Centre of Excellence for **Information Sharing**

Information sharing in Greater Manchester:

Trafford Care Co-ordination Centre

Leadership, collaboration and co-design: the initial development and impact of the Trafford Care Co-ordination Centre (TCCC)

Introduction

Devolution in Greater Manchester underpinned by information sharing

This case study is one of a series which explores information sharing in Greater Manchester (GM). It forms part of the Centre of Excellence for Information Sharing's work to support 'GM-Connect'.

GM-Connect is new data commission, established in 2015/16 as a key enabler for integrated public service reform and devolution across Greater Manchester.

GM-Connect's role is to champion, co-ordinate, facilitate and deliver data sharing activity across GM, focusing on opportunities to:

- Add value and create insight.
- Help improve and re-design services, especially at points of transition.
- Deliver better outcomes, for the city region and its residents.
- Join up information silos and break down barriers to sharing data.

GM has led the way for devolution to local places[1] and aspires to do the same with information sharing. As a result, the devolved powers set out across a series of devolution agreements cover not only services such as health, transport, housing and skills, but also cross-cutting enablers such as governance and information sharing.

Information sharing is seen as fundamental to delivering GM's public service reform ambitions, as by transforming the way information is used, this will empower GM's frontline workforce to make more informed decisions about how and when they work with individuals and families. It will also support early intervention and prevention, helping ensure that the appropriate services are delivered at the right time, supporting people to become healthier, resilient and empowered.

In this case study we focus on the role of information sharing in supporting health and social care integration, another area where GM is leading the way – with devolved control over integrated health and social care budgets since 1 April 2016. A key strand of GM's devolution ambitions, health and social care integration aims to deliver not only improved health but also improve wellbeing, reduce worklessness and support people back into employment as a result.

Greater Manchester's vision for devolution

"...to ensure the greatest and fastest possible improvement to the health and wellbeing of the 2.8 million people of Greater Manchester."

[1] In April 2011, GM established the first combined authority in the country (GMCA), and has since agreed a series of devolution agreements with central government in 2014, March and July 2015 and most recently March 2016.

Background: Care co-ordination in Trafford

One of ten boroughs in GM, Trafford has a diverse population of over 230,000 with a wide range of healthcare needs. These needs are met by healthcare organisations both within the district and in nearby areas, including NHS Trafford Clinical Commissioning Group (CCG), Trafford Council, Pennine Care (community health providers), Central Manchester Hospitals, Salford Royal Hospital and University Hospital of South Manchester (Wythenshawe).

A history of integrated care development in Trafford has led to the development of a whole series of community integrated services which work well, but can be hard to navigate around.

As a result, a focus on 'care co-ordination' has developed, grown out of the realisation that putting in place new ways of delivering treatment would not necessarily result in patients being referred into them. Not unless GPs, patients and those providing treatment were supported and assisted in navigating the redesigned healthcare system and in changing the way they work together.

Care co-ordination is at the heart of Trafford's approach to health and social reform, and as such is described as "our big idea" in Trafford's locality plan.[2] The Trafford Care Co-ordination Centre (TCCC) is not only seen as a key 'transformational development' itself, but is also central to supporting Trafford's other transformational priorities, such as:

- A shift in activity from hospitals to the community.
- A holistic approach to health and social care that considers an individual's wider circumstances.
- Improved quality, access and range of support services for people with complex care needs, to support personal resilience.

The TCCC is seen as the flagship development of Trafford's CCG and the first of its kind in the country. More than just a physical building, the TCCC is an approach to supporting people with complex care needs, built on four cornerstones:

- **A local integrated digital care record** (bringing together data from GP records, hospital admissions/discharges, and care co-ordination notes).
- **An 8am-8pm call centre, offering a single point of contact**, staffed by a mixture of administrators and clinicians (specialist nurses) with role-based access to patient records.
- **A Trafford focused directory of services** (supporting GPs to signpost to the most relevant services, and enabling more self-help by patients).
- **A 'data lab'** – a development and analytics function which uses anonymous data from TCCC to guide commissioning decisions, inform service design, and effectively target marketing.

[2] A series of locality plans, one for each of the ten local authority areas of GM, underpin GM's five-year plan for health and care devolution – known as 'Taking Charge of our Health and Social Care in Greater Manchester'. Locality plans set out what will be delivered in their area and how the savings from the integrated better care models and prevention will be delivered.

Aims and expectations of the TCCC

Developed by the CCG and its delivery partner - CSC[3] - as an enabler of change (rather than an end in its own right), the TCCC's approach is solution led and built around patient needs.

Designed ultimately to avoid unnecessary hospital admission through better informed clinical decision making process, the TCCC is expected to:

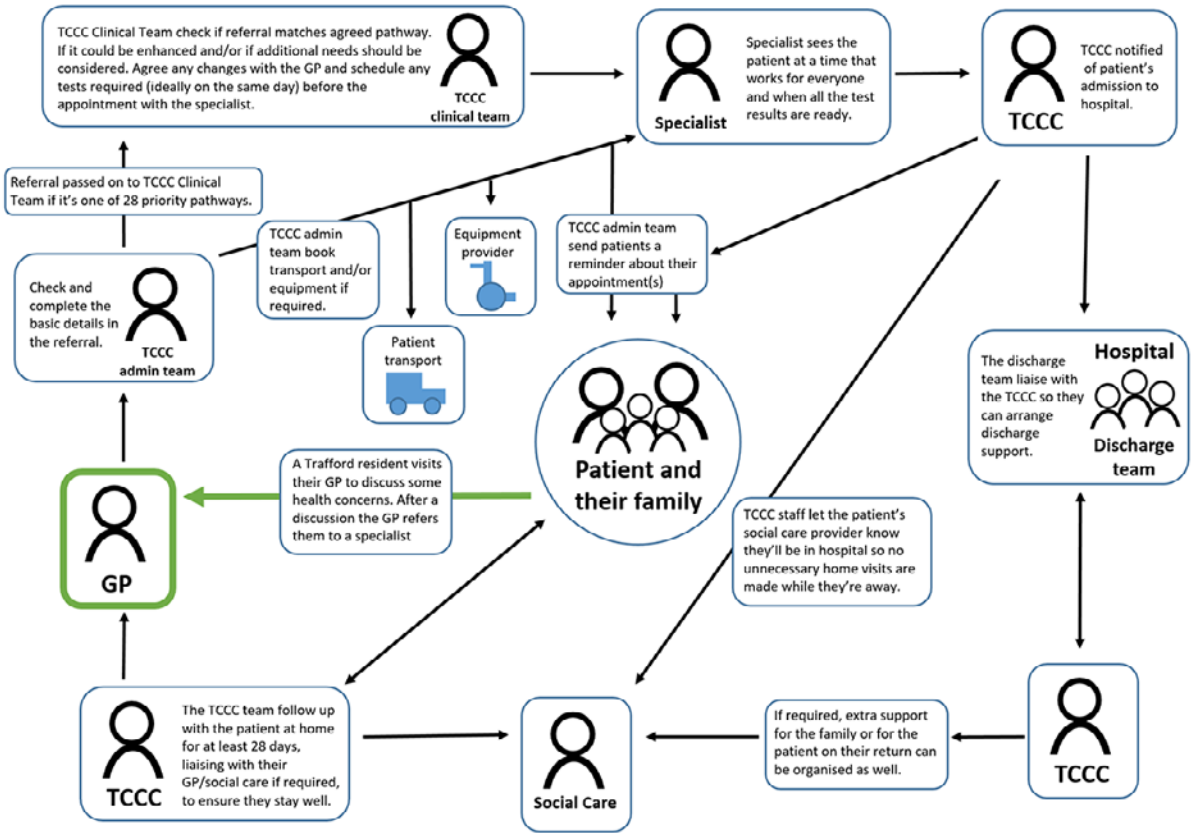
- Improve the quality and alignment of referrals to specialist services, though the use and monitoring of agreed clinical pathways (referral management).
- Reduce bed-blockages in hospitals by medically fit patients (discharge management).
- Improve outcomes for patients, and families, with chronic conditions by helping them co-ordinate multiple health and social care needs (complex care co-ordination services).
- Divert demand away from acute, hospital-based services, to community-based services and social support, by signposting patients and healthcare practitioners to the most appropriate service, third party providers, and/or self-help resources (enquiry management).
- Drive intelligent commissioning of services based on real evidence of patient journeys/needs, and support earlier identification of patients' complex care requirements (analytics).

More importantly, as a result of providing co-ordination, oversight and accountability between transitions of care, the TCCC will deliver tangible benefits for patients, such as:

- Reduced waiting times.
- Fewer hospital visits.
- Care for patients and their family.
- Proactive health management.
- Single point of contact for patients, and family/carers.
- Help to find and engage with community support groups.
- Swifter discharge from hospital, as co-ordination ensures both practical and medical needs are being met.

[3] The Trafford Care Co-ordination Centre (TCCC) service is delivered and co-managed by Computer Sciences Corporation (CSC) - a global provider of technology-based products and services, whose systems can be found in over 80% of NHS trusts – www.csc.com). Mastercall, the regular provider of Trafford's Out-of-Hours service, is contracted to provide both clinical and administrative operational delivery within TCCC.

TCCC - how it works and who's involved



The approach to creating the TCCC – leadership, collaboration and co-design

Leadership

Underpinning the TCCC's solution-led design has been the existence of a shared vision, signed up to by all the key organisations, and set out in Trafford's health and social care reform locality plan. This vision is based on the recognition that using a care co-ordination approach to tackle hospital re-admissions (which cost Trafford CCG around £6m a year), has the potential to play a key role in tackling the future funding gap facing health and social care services across the area.

However, successfully turning this idea into reality has required commitment upfront to develop the partnership, relationships, and information sharing agreements required to implement a shared approach to care co-ordination.

So, whilst the TCCC itself is in the early stages of delivery, its journey actually started over two years ago with Trafford CCG taking a lead role in delivering the shared vision for care co-ordination, starting with the joint tendering and procurement for a 'patient care co-ordination service' by the CCG and Trafford Council in 2013/14.

Service procurement 2013-14 → **Joint visioning 2014-15** → **Referral and transport booking service July 2015** → **Referral management Jan 2016** → **Discharge and care co-ordination Summer 2016**

Following the procurement exercise, and the selection of Computer Sciences (CSC) Limited as the TCCC delivery partner, Trafford CCG and CSC have worked closely together (taking on a joint leadership role). One example of this being the involvement of senior managers from the CCG on each of the TCCC operational steering groups (such as the 'discharge management steering group').

During the development and roll out of the different TCCC workstreams (referral booking, referral management, discharge management etc.), CSC and Trafford CCG worked together to ensure regular communication not only between workstreams, but also between partners. For example, they hold weekly conference calls with partners (led by CCG) to provide progress updates and get feedback. By looking at both workstream specific and cross cutting issues in these calls, such as information governance and communications, this approach ensured partners were able to continue to help shape the development process, and retain a stake in the TCCC as a true partnership initiative.

As a result of strong joint leadership by Trafford CCG and CSC partners, the local healthcare economy has been successfully engaged in the TCCC's development, for example:

- Developing and agreeing information sharing protocols with a range of stakeholders (including GPs, local hospital trusts, Trafford Council).
- Engaging and securing buy-in from local GPs – through an ongoing GP visiting programme, which in 'round 1' saw 32 (of 33) GPs signing up to the TCCC information sharing protocols (by autumn 2015) and in round 2 is helping 'fine tune' the care co-ordination and risk stratification processes.
- Working with local GPs, IG leads within the local NHS trusts, and patients, to produce and disseminate a range of TCCC communications materials, including fair processing notices and information leaflets for patients and practitioners.

Collaboration and co-design

1) Brokering information sharing arrangements

Trafford CCG played a key brokering role during the development of the Information Sharing Protocol (ISP) which underpins the TCCC model, identifying and bringing together key partners - Trafford Council, the local acute hospital trusts, the Christie NHS Foundation Trust (specialist cancer hospital for GM), Pennine Care (the community healthcare provider in Trafford), and local GPs.

Partners were engaged in the development of the ISP through a range of meetings and events, including:

- Strategic leadership discussions regarding an initial memorandum of understanding between partners.
- Meetings with the local medical council (LMC), undertaken by Trafford CCG's chief operating officer (with support from the CCG's information governance [IG] lead).
- A series of three workshops to develop the ISP, and ongoing meetings to refine it, involving IG leads from all partner organisations. This collaborative approach to the development of the TCCC ISP, meant that all partners could help to shape the agreement and had a number of opportunities to raise, discuss and collectively address any areas of concern. Specific issues which were dealt with in this way, during the development of the TCCC ISP, included:

  Partner responsibilities to review the compliance of internal practices (with relevant legislation, caldicott principles, and the ISP itself).

  Development and embedding of a TCCC dissent management process as a key part of the ISP.

  Expanding the information assurance standards partners are required to meet, by adding 'ISO27000 standards' as an example alongside compliance with level two of the IG toolkit.

2) Collaborative approach to discharge service design

In addition to collaboration with partners to develop the ISP, Trafford CCG and their delivery partners also worked with hospital discharge teams in the development and design of the TCCC discharge service.

This collaborative approach continued into the implementation stages, with TCCC staff walking the wards with the discharge team, and jointly developing communications material for both patients and clinical staff.

TCCC discharge service

Triggered by the hospital emailing a 'section 2' discharge form, the TCCC's discharge service provides co-ordination of care (transport, social care, appointments etc.) for discharge patients for a period of 28 days from the date of actual discharge. The TCCC staff also liaise with the hospital discharge teams in advance of discharge, to avoid delays to discharge as well as working towards the shared aim of preventing unnecessary readmission to hospital.

Managing your discharge

Before you leave hospital the TCCC's team of experienced clinicians will, with your agreement, work with other organisations, to co-ordinate all the services and/or adaptations you require for an efficient discharge. This may include things like special equipment in your home, community nursing, respite care, social care and transport home.

Within 24 hours of returning home you will receive a welcome phone call from a care co-ordinator at the TCCC to make sure you are happy with the services that have been put in place for you. They will stay in touch with you for up to 28 days to make sure you have everything you need.

By building a relationship with you your care co-ordinator will be able to assess your care and help to keep you comfortable and reassured at home.

You and your family members can contact your care co-ordinator directly if you have any concerns about your care. They are able to intervene at an early stage should you require extra care and help prevent you going back into hospital.

During this period any appointments or community visits will be arranged by your care co-ordinator meaning you have one point of contact for all your care requirements.

By managing your discharge in this way we aim to keep you and your family reassured and bring together all the services and care you need.

Trafford Care Co-ordination Centre

A co-design approach was also used by CSC to develop the discharge processes used by the TCCC clinical team. Specifically, the specialist nurses in the clinical team worked together with CSC's technology practitioners and project managers to map out the discharge process. An initial four stage model was created in the first co-design session, which was then added to (in a post-it note exercise) to develop the detail. The TCCC clinical team found this to be a "positive, and interesting approach" and valued the chance to design the system in this way. The co-design approach was also applied to the development of the complex care service, with lessons learnt from the discharge module as representatives from the clinical team were involved earlier in the process.

3) Co-production of the directory of services

A key part of the TCCC is the development of a comprehensive directory of services. Based around the 28 priority referral pathways, the directory of services is a database of conditions and services which is available to support GPs when referring patients, and the TCCC clinical team when delivering discharge management services. It also contains clinical information and guidelines for each of the 28 priority conditions, written jointly by clinical professionals from Trafford CCG and others working on behalf of CSC.

National policies and guidelines, such as map of medicine (MoM) and NICE guidelines are also included in the directory, in order to provide everything required to support a GP in making accurate referrals. The clinical pathway (a local map of medicine), which is used by the TCCC clinical team to review and support GPs referrals is also included.

In order to gather information on local services, the TCCC staff worked in collaboration with local hospital trusts. Rather than trying to contact every individual service provider directly, hospital booking office managers were approached directly and asked to complete a template with details of services related to the 28 priority conditions. The returned templates contained details of both services provided at the hospital and those provided in the community, to support the aim of increasing referrals to community based services.

The heavy day-to-day workload on the hospital booking teams meant it wasn't always easy to get the information required quickly. So, the next stage of development for the directory will be to enable partners, both hospital trusts and voluntary sector providers, access to update and add new service information directly into the directory, making it a truly shared and co-authored product.

A robust review system and mechanisms of checking amended/new entries by the TCCC team will support the 'self-management' of partner content, but overall this approach will still help to speed-up the process considerably.

Challenges faced and approaches to tackling them

Complexity of large health organisations		
Challenge	**Approach**	**Outcome (not necessarily all solutions)**
TCCC found it a relatively quick process to get sign-up to the Information Sharing Protocol from GPs (once the content of the protocol was agreed). However, this process took longer than expected when trying to get sign-up from the acute trusts due to the complexity of the organisations.	Weekly conference calls with partners (led by CCG). The calls were used to provide updates on TCCC service development, progress and to ask for feedback from partners. Covering a range of cross-cutting issues such as information governance and communication, the calls provided a space to check with partners where they were at regarding signing off the Information Sharing Protocol.	All trusts signed up to TCCC Information Sharing Protocol. Slight delay to go live date for discharge and care co-ordination services, but full engagement from partners secured.

Practitioner engagement across all levels		
Challenge	**Approach**	**Outcome (not necessarily all solutions)**
A series of face to face visits and phone calls to GP practices has helped the TCCC to successfully raise awareness of their services and engage with GPs themselves. However, a challenge has been identified to ensure messages about the TCCC are effectively cascaded to all practice staff.	Closer monitoring of the attendees for the second round of GP visits (part of an ongoing engagement programme run by the TCCC). This is being used to improve understanding of who is being reached. For example, checking attendance notes to find out if the meetings are being attended by just the GPs or if other staff are also involved, such as practice managers, practice nurses etc. This information is then used to shape the follow-up activity, for example arranging for practice managers to visit the TCCC.	Awareness of the TCCC services is increased across a range of primary care staff. Direct meetings with GPs and practice managers is helping to ensure 'hearts and minds' are won as a result of the engagement activity, improving buy-in and support for TCCC services and role.

Making time to build relationships		
Challenge	**Approach**	**Outcome (not necessarily all solutions)**
When developing the discharge management service, the TCCC team recognised that additional time needed to be allocated to talk about discharge processes with trusts and build relationships with discharge teams.	Acceptance that there would need to be a slight delay to the go live date to accommodate relationship building activity. Including in the development programme time for members of the TCCC clinical team to walk the wards and talk directly to discharge teams 'nurse to nurse'. Care was taken by the TCCC staff to avoid talking to patients to prevent confusion about who is providing the care. Additional TCCC material developed about the discharge service to support staff engagement and patient understanding.	Building of relationships and shared outcomes between TCCC staff and local discharge teams. Strengthening relationships through creation of shared successes - e.g. discharging the first patient together.

Prioritising information governance fron the start		
Challenge	**Approach**	**Outcome (not necessarily all solutions)**
At the start of the TCCC's development the main 'information issue' being considered was information security. This was in part due to the lack of an information governance (IG) lead within the programme team. This created challenges around resourcing information governance discussions and making sure IG as an issue was integral to project development early on, alongside other potentially 'competing' cross-cutting issues.	The CCG's IG lead, brought in initially as an advisor, took on the role of information governance delivery. The embedding of IG within the project management was also underpinned by using risk logs and having named managers (from within the CCG) leading on operational steering groups.	The IG lead's involvement in the weekly conference calls enabled them to pick up IG issues with partners. The TCCC development team were able to identify potential conflicts between the speed of progress on IG discussions and other aspects e.g. technical capabilities such as setting up secure email.

Developing a shared approach to managing dissent		
Challenge	**Approach**	**Outcome (not necessarily all solutions)**
During the development of the TCCC Information Sharing Protocol the need to manage patient requests to 'opt out' of data sharing was raised by partners. Three ways that patients might want to register their 'dissent from sharing data' were identified: 1. The patient informs their GP. 2. The patient is asked if they want to be enrolled in a TCCC service (e.g. complex care co-ordination) at their GP practice or other location, and decides to dissent. 3. The patient contacts the TCCC directly by telephone or e-mail and requests to dissent from sharing data with the TCCC.	Regular meetings held by the TCCC with local health partner and Council IG leads – provided a mechanism to discuss and develop dissent management approaches for each of the identified scenarios. Through these discussions, and building on existing relationships and understanding, partners agreed that the TCCC would manage the dissent process. The TCCC enquiry team was agreed to be the initial point of contact in all scenarios when a patient wishes to dissent, or is unsure of the implications of dissenting. Managing enquiries directly from patients or from a partner organisation passing on a patient's wishes.	Opt out from the TCCC's services and data sharing processes are currently minimal. Opt out requests are being managed centrally by the TCCC by: ▶ Speaking to the patient explaining the full implications of dissent/opt out. ▶ Sending a letter with an opt-out form for completion and return to the TCCC. ▶ Notifying relevant partners of the patients opt out. A comprehensive dissent management process has been documented and added as an appendix to the TCCC Information Sharing Protocol signed by all partners.

Agreed data sharing delayed by technology issues		
Challenge	**Approach**	**Outcome (not necessarily all solutions)**
Despite gaining agreement from adult social care partners for information sharing, the flow of data was delayed by technology issues, namely the lack of access to the secure NHS N3 Network.[4]	Solution identified and implemented to enable information sharing via a local community of interest network (CoIN).	TCCC staff are able to access social care data to support referral management, care co-ordination and discharge support, in order to improve patient journeys.

[4] For more information, see - http://n3.nhs.uk/NewtoN3/N3enabling21stCenturyhealthcarefortheNHS.cfm

Supporting patient communication and understanding		
Challenge	**Approach**	**Outcome (not necessarily all solutions)**
The challenge facing the TCCC is to ensure that literature it produces about its services is as effective as possible, as it supports the frontline staff and clinicians who use it. Patients eligible for support from the TCCC may be referred to the TCCC by their GP or the discharge team at their local hospital. With this in mind, partners to the TCCC Information Sharing Protocol have agreed that: "It is good practice to obtain explicit consent from patients at initial point of contact by the TCCC, acute hospital staff (e.g. discharge teams) or Trafford GP. Partners' literature about the TCCC has been produced to support partners in actively informing patients about the services offered by the TCCC, and how their personal confidential data may be used and to whom it may be disclosed for the purposes of the TCCC service.	A key part of the TCCC's approach to developing fair processing notices and patient leaflets has been to work collaboratively on the content of these documents with GPs, hospital discharge teams, Information Governance leads, and patient representatives. Making changes as a result such as, including a list of all partner organisations' names and logos to help people understand who data would be shared between. The TCCC also take on the role of managing the production and distribution of these documents to GP practices and other relevant locations. Alongside the development of leaflets, the TCCC team have included time in their ongoing programme of GP engagement to get feedback on from clinicians on what they feel patients need to know and how best this can be communicated.	GPs are involved in shaping not only the content of patient leaflets but also inputting into decisions about how and by who consent conversations should take place. Patient feedback on the TCCC service is being gathered by the TCCC team and used to help improve communications about the service and its benefits to both patients and practitioners. A TCCC newsletter for partners has been developed to support practitioners in understanding the services offered, and the progress being made on new services, so they are well placed to cascade this knowledge to other staff and patients.

Providing real-time insight from pseudonymised data		
Challenge	**Approach**	**Outcome (not necessarily all solutions)**
Risk stratification using nationally collected hospital (SUS) data can be helpful but is based on data which is about 4-weeks old when it is received locally, and is only delivered weekly. Part of the TCCC service is providing Risk Stratification on behalf of local GPs. The data gathered through delivery of the TCCC services potentially offers a real-time source of local data that could enable risk stratification. The challenge facing the company delivering the TCCC (known as CSC) was that they weren't able to anonymise or pseudonymise data, so to utilise the TCCC service data for risk stratification a Section 251 approval might be required (a potential lengthy process which could delay implementation).	The need to secure a section 251 consent was avoided by the development of an alternative arrangement which uses a 3rd party (Mede Analytics) to carry out matching of data pseudonymised at source. This approach was developed following early discussions with the Information Commissioner's Office (ICO), which led to the decision that the CCG would be the data controller, and consultation with partners locally. Additional safeguards built into the approach include: ▶ Data security and Information Governance (IG) compliance requirements in the contract between the CCG and CSC. ▶ Strict access control, with only GPs and TCCC clinical staff having access to the de-identified personal data reports for direct care.	Mede Analytics have had confirmation from the Confidentiality Advisory Group (CAG) that support for section 251 is not required. The ICO concluded that having reviewed the controls described in the paper presented to the CAG, the data processed by the Mede Analytics tool would not be covered by the Data Protection Act's definition of personal data. The ICO recognises that there is the slight possibility of re-identification, but accepts that the given purpose and safeguards included within the solution render the data appropriately de-identified.

Successes

1) Securing and sustaining GP 'buy-in'

One of the early successes of the TCCC has been the ability to secure and sustain buy-in from local GPs. Gaining agreement to the ISP which underpins the delivery of the TCCC's services, and engaging GPs in an ongoing programme of dialogue to help shape its development.

A focus on GP engagement has been key to the development of the TCCC from the beginning, with the initial conversations with the local medical council (LMC) regarding the local enhanced GP scheme acting as a key starting point. To help ensure buy-in at this stage, the chief operating officer (COO) attended a number of LMC meetings to discuss the aim of the TCCC and the information sharing arrangements involved, these presentations were supported by the CCG's information governance lead.

These discussions helped explain that the information sharing agreement was the same for all local GPs but would need to be signed by each individual practice, and provided a forum in which GPs could raise concerns or questions. The main issue raised in the TCCC discussions was around the consent model, so this was an area of focus within the ISP in order to help reassure local GPs.

The initial meetings with the LMC and GPs also provided an opportunity to explain that the TCCC is about more than an integrated care record, as it is also about referral management on behalf of GPs, discharge management, complex care management, analysis and risk stratification. Helping to secure buy-in by setting the information sharing in context of shared partnership reform aims and potential benefits for patients.

In addition to engaging the LMC, the TCCC has been actively engaging with local GPs through a phased programme of 1:1 visits with each local GP practice. The first round of visits focused on introducing the TCCC and securing buy-in to the ISP (signed-up to by 32 of 33 GPs as a result). In the second round, the TCCC shared progress, sought feedback and encouraged GPs to start identifying patients eligible for the complex care co-ordination and risk stratification processes.

Factors which have contributed to the success of this ongoing programme of GP engagement include:

- The involvement of a practising GP (with previous experience of working in Trafford) as part of the team delivering the engagement visits. Helping to give credibility to the engagement process and a sense of shared understanding of issues raised.
- Creation of a single point of contact for GPs within the TCCC team to encourage engagement and feedback in-between visits.
- Co-location of the GP liaison role within the TCCC admin and clinical teams, helping to ensure any GP related issues are passed on and responded to.
- Actively asking GPs for both feedback on current services and input to help shape new processes. As a result, gaining understanding of GP preferences on a range of issues, such as the use of templates, the role of the GP and TCCC in referral consent and information sharing consent conversations, and identifying opportunities for improvement.

2) Developing trust, improving quality and patient outcomes

Before the creation of the TCCC, referral monitoring in Trafford was carried out through a programme of GP peer review. Using a 'red, amber, green' scoring system, the peer review process focused on checking the 'correctness' of the referral, rather than the quality of the referral. As the process wasn't linked with the referral booking system, the peer review wasn't able to take account of actual patient experience.

With the establishment of the TCCC, the peer review process was replaced by the referral monitoring service delivered by the TCCC staff. As the TCCC also delivers the referral booking system and uses locally developed clinical pathways for 28 priority conditions, the change has helped improve the ability to assess the quality of the referrals both in line with local guidelines but also incorporating patient feedback.

The change in referral management process resulted in some concerns being raised by GPs initially. However, the work carried out by the TCCC clinical team and GP liaison to build trust and a shared understanding of the service has both addressed initial concerns, and resulted in a 90% acceptance rate by local GPs for recommended amendments to referrals made by the TCCC clinical team.

The TCCC clinical team felt that key to this successful transition was:

- Helping GPs to understand the value of the service to their patients.
- Developing a new way of working which acknowledged the potential for GPs to feel 'threatened' by the change, using diplomacy and careful choice of language (e.g. 'recommended' changes not 'required' changes to referrals).
- Adapting their approach to reflect the variety of ways of working by different local GPs.

The impact of the work done by the TCCC clinical team is starting to be seen in the referral letters produced by local GPs. The letters build trust and create a sense of shared ownership of the new approach to referral management. GPs are starting to include more detail and use a common language for these letters, including elements from the locally amended map of medicine referral pathway. This means both improvements in the quality of referrals and, ultimately, improved outcomes for patients and their families.

Improving outcomes for patients and their families – an example of how the TCCC is making a difference

A staff member from a care home needed a patient moving to a nursing home, the patient was bed bound and her husband was blind, they were all getting very agitated as no one would agree to fund this move. The TCCC made numerous calls to the funded nursing care team who then checked their records to see if the CCG would fund this patient. After a lot of phone calls back and forth it was eventually authorized and the carer was called back, she was very grateful and stated that she couldn't thank us enough as she had already spent the best part of the day trying to sort this out and then was amazed that one phone call to us and everything was in place.

Key learning and next steps

The TCCC is still in the early stages of delivery, but the model is already creating impact locally and offering key learning which can be applied locally and further afield, including:

- The importance of a shared vision with strong leadership to support new ways of working and the information sharing which underpins them.
- The value of early, proactive and ongoing engagement with key stakeholders (such as GPs and information governance leads) to developing agreed approaches to consent and dissent.
- The need to embed information governance into programme management arrangements at an early stage to enable co-ordination with other cross-cutting workstreams.
- The benefit of collaboration with partners, including clinicians, frontline practitioners and patients in the development of effective communications materials (to raise awareness of both the service and the information sharing which underpins it).
- The value of 'clinician to clinician' collaboration in building trust and shared objectives.
- The importance of carefully selecting language when working with partners through periods of change.

Further learning will no doubt be provided by the continued development of the TCCC and the evaluation of services which the TCCC's data will support. Next steps for the TCCC, offering opportunities for further learning, include:

- The development of a secure web portal to give role-based access to views of combined patient records to GP, hospital clinicians and social workers. Alongside exploring the potential for limited access to such a portal for other public sector organisations.
- The extension of the data sharing arrangements to include a wider range of services with a role to play in supporting wellbeing, such as housing associations, patient transport/ambulance services, care homes, hospices and healthcare focused charities. Starting with discussions to identify what data fields might be needed, and why, in order to plot scenarios.
- The planned move towards self-management, by service providers themselves, of information about local services contained within the directory of services, to support a broader scope covering services provided in neighbouring areas.
- The development of patient access to the directory of services (via an enquiry management portal or tab), to enable the public to tap into self-help areas such as help and advice for healthy living.

Exploring the potential for this learning to be applied more widely across GM will also be a key opportunity for both the TCCC and GM-Connect.

Find out more

To find out more about our work in GM visit **www.informationsharing.org.uk/GM**

Acknowledgements

The development of this case study has only been possible thanks to the time, information and help offered by the staff of the Trafford Care Co-ordination Centre, NHS Trafford CCG and GM-Connect. Appendix one

Appendix one

TCCC information sharing protocol – summary

Development and signatories

- Developed with partners through a series of workshops and meetings.
- Signed by the caldicott guardian/ senior information risk owner (SIRO) and designated information governance (IG) lead in each partner organisation.*

Roles

- CCG are the data controller for personal confidential data shared for the purposes of using the TCCC service.
- Computer Sciences (CSC) limited are the data processor for the purposes of providing the TCCC service on behalf of the CCG and Trafford GP practice partners.
- The TCCC Contract places detailed obligations on CSC (and any sub-contractors) to ensure that they maintain the confidentiality and security of any personal confidential data which it processes for the purposes of the TCCC Contract, at all times.
- Mede Analytics are the data processor for the purposes of providing the pseudonymised business analytics and risk stratification solution to the TCCC, CCG and Trafford GP practice partners.

Legal basis for sharing

- A shared consent and a dissent model – based on obtaining explicit patient consent where-ever possible.
- TCCC partners are able to share personal confidential data with the TCCC and other TCCC partners (for the purposes of this protocol) as they can satisfy the following conditions for processing of sensitive personal data:

  'Necessary for medical purposes', including 'the provision of care and treatment and the management of healthcare services' (section 8, schedule 3 of the DPA) and/or

  By obtaining 'explicit consent' (section 1, schedule 3 of the DPA) in accordance with the purposes listed in the ISP.

* Central Manchester University Hospitals NHS Foundation Trust (CMFT)
University Hospitals South Manchester NHS Foundation Trust (UHSM)
Salford Royal NHS Foundation Trust (SRFT)
Pennine Care NHS Foundation Trust (PCFT)
Greater Manchester West Mental Health Foundation Trust (GMW)
The Christie NHS Foundation Trust
Trafford Council
Trafford GP Practice(s)
NHS Trafford Clinical Commissioning Group (CCG)
Mastercall Healthcare