

NHS Community Health Services Data Plan, 2024/25 to 2026/27

April 2024





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Summary

Community health services (CHS) are key to the NHS's mission to deliver high-quality, safe and co-ordinated care, closer to home for patients, who are at the heart of everything we do. However, the health and care system cannot consistently draw reliable insights from CHS data at national, system or local level, to optimise and improve services, patient care and outcomes across care pathways.

The sector is diverse, including NHS trusts, community interest companies, independent organisations and hospices. There is highly variable digital and data maturity across provider organisations, and challenges including data quality, timeliness and relevance. This plan builds on existing health data strategies, including [Data Saves Lives](#) and the [Plan for Digital Health and Social Care](#), to address these challenges. It sets out the actions NHS England is taking (summarised in Annex A) and suggested actions for providers and integrated care boards (ICB).

Our long-term vision is a single source of the truth about community health services from which the NHS can easily draw the timely, actionable insights we need. To overcome the challenges and deliver this vision, we are focused on the following solutions over the next three years:

- modernise CHS data architecture
- define core data requirements
- standardise definitions of community health services
- targeted data quality improvement
- support the development of provider data capabilities.

By working together with providers, ICBs and others we can unlock the full potential of CHS data to improve patient care in and beyond community health services. We would like to thank everyone that inputted into the development of this plan, which included providers, systems, national and regional NHS England colleagues and people with lived experience.



Case for change

CHS data currently plays an important role in our understanding of community health services (see case studies, Annex B). It includes aggregate collections capturing [CHS waiting lists](#), [delayed discharges from community beds](#) and [community bed capacity](#), patient-level collections including the [Community Services Data Set \(CSDS\)](#) which is used to [measure performance against the 2-hour urgent community response \(UCR\) standard](#), and data requests from local commissioners. However, there are multiple barriers to CHS data being a powerful insight tool to plan and optimise care at individual, population and national level.

At provider level, collecting accurate data about community services can be challenging due to variable digital and data maturity, and capacity constraints. Limited interoperability (information flow across organisations) of provider IT systems and complex information governance (IG) procedures make it difficult to deliver and plan joined up, integrated care locally. The smallest organisations do not necessarily have an Electronic Patient Record (EPR) and where EPRs exist, they are often not suitable for community health services.

The burden on providers of reporting data is high relative to the benefits. Collection methods are relatively manual and national data is not timely enough or consistently collected at patient-level to be widely used by ICBs to plan and optimise care across care pathways (which requires patient-level health data to be linked). This means providers are duplicating flows of data locally and nationally.

The breadth of CHS data and formats in which it is made available also make it challenging to navigate and use. The diversity of community service delivery is challenging to reflect in national data specifications, which undermines confidence in the reliability of data to tell us what is happening across the country. There is a lot of data, but there are key gaps in user's need to understand health inequalities, patient outcomes and experiences, and quality of care in community health services.

This lack of use leads to poor data quality and limits what it can reliably tell us about community health services, leading to a cycle of low use and poor quality. The more community data is used, the faster it will improve.



Vision and aims

This vision was developed with stakeholders from across the sector.

Data about community health services is relevant, good quality, linkable, consistently defined and of low burden for providers to collect.

There is a single source of the truth about community health services from which the NHS can easily draw the timely, actionable insights we need to deliver high quality, safe, personalised care, and best outcomes for people.

To achieve this, we are focused on four aims:

1. **Reduce the time to insight:** Data needs to show what is happening in community health services in as close to real time as possible, to generate insight that helps shape interventions and improvements to services, patient outcomes and experiences.
2. **Reduce the burden on organisations:** It needs to be low burden for providers to collect good quality, timely data, to share it securely with those who need it and to draw insights from it.
3. **Improve data quality:** There needs to be confidence in the accuracy of CHS data as a source of insight on which to base decisions about patient care and services.
4. **Increase alignment to user needs:** Data needs to consistently reflect what users need to know about community health services to support them to understand patient journeys across care pathways, and improve patient care and outcomes.


Solutions


NHS England are focused on taking the following actions to address CHS data challenges. Delivery is dependent on the progress of wider NHS plans regarding data, digital transformation and community care. The additional investment in NHS digital and information technology in the [Spring 2024 Budget](#) is also an enabler.



- 1. Define core CHS data requirements:** Data needs to reflect what users need to know about community health services.
 - 1.1. With input from providers, we have developed a core, streamlined national CHS data specification as part of the [Community Faster Data Flows \(FDF\) Programme](#). This will be iterated over time to support NHS priorities and operational decision-making at local and national level.
 - 1.2. By April 2024, we will produce a roadmap for CHS data development that recommends what national data will be collected in future and how, and an overarching data model that reflects user requirements and priority models of care.
 - 1.3. CHS data also needs to be agile to changing priorities. By September 2024, we will establish transparent change processes for all national CHS specifications, with appropriate governance.
 - 1.4. CHS data increasingly needs to capture clinical outcomes, and patient outcome and experience measures, to assess pathways of care and improve delivery of community health services. We will work with the sector to develop such measures for specific priority pathways or patient cohorts, based on community priorities.
 - 1.5. Finally, core CHS data needs to continue to include items required to develop both a patient-level information and costing system for community, and community currencies. This will support identification of patients across pathways and settings and maximise use of NHS resources.

- 2. Standardise definitions of community health services:** To understand and compare what is happening in community health services across the country, we need clear and consistent measures and definitions of services.
 - 2.1. Standardising definitions and measures of community health services is challenging given the diversity of services. However, without a degree of standardisation, unwarranted variation and inequalities cannot be reliably identified, making it difficult to deliver equitable patient care and value for money for the public.
 - 2.2. By March 2025, we will review guidance for national CHS data specifications to ensure it is clearly defined which providers and services are in scope, and on an ongoing basis work with the sector to develop definitions for specific community services based on community priorities.

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- 2.3. Tackling long waits for community services is a top priority. By November 2024, we will develop a method of measuring waiting times in community health services at record level to provide reliable, comparable information about waits across the country.
 - 2.4. With more consistency in CHS data, benchmarking tools such as [the Model Health System](#) will become even more useful and we can effectively tackle unwarranted variation and drive improvement.
- 3. Modernise CHS data architecture:** A data architecture describes how data is managed, from collection through to transformation, distribution and consumption. CHS data architecture needs to enable near-real time data to generate insight that supports operational decision making. It also needs to provide low burden mechanisms for providers to collect and share data securely with those who need it.
- 3.1. The [FDF Programme](#) aims to provide timely high-quality data to support decision making by implementing an automated, record-level daily data collection. It seeks to reduce the reporting burden on providers by enabling rationalisation of current data collections from NHS England and ICBs. Early adopter providers are submitting patient-level data against a core specification (described at 1.1) and pseudonymised data is flowing into a secure platform controlled by NHS England.
 - 3.2. A phased approach to onboarding all CHS providers to Community FDF is planned to start from May 2024, based on learning from the early adopter phase and formal evaluation, and alongside a national support offer. Providers will flow a core specification of data into the [Federated Data Platform \(FDP\)](#) where it will be available to participating providers and their ICBs.
 - 3.3. A long-term aim is to move to a single source of community data which can be used for operational purposes by providers and systems and provide data required for secondary uses within the NHS at system, regional, and national level.
 - 3.4. Decisions about the future of existing CHS datasets, including the CSDS and SitReps, will only be made once FDF has been robustly tested and following appropriate review and consultation with data users. By May 2025, we will review CHS datasets to inform decisions and plans regarding transition to automated, daily data flows.
 - 3.5. The ambition is that CHS data is increasingly able to be linked with other health and care data within secure, accessible and interactive data platforms to provide the NHS



with greater insight into the whole patient pathway. Alongside this, we recognise the need for an aligned, strategic approach to primary care and CHS data development that supports integrated care, and will develop this by March 2026.

- 3.6. More timely data will support data quality improvement and, by April 2025, we will develop data visualisation tools for Community FDF, including feedback on data quality, to enable providers to identify and make improvements quickly.
- 3.7. Reducing any unnecessary data collections will also support progress towards [NHS Net Zero](#) by minimising emissions associated with data storage. By March 2026, we will assess the carbon emissions associated with Community FDF.

Faster Data Flows

Benefits to providers:

- quickly see the data they have reported in an accessible visualisation platform.
- management information available in near-real time.
- manual reporting replaced by or reduced with automated flows, freeing up staff time. ICBs and NHS England will be able to pull reports at different times for different purposes from a single source, enabling local flows and/or national aggregate collections to be reduced or stopped.
- ability to compare performance and activity to other providers.


Benefits to ICBs:

- close to real time activity data for response and recovery planning, individual care co-ordination and identifying pressures before crisis.
- access to same flow of data as their providers, supporting collaborative working.
- provides historical and planned activity data for a full view of capacity.
- access to a visualisation platform to draw insights into their system easily and quickly, and compare performance to other systems.

4. **Targeted data quality improvement:** The NHS needs confidence in the accuracy of CHS data as a source of insight; in particular, to tackle health inequalities, target improvement at particular cohorts of patients, and for effective workforce planning.



- 4.1. We will continue to provide targeted support to providers to improve the quality of data items that support CHS priorities, which will evolve over time.
- 4.2. To tackle health inequalities we will develop plans to improve data on the ethnicity, deprivation, gender, age and specific clinical conditions identified in [Core20PLUS5](#) of those people who need community health services.
- 4.3. To improve care for cohorts of patients across health settings, we will develop plans to support the consistent use of clinical coding such as diagnosis (condition) in CHS data.
- 4.4. Reliable information about the CHS workforce is vital to support appropriate staffing, so we will work with DHSC to ensure community health service representation in any plans to review the National Workforce Data Set from April 2024.
- 4.5. Finally, we recognise providers face multiple demands and challenges and therefore by April 2026, we will review possible financial incentives, and financial and regulatory levers, that could support CHS data quality improvement.
5. **Support development of providers' data capabilities:** All providers of community health services should have the capability to record, flow and use good quality data, supported by the right tools and resources.
 - 5.1. Digital transformation of CHS is fundamental to improving data and services. We will continue to engage with clinical IT system suppliers and providers to support Integrated Care Systems (ICS) to address the challenges providers of community health services face with EPR system functionality, procurement and interoperability (ease of information flow between IT systems across organisations). And by April 2025, we will review the NHS approach to CHS information standards, which would enable easier information flow across providers and to systems.
 - 5.2. We recognise less digitally mature providers can find it challenging to flow data against national specifications and may need support as we modernise CHS data architecture. By March 2025, we will engage with less digitally mature providers to understand their needs, and design any appropriate national support for them to subsequently flow data.
 - 5.3. Good practice in improving and using CHS data, and overcoming barriers, needs to be shared across providers and ICSs. Demonstrating where data has improved care



and services will encourage its use across the NHS, in turn driving up quality. By September 2024, we work with NHS England regions to develop and implement an effective approach to harnessing and spreading good practice across the sector. And by November 2024, we will develop guidance for CHS providers on what good data quality looks like.

Recommended actions for providers and ICBs

Our vision for CHS data will only be realised through system-wide, partnership-based working. ICBs should already be assessing their digital maturity and developing strong digital foundations for CHS data, based on the [What Good Looks Like Framework \(WGLL\)](#) framework and using the [ICS Intelligence Functions toolkit](#) to develop their use of data. The following actions to consider were identified following engagement with providers and ICBs.

CHS providers

1. Onboard to the [Community FDF Programme](#) from 2024/25 and consider how you can best use this data flow operationally.
2. Develop a plan for CHS data management, use and improvement, with input from clinical and non-clinical staff. See [guidance](#) on what this should include.
3. Have a named strategic lead for CHS data, and clear roles and responsibilities for driving CHS data improvement in your organisation.

ICBs

1. Encourage your commissioned providers of community health services to onboard to the [Community FDF Programme](#) from 2024/25.
2. Use daily flows of data from Community FDF and identify opportunities to rationalise local flows from your providers as a result.
3. Develop a strategic plan for CHS data management, use and improvement in your ICS, with input from clinical and non-clinical representatives. See [guidance](#) on what this should include.
4. Have a named strategic lead for CHS data and clear roles and responsibilities within your ICB for driving system-wide data improvement.

Next steps

We will develop national implementation plans and work with the CHS sector and system leaders to deliver the actions and realise the ambitions in this plan.

Please follow our [FutureNHS page](#) for updates, or contact england.communityhealthservicesdata@nhs.net

Annex A: Summary of NHS England actions

The following table lists all the actions NHS England has committed to delivering in this plan.

Action	Delivery/start date
Produce a roadmap that recommends what and how national CHS data will be collected in future, and an overarching data model that reflects user requirements and priority models of care.	By April 2024
Work with the Department of Health and Social Care (DHSC) to ensure CHS representation in any plans to review the National Workforce Data Set, to ensure it provides reliable information about the CHS workforce.	From April 2024
Start a phased approach to onboarding all CHS providers onto Community FDF, based on learning from an early adopter phase and formal evaluation, and alongside a national support offer.	From May 2024
Establish transparent change processes for all national CHS specifications, with appropriate governance.	By September 2024
Work with NHS England regions to develop and implement an effective approach to harnessing and spreading good practice across the sector.	By September 2024
Develop a method of measuring waiting times in community health services at record level.	By November 2024
Develop guidance for CHS providers on what good data quality looks like.	By November 2024

Develop data visualisation tools for Community FDF, including feedback on data quality to enable providers to identify and make improvements quickly.	By April 2025
Review guidance for national CHS data specifications to ensure it is clearly defined which providers and services are in scope.	By March 2025
Engage with less digitally mature providers to understand their needs and design any appropriate national support for them to subsequently flow data.	By March 2025
Develop data visualisation tools for Community FDF, including feedback on data quality to enable providers to identify and make improvements quickly.	By April 2025
Review the NHS approach to CHS information standards.	By April 2025
Review existing CHS datasets, with appropriate consultation with data users, to inform decisions and plans regarding transition to automated, daily data flows.	By May 2025
Assess the carbon emissions associated with Community FDF.	By March 2026
Develop an aligned, strategic approach to primary and CHS data development that supports integrated care	By March 2026
Review possible financial incentives, and financial and regulatory levers, that could support and incentivise CHS data quality improvement.	By April 2026
Develop plans to improve data on the ethnicity, deprivation, gender, age, and specific clinical conditions identified in Core20PLUS5, of people who need community health services.	Ongoing
Develop plans to support the consistent use of clinical coding such as diagnosis (condition) in community data.	Ongoing
Work with the sector to develop definitions for specific community services, based on CHS priorities.	Ongoing
Work with the sector to develop clinical outcome, and patient outcome and experience, measures for specific priority pathways or patient cohorts based on CHS priorities.	Ongoing

Engage with clinical IT system suppliers and providers to support ICSs to address the challenges providers face with EPR system functionality, procurement, and interoperability.	Ongoing
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Annex B: Case studies

Case study 1: CHS SitRep supporting CHS recovery

The [Community Health Services SitRep](#) is the key mechanism that allows NHS England national and regional teams to assess community waiting time and waiting list information. Nationally, this data has improved our understanding of the backlog across community health services, enabling us to identify and analyse long waits, and provided a more standardised view of waiting lists across the country. This has informed our CHS recovery planning, enabling us to develop a programme of work to reduce waits for patients community health services.

NHS England regions also use the SitRep in work with systems to set realistic ambitions for provider and service improvement, and to manage their waiting lists. For example, the London region uses the data to monitor waiting lists, analyse the backlog and waiting times across all reporting months, benchmark with other regions, and review trends and highlight issues at service level.

Case study 2: CSDS supporting UCR service delivery

2-hour UCR services provide urgent assessments, care and treatment while people recover in their own home or place of residence, to keep them out of hospital. Transparent data has enabled UCR services and NHS England to effectively monitor the national standard of 70% of 2-hour crisis response demand met within 2 hours. The [National UCR Power BI dashboard](#) uses the CSDS monthly data to provide a system-level view of UCR activity and performance. Almost all UCR providers are now submitting data to CSDS.

Using the dashboard, the NHS England East of England team can understand the scale of demand for 2-hour response by referral reason, which has highlighted those conditions for which large numbers of the population are requiring a crisis intervention. They have also used the dashboard to work with provider business intelligence teams develop a consistent approach to mapping activity, which will allow meaningful comparison between services in the future.

