NHS
Shropshire, Telford and Wrekin

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RISK STRATIFICATION POLICY

VERSION CONTROL

Document Location

This document is only valid on the day it was printed.

The current version of this document will be found in the shared drive

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Version	Date	Author	Change Description
1.1	02.05.19	Sara Spencer	First draft for circulation and discussion at Audit Committee
1.2	21.05.19	Sara Spencer	Final agreed paper
1.3	01.12.2021	Sara Spencer	Policy amended to reflect single commissioner CCG with Telford & Wrekin

Approvals

This document requires the following approvals:

Name / Committee	Title (if individual)
Claire Skidmore	SIRO
Shropshire Telford & Wrekin ICB Audit Committee	
Nick White	Caldicott Guardian

Distribution

This document has been distributed to:

Name and job title / External organisation / 'All staff'	Date of Issue	Version
All Shropshire Telford & Wrekin CCG ICB Practices	Jan 2022	1.3
Information Governance Teams and Business Intelligence leads at Midlands and Lancashire Commissioning Support Unit	Jan 2022	1.3
Global notice to all staff that the Policy is available on the S: drive	Jan 2022	1.3

Introduction

Purpose of Policy

1. This policy provides the organisation with the actions agreed necessary to ensure that Risk Stratification is undertaken in line with current legislation.

2. The required actions are set out in the document 'CAG 7-04(a)/2013 compliance for CCGs' published by NHS England: http://www.england.nhs.uk/ourwork/tsd/ig/risk-stratification/ and are included in summary in this policy.

3. Each organisation must submit an assurance statement that is signed off by NHS England to be included on the Risk Stratification register. Once on the register, the organisation has a lawful basis for appropriate data use, provided that the conditions of processing are met.

Risk Stratification

Risk stratification tools have had a profound impact on the delivery of health services across the developed world. These tools use relationships in historic population data to estimate the use of health care services for each member of a population. Risk stratification tools can be useful both for population planning purposes (known as "risk stratification for commissioning") and for identifying which patients should be offered targeted, preventive support (known as "risk stratification for case finding").

NHS England's position statement

4. NHS England encourages ICBs and GP practices to use risk stratification tools as part of their local strategies for supporting patients with long-term conditions and to help prevent avoidable unplanned admissions.

5. NHS England has asked ICBs to take the lead in agreeing the details of the risk stratification with their participating GP practices so that the arrangements support the ICB's wider strategy for patients with long-term conditions.

6. ICBs may themselves commission risk stratification services to support commissioning decisions more generally (risk stratification for commissioning). In this case, knowledge of the risk profile of a population can be useful for commissioning wider preventive services and for promoting quality improvement across member practices.

7. In both cases, ICBs need the support and agreement of their member GP practices if risk stratification is to be conducted most effectively.

Policy Statement

8. The ICB will implement the requirements of the Risk Stratification Assurance Statement through the actions set out below.

i. Information Sharing Agreements drawn up and agreed between partners involved in the Risk Stratification Process. This will include the ICB, GP practices, other providers and the CSU or/and the Risk Stratification Supplier.

ii. A Data Protection and Impact Assessment (DPIA) completed by the ICB as per the Information Commissioners Office's (ICO) guidance. This may be undertaken jointly by all partner organisations involved in the risk stratification process.

iii. An ethical review takes place. Risk stratification is comparable to screening because it uses a population's data to identify individuals that are at sufficiently high risk of a Triple Fail event (such as an unplanned hospital admission) to justify offering a preventive intervention (such as the support of a community matron). However, any screening test has the potential to cause more harm than good; for example, by exposing patients to false positive and false negative results and for these reasons, strict ethical guidelines are required to safeguard against the inappropriate use of risk stratification. These are set out in Appendix A to the policy.

iv. The ICB has contracted with risk stratification suppliers to carry out risk stratification using accredited software. Following the ethical review completed by the CSU, the ICB selected a suitable risk stratification tool based on the following factors:

- the adverse outcome to be predicted;
- the accuracy of the predictions;
- the cost of the model and its software and;
- the availability of the data on which it is run.
- IG considerations

v. The responsible clinician will use their own clinical knowledge in conjunction with the ranked risk score for their patients automatically generated from the risk stratification tool to determine which patients would most benefit from support from alternative preventative services. The decision is based both on the risk stratification outputs and any other information known to them.

vi. The ICB will develop one or more preventative interventions that will be offered to high and moderate risk patients. Clinician's will refer patients to preventative services only with their consent. Within the Shropshire Telford and Wrekin ICB the risk stratification scheme offers opportunities to refer patients into :-

a) An integrated framework which introduces systems and processes needed to support individuals with and long term conditions through seamless proactive partnership working

b) 'Self Care' to empower and support patients in order to prevent or delay the development of a long term disease and also to help them better manage their health once a disease has been diagnosed. The Self Care element focuses on those patients at moderate risk.

The ICB may use anonymised data to support high level service planning and to understand the relative population that may fall under different risk scores

vii. The risk stratification process will be carried out in the following manner:

a. Data is received in a “de-identified data for limited access” form (i.e. NHS number as the patient identifier) or is pseudonymised on landing; **AND**
b. Processing is within a “closed box” with strict role based access control; **AND**
c. Re-identification is solely for the purpose of direct care and is available only to those with a direct clinical care relationship with the patient.
d. Any publication of data other than in accordance with c. above must be anonymised in line with the ISB Anonymisation for publication standard.

viii. The organisation responsible for undertaking the risk stratification processing ensures that a detailed process is written to outline:

- The secure mechanism for receipt and processing of data within the risk stratification tool
- Data retention periods and data destruction
- Audit trails in place and confidentiality audits enabled
- The minimum data set(s) necessary to be collected and processed
- Training for staff handling data for purpose of risk stratification
- Process for reporting breaches identified

A high level procedure based on the detailed process for risk stratification is included in the Data Processing Agreement for risk stratification and is attached at Appendix B.

ix. A privacy notice is in place for all patients and service users to inform them that their data may be used for risk stratification purposes. The privacy notice provides:

- an explanation of risk stratification,
- clarity about who the data controller and data processors are,
- a description of what type of data will be used for risk stratification,
- detail the rights individuals can exercise in relation to this i.e. the right to access their personal data and to object to its use for this purpose and how to exercise this right.

x. A process is in place to ensure patient objections can be handled and processed by the GP and CSU/risk stratification supplier.

Scope

9. This policy will apply to all GP practices and ICB staff within the membership of Shropshire Telford and Wrekin Integrated Care Board.

10. The following members of staff will have access to the identifiable data to support the clinical management of the patient by the practice staff:

- Data Quality Facilitators (Midlands & Lancashire CSU) and selected staff from MLCSU as the data processor.
- GP Practice staff to provide direct care

Roles & Responsibilities

12. Shropshire Telford and Wrekin ICB will commission a suitable risk stratification tool that is compliant with national guidance for use by themselves for high level service planning (anonymised data) and for practices use (patient confidential data)

13. Shropshire Telford and Wrekin ICB Practices will be able to access the risk stratification tool to explore the risk scores for their patients and to enable proactive referral to alternative services to take place with patient consent.

14. Midlands and Lancashire Commissioning Support Unit (MLCSU) will update and maintain the risk stratification tool on a monthly basis and ensure all processing of data is in accordance with national guidance.

Distribution & Implementation

15. This document will be made available to all Officers as follows :-

- Shropshire Telford and Wrekin ICB – Document saved and made available via the "Shared Drive" in the policies folder
- Shropshire Telford and Wrekin ICB Practices – Document to be emailed to practices via practice distribution lists
- Risk Stratification Supplier – Copy of document to be emailed to Information Governance and Business intelligence leads
- A global notice will be sent to all ICB staff notifying them of the release of this document.

Training

16. The ICB has a contract with Midlands and Lancashire CSU to provide the risk stratification service. The CSU is responsible for training staff. All staff are bound by the policies and procedures of NHS Digital as well as those of the CSU. All Staff complete mandatory Information Governance and Security training.

Monitoring

a. Compliance

17. Compliance with the policies and procedures laid down in this document will be monitored via each organisation (Shropshire Telford and Wrekin ICB / Shropshire Telford and Wrekin ICB Practices / MLCSU).

18. The ICB SIRO in conjunction with MLCSU Information Governance Team is responsible for the monitoring, revision and updating of this document.

b. Equality Impact Assessment

19. This document forms part of Shropshire Telford and Wrekin ICBs commitment to create a positive culture of respect for all staff and service users. The intention is to identify, remove or minimise discriminatory practice in relation to the protected characteristics (race, disability, gender, sexual orientation, age, religious or other belief, marriage and civil partnership, gender reassignment and pregnancy and maternity), as well as to promote positive practice and value the diversity of all individuals and communities.

As part of its development this document and its impact on equality has been analysed and no detriment identified. The Equality Impact Assessment is attached at Appendix C.

References

20. The following references can be accessed via the links provided:

- Data Protection Act 2018 available from http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted
- NHS Constitution: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx
- Access to Health Records Act 1990 available from https://www.legislation.gov.uk/ukpga/1990/23/contents
- Human Rights Act 1998 available from https://www.legislation.gov.uk/ukpga/1998/42/contents
- Freedom of Information available from https://www.legislation.gov.uk/ukpga/2000/36/contents
- Record Management available from http://www.nationalarchives.gov.uk/recordsmanagement
- Common Law of Confidentiality https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_5803173
- NHS Confidentiality- code of Practice available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253
- Caldicott Report available from: https://www.gov.uk/government/publications/the-caldicott-principles

Appendix A- Ethical Review

In 1968, The World Health Organization published ten prerequisites that should be met by any ethical screening program known as the Wilson and Jungner criteria; they have recently been adapted for risk stratification purposes:

i. The Triple Fail event should be an important health problem.
ii. There should be an intervention that can mitigate the risk of the Triple Fail event.
iii. There should be resources and systems available for timely risk stratification and preventive interventions.
iv. There should be sufficient time for intervention between stratification and the occurrence of the Triple Fail event.
v. There should be a sufficiently accurate predictive risk model for the Triple Fail event.
vi. The predictive risk model and impactability model should be acceptable to the population.
vii. The natural history of the Triple Fail event (i.e., the practices and processes that typically lead to the event) should be adequately understood by the organisation offering the preventive intervention.
viii. There should be an accepted policy about who should be offered the preventive intervention.
ix The cost of risk stratification should be “economically balanced” (i.e., it should not be excessive in relation to the cost of the programme as a whole).
x. Risk stratification should be a continuous process, not just a "once and for all" occurrence.

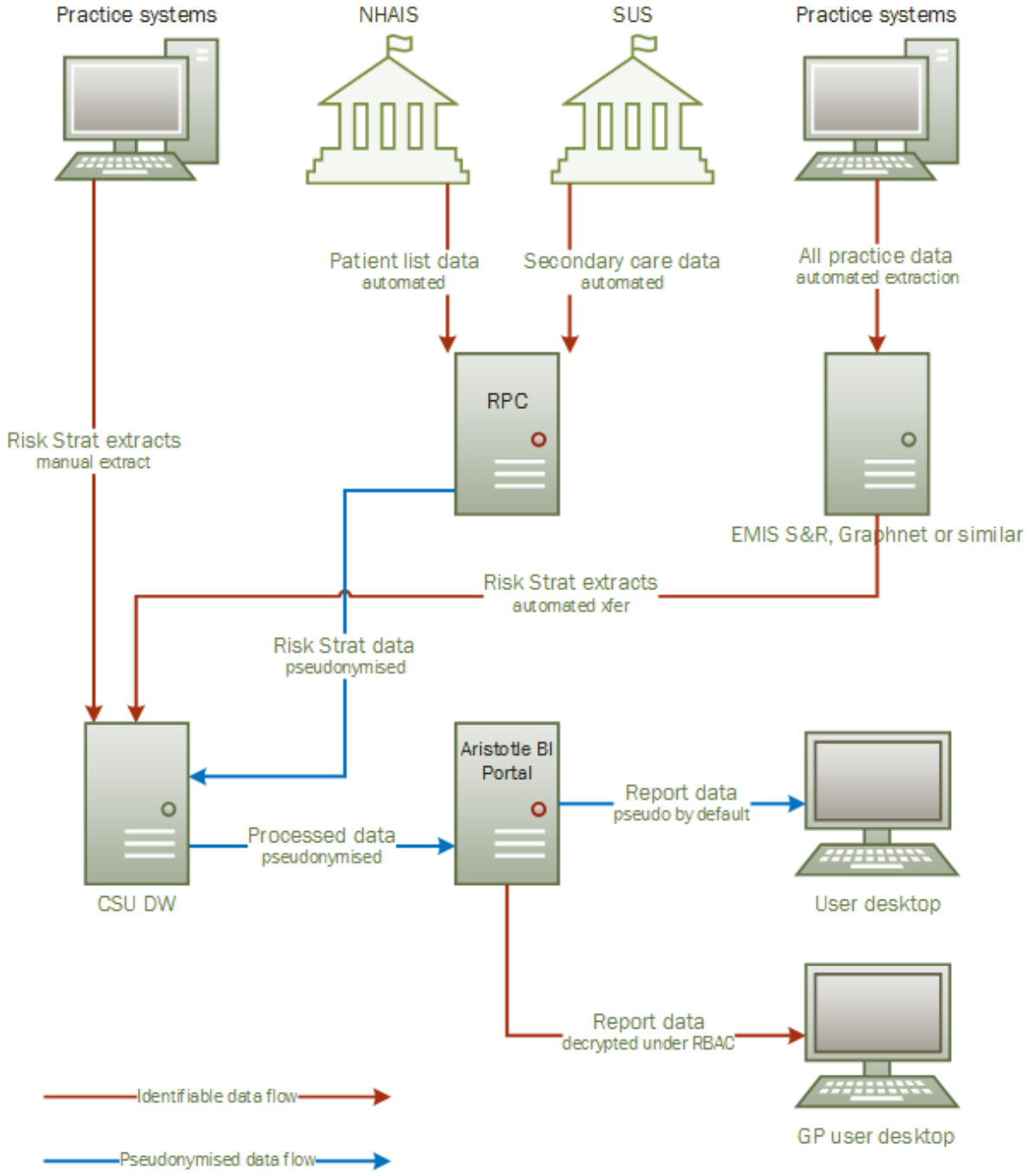
Source: Lewis et al., 2013, based on Wilson & Jungner, 196816

Appendix B – Risk Stratification Assurance Statement – Description of Policies & Procedure's in relation to Data and Security

Risk Stratification (RS) Assurance Statement

Description of policies & procedures in relation to data & SECURITY

DATA & data flow



Extraction of data from GP systems

Primary Care data is extracted from GP systems either directly by the Primary Care Data Quality team (PCDQ), via EMIS Enterprise Searches & Reports (EMIS-SR), via MIQUEST queries, or automatically via the Graphnet or similar centralised, hosted solution.

The PCDQ team request authorisation from the Practice prior to running any extract, and only extract the fields required for the Risk Stratification algorithm (essentially patient identifier, details of disease registers and other Read/SNOMED codes used by the algorithm – the precise specification for the data items used in the Combined Predictive Model runs to several pages and is not included here, but can be supplied on demand). Extracts are downloaded directly by the BI team or sent via secure FTP to the CSU, where the data is pseudonymised and then passed on to the CSU Data Warehouse for processing within the RS tool. Extracts are deleted once notification is received of successful transfer to live systems in the CSU Data Warehouse.

Data received via Graphnet or other centralised service is automatically transferred to the CSU using direct links or Secure FTP. An extract of data required for RS is then taken, pseudonymised, and passed to the CSU Data Warehouse for processing. Unused data is then deleted.

Patient List data and Secondary Care data

Patient list data (NHAIS data) and secondary care data (SUS data) are already flowing into the RPC under existing national s251 agreements. The recent s251 specifically covering Risk Stratification allows for the flow of identifiable data into the CSU for Risk Stratification purposes, however the CSU's current solution does not require this as it operates purely on pseudonymised data.

HANDLING PATIENT OBJECTIONS & SENSITIVE DATA

There are 2 types of automatic removal of data from use within the RS tool:

- Sensitive records – the record is not used by the risk stratification tool
- Dissent to share data – all records for the patient are removed from the risk stratification data feed

A full list of all the codes checked for is included as Appendix i.

In both case this process is handled within the CSU landing environment and no data is passed on to the main CSU servers for processing. PCDQ teams should also look to implement checking at the point of extract to ensure patient dissent is respected and the data would never leave the GP practice system in the first place.

Note that dissent to share *identifiable* data is not implemented, as the process already de-identifies the data before it is used within the RS tool, and only re-identifies for users with a legal right of access.
It should also be noted that if a patient dissents to share their GP data and this is implemented at the point of extract then they will still appear in the RS tool as we will not have this data to action.

Type 2 objections apply to data flowing out of the DSCRO for purposes other than direct care; all datasets used in Risk Stratification are passed through the HSCIC "washing machine" application to remove type 2 objectors from the data completely before it leaves the DSCRO.

Data Processing and reporting within the CSU

All data supplied to the CSU for use in the RS tool is pseudonymised. In this way the CSU solution is already compliant with the NHS England requirements for Risk Stratification (see useful links 3&4) by providing a solution where no identifiable data is used in the processing or made available to users without a direct clinical relationship with the patient. This process will be able to legally continue when the current s251 expires as it is not dependent on the flow of identifiable data from the DSCRO to the CSU.

Secondary care data is combined with primary care data and fed into the Combined Predictive Model (CPM) algorithm developed by the King's Fund. Risk scores are produced for each patient within a practice or CCG and ranked in a report available to Aristotle system users. A 'drill-through' function is provided to allow clinical users to see detailed information relating to the patient's medical history.

By default all the report data is presented in pseudonymised form and there is no facility for any unauthorised user to decrypt and discover the patient's NHS number in the clear. However, for authorised users with a direct clinical relationship with the patient, e.g. GP, Matron, then the NHS number is automatically decrypted at the point the report is run and presented to the user in the clear.

Note that no data is stored within the CSU systems in clear form.

The Combined Predictive Model Algorithm

The CPM algorithm was developed by the King's Fund as a successor to the PARR (Patients at Risk of Readmission) and PARR+ tools. The algorithm builds on its predecessors by combining secondary care data and GP practice data to give a higher level of predictive accuracy, particularly for patients with no recent history of secondary care treatment. In essence the model uses secondary care activity data and GP system data relating to long-term conditions and disease registers to predict the likelihood of emergency hospital admission within the next 12 months; patients are ranked and grouped into categories based on anticipated intervention level (case management, disease management, supported self-care, prevention & wellness promotion).

The development of the algorithm into a working tool was undertaken by the former Blackpool PCT, and included clinical input from GPs, Community Matrons and other clinical staff, as well as Public Health and statistical specialists.

The predictive accuracy of the algorithm has been improved slightly since its release as part of a piece of work commissioned by the former North West SHA, and subsequently validated by the University of Manchester.
In addition the former DSCRO:NW commissioned another piece of work to compare CPM with other Risk Stratification algorithms in current use around the country to see if further gains in predictive accuracy can be achieved; results from this are pending.

Retention policy

As outlined above, no clear GP system data is held beyond the point of being successfully processed, pseudonymised and passed on to the CSU Data warehouse for processing within the RS tool.

Historical SUS and patient list data is held in clear within the RPC in line with the retention policies of the HSCIC (usually between 5-7 years depending on the exact dataset).

Historical RS scores are held within the CSU Data Warehouse but only in pseudonymised form.

ACCESS AND SECURITY

Access to clear patient data within the DSCRO

All staff with access to clear patient data within the DSCRO have been seconded to the NHS Digital to give them legal rights to work with this data. All staff are bound by the policies & procedures of the HSCIC as well as those of the CSU, and mandatory Information Governance & security training is a necessary requirement of secondment.

Other Decryption of pseudonymised data

Only staff who have been seconded to the HSCIC are able to access the functionality to decrypt pseudonymised patient identifiers on an ad-hoc basis.

Authorised users have the patient NHS number decrypted automatically by the RS reporting tools but have no access to the functionality, or encryption keys, that underpin this process.

Role based access controls (RBAC)

All users of the Aristotle BI product (which delivers the RS reporting tools) are required to register and be authorised by an existing user designated as an approver. In the case of GP practices or other clinical users (e.g. Community Matrons) then access to clear patient data can also be granted but this too must be authorised by the agreed practice approver (usually the practice manager or a member of the GP team).

CCG and CSU users cannot have access to clear patient data in the Aristotle reports (the only exception to this is when HSCIC seconded staff are involved in product development tasks that require testing using clear data).

All users are offered training in the use of the Aristotle BI products including the RS reporting tools.

Andy Burns

Data Warehouse & Security Manager

14th February 2017

Appendix 1 – exclusion codes

The codes flagged below should be excluded at patient level; any patient with a record containing one of these codes should have ALL of their data removed from Risk Stratification processing (this includes removing them from the patient list as well), but this only occurs where that data is supplied to the DSCRO from GP systems. If data is excluded at source then we are unable to filter without a secondary feed.

Code	Description	Exclude
93C1.	Refused consent for upload to local shared electronic record	Y
93C3.	Refused consent for upload to national shared electronic	N
9M1..	Informed dissent for national audit	N
9R1..	Confidential patient data	N
9R11.	Conf data - patient not to see	N
9R12.	Conf data - not to be reported	Y
9R13.	Conf data - staff not to see	Y
9R14.	Conf data - paramedics not see	N
9R15.	Conf data - other Dr not see	N
9R1Z.	Confidential data NOS	N
9Nd1.	No consent for electronic record sharing	Y
9Nd9.	Declined consent for Primary Care Trust to review patient record	Y
9NdH.	Declined consent to share patient data with specified third party	Y
9NdJ.	Consent withdrawn to share patient data with specified third party	Y
9Oh8.	Personal risk assessment declined	Y
9Oh5.	Multi-professional risk assessment declined	Y
9Nu4.	Dissent from disclosure of personal confidential data by Health and Social Care Information Centre	N
9Nu5.	Dissent withdrawn from disclosure of personal confidential data by Health and Social Care Information Centre	N
9q7.	Declined consent for use of patient data in risk stratification for unplanned admissions	Y

These codes should be excluded at record level; any record containing one of these codes, or sub-codes, should not be used within the Risk Stratification tool (even in pseudonymised form)

Description	Code
HIV risk lifestyle	13N5.
HTLV-3 antibody test	43C%
Human immunodeficiency virus antibody level	43WK.
HIV antibody/antigen (Duo)	43d5.
HIV 1 PCR	43h2.
HIV1 antibody level	43W7.
HIV2 antibody level	43W8.
HIV viral load	4J34.
Antenatal HIV screening	62b..
AIDS contact	65P8.
AIDS carrier	65QA.
Notification of AIDS	65VE.
Advice about HIV prevention	67I2.
AIDS (HTLV-III) screening	6827.
Patient advised about the risks of HIV	8CAE.
Acquired immune deficiency syndrome	A788%
Human immunodef virus resulting in other disease	A789%
[X]Hiv disease resulting in other infectious and parasitic diseases	AyuC4
[X]Dementia in human immunodef virus [HIV] disease	Eu024
[D]Laboratory evidence of human immunodeficiency virus [HIV]	R109.
[V]Human immunodeficiency virus – negative	ZV018
[V]Contact with and exposure to human immunodeficiency virus	ZV019
[V]Asymptomatic human immunodeficiency virus infection status	ZV01A
[V] Family history of immunodeficiency virus [HIV] status	ZV19B
[V] Human immunodeficiency virus counselling	ZV6D4
[V]Special screening examination for human immunodeficiency virus	ZV737
H/O: venereal disease	1415
Chlamydia antigen test	43U%
Syphilis and other venereal diseases	A9%
Molluscum cantagiosum	A780.
Molluscum contagiosum with eyelid involvement	A7800
Chlamydial infection	A78A
Chlamydial infection of lower genitourinary tract	A78A0
Chlamydial infection of pharynx	A78A1
Chlamydial infection of anus and rectum	A78A2
Chlamydial in of pelvic peritoneum other genitourinary organs	A78A3
Chlamydial conjunctivitis	A78A4
Chlamydial infection, unspecified	A78AW
Chlamydial infection of genitourinary tract, unspecified	A78AX
Venereal disease contact	65P7.
Venereal disease carrier NOS	65Q9.
Venereal disease screening	683200%
Genital warts	A7812
Other maternal venereal diseases during pregnancy, childbirth and the puerperium	L172%
[V]Contact with or exposure to venereal disease	ZV016
[V]Other venereal disease carrier	ZV028

[V]Screening for venereal disease	ZV745
H/O: abortion	15.43
Preg. termination counselling	6776
Hysterostomy and termination of pregnancy	7E066
Dilation of cervix uteri and curettage of products of conception from uterus	7E070
Curettage of products of conception from uterus NEC	7E071
Suction termination of pregnancy	7E084
Dilation of cervix and extraction termination of pregnancy	7E085
Termination of pregnancy NEC	7E086
Requests pregnancy termination	8M6..
HSA1-therap. abort. green form	956%
Reason for termination of pregnancy	9Ea%
Refer to TOP counselling	8H7W.
Legally induced abortion	L05%
Illegally induced abortion	L06%
[V]Infertility management {?all daughter codes}	ZV26%
Treatment for infertility	8C8%
Introduction of gamete into uterine cavity	7E0A%
Endoscopic intrafallopian transfer of gamete	7E1F2
Marital status {not all daughter codes apply}	133%
Complaints about care	9U%
Imprisonment record	13H9.
In prison	13HQ.
Husband in prison	13I71
Prison medical examination	6992
Place of occurrence of accident or poisoning, prison	T776.
[V]Conviction in civil and criminal proceedings without imprisonment	ZV4J4
[V]Problems related to release from prison	ZV4J5
[V]Imprisonment	ZV625
History of abuse	14X..
History of physical abuse	14X0.
History of sexual abuse	14X1.
History of emotional abuse	14X2.
History of domestic violence	14X3.
Suspected child abuse	1J3..
Child maltreatment syndrome	SN55.
Emotional maltreatment of child	SN550
Nutritional maltreatment of child	SN551
Non-accidental injury to child	SN552
Battered baby or child syndrome NOS	SN553
Multiple deprivation of child	SN554
Physical abuse of child	SN555
Child maltreatment syndrome NOS	SN55z
Sexual abuse	SN571
Child battering and other maltreatment	TL7..
Assault by criminal neglect	TLx4.
Abandonment of child with intent to injure or kill	TLx40
Abandonment of infant with intent to injure or kill	TLx41
Abandonment of helpless person NOS	TLx4z
[V]Family history of physical abuse to sibling	ZV19C

[V]Family history of physical abuse to sibling by family member	ZV19D
[V]Family history of sexual abuse to sibling	ZV19E
[V]Family history of sexual abuse to sibling by family member	ZV19F
[V]Family history of mental abuse to sibling	ZV19G
[V]Family history of mental abuse to sibling by family member	ZV19H
[V]Family history of sibling abuse NOS	ZV19J
[V]Family history of sibling abuse by family member NOS	ZV19K
[V]Problems related to alleged sexual of abuse child by person outside primary support group	ZV4F9
[V]Problems related to alleged sex abuse child by person within primary support group	ZV4G4
[V]Problems related to alleged physical abuse of child	ZV4G5
[V]Child abuse	ZV612

GLOSSARY OF TERMS

Term	Description
CPM	Combined Predictive Model; a risk stratification solution developed by the King's Fund and implemented locally by the former Blackpool PCT, now rolled out across Lancashire as the CSU's Risk Stratification product. Utilises secondary care & primary care data.
CSU	Commissioning Support Unit; the supplier of Business Intelligence tools to the CCGs and GPs, including Risk Stratification.
DSCRO	Data Service for Commissioners Regional Office; part of the HSCIC that is hosted locally by CSUs and allows for the receipt of PCD, and onward dissemination if legally approved
HSCIC	Health and Social Care Information Centre
MIQUEST	A generalised querying & extraction tool that allows for standardised datasets to be extracted from different GP systems
PCD	Patient Confidential Data; anything deemed to be identifiable or confidential e.g. NHS number, postcode, Date of Birth, Name, Address
PCDQ	Primary Care Data Quality; PCDQ team members undertake the extraction of data from GP Practice Systems for use in Risk Stratification tools
RS	Risk Stratification; the process of predicting the comparative likelihood of urgent or emergency healthcare treatment in the future (usually likelihood of emergency admission to hospital over the next 3,6,12 months). Scores are generated using current and historical data for secondary & primary care conditions and ranked against a cohort of other patients, usually all patients within a practice or CCG

S251	Section 251; part of the Data Protection Act that allows for the suspension of the Duty of Confidentiality where approval has been given by the Secretary of State for Health on the advice of the Confidentiality Advisory Group
SUS	Secondary Uses Service; national system supplying patient level data on secondary care activity

USEFUL LINKS

1) NHS Digital Service for Commissioners pages:
https://digital.nhs.uk/services/data-services-for-commissioners

2) NHS England Information Governance pages:
http://www.england.nhs.uk/ourwork/tsd/ig/

3) NHS England Risk Stratification pages, including s251/assurance statement details:
http://www.england.nhs.uk/ourwork/tsd/ig/risk-stratification/

4) NHS England advice for GPs and CCGs on Risk Stratification (PDF document):
https://www.england.nhs.uk/ig/risk-stratification/

Appendix C Equality Impact Assessment

STW CCG EIA Risk Stratification.xlsx

----------Risk Stratification Policy End----------