# **Data Into Action**: Data Led Models, Support Document

## 1. Introduction

This guide outlines a comprehensive plan for the successful rollout and implementation of data led and risk stratified models of care across local services. It is intended for programme leads, operational teams, clinicians, analysts, and all stakeholders involved in the adoption and use of linked data tools at Place level.

This document is intended as guidance for the processes outlined, however the Data Into Action programme does not act as a governor for any of the proposals submitted to the programme for approval. The role of the Data Into Action Programme is to process approvals for data access.

Requesters should contact the Data Into Action via dataintoaction@cheshireandmerseyside.nhs.uk for access to all documents referred to in this guidance. This document covers the end-to-end rollout process, from onboarding and training to governance and ongoing support, including the pathway for accessing both Personally Identifiable Data (PID) and de-identified data. The guide is based on lessons learned from our rollout to some areas across Cheshire and Merseyside and is designed to be practical, adaptable, and replicable.

2. Project Overview

The rollout of risk-stratified, data-led models of care is a key priority for Cheshire & Merseyside ICB, as with programmes such as Data Into Action already well-established and working with ICB functions such as Business Intelligence and the Population Health team to help shape national direction, a position further reinforced by the latest Neighbourhood Health guidance. System data can act as a catalyst for greater clarity, alignment and impact of models of care, but this does require co-ordination and management to mobilise safely and effectively. Many services have now adopted data led models, with additional services developing proposals to use the dashboards available. This document aims to help with that process and includes core topics around data access and how to get help. This is an iterative process, and we intend to build upon these resources over time.

### Governance and Oversight

It is recommended to establish or repurpose existing local governance to provide strategic direction and oversight of all proactive work. An example terms of reference for a Population Health Management Group (Proactive Care) are included within this blueprint. This group, once established would meet monthly, ensuring alignment with local health priorities and monitoring progress.

It is suggested that this group is chaired by the Place Clinical Director and involves representatives from primary care, relevant Community Providers / Mental Health Providers are and the ICB.

### CIPHA Data and Dashboards

The **CIPHA (Combined Intelligence for Population Health Action)** platform provides secure access to linked health and care data. It supports proactive decision-making, better planning, early intervention, and targeted service delivery, particularly for high-risk populations and addressing health inequalities. The data within CIPHA includes:

* GP data including diagnosis, long-term conditions, personal data
* Community data
* Mental health data
* Acute data
* Risk stratification algorithms using the Johns Hopkins model

This data is linked together to provide a set of insightful dashboards which can be used to identify patient cohorts, trends and characteristics to support the identification, implementation and monitoring of a variety of care models. These dashboards are available in both personally identifiable (PID) and non-personally identifiable (“de-identified) versions

The dashboards currently available include:

* Enhanced Case Finding
* Fuel Poverty
* Complex Households
* Elective Recovery
* Frailty
* Diabetes
* High Intensity Users
* Serious Violence (available in de-identified version only)

Some members of staff, such as commissioners and those not involved in direct patient care, will use the non-identifiable versions of these tools. Those in clinical roles may need access to the identifiable version of these dashboards and are required to seek approval from the Data Access & Asset Group in those cases.

### Example Use Cases and Pilots

* Telehealth: Targeting high-risk patients with COPD, heart failure, and diabetes.
* Integrated Care Neighbourhood Teams: HIU Pilot, identifying high A&E users for holistic assessments, revealing needs for more mental health support. Frailty project – identifying elderly frail with a range of health conditions alongside social determinant issues.
* Diabetes: Enhanced Case Finding and targeting individuals with high HBA1C and A&E attendances.
* High Intensity Users Pilot: Identifying high A&E users for holistic assessments, revealing needs for more mental health support.
* Community Respiratory Team: Using PID data to identify and review patients with respiratory conditions and exploring access to the Fuel Poverty dashboard.
* Chronic Kidney Disease: Criteria development in progress a risk stratified model to support those most vulnerable patients.

These examples show how data-led proactive case finding, enables earlier interventions, better care coordination, and alignment with broader health aims.

## 3. Onboarding Process

The onboarding process ensures the safe and effective use of linked data dashboards by local services. It follows a step-by-step approach for services to trial the tool and apply for PID access.

### Access to non-identifiable dashboards

Organisations and associated staff that have signed up to the Population Health Data Sharing Agreement can obtain access to the non-identifiable versions of the available dashboards containing data for their own organisations with relative ease. NHS trusts, Local Authorities, and approved partner organisations can access non-identifiable population health data for planning, monitoring, and improving services. These tools provide valuable insight from LSOA and ward level up to the Cheshire & Merseyside footprint. They are often used as a preliminary to any direct care models requiring identifiable data, as they give the opportunity to test scenarios, assess population needs and explore potential proactive criteria.

In order to access de-identifiable dashboards for your own organisation, complete the access request form with details of your role and the dashboard needed and email this to cipha.support@midmerseyda.nhs.uk

### Access to Personally Identifiable (PID) Dashboards

This PID version of the dashboards can only be accessed and used by services for the purpose of direct patient care, in line with Caldicott principles and information governance requirements.

Getting access to dashboards with PID requires engagement with a process which is overseen by the Data Asset and Access Group (DAAG), which operates within the Cheshire and Merseyside ICB Data Into Action Programme. There are strict criteria which must be satisfied in order to get access to identifiable data and it is important to allow sufficient time for this process when planning a project requiring this type of access. The Data Into Action Team can help support data access requests, and hosts regular ‘clinics’ that people can book into for advice and support. Please email dataintoaction@cheshireandmerseyside.nhs.uk to request a booking.

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| **✅ Top Tips for the Data Access Request Process:**• Clear purpose: Ensure you have a clear purpose and use case for access to the data; DAAG will need this to approve any access.• Engage the Data into Action Programme early: Discuss your initial thoughts/plans on the access needed and for what purpose with the DIA team. This will help to identify any potential challenges and issues early in the process and will provide advice on how best to progress with the request. Email: dataintoaction@cheshireandmerseyside.nhs.uk• Engage with general practice early on in the process: Local GP-led organisations such as the Local Medical Committee or Primary Care Networks are key stakeholders in the development of these projects. Early engagement with them is essential to gather feedback, secure support, and ensure the project aligns with primary care clinical priorities. This engagement should ideally be facilitated or overseen by the relevant Place Proactive Care Group.• Alignment with local services/Place: Work with Place leads to ensure the project aligns with other plans and projects underway. It is important to put the patient at the heart of these designs, avoiding multiple contacts from different teams, and ensuring that the most relevant team is the first to offer support. As noted in section 2 above, this co-ordination will ideally be managed via a Proactive Care Group at Place level or similar governance structure.• Despite this direct access, services must still work closely with GP practices as often they do need their engagement to help establish the legal basis for direct care. |

### PID Access for GP Practices

As the data controllers, GP practices can access the identifiable versions of dashboards for their own practice’s data without having to request access from DAAG. Complete the access request form with details of your role and the dashboard needed and email this to cipha.support@midmerseyda.nhs.uk

### PID Access Process for Secondary Care Teams, Community Providers and Local Authorities in developing community models.

1. Develop draft proposal engaging key stakeholders including primary care representatives using the non-identifiable version of the dashboard.
2. Work with the local Population Health Management Group (Proactive Care) (or similar governance) to seek local feedback and support.
3. Discuss with DIA team to determine if there is a likely precedent in place with a comparable team / model.
4. Complete a Data Access Policy Amendment (DAPA) form for DAAG to consider the suitability of the request, it’s compliance with the data sharing agreement and relevant information governance rules. Once access has been granted, the DIA Team will ensure that appropriate access is granted.
5. Pull patients lists and engage the GP Practices with your plans, providing them with the options to ratify the list of patients or for their practice to opt out of the intervention.
6. Once authorisation has been provided, contact can be made with patients, and the project can move to delivery.

### PID Access Process for PCNs

In order for PCNs to access identifiable data, for example one GP Practice requesting access for the PCN as a whole, the Data Access Policy Request form still needs to be completed and sent to dataintoaction@cheshireandmerseyside.nhs.uk. However if the chair of DAAG agrees that an appropriate precedent is in place, access can be granted immediately, and then the request will be presented to the next DAAG meeting for noting. A copy of the DSA between Practices within the PCN will also need to be supplied.

## 3. Example Step-by-Step Rollout Plan Using Non-PID data

In many cases, an exploratory phase can be carried out using non identifiable data. Some example steps for this approach are below:

1. Initial Access: Services are granted access to the non-PID version to explore dashboards and develop initial search criteria.
2. Define Target Cohort: Services define the patient cohort based on clinical or demographic criteria.
3. Generate Patient List: The service generates a non-PID list based on the defined criteria.
4. Partner with GP/PCN: The service collaborates with a local GP practice or PCN to test an approach based on a proposed criteria (20–30 patients).
5. Referral and Case Management: Identified patients are referred by the GP based on proposed criteria
6. The service reviews, treats and supports the patient as expected with this new model of care.
7. Evaluation and Learning: The approach is evaluated, and findings are shared with the Steering Group.
8. Applying for PID Access: If the pilot is successful, the service applies for full PID access following governance approval.

**Important:** *Approval is granted only for the specified cohort criteria and does not permit unrestricted use of the dashboard.*

**Important:** In all instances, services must recognise that they are acting as an *agent of the GP practice, establishing a direct care relationship on behalf of the Practice*. These are the GP’s patient lists, and practices must be:

* Informed of any case-finding activity
* In agreement with the approach
* Consulted before any patient is contacted
* Provided with feedback through appropriate channels (e.g. EMIS, discharge letters)

## 4. Training, Support & Peer Learning

Training is available through the Data into Action Academy which provides a comprehensive three-month programme for professionals involved in service delivery across the Cheshire and Merseyside Integrated Care System. The Academy includes:

* Virtual workshops
* Active learning sets via Microsoft Teams
* CPD accreditation (10.5 points)

### Peer Learning and Community Support

Services benefit from a collaborative learning environment where experiences and best practices are shared. Peer-to-peer support enhances effective tool use across services. We have a number of services across C&M who have adopted the use of these approaches who would be supportive of providing peer-to peer support, please contact us if you would like to know more about our peer support offer.

### Additional Resources

Short video demonstrations of tool functionalities are available. For more information, contact the Data into Action team.

Additional, bespoke training sessions and Masterclasses may be able to be arranged if there is a requirement to help mobilise a project.

## 5. Referral Pathways & Coding Requirements

### Referral Approaches

Two referral models are available based on data access:

1. GP/PCN-Led Referral Approach: Services generate non-PID lists, and GP practices run the same search to create PID data for referrals.
2. Service-Led Referral Approach with PID Access: Services with PID access can directly identify, contact, and manage patients.

*In both approaches, services must still work closely with GP practices to ensure:*

* Patient eligibility and suitability is agreed upon.
* GPs remain informed about all patient activity and outcomes.
* Feedback is routinely shared via EMIS entries, discharge summaries, or other established channels

### Suggested Coding Requirements

To support tracking and evaluation, services could apply the following SNOMED codes in the patient’s GP record:

* Proactive Care Ended
* Targeted Proactive Care Needs Assessment
* Targeted Proactive Care Needs Assessment Declined

**Sample Onboarding Checklist**

* ☐ Confirm service criteria and readiness
* ☐ Access non-PID version of tool
* ☐ Define and run search criteria
* ☐ Identify GP practice for collaboration
* ☐ Case manage initial cohort (e.g., 20–30 patients)
* ☐ Capture outcomes and submit evaluation
* ☐ Apply for PID access (if needed)
* ☐ Complete IG and approval documentation

**Training Materials**

* Video demos for case finding and tool navigation
* Quick-start guides for new users
* Case study examples from other services
* Information on the Data into Action Population Health Management Academy: [Data into Action](https://dataintoaction.cheshireandmerseyside.nhs.uk/academy/)

**Approval Forms/Templates**

* CIPHA User Access Request Form (Non PID or PID)
* DAAG & LMC Data Access Policy Form
* Data Sharing & Risk Stratification Guidelines
* Coding for Enhanced Case Finding Patients

For access to the above documents, contact the Data Into Action team.