NHS England

Data Sharing Requirements to support Development of Urgent and Emergency Care Dashboards – Guidance for Data Providers

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Medical	**Operations and Information**	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
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Publications Gateway Reference:	**06027**
Document Purpose	Guidance
Document Name	Data Sharing Requirements to support Development of Urgent and Emergency Care Dashboards – Guidance for Data Providers
Author	NHS England / Data Services for Commisisoners
Publication Date	04 November 2016
Target Audience	Care Trust CEs, Foundation Trust CEs , NHS Trust Board Chairs, Emergency Care Leads
Additional Circulation List	
Description	NHS England is keen to promote best practice around the deployment and utilisation of Urgent and Emergency Care Dashboard Business Intelligence Solutions and encourage all health economies to develop and roll out this functionality during 2017/18. This guidance sets out the data requirements for this.
Cross Reference	NA
Superseded Docs (if applicable)	NA
Action Required	NA
Timing / Deadlines (if applicable)	**Implementation as part of 2017-18 contract requirements**
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Document Status

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Data Sharing Requirements to support Development of Urgent and Emergency Care Dashboards – Guidance for Data Providers

Version number:1

First published November 2016

Prepared by: Data Services for Commissioners Programme

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1 Introduction

NHS England is keen to promote existing best practice around the deployment and utilisation of Urgent and Emergency Care Dashboard Business Intelligence Solutions and encourage all health economies to develop and roll out this functionality during 2017/18. These capabilities will enable local health economies to analyse and understand patient referrals, pathways and outcomes within the wider urgent and emergency care system and help inform commissioning decisions for urgent and emergency care services.

Accessing these patient flow data and the subsequent shifts in activity after system changes will help in the evaluation of the effectiveness of individual and compounding system changes.

The development of Urgent and Emergency Care Dashboards is dependent on urgent and emergency care service providers flowing appropriate data to commissioning support organisations via DSCROs and, and in particular data on 111 service activity. This document describes the minimum expected set of data to support urgent and emergency dashboard development (section 2) and how these data will be used to fulfil analysis requirements (section 3).

Providers should note that their commissioners will be asking for these data to be included in agreed national and local commissioning data flows as part of the negotiation around S23.9 (Contract Management, Reporting and Information Requirements) of the NHS Standard Contract 2017-19

2 Data Requirement

2.1 Data flows

i. All providers of Urgent and Emergency Care (UEC) services need to share data with commissioners meeting the requirements set out in this guidance and meeting the minimum standard data specification detailed in the attached spreadsheet in Annex A.

ii. Annex A (Minimum data requirements for UEC dashboard) contains the minimum requirements for data to enable the dashboard and meet the reporting requirements for all parts of the UEC system. APC, A&E and OP flows are anticipated to be met via existing local flows or existing national commissioning data flows. The section relating to 111 data may be a new requirement for some providers of these services.

iii. The full specification of the flow is for local determination, although minimum expectations are set out in this document.

iv. Data must include an NHS Number, ideally validated and verified, to ensure DSCROs can de-identify patients consistently and replace NHS Number with a pseudonym in DSCRO data disseminations to recipients.

v. De-identified data will be shared with CCGs or their selected data processor (e.g. CSU or LPF provider) where the pseudonym can be used to link with other urgent care data flows.

vi. Existing local flows of data should be reviewed and adapted to ensure they meet the requirements of the table in Annex A.

vii. The NHS England Data Services for Commissioners programme has developed a 111 integrated Urgent Care data specification that provides a consistent and standardised approach to extraction of data. This was developed from reviewing the data currently flowing from providers to commissioners to identify a consistent specification. This covers all the 111 data required under Annex A to produce the dashboard, and could be implemented to provide a comprehensive data set to support all commissioner requirements for data. The specification can be downloaded from the NHS England website - https://www.england.nhs.uk/ourwork/tsd/data-services/commissioning-flows/local-data/

This document does not cover compliance with information governance requirements and related documents such as safeguards and controls that comply with the *Anonymisation: managing data protection risk code of practice*[1] published by the Information Commissioner, and data sharing agreements. These aspects will be covered as part of the usual contract negotiations between service providers and commissioners.

[1] https://ico.org.uk/for-organisations/guide-to-data-protection/anonymisation/

3 Analysis Requirement

3.1 Overview of analysis requirements

In order to understand and improve the Urgent and Emergency Care systems across England, CCGs are required to measure, monitor, report and, where appropriate, action improvements to the system, based on robust analysis of system activity.

This will require a range of analyses to assess system usage (volumes, rates, identification of frequent users etc.), system entry and exit (treatments and dispositions, arrivals, admissions and discharges) and inappropriate system usage (driven by patients or the service).

To do this, it is imperative that local health economies understand how and when patients access the system, how they navigate through the system and how patients exit the system. In order to provide a standard suite of reports and analytical tools, it is critical that consistent data be available across all CCGs.

In order to achieve the requirement outlined above, the commissioning support organisations will need to be able to link these datasets through pseudonymised patient identifiers.

3.2 Analyses anticipated from dashboards

Basic metrics:

- Volumes – number of calls, attendances, emergency admissions between selected dates – output in charts and tables
- Rates – calls, attendances, emergency admissions per 1,000 commissioner population between selected dates – output in charts and tables

Activity analysis:

- 111 disposition data (Allocated Care Type) i.e. Ambulance dispatch, Recommended to attend A&E or Urgent Care equivalent, Recommended to attend primary and community care, Recommended to attend other service, Not recommended to attend other service – output in charts and tables
- A&E Activity (source / disposal, diagnosis and treatments, In/Out of hours, time spent in A&E) – charts and tables
- Emergency Admission Activity (admission/discharge methods, HRGs, procedures, diagnosis, LOS) – charts and tables

In all three cases, also produce charts and tables of frequent callers, attenders, admissions above a user defined threshold between specified dates and a range of other selections such as time of day / day of week available

Patient characteristics such as age, sex, and incident location, will also need to be analysed for all delivery points. This will be possible by the use of the unique pseudo identifier within the system to link back to the source data within appropriate DSCRO services.

3.3 Advanced analyses to be provided

A **Data Quality** Indicator must be calculated to provide the context for the robustness of the analyses reliant on linked data (NHS Number present in 111 dataset)

Minimum of 4 metrics are suggested to understand the UEC system further:

1. Patient calls 111, advised to attend A&E and attend within 24 hours - A&E treatment and discharge type.

2. Patients calls 111, advised to attend A&E but do not attend within 24 hours.

3. Patient calls 111, advised a disposition other than A&E, but attends A&E within 24 hours - A&E treatment and discharge type.

4. Patient calls 111, advised a disposition other than A&E, but is admitted to a hospital within 24 hours – Emergency admission treatment and discharge type.

The above 4 metrics will be able to be interactively viewed at a national, regional, STP and CCG level as appropriate by the analysis users (including commissioners and urgent care networks). Patient level characteristics will need to be analysed for all 4 metrics through further dynamic interaction with the system as outlined in the functionality and presentation section above, using for example, time of day / day of week, to understand pressure points.

In addition, further guided drill down and a delivery point perspectives will be provided. Accessing these metrics pre and post system changes will also help in the evaluation of the effectiveness of system changes. The unique pseudo identifier within the system outputs will be able to be used to link back to the source data within appropriate DSCRO services to support the additional use of identifiable data items such as age, sex, incident location, and other patient demographics enabling further analysis of these identified cohorts above.