Centre of Excellence for **Information Sharing**

Sharing health data to improve outcomes for families and children: **Staffordshire case study**

Contents

Introduction

The Troubled Families Programme was set up in 2012 to support families with multiple and complex problems. In the past, these families have often been failed by services which have tried to respond to the one problem that presented itself to that service at that particular time – whether it was truancy, domestic violence, anti-social behaviour or unemployment – but failed because they have been incapable of dealing with the many interrelated problems the family is facing.

Information sharing has been at the heart of the Troubled Families Programme since it first began. Not only does information sharing allow the most complex and costly families to be identified (by using data to cross reference the demand they are placing on different services), information sharing also means problems can be tackled more effectively. For example, persistent truancy is easier to address when the keyworker knows that a parent has very poor mental health and is struggling to get out of the house themselves.

As the current programme's evaluation is already showing, many areas have made great progress with data sharing, but others still have a way to go and sharing health information has been a problem for some. For this reason, the Department for Communities and Local Government (DCLG) has worked with the Department of Health (DH), the Centre of Excellence for Information Sharing (the Centre), local authorities and health bodies in Staffordshire and Oldham to test new approaches to sharing health information.

As part of this project, the Centre has worked with local services to identify the cultural barriers and enablers to sharing health data and looked to capture good practice which others can adopt. During this work, the Centre identified a number of significant obstacles to sharing information between local authorities and health organisations. Patient confidentiality and legal 'gateways' are crucial factors for health organisations when considering whether to share information and what information should be shared. However, cultural barriers also play a significant role in health's decision when considering whether to share with council-led troubled families teams. There are also concerns around whether health information can be shared prior to engaging with, and discussing information sharing with families and whether sharing this information can be justified on the basis that it would directly benefit families by improving their health needs (alongside tackling other interlinked issues).

To understand this further, Engagement Managers from the Centre (with DCLG and DH support) carried out a series of visits, semi-structured interviews, and supported workshops with key professionals involved in the management and the delivery of both the Staffordshire and Oldham Troubled Families Programmes. This case study reviews the Staffordshire programme.

Background to the Staffordshire programme

The Troubled Families Programme in Staffordshire is known locally as 'Building Resilient Families and Communities' (BRFC). Key health and council services work to a shared local vision - enabling families to be 'safe, healthy, self-reliant, educated, responsible and informed'[1] by coordinating support across local services – delivered through a partnership approach to workforce development, joint commissioning, and improved information sharing.

Phase one of the programme demonstrated local priorities around 'Hidden Harm' (domestic violence, mental health, and substance abuse), which strengthened the case for sharing information between the health-care sector and the BRFC programme.

The BRFC programme is managed through a commissioning framework, by the Community Safety and Families department of Staffordshire County Council (SCC). Troubled families funding from DCLG is split between SCC and the district teams, with upfront 'attachment fees' funding the central programme costs (within SCC), whilst 'Payment by Results' funding goes to district teams, who use this to commission additional local activity. This strategic decision was taken to enable buy-in and information sharing between the district councils and the county council.

Approaches to developing information sharing have included:

- building information sharing into commissioning for public health services; and
- building relationships with mental health services.

These individual arrangements have been supported by the BRFC programme operating under the county's overarching One Staffordshire Information Sharing Protocol. This is supported by individual Information Sharing Agreement (ISA) appendices for each specific project. These ISAs cover specific details governing information sharing including the legal gateways and who information is shared with. ISAs are in place between the BRFC programme and two health trusts (Staffordshire and Stoke on Trent Partnership Trust, and South Staffordshire and Shropshire Mental Health Trust). These ISAs are limited to the scope of the current information sharing arrangement that involves the sharing of profiling data for families who already meet two or more eligibility criteria to check if they also meet the health criteria. The aims are for health information sharing to occur at the same point as other partners information so that identification considers health criteria alongside other eligibility criteria. Progress towards this is through BRFC's stepped approach to the development of information sharing and at points this will require the supporting ISA to be revised and reissued.

[1] www.staffordshire.gov.uk/community/community/Building-Resilient-Families-and-Communities.aspx

BRFC delivery model - what's Staffordshire's approach to troubled families?

Identification

What: Profiling data comes through local authority data sources and partner databases.

How: Information is shared under a legal basis agreed within a specific ISA with each partner. The information is then inputted into a secure in-house developed IT system and the BRFC data team pass the enriched family profile to the relevant district Family Intervention Project (FIP) team.

Who: Data sources include police, youth offending, school census. The BRFC data team holds the information.

Validation

What: Families who meet two criteria are identified and profiles are validated and enriched.

How: FIP staff contact partner agencies and share information under confidentiality agreement.

Who: FIP worker and partner agencies.

Example
After profiling, the FIP coordinator will meet with the local health visitor to check if a family is receiving 'Universal Partnership Plus' (UPP) support, and identify the name of the allocated health visitor so they can be engaged in coordination of support. FIP team members also liaise with Family Nurse Partnership (FNP) practitioners to identify pregnant teenagers/teenage parents who aren't receiving support from the FNP programme.

Assessment

What: Full assessment of family needs and family consent secured.

How: The 'Outcomes Star' frames discussion with the family and validates that the information held reflects the families situation.

Who: FIP worker and family.

Monitoring

What: Regular progress with families is input into the IT system.

How: Partners update their own systems about contact with families and provide evidence directly to the BRFC team.

Who: Dedicated administrator for BRFC team inputs information.

Staffordshire use an 'Outcomes Star' to capture the family's perceptions of their strengths and needs. This includes categories on physical health and wellbeing, so will support a focus on health and the identification of health services involved with families already identified.

Cultural barriers to information sharing

Discussions with the BRFC programme team and their partners in Staffordshire highlighted a range of issues which are perceived to be challenges to information sharing. The table below outlines the challenges, the approach taken to overcome these and the outcome.

Information sharing maturity		
Challenge	**Approach**	**Outcome**
Partners found: ▸ Information sharing with one another develops at a different speed. ▸ Health partners needed time and reassurance before they were confident that information would be shared safely.	**Partners have:** ▸ Invested time in developing relationships with their respective Information Governance (IG) and IT leads to understand and address issues and concerns. ▸ Taken a stepped approach to developing information sharing that accommodates and works to all partners' capacity.	▸ A mature relationship with a mental health provider with more provision for information sharing. (See page 11 for a more detailed look at how mental health have achieved this).

Risk and fear		
Challenge	**Approach**	**Outcome**
Partners found: ▸ Health trusts can be protective of clinical data as they fear breaching confidentiality and have concerns about the security of the methods used for sharing information.	**Partners have built information sharing into the BRFC operating model by**: ▸ Being clear on the specifics of what is needed and why – sometimes only non-clinical data is required. ▸ The use of confidentiality forms for organisations to sign at meetings. ▸ Key worker training on good practice on information sharing and how to approach securing consent from a family. ▸ District teams only see the family profiles for the families in their district and the use of technology has advanced from fax to secure email.	▸ This approach has improved confidence around information sharing between Social Care and NHS partners. ▸ Health partners understand that often the information requirements are non-clinical e.g. appointment times and therefore don't impact on patient confidentiality. ▸ The level of information shared is appropriate to enabling the FIP workers to coordinate support for families, e.g. information about if a member of the family is receiving a health intervention and details of appointment times are used to prevent double booking of appointments.

Information governance

Challenge	Approach	Outcome
Partners found: ▸ Partners at a high level were concerned whether information sharing was legal.	**Partners have:** ▸ Used guidance from central government about data sharing to support troubled families. They found it reassured partners that sharing is legal. ▸ The FIP team use this guidance with statutory and non-statutory health providers at both strategic and operational level.	▸ Health IG leads are more willing to investigate opportunities to share information when provided with the government guidance. ▸ But some partners are still unwilling to share despite having a protocol in place so further work to address each organisation's other concerns and barriers to sharing is needed.

Case study:

The FIP team were working with a family whose child had very poor attendance at school and had been absent for some considerable time. The parents said this was due to medical reasons but the school had no evidence of this, so concerns were raised for the child's wellbeing. Mum gave the FIP keyworker the name of the consultant at the hospital. The hospital asked the FIP worker to send a written request, so this was sent along with government guidance. The hospital then confirmed they were working with the child, providing basic information which didn't require the family's consent.

Building trust

Challenge	Approach	Outcome
Partners found: ▸ A level of trust needs to be established before information is shared. ▸ In particular practitioners felt that if they didn't have a clinical background or a common language then clinicians (in particular GPs) were less inclined to engage with them.	**FIP workers have:** ▸ Learnt to understand the individual personalities of their partners. ▸ Engaged with GPs through trusted partners in common e.g. school nurses. ▸ Offered specialist expertise to complement the work undertaken by health professionals to further develop trusted relationships.	▸ Once relationships have been built up and recognition and credibility secured from health practitioners then information is shared more easily. ▸ In particular, 'partners in common' are able to reduce information sharing burden by filtering information flows and using common language.

Engagement

Challenge	Approach	Outcome
Partners found: ▶ There was poor and inconsistent attendance from some partners at their strategic board. ▶ This created a lack of awareness from these partners on the benefits of the programme and meant no positive messages are passed on to the wider partnership. ▶ Partners do not recognise shared benefits as there is a lack of alignment of national indicators which affects the ease and effectiveness of data sharing.	**Partners have:** ▶ Revised the strategic leadership and governance arrangements as part of the Children's Transformation Programme and introduced a new Families Strategic Partnership Board (FSPB). ▶ Started communicating the benefits of engagement with the BRFC programme to health partners. This is easier in phase two of the programme as they reach the 12-month point, the team can start to report on health referrals and measure success against health criteria and use this to develop relationships and discussions about data sharing (in due course).	▶ The FSPB currently includes health representatives from the Community NHS Trusts, NHS England, Public Health, and CCG representatives from both North and South Staffordshire. This has strengthened the engagement with health. ▶ An opportunity to report on health referrals has been identified around monitoring how many families who are re-referred into the BRFC programme have a health marker, as this would provide the programme team with evidence of their positive impact on tackling health issues.

Organisational complexity

Challenge	Approach	Outcome
Partners found: ▶ There are a large number of different organisations who make up the local health sector, and the different but linked sub-sectors within this, and the complex overlapping of health and council boundaries creates confusion with regard to health information sharing.	**BRFC have:** ▶ Shared data analysis with the locality partnership. This has helped to highlight shared outcomes to inform the targeting of engagement with health partners. ▶ Analysed data on family health issues within phase one and used data from the use of the Family Outcomes Star as a measurement tool for health and wellbeing (and other criteria). ▶ Targeted specific individual services when asking for attendance at their meetings, namely health visitors, school nurses, and substance misuse services.	▶ Mental health and substance misuse were identified as priority health issues, and school nurses as key partners. ▶ Targeted data analysis was used to gain buy-in by using the analysis to demonstrate shared outcomes. ▶ The Lichfield District partnership meet quarterly as a strategic group and has been identified as successful at engaging health partners - particularly GPs.

Joint working		
Challenge	**Approach**	**Outcome**
Partners found: ▶ Silo working and operational barriers within and between organisations hinder joint working and information flow. ▶ Silo working is exacerbated by organisational transformation agendas resulting in changes in personnel and structures.	**Partners have:** ▶ Co-located FIP workers within Stafford district with a member of the adult substance misuse team to aid joint working. ▶ This co-location approach was developed from an existing partnership arrangement with the Recovery is Out There (RIOT) service, who are based in a local residential mental health unit. The FIP team have commissioned the creation of a specific link person from within RIOT to work with the FIP team and who the FIP team can make referrals to.	▶ Benefits of co-location have been seen in terms of improving relationships between the services, improved understanding of each service and the links between them, and being able to identify and plug gaps. ▶ An example of a well-established partnership is when housing benefits arrears is flagged up as part of a benefit and revenue pilot in Newcastle-Under-Lyme. For those families identified as being in the BRFC programme, eviction proceedings are withheld as long as they are working productively with the programme.

'Think Family'

Challenge	Approach	Outcome
Partners found: ▸ Some providers are often focussed on working with the individual and don't recognise the benefits to be derived from understanding and addressing wider family needs. ▸ FIP practitioners are required to consider wider family needs and impacts, plus potentially complex family/living arrangements. This contrasts to the ways of working of many of the partners involved. ▸ Children's and Adolescent Mental Health Services (CAMHS) already 'Think Family'. This makes it easier for them to understand and engage with the BRFC approach and work with other non-health agencies such as schools.	**Partners have:** ▸ Developed and delivered 'Think Family' training to the voluntary sector providers initially. ▸ Developed and embedded family focussed Early Help Assessment process in Children's Social Care. ▸ Recognised the opportunity and so focussed on developing a family focussed approach with CAMHS.	▸ BRFC have generated an appetite for 'Think Family' training and they embedded 'Think Family' in children's social care. ▸ Through successful collaborative working with CAMHS, partners have developed evidence of improved effectiveness and outcomes that can be used to secure commitment of other mental health providers. ▸ FIP workers successfully engaged with health partners to use their knowledge of the family to help the health professional.

Case study:

A FIP worker knew that an individual in the family they were supporting had not made their mental health appointment. The FIP worker took the opportunity to go and meet with the mental health professional (at the time of the missed appointment) as they knew they would be available at that time. This worked well as the family situation was very complicated and the parents had split up but the mental health key worker didn't know they were working individually with the parents of the child. So each parent was talking about the other in their sessions but the mental health worker hadn't been able to make this connection until they engaged with the FIP worker (who shared this information).

Developing information sharing with mental health

Driver: mental health a local priority health issue

Mental health has been identified as a priority health issue for the BRFC programme in Staffordshire.

Contact with local mental health commissioners

In recognition of this, the central BRFC programme team approached both adult and children's mental health commissioners for help thinking about how mental health information can be shared to better support troubled families.

Commissioning of mental health services in Staffordshire is geographically split between the north and the south of the county and is coordinated between the localities CCGs and county council with guidance from the countywide Staffordshire Adult Mental Health Strategy.

Invitation to local leadership board meetings

The lead commissioner for adult mental health services in North Staffordshire, who is based within the county council, was invited to attend the BRFC Strategic Leadership Board meetings. Being part of the board meetings was a new role for the adult mental health commissioner, and introduced them to the new agenda of 'troubled families'. In addition, their participation in BRFC board meetings has helped everyone on the board to recognise the role of mental health in building resilient families.

Result: decision to upskill frontline workers with mental health training

A key result from this involvement of mental health commissioning has been the decision to upskill frontline BRFC workers through mental health training to enable them to deliver low level mental health interventions to the families they are working with and to support the appropriate signposting and referrals to mental health services. This training has helped build relationships with the local Mental Health Trust, and is felt to be improving referrals and ultimately the support provided to troubled families.

Next steps

The next step is to evaluate the impact the practitioner training has had through looking at the sources of mental health referrals and the difference between the mental health outcomes achieved by those families supported by the BRFC programme and those who are not. This will also start to reveal the benefits that have been delivered for and through improved information sharing.

The development of information sharing with mental health to identify eligible families

A key holder of mental health data in Staffordshire is the South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT). The SSSFT are the primary provider of both adult, child and adolescent mental health services in the county. The data sharing discussions between the BRFC programme and SSSFT are one of the most mature partnerships regarding health data sharing, so provide an insight into the challenges, and steps taken. An Information Sharing Agreement (ISA) between the BRFC programme and SSSFT came into effect in March 2016.

Driver: recognition at the frontline

In the first phase of the programme a local health visitor suggested that sharing of mental health data, which health visitors had access to, but couldn't share, might be something BRFC could pursue to improve outcomes for families. Further to this, frontline FIP workers report that nearly all the families worked with have health needs.

Challenge: Information Sharing Agreement (ISA)

The need for an ISA was highlighted as the initial barrier, so as a first step the information governance lead within Staffordshire County Council worked with the BRFC to identify the right people to talk to within SSSFT and supported introducing the overarching One Staffordshire Information Sharing Protocol[2] (which all partners are signed up to) through a formal presentation to the SSSFT board.

In addition to the existing overarching protocol, a new specific ISA was required between SSSFT and BRFC to support information sharing that would enable the identification of families with health criteria. Following negotiations, an individual ISA was agreed and signed that covered the legal basis for sharing and the approach. This approach followed that recommended by the guidance document prepared by the DH in collaboration with the DCLG, and Public Health England.[3] In summary, BRFC provides the mental health trust with a list of individuals who already meet the troubled families criteria, the mental health trust then cross-reference this against their own data and place a flag against those individuals who are actively receiving a mental health service. Finally this list is returned to BRFC.

Approach: embedding the ISA into SSSFT

After the signing of the ISA it was assumed by BRFC that the data would automatically flow but when this didn't happen they realised that the agreement wasn't fully embedded in SSSFT.

To tackle this, the BRFC data analyst worked with the lead commissioner for adult mental health to identify and develop relationships with key individuals in SSSFT who were responsible for the management and handling of information so that the ISA could become embedded within SSSFT. Through establishing a relationship with the head of IG for SSSFT, the BRFC data analyst was able to clarify the information requirements and commitment needed from them and this then opened up the flow of data.

[2] See, www.staffordshire.gov.uk/community/InfoShare/InfoShareHome.aspx

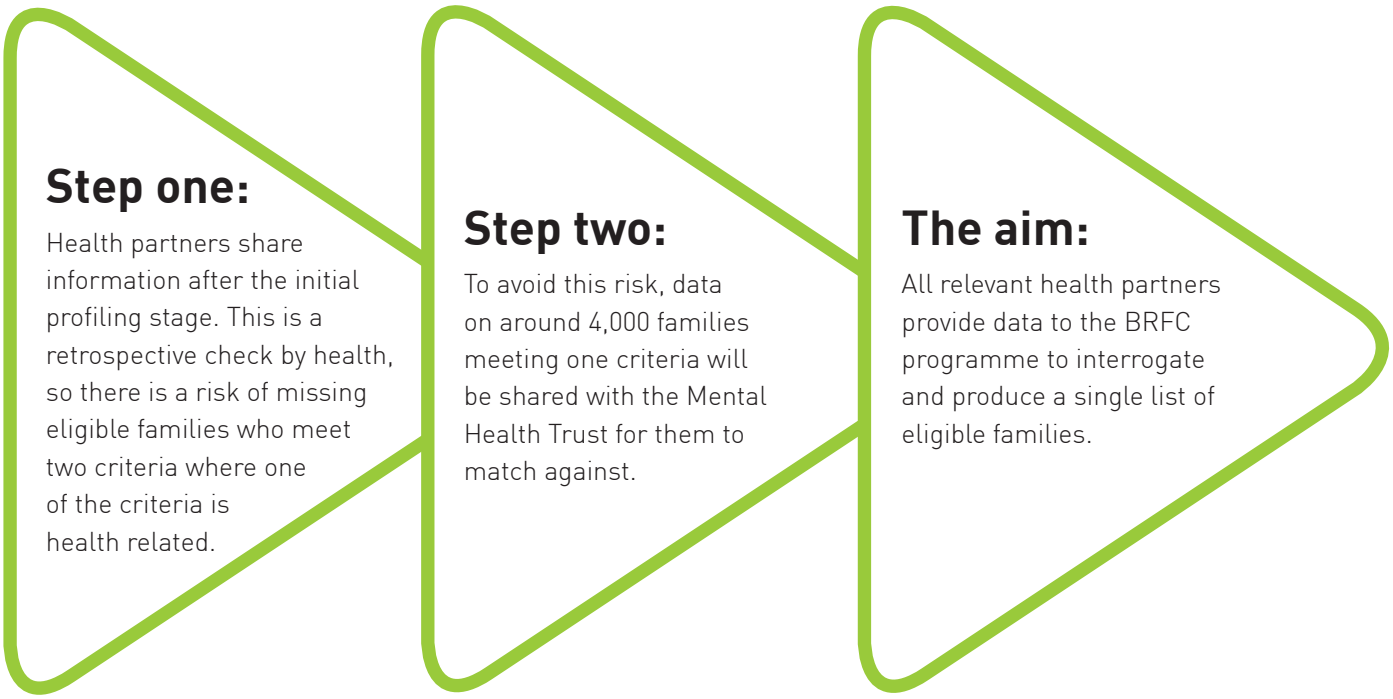
[3] See, 'Interim Guidance for Troubled Families Programme Early Starter Areas Sharing health information about patients and service users with troubled families' - www.gov.uk/government/uploads/system/uploads/attachment_data/file/370960/data_sharing_guidance.pdf

Result: better direction of resources and operational changes

The steps taken so far have involved BRFC providing SSSFT with the profiling data that identifies individuals with a match against the various troubled families eligibility criteria. SSSFT then cross reference this information with their records to identify if any of the individuals are an active referral across the range of mental health services and if so place a mental health flag against these individuals. SSSFT then pass this information back to BRFC who input the information back into their data solution so that they can then identify those families with mental health criteria.

As a result of this additional work to embed the ISA and ensure understanding of it, SSSFT have been able to direct their resources and make the operational changes needed to support information sharing that is identifying eligible families with mental health criteria. This development has been taken as a stepped approach to the development of information sharing which recognises and works within the capacity of each partner.

Stepped development of mental health information sharing



Lessons learnt:

- Make use of government guidance on information sharing to support confidence and commitment of service providers to share at both a strategic and operational level.
- Develop understanding of where service providers are regarding information sharing and work from this position. This considers their current experience, confidence, capability and capacity to share information.
- Don't assume that with the strategic level sign-off of a formal ISA that information will automatically start to flow between health providers.
- Developing information sharing takes time and work needs to be done collaboratively to progress in a stepped approach that recognises and works within service providers limitations, including available resources.
- Identify, secure introductions and take time to develop relationships with the key individuals within the mental health provider organisations who are involved in handling information. Support them in developing their understanding of the reasons for sharing information, what information is required, and the level of commitment required.
- Develop your understanding of and relationships with partners through various approaches e.g. staff training, targeted engagement of individual mental health service providers and development of joint and co-located working arrangements.

Commissioning as an enabler of information sharing – school nursing, family nurse partnership, and 0-5 early years' commission

SCC made an active choice to take a commissioned based approach to delivering the Troubled Families Programme and have embedded requirements for information sharing (to support the BRFC programme) into their commissioning specifications for relevant commissions, including health services.

This creates levers to move forward data sharing discussions with partners, and is an approach which they plan to use in future contracts, for example Universal Partnership Plus.

The Centre's Engagement Managers discussed the various commissions which have taken place so far:

- School nursing commission – a specific troubled families section has been written into the commissioning specification for the provision of school nursing in Staffordshire by the troubled families co-ordinator. Data is provided by name/address/school the child attended.
- Family Nurse Partnership (FNP) - commissioned in some districts only, and delivered by two different providers (Staffordshire and Stoke on Trent Partnership in one area, and a social enterprise in another). A data sharing protocol has been put in place for the FNP, and data sharing built into the contract as a requirement for both providers (with support from the county council contracts team), but BRFC found that the social enterprise provider was more 'up for' information sharing. The details of the information sharing requirements contained in the NHS contract inherited by SCC weren't quite right as although establishing data would be shared, it did not specify what data was required. Under the terms of the original contract, FNP were collecting and thus could provide output based data (e.g. number of families worked) but not the family level information BRFC required. Under the children's service transformation agenda, additional conversations are taking place with partners about developing the capability to share this more granular level of data.
- 0-5 early years' contract - this is the next commission due which BRFC are planning to embed information sharing requirements. However, they want to widen this approach to 0-19 years commissioning.

Lessons learnt:

- Take proactive steps to find out what data local organisations have - the BRFC coordinator seeks knowledge about the data which local agencies have and/or collect - not necessarily by asking them directly, but through involvement in other activities e.g. children's centres at district level.
- The BRFC team look at opportunities for joining up not just around data sharing, but also front line worker co-ordination. For example, in addition to a data sharing requirement, the school nursing contract also contains a Key Performance Indicator (KPI) for the number of troubled families they are supporting (but not the lead agency). The BRFC programme plan aims to look at a similar approach to linking health visitor KPIs to data sharing requirements.
- Be very specific about the type of data to be shared, especially when it is patient identifiable data, and what level of granularity is required i.e. information at individual and family level. This is both to improve the ease in which the data is transferred into the BRFC system; but also to ensure both parties know what the commitment is before signing and ensure that systems are in place to collect data at the level required.
- Be very clear on the purpose for having the data requested (the BRFC co-ordinator has worked closely with the data analyst team to help do this).

What happened next

Following the writing of this case study, partners in Staffordshire have focussed on two priority areas for the development of health information sharing:

1. They have secured strategic engagement and support from health partners at the county level. This has included; health partners from the six CCGs and another key physical and mental health provider (Staffordshire and Stoke on Trent Partnership NHS Trust). This has been achieved through a restructuring of the BRFC governance arrangements. The leadership group has been incorporated into the Family Strategic Partnership Board which now holds oversight of BRFC and reports directly into the Health and Wellbeing Board.

2. They have developed an operational district level GP and mental health information sharing 'good practice' pilot which is geographically targeted. This pilot is targeted on two areas (Cannock and Tamworth) identified by the analysis of the families with mental health criteria identified through the information sharing between BRFC and the SSSFT. Health partners were engaged in the design of the pilot and this has been key in securing their commitment to the sharing of health information.

BRFC have also been working on embedding information sharing and their broader learning into wider operational practice and local service transformation by:

- Building BRFC's own understanding of the health landscape.
- Highlighting the health outcomes that are being realised through the BRFC programme.
- Developing language that will also resonate with health partners.

BRFC are strengthening transformation within the local authority as they are rolling out a place-based approach to working and it is expected that the district level GP and mental health information sharing pilot will be integrated into the place-based working. This will be rolled out across the county in phases.

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