULTANT CODE is derived from either the GENERAL MEDICAL COUNCIL REFERENCE NUMBER for GENERAL MEDICAL PRACTITIONERS, or the GENERAL DENTAL COUNCIL REGISTRATION NUMBER for GENERAL DENTAL PRACTITIONERS (where the dentist doesn't have a GENERAL MEDICAL COUNCIL REFERENCE NUMBER).
Contracted out Indicator	Flag indicating whether patient activity was contracted out.
HIV category code	Clinically designed clinical pathway for three groupings of adult patients that supports an annual year of care approach. Category 1: New (newly diagnosed or newly on ARV drugs) Category 2: Stable Category 3: Complex The currency only applies to HIV Adult outpatients and NOT inpatient or paediatric care. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214924/HIV-Outpatients-A-Simple-Guide.pdf
Patient Pathway Identifier	The field together with the ORGANISATION CODE of the issuer uniquely identifies a PATIENT PATHWAY.
Organisation Identifier (Patient Pathway Issuer)	The Organisation code of the organisation issuing the Patient Pathway identifier

Activity Information – Accident and emergency

Field Name	Description
Organisation Identifier (Code of Provider)	The organisation code of the health care provider, providing the service

CDS Unique Identifier	A Commissioning Data Set data element providing a unique identity for the life-time of an episode carried in a Commissioning Data Set message.
NHS Number	The primary identifier of a person within the NHS in England and Wales
NHS number status indicator	Codes in this field indicate whether the patients' NHS Number is present, and if it is verified. If the NHS Number is absent, the indicator gives the reason why.
Postcode	Post code of usual address
Date of Birth	Date of Birth is the date of birth of the patient
Person Stated Gender Code	The gender of a PERSON.
Attendance ID	Identifier allocated by an A&E department to provide a unique identifier for each A&E attendance
HRG	HRG based on the 16/17 Reference Cost HRG grouper
Consultant	The CONSULTANT CODE is derived from either the GENERAL MEDICAL COUNCIL REFERENCE NUMBER for GENERAL MEDICAL PRACTITIONERS, or the GENERAL DENTAL COUNCIL REGISTRATION NUMBER for GENERAL DENTAL PRACTITIONERS (where the dentist doesn't have a GENERAL MEDICAL COUNCIL REFERENCE NUMBER).
Contracted out Indicator	Flag indicating whether patient activity was contracted out.
Arrival date and time at A&E	Arrival date and time of a patient in the A&E department
Departure date and time from A&E Department	The departure date and time of a patient from the A&E department. Only patients with a department date and time within the reporting period should be included.

Department type	A classification of A&E department type according to the activity carried out.

Costing information

Field Name	Description
Collection Activity ID	Unique identifier to report activities, which are measurable amount of work, performed using resources to deliver elements of patient care. Patient activity can be recorded and reported through various feeding systems.
Collection Resource ID	Unique identifier to report resources, which are components used to deliver activities, such as staffing, supplies, systems and facilities.
Collection Activity count	The number or duration of activities undertaken, eg number of tests or duration in theatre
Total cost	The unit costs on a full absorption basis, which should equal the sum of patient facing and support costs (department and organisation) for each resource reported

Annex B

Trust Name
NORTHAMPTON GENERAL HOSPITAL NHS TRUST
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
HEART OF ENGLAND NHS FOUNDATION TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
THE DUDLEY GROUP NHS FOUNDATION TRUST
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BURTON HOSPITALS NHS FOUNDATION TRUST
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
TAUNTON AND SOMERSET NHS FOUNDATION TRUST
PAPWORTH HOSPITAL NHS FOUNDATION TRUST
POOLE HOSPITAL NHS FOUNDATION TRUST
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
MID YORKSHIRE HOSPITALS NHS TRUST
PENNINE ACUTE HOSPITALS NHS TRUST
HARROGATE AND DISTRICT NHS FOUNDATION TRUST
GATESHEAD HEALTH NHS FOUNDATION TRUST
DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST
STOCKPORT NHS FOUNDATION TRUST
LEEDS TEACHING HOSPITALS NHS TRUST
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST
THE CHRISTIE NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
EAST CHESHIRE NHS TRUST
SALFORD ROYAL NHS FOUNDATION TRUST
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST
BOLTON NHS FOUNDATION TRUST

ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE WALTON CENTRE NHS FOUNDATION TRUST
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST
IMPERIAL COLLEGE HEALTHCARE NHS TRUST
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST
ROYAL FREE LONDON NHS FOUNDATION TRUST
LEWISHAM AND GREENWICH NHS TRUST
CROYDON HEALTH SERVICES NHS TRUST
DARTFORD AND GRAVESHAM NHS TRUST
SURREY AND SUSSEX HEALTHCARE NHS TRUST
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST
BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST
EAST SUSSEX HEALTHCARE NHS TRUST
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
WEST SUFFOLK NHS FOUNDATION TRUST
IPSWICH HOSPITAL NHS TRUST
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST
EAST AND NORTH HERTFORDSHIRE NHS TRUST
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST
THE ROYAL MARSDEN NHS FOUNDATION TRUST
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST
BARTS HEALTH NHS TRUST
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
NORTHERN DEVON HEALTHCARE NHS TRUST
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST
ROYAL BERKSHIRE NHS FOUNDATION TRUST

Board Meeting – Public Session

Title of paper:	**Direction from NHS England for 'General Practice Contract Data Collections'**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 05 a v
Paper presented by:	James Hawkins Director of Programmes
Paper prepared by:	Dave Roberts Head of Business and Operational Delivery, Primary Care Domain
Paper approved by: (Sponsor Director)	Professor. David Hughes Director of Information and Analytics
Purpose of the paper:	Provide the NHS Digital Board with the information necessary to consider the Direction that is required to support the 'General Practice Contract Data Collections' and approve its acceptance.
Additional Documents and or Supporting Information:	1) Draft copy of Direction for 'General Practice Contract Data Collections' 2) Draft copy of Direction Annex for 'General Practice Contract Data Collections'
Please specify the key risks and issues:	The collection and extraction of data for these 2017-18 services is deemed as low risk as only aggregate level data will be collected / extracted and all of these services will have been through the appropriate governance process prior to their first data collection / extraction. These collections and extractions will run during the 2017-18 financial year (that is: 1 April 2017 to 31 March 2018). The NHS Digital Board accepting this Direction on 28 March 2017, and the necessary assurance being provided by the Standardisation Committee for Care Information (SCCI) prior to 31 March 2017, and by Data Coordination Board (DCB) from 1 April 2017, will mean that the necessary governance will be in place prior to these data being collected and extracted[1].
Patient/public interest:	Indirect

[1] All 5 collections and 12 of the 14 extractions are scheduled to be assured by SCCI on 29 March 2017; the remaining 2 extractions will be assured by DCB once their specifications have been finalised.

Supplementary papers:	Appendix 1 - General Practice Contract Data Collections' Appendix 2 - Annex General Practice Contract Data Collections'
Actions required by the Board:	The NHS Digital Board is asked to accept the Direction from NHS England for the General Practice Contract Data Collections at the NHS Digital Board meeting on 28 March 2017.

Direction from NHS England for 'General Practice Contract Data Collections'

Published 28 March 2017

Information and technology
for better health and care

Contents

Executive Summary

NHS England wishes to Direct NHS Digital to establish and operate a system for the collection and analysis of data for the 'General Practice Contract Data Collections'. This paper provides the NHS Digital Board with the information necessary to consider the Direction that is required to support this work (see Supplementary Papers 1 and 2) and approve its acceptance.

Background

The 2017-18 General Medical Services (GMS) contract (referred to as the GP contract) has been agreed between NHS Employers, on behalf of NHS England, and the British Medical Association (BMA) General Practitioners Committee (GPC)[1]. As in previous years, NHS Digital will collect[2] or extract[3] data for a number of the services included in this contract. This will involve collecting and extracting aggregate level data from general practices in England. No patient level data, or patient identifiable data, will be collected or extracted; Type 1 opt-outs and Type 2 opt-outs will not apply. Each collection and extraction is voluntary and general practices will choose whether or not they wish to participate. A Direction, issued under section 254 of the Health and Social Care Act 2012, from NHS England to NHS Digital is required to provide the legal basis for the collection and extraction of these data. This Direction will cover all of the GP contract services collections and extractions that form part of the 2017-18 GP contract, of which there are 19 in total (5 collections and 14 extractions).

Recommendation

The recommendation is for NHS Digital Board to accept the Direction from NHS England for the General Practice Contract Data Collections at the NHS Digital Board meeting on 28 March 2017.

Implications

Strategy Implications

By collecting and extracting these data, NHS Digital supports a number of the objectives outlined in their data and information strategy[4] (the themes of these objectives are shown in ***bolded italics*** below). The right ***data content*** will be collected and extracted in a way that minimises burden on the data providers (general practices). ***Data access*** is supported as all of these data will be published in an easily accessible form by the NHS Digital Primary Care

[1] http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/GMS/Summary%20of%20201718%20GMS%20contract%20negotiations.pdf

[2] Via the Calculating Quality Reporting Service (CQRS).

[3] Via the General Practice Extraction Service (GPES).

[4] See page 61 to 88 of the NHS Digital Board Papers from the meeting on 30 November 2016: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/572748/20161130_NHS_Digital_Board_Papers_WEB.pdf

Domain team. These ***publications*** will be relevant and will include the appropriate ***analysis***, which will provide customers and users with meaningful information. ***Data science*** will also be supported as work is currently ongoing in developing innovative and interactive ways of presenting all of the data NHS Digital collects at general practice level for activity that occurs within a primary care setting, of which these collections and extractions will be included.

Financial Implications

NHS Digital and NHS England are in the process of finalising a work package that will cover the costs for NHS Digital collecting and extracting these data. These costs will be taken from the standard CQRS and GPES charging model. Once finalised, this work package will be taken through the NHS Digital Investment Sub-Group (ISG) process. Staff costs from the NHS Digital Primary Care Domain team for analysing and publishing these data will be covered by Grant in Aid funding.

Stakeholder Implications

The majority of these GP contract services include a payment component (that is: general practices are paid for the activity that they have carried out as specified in the services). Payments to general practices are based on the data that are collected / extracted. These collections and extractions also include data that are required for management information purposes. The collection and extraction of these data, and CQRS calculating the necessary payments, reduces the workload on local area teams that are involved in the management of these services. The impact of not collecting these data would result in general practices not receiving payment for meeting the requirements of these services. NHS England would be unable to monitor general practices. There would also be no data available to use for commissioning / planning purposes. No data would be published, which would mean that members of the public would be unable to see how general practices in England perform in these services.

Handling

Following the NHS Digital Board acceptance of this Direction, a Data Provision Notice will be issued to all general practices in England prior to the date that these data will first be collected / extracted[5]. This Notice will inform general practices of the key information, including the form, manner and period, of these collections and extractions. Each collection and extraction will be offered out to all general practices in England via CQRS; each general practice may choose whether or not to participate in these data collections and extractions.

Risks and Issues

The collection and extraction of data for these 2017-18 services is deemed as low risk as only aggregate level data will be collected / extracted and all of these services will have been

[5] Due to timescales, the Data Provision Notice will not be issued six weeks in advance of the date that these data will first be collected / extracted; the Joint GP IT Committee have been informed of this and, at the time of writing, no objections have been raised.

through the appropriate governance process prior to their first data collection / extraction. Of the 19 services included in the 2017-18 GP contract, 18 of these services had equivalent collections and extractions in 2016-17[6]; all of these were assured by SCCI. CQRS and GPES are both established systems and general practices in England are familiar with how these collections and extractions work; user guidance is available on the NHS Digital webpage[7]. General practice participation is usually high due to the majority of these collections and extractions including a payment component. The NHS Digital GPES and Solutions Assurance teams will work closely with the general practice system suppliers to ensure that each extraction is developed, tested and certified prior to going live; each extraction will then be monitored once it moves into a live environment. This will provide the necessary level of assurance for the full end to end extraction process.

Corporate Governance and Compliance

For each collection and extraction, the appropriate governance assurance will be in place prior to the date that these data will first be collected / extracted. This assurance will be provided by either the Standardisation Committee for Care Information (SCCI) or the Data Coordination Board (DCB)[8]. The assurance for these collections and extractions will include a detailed burden assessment from the Burden Advice and Assessment Service (BAAS); this will consider the overall burden placed on general practices in these data being collected via the CQRS portal or extracted from their clinical IT systems via GPES.

Management Responsibility

- Executive Director: Prof. David Hughes (Executive Director of Information and Analytics at NHS Digital)
- Information Asset Owner: Dave Roberts (Head of Business and Operational Delivery, Primary Care Domain, NHS Digital)
- Programme Manager: Audra Stringer (Programme Manager, CQRS, NHS Digital)
- Programme Manager: David Heaslet (Programme Manager, GPES and GPSoC, NHS Digital)

Actions Required of the Board

The NHS Digital Board is asked to accept the Direction from NHS England for the General Practice Contract Data Collections at the NHS Digital Board meeting on 28 March 2017.

[6] Standard changes, such as date changes (and code changes where relevant), will be made to each of these collections and extractions between 2016-17 and 2017-18. Some of these collections and extractions will also include other non-standard changes (such as wording changes to count titles, changes in collection / extraction frequency and the addition / removal of counts). All of these changes (both standard changes and non-standard changes) are deemed as minor changes.
[7] https://digital.nhs.uk/GP-Collections
[8] All 5 collections and 12 of the 14 extractions are scheduled to be assured by SCCI on 29 March 2017; the remaining 2 extractions will be assured by DCB once their specifications have been finalised.

D I R E C T I O N S

NATIONAL HEALTH SERVICE, ENGLAND

The Health and Social Care Information Centre (Establishment of Information Systems for NHS Services: General Practice Contract Data Collections) Directions 2017

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

In accordance with section 254(5) of the Health and Social Care Act 2012, the National Health Service Commissioning Board has consulted the Health and Social Care Information Centre before giving these Directions[1].

Citation, commencement and interpretation

1. These Directions may be cited as The Health and Social Care Information Centre (Establishment of Information Systems for NHS Services: General Practice Contract Data Collections) Directions 2017 and shall come into force on **[date].**

2. In these Directions–

"The 2012 Act"	means the Health and Social Care Act 2012[2];
"The Board"	means the National Health Service Commissioning Board[3];
"HSCIC"	means the Health and Social Care Information Centre[4];

[1] S.I. 2013/259
[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.
[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

"Relevant Organisation"	means General Practice in England;
"Specification"	means the General Practice Data Collection Specification version **N.N** dated **DD/MM/YYYY** and annexed to these Directions at Annex A or any subsequent amended version of the same document approved by the Board which supersedes version **N.N**;
"Service Specification"	means a Quality Service Request that is listed with status "approved" in the Specification.

Establishing and Operating the General Medical Services Contract Data Collections Information System

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

(2) The information referred to in sub-paragraph (1) is set out in the Service Specifications.

(3) The Board directs HSCIC to carry out the activities described in sub-paragraph (1) in accordance with the Service Specifications and generally in such a way as to enable and facilitate the purposes that are described in the Service Specifications.

S254(3) - Requirement for these Directions

4. In accordance with section 254(3) of the 2012 Act, the Board confirms that it is necessary or expedient for it to have the information which will be obtained through the HSCIC complying with these Directions in relation to the Board's functions in connection with the provision of NHS Services.

Fees and Accounts

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

6. The HSCIC must keep proper accounts, and proper records in relation to the accounts, in connection with the General Practice Contract Data Collections Information System.

Review of these Directions

7. These Directions will be reviewed when the Specification or a Service Specification is amended. This review will include consultation with the HSCIC as required by sub-section 254(5) of the 2012 Act.

Signed by authority of the NHS Commissioning Board

Sir Bruce Keogh
Caldicott Guardian

[INSERT DATE]

Annex A – Specification

(This Document has been removed and can be found in the Shared Documents Folder)

Annex A: General Practice Data Collections Specification

Version: 0.6
Date: 02/03/2017

Purpose:

This document forms the specification for the Direction that NHS England will issue to NHS Digital to establish and operate a system for the collection and analysis of information for the 2017-18 General Practitioner (GP) contract services, which make up part of the 2017-18 General Medical Services (GMS) contract.

Background:

The services listed in this specification form part of the 2017-18 GMS contract[1], which has been agreed between NHS Employers, on behalf of NHS England, and the General Practitioners Committees (GPC) of the British Medical Association (BMA).

Data for each service will either be manually collected via the Calculating Quality Reporting Service (CQRS) or automatically extracted via the General Practice Extraction Service (GPES), or will involve a combination of both manual collections via CQRS and automated extractions via GPES. Data will be collected and / or extracted after the reporting period (for example: month) in question.

The majority of the collections and extractions covered by this Direction are for existing services that were included in the 2016-17 GMS contract. NHS Digital either collected and / or extracted data on these services for the 2016-17 financial year; all of these services were assured by the Standardisation Committee for Care Information (SCCI).

List of collections and extractions covered by this Direction:

Listed below are the collections and extractions that are covered by this Direction. The start date, and the frequency of how often the data are collected and / or extracted, varies across the services that are covered by this Direction; this information is shaded in light blue in the table below. Where applicable, a Quality Service Request form has been produced for each service. This form provides a full textual description of the data that will be collected / extracted for each service; the Quality Service Request details are shaded in light grey in the table below.

1 http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/GMS/Summary%20of%20201718%20GMS%20contract%20negotiations.pdf

Collection / extraction details					Quality Service Request details (where applicable)		
Collection / extraction name	**Start date**	**End date**	**Frequency**	**Type**	**Reference**	**Title and Version**	**Status**
Alcohol related risk reduction scheme 2017-18	01/04/2017	31/03/2018	Bi-annual	GPES	QSR1718015	Alcohol_v0.1	Approved
Childhood seasonal influenza vaccination programme 2017-18	01/09/2017	31/03/2018	Monthly	GPES	QSR1718013	TBC	Draft
Frailty 2017-18	01/04/2017	31/03/2018	Quarterly	GPES	TBC	TBC	TBC
Hepatitis B (newborn babies) vaccination programme 2017-18	01/04/2017	31/03/2018	Monthly	CQRS	QSR1718002	Hepatitis B for new born babies v1.0	Approved
HPV booster vaccination programme 2017-18	01/04/2017	31/03/2018	Monthly	CQRS	QSR1718004	HPV completing dose (booster) programme_v1.0	Approved
Learning disabilities health check scheme 2017-18	01/04/2017	31/03/2018	Quarterly	GPES	QSR1718017	LDHealthchecks_V1.0	Approved
Meningococcal ACWY vaccination programme 2017-18	01/04/2017	31/03/2018	Monthly	GPES	QSR1718010	MenACWY_v1.0	Approved
Meningococcal B vaccination programme 2017-18	01/04/2017	31/03/2018	Monthly	GPES	QSR1718006	MenB_v1.0	Approved
Meningococcal booster vaccination programme 2017-18	01/04/2017	31/03/2018	Monthly	CQRS	QSR1718003	Meningococcal Completing Dose (booster) programme _v1.0	Approved
Measles, mumps, rubella (MMR) vaccination programme 2017-18	01/04/2017	31/03/2018	Monthly	CQRS	QSR1718001	MMR_v1.0	Approved
PCV Hib/Men C vaccination programme 2017-18	01/04/2017	31/03/2018	Quarterly	CQRS	QSR1718005	PCVHibMenC_v1.0	Approved
Pertussis in pregnant women vaccination programme 2017-18	01/04/2017	31/03/2018	Monthly	GPES	QSR1718007	Pertussis_v1.0	Approved
Pneumococcal polysaccharide vaccination programme 2017-18	01/04/2017	31/03/2018	Monthly	GPES	QSR1718009	Pneumococcal_v1.0	Approved
Quality and Outcomes Framework (QOF) 2017-18	01/04/2017	31/03/2018	Monthly	GPES	Not applicable	Not applicable	Approved
Indicators no longer in QOF 2017-18	01/04/2017	31/03/2018	Annual	GPES	TBC	TBC	TBC

Rotavirus (childhood routine immunisation) vaccination programme 2017-18	01/04/2017	31/03/2018	Monthly	GPES	QSR1718008	Rotavirus_v1.0	Approved
Seasonal influenza vaccination programme 2017-18	01/09/2017	31/03/2018	Monthly	CQRS and GPES	QSR1718014	TBC	Draft
Shingles (catch up) vaccination programme 2017-18	01/04/2017	31/03/2018	Monthly	GPES	QSR1718011	Shingles catch up_v1.0	Approved
Shingles (routine aged 70) vaccination programme 2017-18	01/04/2017	31/03/2018	Monthly	CQRS and GPES	QSR1718012	Shingles routine_v1.0	Approved

Technical specification documents:

For each service that involves an automated GPES extraction, NHS Digital's Primary Care Domain will produce a technical specification document. This document will underpin how the data extraction will work. It will clearly define exactly what data will be included in the extraction, and in exactly what time period these data should be considered.

The technical specification documents will be published on the NHS Digital webpage[2]. These documents will also be sent to the general practice system suppliers so that they can successfully implement the data extractions for each service.

A Technical Requirements document, listing all of the codes used within the services covered by this Direction (apart from QOF 2017-18 and Indicators no longer in QOF 2017-18), will be published by NHS Employers on their webpage[3].

Assurance:

The collections and extractions covered by this Direction will be assured and approved by either the Standardisation Committee for Care Information (SCCI)[4] or the Data Coordination Board (DCB) prior to the date that these data will first be collected or extracted.

All Quality Service Request forms will also be agreed by the following parties: NHS Employers, NHS England and the NHS Digital CQRS, GPES and Primary Care Domain teams.

For each automated GPES extraction, the technical specification document is not produced until after the Quality Service Request form has been agreed. Each technical specification is produced by one analyst within the Primary Care Domain team before then being quality checked by a different analyst within the team. Once this initial quality check has been performed, the technical specification document is subject to a further quality check involving the whole team.

NHS Digital Senior Clinical Advisors agree and check the codes that are included in these technical specification documents. For some services, such as QOF, Clinical Advisors from the National Institute for Health and Care Excellence (NICE) may also advise on any code queries. The QOF technical specification documents are also sent to the Joint GP IT Committee for an additional review.

Once the technical specification documents are finalised and agreed, they are sent to GPES for implementation. The NHS Digital GPES and Solutions Assurance teams work closely with the general practice system suppliers to ensure that each extraction is developed, tested and certified prior to going live; each extraction is then be monitored once it moves into a live environment. This provides the necessary level of assurance for the full end to end extraction process.

The Technical Requirements and Guidance and Audit Requirements documents published by NHS Employers may be read in conjunction with the technical specification documents to further aid the interpretation of these services.

Publication of data:

Data that are collected and / or extracted for the services covered under this Direction will be published by the NHS Digital Primary Care Domain team. The QOF 2017-18 data will be published

[2] http://content.digital.nhs.uk/qofesextractspecs and http://content.digital.nhs.uk/esbrv7
[3] http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services
[4] http://content.digital.nhs.uk/isce

separately to all of the other collections and extractions, which will form part of the GP Contract Services 2017-18 publication. It is anticipated that the data will be published at some point after 31 March 2018 (that is: the end date for all of the collections and extractions covered by this application) but this is yet to be confirmed. Details of when the data will be published will be announced on the NHS Digital Publication Calendar[5].

[5] http://content.digital.nhs.uk/pubs/calendar

Board Meeting – Public Session

Title of paper:	**NHS Digital Board Forward Business Schedule 2017-18**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 05 c
Paper presented by:	Chair
Paper prepared by:	Nicola Rhodes, Senior Secretariat Support Manager
Paper approved by: (Sponsor Director)	None
Purpose of the paper:	This paper details the NHS Digital Board forward business schedule for the financial year 2017-18. Please note this schedule is subject to frequent change.
Key risks and issues:	N/A
Patient/public interest:	Corporate Governance – decision making
Actions required by the board:	**To note for information**

NHS Digital – Public Board Meeting Forward Business Schedule 2017-18 [i]

03 May 2017	31 May 2017	06 September 2017	01 November 2017	31 January 2018	07 March 2018
Board Businessand Governance	***Board Businessand Governance***	***Board Businessand Governance***	***Board Businessand Governance***	***Board Businessand Governance***	***Board Businessand Governance***
Register of Interests – for information Minutes of previous meeting – to ratify Matters Arising – for comment Progress on Action Points – for information	Register of Interests – for information Minutes of previous meeting – to ratify Matters Arising – for comment Progress on Action Points – for information	Register of Interests – for information Minutes of previous meeting – to ratify Matters Arising – for comment Progress on Action Points – for information	Register of Interests – for information Minutes of previous meeting – to ratify Matters Arising – for comment Progress on Action Points – for information	Register of Interests – for information Minutes of previous meeting – to ratify Matters Arising – for comment Progress on Action Points – for information	Register of Interests – for information Minutes of previous meeting – to ratify Matters Arising – for comment Progress on Action Points – for information
Governance and Assurance	***Governance and Assurance***	***Governance and Assurance***	***Governance and Assurance***	***Governance and Assurance***	***Governance and Assurance***
Annual Review of Board Effectiveness Report 2016-17	NHS Digital Annual Report and Accounts for 2016-17		Scheme of Delegated Financial Authorities 2017-18 (update)	Arrangements for the Annual Review of Board Effectiveness 2017-18	Corporate Governance Manual 2017-18 Scheme of Delegated Financial Authorities 2017-18 (update)
Strategic Operational Delivery and Performance	***Strategic Operational Delivery and Performance***	***Strategic Operational Delivery and Performance***	***Strategic Operational Delivery and Performance***	***Strategic Operational Delivery and Performance***	***Strategic Operational Delivery and Performance***
Board Performance Pack Data Release Audit Annual Report 2016-17	Board Performance Pack	Board Performance Pack Corporate Business Plan 2017-18 (Final)	Board Performance Pack Mid-year review of Corporate Business Plan 2017-18	Board Performance Pack Staff Survey Results 2017-18 Corporate Business Plan 2017-18 (Draft)	Board Performance Pack Information Assurance and Cyber Security Annual Report 2017-18 Corporate Business Plan 2017-18 (Final)
Strategy and Capability	***Strategy and Capability***	***Strategy and Capability***	***Strategy and Capability***	***Strategy and Capability***	***Strategy and Capability***
System Wide Support and Engagement	***System Wide Support and Engagement***	***System Wide Support and Engagement***	***System Wide Support and Engagement***	***System Wide Support and Engagement***	***System Wide Support and Engagement***
Governance and Assurance	**Governance and Assurance**	**Governance and Assurance**	**Governance and Assurance**	**Governance and Assurance**	**Governance and Assurance**
Reports from Sub-Committees	Reports from Sub-Committees	Reports from Sub-Committees	Reports from Sub-Committees	Reports from Sub-Committees	Reports from Sub-Committees
Papers for Information Only	***Papers for Information Only***	***Papers for Information Only***	***Papers for Information Only***	***Papers for Information Only***	***Papers for Information Only***
Forthcoming Statistical Publications Programme Definitions Board Forward Business Schedule 2017-18	Forthcoming Statistical Publications Programme Definitions Board Forward Business Schedule 2017-18	Forthcoming Statistical Publications Programme Definitions Board Forward Business Schedule 2017-18	Forthcoming Statistical Publications Programme Definitions Board Forward Business Schedule 2017-18	Forthcoming Statistical Publications Programme Definitions Board Forward Business Schedule 2017-18 Board Forward Business Schedule 2017-18 and 2018-19	Forthcoming Statistical Publications Programme Definitions Board Forward Business Schedule 2017-18 Board Forward Business Schedule 2018-19
April and May 2017	**June and July 2017**	**August and September 2017**	**October and November 2017**	**December 2017 and January 2018**	**February and March 2018**
Key Meetings	***Key Meetings***	***Key Meetings***	***Key Meetings***	***Key Meetings***	***Key Meetings***
• Board Devleopment day - 05 April 2017 • Board Development Day – 02 May 17 • Statutory Board – 03 May 17 • Assurance & Risk Committee – 10 May 17 • Board Development Day –30 May 17 • Statutory Board – 31 May 17 • Assurance & Risk Committee – 31 May 17	• Information Assurance and Cyber Security Committee – 14 June 17 • Board Timeout – 04 July 17	• Board Development Day – 05 September 17 • Statutory Board – 06 September 17 • Assurance & Risk Committee – 13 September 17 • Information Assurance and Cyber Security Committee- 13 September 17	• Board Development Day – 31 October 17 • Statutory Board – 01 November 17 • Assurance & Risk Committee – 15 November 17 • Information Assurance and Cyber Security Committee – 15 November 17	• Board Timeout – 20 December 17 • Board Development Day – 30 January 18 • Statutory Board – 31 January 18	• Board Development Day – 06 March 18 • Statutory Board – 07 March 18 • Assurance & Risk Committee – 14 March 18 • Information Assurance and Cyber Security Committee – 14 March 18

[i] This is a living document and is subject to regular updates

Board Meeting – Public Session

Title of paper:	**Forthcoming Statistical Publications**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 07 a
Paper presented by:	N/A - For information
Paper prepared by:	Chris Roebuck Director of Publications and Head of Profession for Statistics
Paper approved by: (Sponsor Director)	Professor David Hughes Director of Information and Analytics
Purpose of the paper:	This paper describes NHS Digital Official (and National) Statistics publications published in January 2017 and planned for April – May 2017, and media and web coverage for publications released in January 2017.
Additional Documents and or Supporting Information:	N/A
Please specify the key risks and issues:	N/A
Patient/public interest:	Overview of NHS Digital Statistical Publications
Supplementary papers:	N/A
Actions required by the Board:	For information

Official

Forthcoming Statistical Publications

Author Chris Roebuck

Published 28 March 2017

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Contents

Executive Summary

This paper describes:

- NHS Digital Official (and National) Statistics publications released during January 2017 and planned for April – May 2017;
- Media coverage for press released Official Statistics publications during January 2017;
- Web activity for publications released during January 2017.

Background

As at 01 March 2017, NHS Digital is responsible for 95 active (currently published or planned for future release) series of Official Statistics of which 32 are designated as National Statistics, which means that the UK Statistics Authority (UKSA) recognises them as being compliant with the Code of Practice for Official Statistics.

During the 2015/16 financial year (01/04/15 to 31/03/16), NHS Digital published 294 statistical reports.

Official Statistics are expected to evolve and improve over time, to meet the changing needs of our users, to improve their quality and utility and to respond to changes in their administrative and management data sources.

“Experimental statistics” are new Official Statistics that are undergoing evaluation. A key part of this evaluation is user engagement whereby NHS Digital invites readers to comment on the publications, which helps to inform future releases.

Most NHS Digital Official Statistics are published annually or more frequently. Generally, each edition is similar in content to previous versions but any substantial changes are noted below (note: no such changes are yet planned).

National Statistics are identified below with [NS].

Forthcoming and recently released publications

Official and National statistics

April 2017

New releases: None planned for April 2017

Biennial: None planned for April 2017

Annual

06 April 2017	Health and Care of People with Learning Disabilities - 2015/16

Biannual None planned for February 2017

Quarterly

12 April 2017	NICE Technology Appraisals in the NHS in England (Innovation Scorecard) - to September 2016
11 April 2017	Learning Disabilities Health Check Scheme - England, Quarters 1 and 2, 2016-17
19 April 2017	Numbers of Patients Registered at a GP Practice - April 2017
20 April 2017	NHS Continuing Healthcare Activity - England, Quarter 3, 2016-17
26 April 2017	Seven-day Services - England, October 2015 - September 2016, Experimental statistics
27 April 2017	Statistics on NHS Stop Smoking Services in England - April 2016 to December 2016

Monthly

04 April 2017	Out of Area Placements in Mental Health Services - February 2017
05 April 2017	Maternity Services Monthly Statistics - November 2016, Experimental statistics
12 April 2017	Children and Young People's Health Services Monthly Statistics - December 2016
12 April 2017	NHS Safety Thermometer Report - England March 2016 - March 2017
13 April 2017	Recorded Dementia Diagnoses - March 2017
13 April 2017	Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - February 2017
13 April 2017	Provisional Accident and Emergency Quality Indicators for England - January 2017, by provider
20 April 2017	Mental Health Services Monthly Statistics - Final January, Provisional February 2017
25 April 2017	Improving Access to Psychological Therapies Report - January 2017 Final, February 2017 Provisional + Quarter 3 2016-17
26 April 2017	NHS Workforce Statistics - January 2017, Provisional Statistics
26 April 2017	NHS Sickness Absence Rates - October 2016 to December 2016
27 April 2017	Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), March 2017, Experimental Statistics

May 2017

New releases: None planned for May 2017

Biennial None planned for May 2017

Annual

03 May 2017	Statistics on Alcohol, England - 2017 [NS]
23 May 2017	General and Personal Medical Services, England - As at 31 March 2017, Provisional Experimental statistics

Biannual None planned for May 2017

Quarterly

11 May 2017	Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England - April 2016 to December 2016 - May 2017 Release
11 May 2017	Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England - April 2015 to March 2016 - May 2017 Release
18 May 2017	NHS Outcomes Framework Indicators - May 2017 Release [NS]
25 May 2017	NHS Dental Statistics for England - 2015-16, Third quarterly report

Monthly

03 May 2017	Maternity Services Monthly Statistics - December 2016, Experimental statistics
05 May 2017	Out of Area Placements in Mental Health Services - March 2017
12 May 2017	Children and Young People's Health Services Monthly Statistics - January 2017
19 May 2017	Provisional Accident and Emergency Quality Indicators for England - February 2017, by provider
19 May 2017	Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - March 2017 (M12)
23 May 2017	NHS Sickness Absence Rates - January 2017, Provisional Statistics
23 May 2017	NHS Workforce Statistics - February 2017, Provisional statistics
24 May 2017	Mental Health Services Monthly Statistics - Final February, Provisional March 2017
25 May 2017	Improving Access to Psychological Therapies Report - February 2017 Final, March 2017 Provisional and most recent quarterly data (Quarter 3 2016-17)
31 May 2017	Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), April 2017, Experimental Statistics

Clinical Audits

Clinical Audits are not currently classed as Official Statistics. The Code of Practice for Official Statistics is followed as best practice during the production cycle but the release practises differ.

April 2017

25 April 2017	National Diabetes Audit - Insulin Pump Report

May 2017

None planned for May 2017

User and Media activity

The following tables show web and media coverage figures for Official (and National) Statistics released by NHS Digital in January 2017. Clinical Audits are not included.

Unique page views are the number of times the publication page was viewed during the two-week period following its release. Note that one user could generate more than one unique visit.

Media Units are the total articles or other media coverage for example print, online articles or broadcasts for the publication (each is counted separately i.e. an article appearing in both a newspaper's print and online instances will count as two citations) . The totals in the table include all media units for the month of publication up to the date of writing this paper (see header).

Bars in the tables below indicate the scale of interest generated by each publication.

January 2016

Publication	Date	Unique page views	Media units
Maternity Services Monthly Statistics - August 2016, Experimental statistics	04 January 2017	383	
Data on written complaints in the NHS - 2016/17 Quarter 2, Experimental [NS]	05 January 2017	224	
Out of Area Placements in Mental Health Services - November 2016	06 January 2017	162	
Hospital Accident & Emergency Activity - 2015-16	10 January 2017	1149	159
Children and Young People's Health Services Monthly Statistics - July 2016 to September 2016	12 January 2017	421	
NICE Technology Appraisals in the NHS in England (Innovation Scorecard) - to June 2016	12 January 2017	495	
Recorded Dementia Diagnoses - December 2016	13 January 2017	267	
NHS Safety Thermometer Report - England December 2015 - December 2016	13 January 2017	209	
Numbers of Patients Registered at a GP Practice - January 2017	17 January 2017	322	
NHS Continuing Healthcare Activity - England, Quarter 2, 2016-17	17 January 2017	177	
Provisional Accident and Emergency Quality Indicators for England - October 2016, by provider	19 January 2017	137	
Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatient and Accident and Emergency data - April 2016 - November 2016	19 January 2017	114	
Mental Health Services Monthly Statistics - Final October, Provisional November 2016	24 January 2017	469	
Improving Access to Psychological Therapies Report - October 2016 Final, November 2016 Primary and Quarter 2 2016-17	24 January 2017	600	
General and Personal Medical Services, England - As at 30 September 2016, Provisional Experimental statistics	25 January 2017	605	
NHS Sickness Absence Rates - September 2016 Provisional Statistics	25 January 2017	149	
NHS Workforce Statistics - October 2016 Provisional Statistics	25 January 2017	224	
NHS Vacancy Statistics England - February 2015 - September 2016, Provisional Experimental Statistics	26 January 2017	242	
Statistics on NHS Stop Smoking Services in England - April 2016 to September 2016	26 January 2017	290	
Learning Disability Services Monthly Statistics - Commissioner Census (Assuring Transformation), December 2016, Experimental Statistics	27 January 2017	273	

Recommendation

None – for information only.

Implications

Strategy Implications

These publications and their associated media and web coverage results form part of objective five of our strategy, “Making better use of health and care information” whereby we “are part of the Government’s Statistical Service and adhere to the UK Statistics Authority’s Code of Practice for national statistics. We publish data and statistics in formats that cannot be used to identify individual patients, service users or citizens.”

Financial Implications

There are no financial implications of this resolution/proposal.

Stakeholder Implications

This is for information purposes only, for stakeholders to review forthcoming publications and the media and web attention of those previously published..

Handling

There are no handling implications of this resolution/proposal

Risks and Issues

There are no associated risks and issues as this is for information only.

Corporate Governance and Compliance

All Official and National statistics publications adhere to the UK Statistics Authority’s Code of Practice for Official Statistics which fulfil our obligations as a producer of Official and National statistics.

Management Responsibility

Professor David Hughes, Executive Director of Information and Analytics is the sponsor director accountable for these publications. The senior manager with overall responsibility is Chris Roebuck, Director of Publications and Head of Profession for Statistics.

Actions Required of the Board

None – for information only.

Board Meeting – Public Session

Title of paper:	**Streamlining the Independent Information Governance Advice to NHS Digital**
Board meeting date:	28 March 2017
Agenda item no:	NHSD 17 06 07 b
Paper presented by:	Professor Martin Severs Medical Director & Caldicott Guardian
Paper prepared by:	Victoria Williams IGARD Secretariat Manager
Paper approved by: (Sponsor Director)	Professor Martin Severs Medical Director & Caldicott Guardian
Purpose of the paper:	Update the NHS Digital Board on the implementation of IGARD
Additional Documents and or Supporting Information:	Appendix A: IGARD Press Release Appendix B: IGARD Member Biographies Appendix C: IGARD membership turnover table Appendix D: Final DAAG Dashboard
Please specify the key risks and issues:	The paper provides an update with regard the transition from Data Access Advisory Group (DAAG) to IGARD on the 01 February 2017
Patient/public interest:	Direct public interest as establishes independent oversight of NHS Digital data disseminations
Supplementary papers:	Appendix A: IGARD Press Release Appendix B: IGARD Member Biographies Appendix C: IGARD membership turnover table Appendix D: DAAG Dashboard
Actions required by the Board:	The Board is asked to • receive the update with regard the transition from DAAG to IGARD including press release and member biographies, • receive the final DAAG dashboard, • receive the IGARD Membership turnover information.

Streamlining the Independent Information Governance Advice to NHS Digital

Published March 2017

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Contents

Appendices

Executive Summary

The Board is asked to receive an update with regard to the Independent Group Advising (NHS Digital) on the Release of Data (IGARD).

This paper presents the member biographies, recent IGARD press release, proposed member future turnover and final Date Access Advisory Group (DAAG) dashboard.

Background

DAAG transitioned to IGARD on the 1st February 2017. NHS Digital has listened to feedback from all stakeholders in its design and implementation of IGARD and, as such, feels it represents a positive step change in accountability, quality and transparency.

On the 13th February 2017, the Media Team released a press release via the NHS Digital Website and Twitter, with any press enquiries dealt with via the Media Team (see appendix A).

Three independent members of DAAG: Dr Joanne Bailey, Dr James Wilson and Dr Eve Sariyianndou were invited to join IGARD to ensure IGARD has the expertise and experience to continue to advise NHS Digital. The new IGARD membership of Chris Carrigan, IGARD chair, three lay members with strong lay representation and three specialist members with a range of legal, regulatory and research backgrounds provide a balanced portfolio:

- Anomika Bedi, Specialist Member
- Nicola Fear, Specialist Member
- Jon Fistein, Specialist Member
- Kirsty Irvine, Lay Member
- Debby Lennard, Lay Member
- Sarah Baalham, Lay Member

All IGARD members are independent of NHS Digital, appointed by an open process and do not represent any group or organisation, with biographies for each attached at appendix B. Following IGARD's implementation in February 2017, the overall change in the membership will be approximately one third of members in a given year from 2018 onwards (see appendix C). To help give consistency and provide continuity, it also enables rotation of members as issues develop and as the Group comes to have a greater understanding of information governance (IG) issues in the new health and care landscape.

The final DAAG dashboard is provided at appendix D. The management information for IGARD will continue to include the dashboard along with additional commentary and charts and will feed into IGARD's annual report produced at the end of each financial year.

Recommendation

The Board is asked to receive;

a. Receive the IGARD launch article
b. IGARD member biographies
c. IGARD Member proposed turnover of membership
d. Final DAAG Dashboard

Implications

Strategy Implications

The transition from DAAG to IGARD represents the completion of NHS Digital's plans to strengthen and streamline the independent IG advice and oversight we provide for data disseminations.

Financial Implications

The establishment of IGARD has been included in current financial plans and the resources to establish and run the group have been allocated to the Information Governance & Standards Assurance (IGSA) Portfolio for the current financial year.

A Professional Services Business Case has been drafted for submission via the usual NHS Digital route for Ministerial approval, for three years commencing in financial year 2017/18.

Stakeholder Implications

Stakeholders were consulted in Summer 2015. The board received and supported the report '*You Said We Did'* on 23 September 2015[1]. There are no expected implications for stakeholders in the transition from DAAG to IGARD other than improved transparency, accountability and openness

Handling

The Secretariat team will continue to work with the 'Core Business' communications team (led by Paul Butler) in tandem with media and web colleagues if/as necessary.

Risks and Issues

The main risk is of perceived failure to establish independent oversight of NHS Digital data disseminations following the Partridge Report, recommendations and the NHS Digital response to that report. The IGARD proposals are in line with Partridge's recommendations, NHS Digital requirement to streamline and strengthen independent advice to NHS Digital and are informed by the 2015 consultation with the public

Corporate Governance and Compliance

The transition from DAAG to IGARD underpins and strengthens the commitments given by NHS Digital towards transparency, accountability and independence. Membership rotation has been given due consideration and a proposed table agreed with Professor Martin Severs for implementation from 2018 and every year thereafter.

Management Responsibility

The delivery of IGARD will be the responsibility of the Director of Information Governance & Standards Assurance and IGARD Chair, reporting to Professor Martin Severs. The Strategic Head of IG and Deputy Caldicott Guardian will provide advice and guidance to IGARD on a continuing basis in their senior IG and clinical roles

[1] NHS Digital's Minutes of Board Meeting- 23/09/15 Item 4.6(f) 15 05 04 (f) – Streamlining the Independent IG Advice to HSCIC

Actions Required of the Board

The Board is asked to receive the updated report with regard to the transition from DAAG to IGARD and associated appendices.

Appendix A: IGARD Launch Article

IGARD formally launches

A new independent group that reviews applications for sensitive NHS Digital data has formally launched with expert members and an enhanced transparency remit.

IGARD considers applications through the Data Access Request Service as a replacement for the Data Access Advisory Group (DAAG).

It aims to improve accountability, quality and consistency through robust, independent scrutiny of NHS Digital data disseminations, as well as provide a voice for stakeholders and members of the public.

The make-up of the new group is as follows:

- Chris Carrigan, Independent Chair
- Joanne Bailey, Specialist Member (former DAAG Member)
- James Wilson, Specialist Member (former DAAG Member)
- Eve Sariyiannidou, Specialist Member (former DAAG Member)
- Jon Fistein, Specialist Member
- Anomika Bedi, Specialist Member
- Nicola Fear, Specialist Member
- Kirsty Irvine, Lay Member
- Sarah Baalham, Lay Member
- Debby Lennard, Lay Member

Chris Carrigan explains: "The IGARD members have an essential role in overseeing and advising NHS Digital on data releases.

"Keeping the balance between using data for the right reasons and protecting those to whom the data relates is a challenging task, but one the group will embrace."

Rob Shaw, NHS Digital's Chief Operating Officer, adds: "IGARD will streamline existing processes and ensure that our data collection, processing and sharing continues to be independently scrutinised by a balanced group of lay and expert members.

"IGARD supports improved transparency, accountability and consistency, which is incredibly important within our broader remit as trusted custodians of patient information.

"We welcome Chris and the other new members to the fold, and we look forward to working with them."

ENDS

Appendix B: IGARD Member Biographies

Chris Carrigan (Chair of IGARD)

Chris Carrigan is a specialist in cancer data and information, but with a particular focus on patient involvement and patient power, based from the University of Leeds MRC Bioinformatics Centre working on the 'use MY data' patient movement. Chris was a founding member of the National Cancer Intelligence Network (NCIN), a partnership putting patients at the heart of how their data is used funded by a range of bodies, including the public sector and leading cancer charities, tasked with providing new insights and intelligence into cancer inequalities, diagnosis, care, outcomes and experience. In 2014 he was named as one of the Health Service Journal's Top 50 Innovators in the NHS for his innovative and collaborative approach to patient empowerment, and also featured on BBC Radio 4's Networking Nation series, where the NCIN was highlighted as a leading example of how best a network can operate

Sarah Baalham (Lay Member)

Sarah Baalham's background is in Social Care Services and the voluntary sector. She has a rare genetic condition which has necessitated a lifetime of NHS care as an in-patient and out-patient, including participating in research. Sarah currently works as a lay member and chair for a number of different professional regulators, as a lay member for the Advisory Committee for Clinical Excellence Awards, and as a Disability Qualified Panel Member for Her Majesty's Courts and Tribunal Service. She volunteers for several health charities.

Dr Joanne Bailey (Specialist Member)

Joanne has been a GP in Hertfordshire for 25 years and has had a particular interest in GP information management and technology for 10 years. She is an elected member of the General Practitioners' Committee UK, British Medical association (BMA) and a member of the Health Informatics Group, Royal College of General Practitioners (RCGP). She was a member of the GP Extraction Service Independent Advisory Group 2012-15 and, following nomination by Dame Fiona Caldicott, chaired the group from July 2014 until its closure in June 2015. She is past chair of the Joint GP IT Committee of BMA and RCGP. Joanne is also a First-tier Tribunal Member (Social Entitlement Chamber), and a medical appraiser for NHS England Central Midlands. She holds a Masters in Healthcare Ethics.

Anomika Bedi (Specialist Member)

Anomika is a Solicitor and a Commercial & Legal Consultant. She has extensive experience of multi jurisdictional and complex contracting and a keen interest in data privacy. Anomika understands how to operationalize legal advice and translate it into practical actions and she uses this skill to help organisations develop and roll out new products and services. Anomika has worked with the international law firm Baker McKenzie. A large part of her career was at Accenture (where she held a variety of roles including as a member of the global leadership team for: Accenture's New Businesses function; for its Innovation and product development business and for its in-house legal function). Anomika holds a masters in law from Kings College, London as well as data privacy

certifications from the International Association of Privacy Professionals. She also sits as a Lay Member on a NICE Guidelines Committee.

Professor Nicola Fear (Specialist Member)

Nicola joined the Academic Department of Military Mental Health (ADMMH) at King's College London in 2004 having trained as an epidemiologist at the London School of Hygiene and Tropical Medicine and the University of Oxford. Nicola has also worked as an epidemiologist for the Leukaemia Research Fund (University of Leeds) and UK Ministry of Defence. Since 2011, Nicola has been Director of the King's Centre of Military Health Research (KCMHR) alongside Professor Sir Simon Wessely. In 2014, King's College London awarded Nicola a Chair in Epidemiology. Nicola is one of the Principal Investigators on the KCMHR military cohort study and leads several studies looking at the impact of military service on families.

Dr Jon Fistein (Specialist Member)

Jon qualified as a medical doctor (1996) and barrister (called to the bar in 2002), Jon has supported NHS, social care, academic, third sector and commercial organisations for the past 15 years. He was Head of clinical ethics and data at the Medical Research Council. Jon currently sits on advisory boards for several national health and social care organisations including Public Health England and the Healthcare Quality Improvement Partnership (HQIP). He teaches medical law and ethics as part of the clinical medical course in Cambridge University and leads the MSc module on law and ethics in healthcare at the University of Leeds, where he holds a Clinical Research Fellowship.

Kirsty Irvine (Lay Member)

Kirsty has spent 15 years working as a solicitor in corporate law firms in both New Zealand and the City of London. Kirsty has previously acted as chair of her local GP practice's Patient Participation Group and is currently a lay examiner for the Royal College of Obstetricians and Gynaecologists and an active volunteer for the Miscarriage Association.

Debby Lennard (Lay Member)

Debby Lennard was a senior civil servant specialising in IT and Project Management until she retired in 2015. Since then she has become involved in health research and provision. She sits as a lay member or patient representative on several boards for organisations including NIHR, CR-UK and NHS Digital. She is a lay reviewer for NIHR and the BMJ. She is an active Patient and Public Involvement (PPI) member on a number of research projects. Debby also advices a community of interest (CIC) company who are implementing a digital intervention to help people their self management of diabetes.

Dr Eve Sariyiannidou (Specialist Member)

Dr Eve Sariyiannidou was a scholar and tutor at the University of Bristol Law School in the areas of the institutional and constitutional law of the EU, as well as open and transparent governance, before joining the European Commission as an independent expert in 2007. The main premise of her work is to provide expertise - in the fields of health, security and criminal justice - with regard to the implementation of EU legislation, programmes and policies, the establishment of a strategic agenda

for data collection, data processing and data sharing systems and their economic, political, cultural and ethical impact on society. Eve was a member of the European Commission Expert Group on Integrated Border Management and prepared the UK's written response to the European Commission Green Paper on detection technologies with emphasis on the data protection of individuals and 'privacy by design'. She is a Life Founder Member of the Association of Commercial Diplomats and a member of the General Practice Extraction Service Independent Advisory Group.

Dr James Wilson (Specialist Member)

James Wilson is Senior Lecturer in the Department of Philosophy and co-director of the Health Humanities Centre at UCL. His main research and teaching areas are public health ethics and ethical issues in the ownership and sharing of information. He is Associate Editor of the journal Public Health Ethics, and was the ethicist for the General Practice Extraction Service's Independent Advisory Group from 2013 until its closure in June 2015. He spent 2011-12 on secondment to the Royal Society as a Senior Policy Adviser on the Science as an Open Enterprise project, which examined the practicalities and ethics of opening up scientific data to broader use.

Appendix C: IGARD Member Turnover (proposed)

It is proposed to rotate IGARD membership as detailed below, with members to IGARD rotating by one third every year from 2018 to ensure transparency and continuity of service. Planned replacement years were by open and transparent process by Professor Martin Severs and the IGARD Secretariat Manager:

Name	Area of Expertise	Year of appointment	Planned replacement years
Chris Carrigan (Chair)	Lay (cancer data / public & patient involvement)	2016	2019
Joanne Bailey (SM)	Doctor / healthcare ethics	2015	2019
Eve Sariyianndou (SM)	Lawyer / health / security / data protection	2014	2018
James Wilson (SM)	Ethics / Philosopher	2015	2018
Anomika Bedi (SM)	Solicitor / data privacy	2017	2020
Sarah Baalham (LM)	Lay (patient / research participant)	2017	2020
Debby Lennard (LM)	Lay (patient / health research)	2017	2021
Jon Fistein (SM)	Doctor / Barrister / Ethics	2017	2021
Kirsty Irvine (LM)	Lay (patient / carer / solicitor)	2017	2022
Nicola Fear (SM)	Researcher / Military mental health	2017	2022

Key: SM – Specialist Member / LM – Lay Member

Appendix D

Final DAAG Dashboard

January 2016 to January 2017

Background information
January 2016 – January 2017

- Number of DAAG meetings during the period Jan 2016 – Jan 2017: **53**
- Number of applicants considered Jan 2016 – Jan 2017: **958**
- Number of applicants considered out of committee Jan 2016 – Jan 2017 by Members: **557**

- Average number of applicants considered by Members per meeting (Jan 2016 – Jan 2017): **18**
- Average number of applicants considered out of committee by Members per week (Jan 2016 – Jan 2017): **10.5**

Chart 1:

Proportion within recommendation decision per application as at 31 January 2017 and for the final meeting of DAAG.

Please note a number of applications are still showing as 'caveat outstanding' due to the fact that a number are group CCG applications where only a certain number within the group have met all caveats including privacy notice caveats and SIRO email issued – the tracker is per application not applicant.

Progress is ongoing to finalise outstanding caveats.

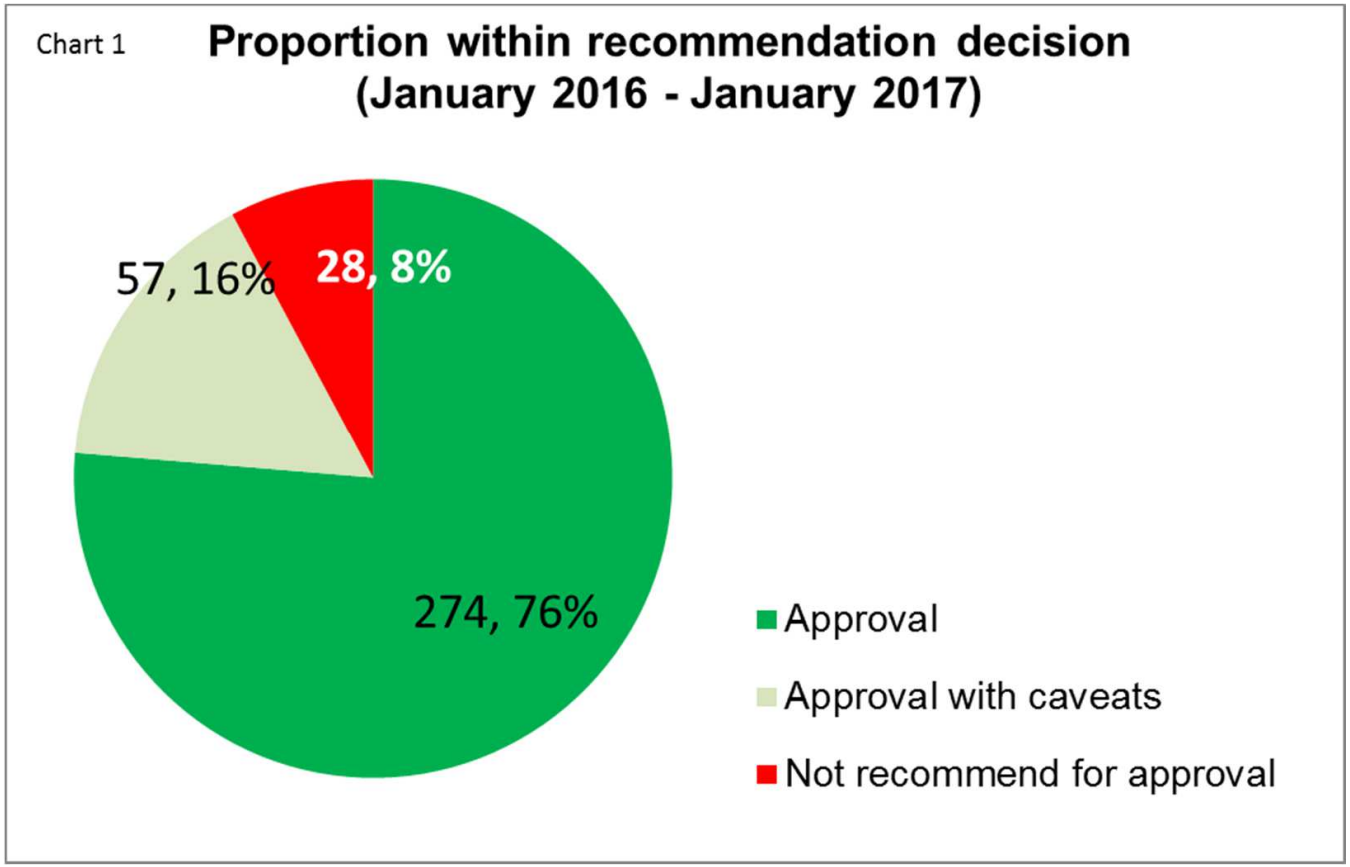

Chart 2:

Recommendation by application type as at 31 January 2017 and for the final meeting of DAAG.

Progress is ongoing to finalise outstanding caveats.

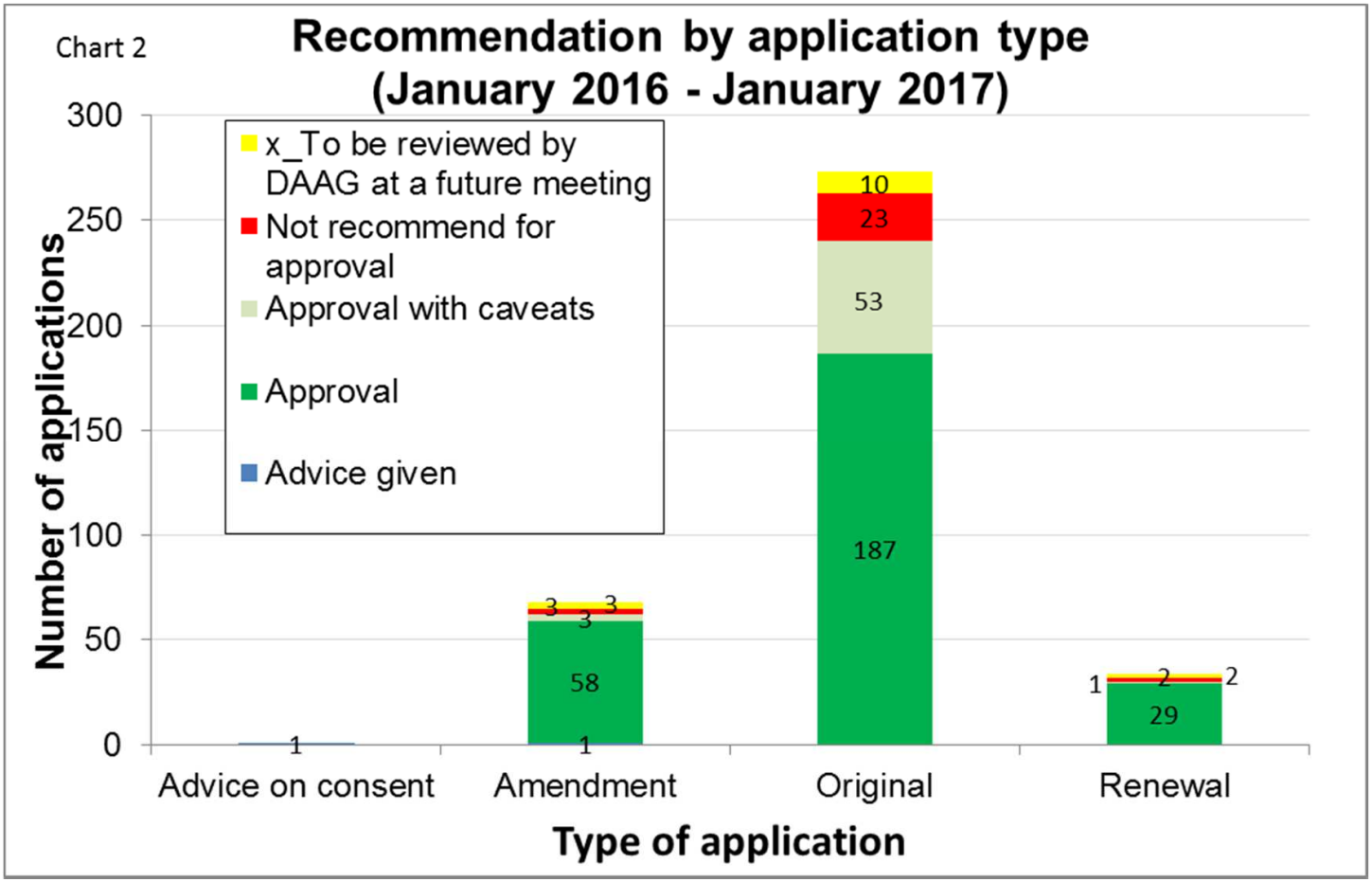

Chart 3:

DAAG decisions by month per application as at 31 January 2017 and for the final meeting of DAAG.

Please note a number of applications are still showing as 'caveat outstanding' due to the fact that a number are group CCG applications where only a certain number within the group have met all caveats including privacy notice caveats and SIRO email issued – the tracker is per application not per applicant.

Progress is ongoing to finalise outstanding caveats.

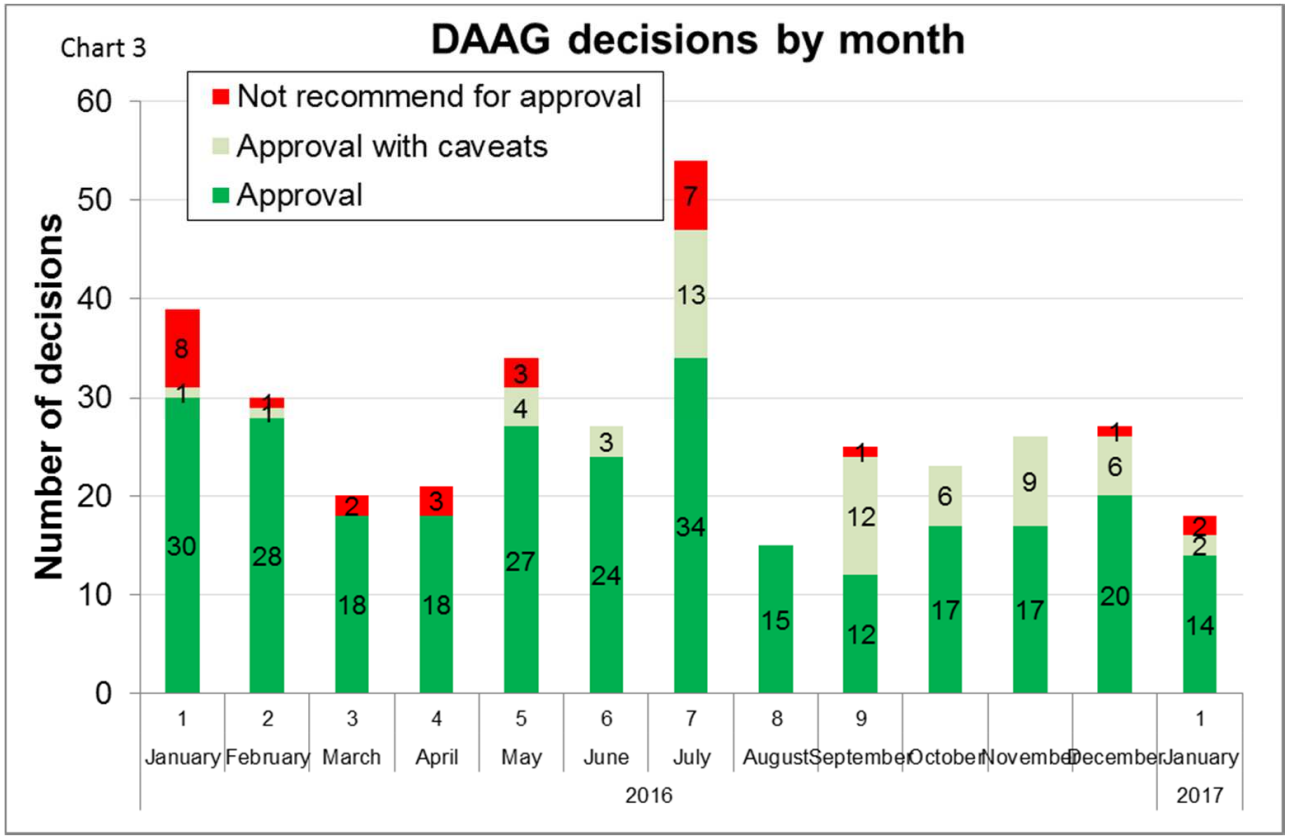

Chart 4:

Recommendation by organisation type per application as at 31 January 2017 and for the final meeting of DAAG.

Please note a number of applications are still showing as 'caveat outstanding' due to the fact that a number are group CCG applications where only a certain number within the group have met all caveats including privacy notice caveats and SIRO email issued – the tracker is per application not per applicant

Progress is ongoing to finalise outstanding caveats.