

# Good practice in Information Sharing in the Foundation Years

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**Note:** The examples of local tools to support best practice which are referred to in this report are available at [www.foundationyears.org.uk/information-sharing](http://www.foundationyears.org.uk/information-sharing) .

## Background

1. The need for good information-sharing across agencies is illustrated by real-life experiences like those below.

*A six month-old child of a depressed mother in a failing relationship, where the local Sure Start Children's Centre did not know of her existence and so was unable to provide support.*

*A private nursery where staff did not share concerns about possible safeguarding issues because they were afraid they would lose the parent's trust and subsequent custom.*

*A young disabled child whose parents had multiple appointments on different days with various professionals at a Child Development Centre, because staff believed that information governance rules prevented them from sharing information.*

*A three-year-old child attending a nursery where staff, noting that she did not talk a great deal, decided to 'give her a term to settle in' before taking action, not knowing that she had previously had support from a home-visiting service coordinated by speech and language therapists.*

2. Information exchange about young children is an issue for **all** agencies providing education, health and social care services. Currently, local authorities struggle to get basic information from the health service about live births, so that children's centres can let new parents know about the services they offer; the health service struggles to get information about what schools children attend so that school nurses can pass on vital information about healthcare needs to teachers. Education and children's services staff are not always sufficiently aware of parents' rights to be asked for consent to share information. They may, for example, discuss information with health staff about a family's difficulties without seeking an agreement first. Conversely, information governance models in health services can place a stress on confidentiality that goes way beyond sensible sharing of information about a child's developmental status and needs.
3. In response to these issues, a joint request from DfE and DH ministers established a short-life 'task and finish' group to:
  - **explore and reflect on how** exemplar information-sharing practices already in train in many local areas can be further promoted;
  - **identify any on-going barriers** which different local partners experience to information sharing;
  - **make recommendations** about how barriers to information sharing might be overcome.
4. The work of the task and finish group was carried out through a series of three full group meetings, rounds of separate one-one discussions and interviews and several case study visits. This evidence fed into a report for Ministers, with

recommendations. This report for Ministers, *Information Sharing in the Foundation Years: a report from the task and finish group* is available on the website of 4Children.

5. In the course of the work, a great deal of good practice in information-sharing was captured. There are robust systems to share live birth data, reorganisations of health visitor and children's centre clusters into hubs to enable strong case plan development, information sharing protocols to strengthen data flow, integrated training and delivery systems, joint targets and work plans, colocation and IT system sharing – even promotional media such as pens for staff to remind them of the key principles of information sharing (Figure 1). So solutions to the problems related to information sharing are already within our grasp.



**Figure 1** Warwickshire have distributed the ‘seven golden rules for information sharing’ pen to staff

6. This good practice has been collated in this report, so as to be available to local commissioners and providers.

## Strategic leadership – joint commissioning of an integrated Foundation Years service

7. The task group was told about the strong strategic leadership in some local areas, across health, social care and education, which promotes the benefits of integrated working and consequent shared access to information.

### Case study 1 Integrated services in Brighton and Hove

This is an example of full integration of health and local authority services. Children's centres are managed as a city-wide service, led by three Neighbourhood Sure Start Service Managers, two with health visitor backgrounds and one from social work. The entire health visiting service for the city has been seconded into the Council through a Section 75 agreement and work as an integral part of the children's centre service.

The integrated children's centre teams are led by health visitors, who supervise outreach workers. In addition there are specialist city-wide teams offering specific support - for example, breastfeeding coordinators to encourage initiation and sustain breastfeeding in areas of the city where this is low. Traveller and asylum seeker families are supported by a specialist health visitor and early years visitor post. Teenage parents are supported by named health visitors and early years visitors at each children's centre.

This model has delivered value for money, transparent and effective use of resources, and safe evidenced based health care delivery. The impact is evident in improvements in breastfeeding rates, obesity rates and a sharp rise in the percentage of children living in the most disadvantaged areas who achieve a good Early Years Foundation Stage Profile score – from 33% in 2008 to 55% in 2011. The most recent children's centre to be inspected by Ofsted was judged to be outstanding in every area; inspectors noted that the health-led model plays a fundamental part in streamlining services and integrating provision. Ante-natal and post-natal services are delivered directly from this Centre. As a result, the Centre reaches 100% of children aged under five years living in the area and has made an impressive impact on children's welfare and family well-being.

### Case study 2 Development of an integrated Early Start service in Leeds

A large scale joint review was undertaken in partnership with Leeds City Council and Leeds Community Health Care NHS Trust, following a six-stage plan involving consultations with parents, strategic leaders and frontline staff. Time was spent scanning the context and exploring local case studies. The key questions being asked were – What do families need? What do we need for our population? How can we build and develop real joint universal pathways?

The next stage was building trust across a large group of staff (approximately 650 Children's Centre staff and 150 Health visitors). The vision was to build truly joint teams in hubs across Leeds.

Middle managers were brought together to talk through the vision and the issues that would need to be faced. This developed a sense of trust that all were involved in the new way of working.

Finally the reorganisation began and brought health visitor case files and workloads in line to match children's centre cluster hubs. This has created alignment between caseloads and children's centre patches, rather than with the GP surgeries. To strengthen the reorganised hubs Leeds have also developed:

- An information-sharing agreement

- New safeguarding principles
- Colocation where possible
- Dual accountability pathways (Universal and targeted pathways in Appendix D)
- An information-sharing script to be used by children's centre staff when seeking parent/carer consent to share information (see Appendix D)

Leeds are now at the implementation phase, with a planned rollout to cover 25 clusters, including a conference, road shows, toolkit launch and training events covering locality information sharing.

All this work has taken a good deal of time and effort - particularly the agreements on information sharing. This had been a problem for many years, as one local practitioner reflected:

*"In terms of the information sharing agreements - having worked for nine years setting up children's centres it has been the ultimate frustration not to be able to share information with partners around families we are working with. Over the years we have tried many routes- one of the most successful being putting 'inserts' into the Red book for parents<sup>1</sup> to give consent to health visitor to then share their name and addresses, obviously fraught with difficulty, but it was a step in the right direction."*

Finding a better solution meant involving a range of stakeholders:

*"When we made a strategic decision to bring children's centres and health visitors together under a jointly drawn up specification between health and local authority, we knew that information sharing was a key component of allowing the teams to work effectively. A working group was set up to tackle and work through all the thorny issues around sharing data, including agreement from the Caldicott guardians. It has taken twelve months but we now have in place an approved information sharing agreement across the community health trust and local authority which gives us a clearly defined and understood process for managing information sharing, confidentiality and consent. We are in the process of notifying every parent in Leeds with children under five about this change, the local authority using individual national health numbers, and data systems sharing- no easy task!"*

**Head of Early Help services**

### **Case study 3 Integrated approaches in Bristol**

Every children's centre in Bristol has a linked health visitor and speech, language and communication therapist. The children's centres receive sophisticated data to inform the priorities for their community, and all live birth and GP move data to support effective outreach work and the delivery of universal and targeted services.

Protocols are in place to share information between health visitors and children's centre leaders (with parents' permission) on any families or children considered vulnerable at the 14 day check. This enables a holistic joint plan to be agreed and hopefully prevents later escalation of difficulties.

A number of specialist children's centres offer community based health assessments for children with multiple and complex needs, associated therapies and a specialist resource base, alongside the regular children's centre core purpose. Joint funded (health and education) Early Support Developmental Assessment posts are an effective example of aligned resourcing and support a shared vision and purpose. The attendance rate at clinics has improved dramatically since the introduction of the Specialist Centres, as families can now access appointments locally and feel much more confident in an environment that they know and trust.

From April 2013, two key members of the Public Health team - the Healthy Early Years Lead (Nutrition and Exercise) and the Breast Feeding Lead, will be joining the Early Years Service in Bristol. This will again strengthen an aligned and integrated approach to achieving improved outcomes for children and families, including those associated with obesity and oral health as well as healthy life styles and early

<sup>1</sup> The parent-held Personal Child Health Record is commonly called 'The Red Book'.

attachment.

8. We saw many examples of **formal frameworks** providing a structure for sharing information and setting out the expectations for services involved. In Blackpool, a memorandum of understanding has been developed to formalise the offer between NHS services and children's centres across the locality. Warwickshire have a similar partnership agreement (available at [www.foundationyears.org.uk/information-sharing](http://www.foundationyears.org.uk/information-sharing)).

#### **Case study 4 Warwickshire's partnership agreement**

This was developed under the leadership of Warwickshire's health lead for children's centres. Herself a former health visitor, she is employed by health but located in the local authority, where she sits on a number of senior leadership teams. The partnership agreement sets out the roles of different agencies in delivering the Healthy Child Programme and children's centre offer. It is linked to Ofsted inspection requirements, which has proved helpful. Every children's centre and health visitor has signed up to the agreement.

9. **Joint commissioning** and posts shared across health and the local authority were also often features of strong strategic leadership. Where there was joint commissioning of an integrated birth (or conception) to five service, information sharing habitually followed. In turn, data gathered as a result of improved information sharing informed effective strategic planning.

#### **Case study 5 East Lancashire Health Coordinator Team**

A team of four health coordinators based within Lancashire Care NHS Foundation Trust acts as the broker between all mainstream health services, the children's centres and well-being providers. Each coordinator covers a locality, and leads across the whole area on specific topics, such as nutrition. The role has been independently evaluated by the University of Central Lancashire as being effective in fast delivery of complex multi-agency projects.

The coordinators provide mentorship on children's centre health development plans as well as providing training and support to Centres to ensure that health activities are evidence based and delivered to high quality standards.

They have led on specific projects, such as a dental access scheme which enables children's centres to make a child's first appointment with a dentist; this has increased the take-up of dentistry in the early years and generated over 7000 new dental attendances. Vitamin D is distributed by all children's centres – important in an area with a high Asian population and a growing problem of Vitamin D deficiency. Uptake of Vitamin D has shown a significant increase from 300 units p.a. to 18000 p.a. within two years of the scheme starting.

There is also an emotional health team, comprising Infant Mental Health Workers and Drug and Alcohol Workers, which focuses on pregnant women and families with an infant or pre-school child. This team's work fills the gap between universal and specialist services. 60% of those completing targeted work with the team are subsequently managed back into universal provision.

Health visitors and children's centre staff provide an integrated service to families. There is a set programme of home visits made by health visitors, with children's centre staff visiting in between to reinforce messages about breastfeeding, weaning, promoting language development and so on.

10. Jointly developed, **outcomes-based specifications** were another feature of good practice observed by the task group.

#### **Case study 6 Blackpool payment by results and information sharing**

Blackpool was part of the payment by results trial for children's centres. There has been much work to achieve strategic link-up in order to help deliver some of the required outcomes. Decisions were taken to cross-link health and children's services strategic groups. On the children's centre payment by results group, health, data colleagues, children's centre leaders (school based and hubs) come together. They have a children's centre Membership Form completed by Health which gives children's centres consent to contact families. At the Healthy Child Programme group, health visitors, school nurses, acute Trust, public health, midwifery, health strategy and early years and family support leads meet up. A link health visitor sits on each of the children's centre advisory board.

Both groups come together to discuss many issues including the offer of free early education places to the most disadvantaged two year olds and two year progress check, as Blackpool was a pilot area for the grant for two year olds.

The close working has allowed establishment of shared targets and joint training such as breast feeding 6-8 weeks, take up of early education places, immunisation and healthy start vitamins.

There was a Memorandum of Understanding between Blackpool children's centres and children's community health services, through a commissioning joint agreement. It has been extended for three years to 2015. Blackpool are keen to link this work with an information sharing protocol to address bulk data sharing (particularly live birth data) and help services to deliver against their shared targets



## Information sharing agreements and protocols

11. A number of local areas have developed effective information sharing agreements and protocols to share live birth bulk data. The key ingredients to success, as evidenced by the examples below, seem to be:
- A current, active, Information-Sharing protocol between Health commissioners and providers) and the local authority/children's centres;
  - A key focus on obtaining consent at the ante-natal, first booking appointment; this is fundamental, and simple.
  - Arrangements to store and forward personal information, which are absolutely secure.

### **Case study 7 Information sharing agreement at Liverpool City Council**

A written Information Sharing Agreement is in place between Liverpool Women's Hospital Trust and Liverpool City Council (Surestart Children's Centres). This agreement can be summarised as follows:-

- A children's centre information leaflet (supplied by the local authority) goes out with the booking appointment for newly pregnant mothers
- A mandatory field has been inserted on the central database, and at the time of the booking appointment, the midwife checks the leaflet has been received, and asks if the parent will give verbal consent for their contact details to be forwarded to their respective children's centre.
- Encrypted reports are produced and forwarded each week, via a secure email account to the relevant children's centres, where authorised staff are provided with the 'code' to access the information within the email
- This information and data is stored securely by the respective children's centres, and contact is then made with the mother-to-be, an appointment arranged, and written consent obtained, for inclusion on the children's centre database.

### **Case study 8 County-wide health initiatives in Lancashire**

Lancashire Care NHS Foundation Trust have developed a consistent approach to information sharing through an agreed protocol and consent procedure with East Lancashire Hospital Trust, Lancashire County Council and voluntary providers of children's centres. Live birth data is transferred on a monthly basis to the Local Authority from where it is distributed to the Centres.

In addition, during pregnancy, there is an Early Notification system for engaging families with their children's centre at the earliest opportunity. Midwives routinely ask pregnant women for consent to share their details with children's centres. The children's centres then make contact to offer whatever support is needed, for example helping to sort out housing problems before the baby is born. There are processes in place to minimise the risk of centres contacting a family who has lost a baby or where contact would be inappropriate.

From 'Bump to Birth and Beyond' is a standardised six week ante-natal programme, delivered by children's centres with input from health visitors and midwives.

The impact of this coherent strategy to develop health through children's centres is demonstrated by Ofsted judgments for the health outcomes, which are well above the national averages.

Developing protocols for sharing information was not without its challenges. The protocol took over a year to set up. Changes in personnel meant key people with knowledge about the aims and purpose of the work were lost. This resulted in aspects of the work being revisited and renegotiated. Strong leadership and clear succession planning are important to achieving a robust agreement that is locally implemented.

12. Further examples of information sharing protocols from two other local areas (Warwickshire and Bristol) are available at

[www.foundationyears.org.uk/information-sharing](http://www.foundationyears.org.uk/information-sharing).

13. First visit forms are another way of sharing birth data with the informed consent of families. The example below from Warwickshire shows how health agencies, working with children's centres, have agreed a system which enables the flow of information to start from the first baby review meeting.

**Case study 9 Example of first visit forms: Warwickshire Early Implementer Site**

Birth data is shared using the 'first visit' form that health visitors complete at the first baby review. On this form the parents give consent to share the birth date, name and address with local children's centres. The Child Health department enters the data on the appropriate system and each month an encrypted list is sent to the data lead in the local authority, who then sends this out to all the appropriate children's centres. The children's centres then send a 'welcome' card with details of all the centre's activities to families. children's centres have agreed not to visit families unless a referral for services has been made - or the parents get back to the children's centres and register for services. As a double check, midwives and health visitors ask parents to register at children's centres. The Trust also informs the children's centres about the total number of babies that have been born each month so that they can gauge the numbers families not registering in their reach area.

14. Formally agreed protocols and data systems can also support cross-border work. Midwives in five London hospitals, for example, have developed a system for secure transfer of information so that it can be passed on when women move from one area to another and that they will receive home visits. This is now being rolled out London-wide.

15. We were impressed by the models provided by the Early Support Programme for children with special educational needs or disabilities, in which parents hold and share information about their disabled child in the form of a Family File and Developmental Journal. Such parent-held records provide a **practical** solution to problems of information sharing, and are consistent with both health service reforms which stress the rights of individuals to have better control of their own healthcare, and education reforms which place parents at the centre of decision-making about their child. They convey a sense of true partnership between professionals and parents and help ensure that information is shared when families move and when information exchange is challenged by transitions between agencies, services, schools and settings. **Key working with families, using an Early Support approach** moreover, helps overcome the literacy and language issues which we identified as a barrier to information sharing for some families.
16. In some local areas, children's centres have successfully used the Early Support Family File with all vulnerable families, not just those with special educational needs or disabilities. Developmental Journals are now available electronically. The Journals are easy-to-use tools to help with observing, recording and celebrating progress, and to identify areas where extra help and support may be needed. All the Journals are guided by the ethos of Early Support, and aim to empower families and put them at the heart of decision-making, supported by a co-ordinated key working approach. They are available at:  
<http://ncb.org.uk/early-support/resources/developmental-journals> .

## Training and professional development

17. We saw and heard about a number of examples of multi-agency training which were helping to build trust between professionals from different agencies, and in turn leading to greater willingness to share information.

### **Case study 10 Joint training in Bowthorpe, Norfolk**

At Bowthorpe Children's Centre in Norfolk the health visiting team is fully integrated within the children's centre and managed by the Centre Leader, who is a social worker. Children, parents and families who are most likely to benefit from additional or intensive support are often first identified in the context of the universal health visiting service, and then offered the most appropriate package of support through the multi-disciplinary team. The whole team is trained in the Solihull Approach, so there is a coherent approach, and a strong, shared language which has enabled a freeing up of roles, a shared professional identity and created the ability to challenge others, and change and create thinking and practice. The centre was judged outstanding by Ofsted.

### **Case study 11 Training in Burnley**

At Lancashire Care NHS Foundation Trust's Chai Centre in Burnley, health visitors have provided coaching and support to children's centre staff on how to keep good records – such as how to identify sources of evidence, and clearly differentiate fact from opinion when writing. They might sit by colleagues and say, for example, 'What made you think that?', or 'What were you thinking when you wrote that?' This has really helped break down barriers caused by different perspectives on record-keeping.

### **Case study 12 Speech, language and communication in Blackpool**

Blackpool now offers a multi-agency and joint universal training programme for health visitors, outreach and children's centre staff. The training on speech, language and communication is delivered by an Educational Psychologist, a speech therapist and early language consultant. This course covers attachment issues, when and how to share information and refer families and is now part of the health visitor induction (which ensures 100% coverage). Each of Blackpool's children's centres and early years settings and childminders (50% of whom are members of practice-sharing professional networks) also all have a Communication Champion, whose role includes receiving and disseminating information and updates from the Early Language Consultant, identifying colleagues' training needs, maintaining parents' information boards, and undertaking additional training in order to advise colleagues and families on speech, language and communication issues.

### **Case study 13 – Joint professional development in Wakefield**

"In Wakefield, the Children's Joint Commissioning Unit is leading co-ordinated delivery of seven local area roadshows. The roadshows showcase Universal and Targeted services, with an emphasis on increasing awareness and understanding of the Health Visiting and School Nursing four-level model and the introduction of the Family Nurse Partnership model.

The roadshows also aim to promote and improve integrated working and we invite key disciplines such as Midwives, Health Visitors, School Nurses, CAMHS, children's centres, Private and Voluntary early years settings, Head Teachers, School Governors, Fire and Police to showcase their service and share good practice in partnership working.

Part of the day is dedicated to a workshop exploring how integrated working and information sharing could be improved to assist early intervention and prevention and how effective communication can be delivered horizontally and vertically through new and existing networks. Service users play an important

part in the whole day's activities by contributing ideas and telling their own stories about their personal (or their family's) positive experiences.

Feedback regarding the roadshows indicates that these are being very well received amongst delegates and are instrumental in improving their knowledge and facilitating networking. Our future plans include facilitating a highly integrated approach to positive outcomes for pre-birth to five years which will include developing children's centres as the main access and delivery point for children's health services. To deliver this ambition we are also working on an IT programme which will ensure that Connecting for Health's System. One is installed in all 23 of our children's centres.

Alongside these tasks, we are also currently redrafting the 0-19 and children's centre and the NHS and private and voluntary partner organisations specifications to ensure they effectively align with each other to promote integrated working , early intervention with focus on most vulnerable and targeted groups.”

18. In Warwickshire, all health visitors have taken part in Early Support training (on Working in Partnership with Families, Developmental Journals, Key Working) provided by the local authority; student health visitors across the East of England have similarly been included in multi-agency Early Support training. In Warwickshire, children's centres are used as community placements for health visitor students.

19. Co-delivery of services can serve a similar function of building skills and trust, as in the case study below.

#### **Case study 14 Training cascade model, Luton**

Three midwives have been seconded to Luton children's centres to provide evidence-based antenatal classes based on Birth and Beyond five themes (Barlow, 2010). Sessions are delivered to couples from 28 weeks of pregnancy and run over five consecutive weeks in Luton's children's centres, offering localised, universal provision and access for vulnerable groups. Each session is two hours long, co-facilitated by children's centre midwives and children's centre co-ordinators or Family Workers. The co-facilitated approach provides support to children's centre staff to build confidence and expertise in delivery of sections of the programme. Running the course within children's centres provides an early introduction to children's centre services, and once parents have completed the sessions they are encouraged to integrate with children's centre activities such as Bumps and Babies groups or adult education. Once their babies are born a further 'week 6' session is offered, a return to a Baby Babble or Baby group within the children's centre to all meet at a reunion. This gives opportunity for children's centre midwives to gain feedback on the content of the previous sessions and outcomes, and for parents to further develop a relationship with the children's centre. Week 6 sessions vary according to each centre, for example Children's Centre Dieticians may attend to give information on weaning. Follow up visits are also offered for debriefing of labour events and to gain information on key public health targets such as breastfeeding. In order to ensure sustainability of the project children's centre midwives are training the Community Midwifery team to deliver sessions 1 and 2, the health visiting team to deliver session 3, and the infant feeding team to deliver session 4. Sessions 5 and 6 will be delivered by children's centre outreach workers. It is expected that once staff are confident in the delivery of the programme the sessions will become part of their everyday workload, and no longer a bespoke project.

## Day to day management and teamwork

20. There are already many examples of health visitors and children's centres working together very successfully 'on the ground', and sharing information appropriately. This is a result of good management; as one Head of Service told us, *'I point out to clinicians on the ground that sharing information never caused anyone to die and that I'll stand by them in court if necessary.'*
21. An integrated 'team' approach in children's centres seems to have particular benefits for information sharing, in that it allows staff to explain to parents who is in the team who together provide support to the family, and to explain that with their consent information will be routinely shared within this team (see Appendix C for an information-sharing model which incorporates this team approach).
22. The two case studies below bring to life the day-to-day conditions which promote an integrated team approach.

### **Case study 15 – a team approach at a Warwickshire children's centre run by Action for Children**

Trust between team members at the Centre has built up over a period of time (three years) when there has been little staff turnover. Staff are co-located; sharing an office and building means more opportunities for informal communication. Efforts have been made to build relationships; having time to get to know each other over shared lunches has been important, as has joint project work (for example on Change4Life and the Early Years Foundation Stage progress report for two year olds).

Staff prioritise attendance at a weekly 'Family Matters' meeting, where packages of support for families are discussed and there are regular discussions about families with a Common Assessment Framework (CAF), Child in Need Plan or Child Protection Plan. All staff who have contact with the parents and children are encouraged to contribute, and know that their observations are important.

All team members are open and honest with parents at each stage – parents know what will be discussed at any meeting of professionals, and why. A lead health visitor comments 'I've had no parent ever say no about information sharing on any subject, as long as we are honest with them and say why.'

The Centre is a pilot site for shared records; a small number of cases have been identified where children's centre staff have a significant role. So far all cases have had a CAF, Child in Need Plan or Child Protection Plan. The health visiting team have assisted with record keeping training for children's centre staff.

Early Support meetings are also held in the Centre, as are a significant number of Child Protection meetings; if possible a crèche is provided. This encourages parental attendance and engagement with Children Centre activities. Staff work as an integrated team with the CAF process, and try to share the role of lead professional between health visitor and Family Support Worker.

Health visitors have monthly meetings with the Centre Co-ordinator to discuss health issues, such as breastfeeding rates or joint antenatal sessions.

Student Social Workers on placement are invited to shadow the health visiting staff, and Student health visitors invited to shadow Family Support Workers to promote understanding of the roles within the team.

A lead health visitor attends local weekly GP practice meetings, so that she can take to the GP any issues a family have asked to be discussed with their doctor.

### **Case study 16 - a team approach at The Chai Centre, Burnley**

This is an example of two teams, a health visiting team and a children's centre team, working together. The two teams are both employed by Lancashire Care NHS Foundation Trust, share an office and co-location makes communication easier. To step across an office and talk to someone is simple, while leaving messages which are returned when you are out is a laborious process.

Sharing records was a major hurdle. It took time and training to get this right, but the result is one set of records for each child.

The teams developed an enhanced version of the Healthy Child Programme, with every family receiving 12 core home visits in the first three years of life. These are enhanced by bespoke packages of care being jointly delivered to families with assessed additional needs.

Health visitors and children's centre workers do some joint visits, particularly where the issues are more complex. Where children's centre workers provide family support, the health visitor is always fully informed and provides on-going guidance and support to the worker. The intensive outreach programme led to a dramatic increase in families accessing services at the Centre and very high levels of engagement are maintained.

As a result of joint working, health visitors have helped children's centre staff develop their skills and the children's centre team has helped health visitors by delivering on-going support to families with lower-level needs and working effectively in an ethnically diverse area.

Integrated working has allowed the teams to use the mix of skills effectively – families are supported by the worker with the right skills and knowledge for them, freeing health visitors to concentrate on the most complex issues.

23. Good management is important in all services for children, not just children's centres and health visiting. In Harrow, for example, strong leadership of the speech and language therapy (SLT) service means that parents are at their first contact with the service always asked for their consent to share information with education professionals who work with their child. There is also a local transition protocol for school entry, so that information that the child has had involvement with the SLT service pre-school will be passed on - in view of the increased risk of later literacy difficulties for children who have experienced an early language difficulty, even if the language difficulty has been successfully treated and the child discharged.

24. GPs form a key part of the information sharing landscape, are vital in ensuring family health and well-being, yet have often felt cut off from the children's centres which can often provide the support their patients need. As one early years lead told us 'GPs need to see that the answer to their prayers is just down the road – a mile away from their patient, at their local children's centre – when they are faced with a child with behaviour problems or a depressed mother or an isolated parent who they could be sending to a local Somali family support group... but they don't know what's on offer, or even whether a children's centre might be working intensively with a family on their list.'

25. We were therefore keen to find examples of good practice in ensuring GPs receive the information they need.

### **Case study 17**

Bowthorpe Children's Centre has been singled out as a model of good practice in partnership with GPs. Shared processes, policies and protocols across the professionals working within the Centre include a child health record keeping system, which is also shared with GPs. The Centre worked with a local GP practice to pilot the East of England Strategic Health Authority System1 Safeguarding Template, prior to roll out across Children's Services in autumn 2012.

### **Case study 18**

In Islington, a 'First 21 months' project has increased the involvement of GPs with children's centres through joint conferences and GP Forums held on children's centre premises. The local authority early years lead has secured short slots on the agenda of various meetings attended by GP to explain the work of children's centres. GP Practice Managers sit on an operational steering group for the Centres, and children's centre leaders make a point of reaching out proactively to this key group.



## What works – a summary

26. From these examples of effective local practice it is clear that **strong, well supported and championed local processes, underpinned by workforce training** are the key to effective information sharing, so that everyone is confident about access to information and the process of consent.
27. **Local information sharing agreements or protocols for information sharing** may be appropriate to address **bulk or pre-planned information sharing**. However they cannot cover every eventuality that a practitioner could encounter and do not contribute to building the necessary practitioner skills and confidence on their own.
28. In order to embed good practice in information sharing at the front-line between health and children's services staff, the effective practice we saw focused on **maximising the skills and confidence of front-line practitioners who have to make these case-by-case information sharing decisions**. This was often achieved by **integrating information sharing advice with appropriate support, guidance and training** and by ensuring that all organisational policies and processes empower and support practitioners in making these information sharing decisions and in sharing information securely.
29. Very often the solution to effective information sharing seemed to require **cultural change** as part of a move towards **stronger integrated working practice**. This in turn was achieved through strong **leadership and strategic vision**.

### **Good practice in information sharing in the early years A factsheet for local commissioners**

#### **Information sharing works best where :**

- Local authorities (exercising their existing Early Years functions and their new Public Health functions) work with the NHS Commissioning Board and Clinical Commissioning Groups to jointly commission an integrated service for children from birth (or minus nine months) to five years and their families, setting out a single set of outcomes, the roles and responsibilities of different agencies and professionals in delivering these outcomes, and a single 'reward' system for achieving them.
- Commissioners build into service specifications, contracts and SLAs requirements to share information effectively and to use inter-operable IT systems appropriate to mobile workers to support information sharing across key partners.
- Commissioners commission local training on information sharing for multi-agency groups.
- Commissioners promote co-location of services
- Commissioners identify level of need for and commission appropriate Team Around Child and key working capacity.
- Local agencies develop formal Partnership Agreements, Service Level Agreements and Memorandums of Understanding, to ensure that information flow is not reliant purely on existing local relationships.
- Local agencies consider boundary issues when developing these agreements and protocols.
- Local authorities and Clinical Commissioning Groups recognise that the development of integrated working, including information sharing requires dedicated time, focus and leadership. Strategic and operational responsibility and capacity for developing these aspects of working practice are clearly defined within the management structure for a local area

### **Good practice in information sharing in the early years A factsheet for local authority early years senior managers and senior health managers**

#### **Information sharing works best where :**

- Children's centre leaders are involved in the training of new health visitors/midwives and health visitors/midwives in the training of children's centre staff, with placements in children's centre and health clinics.
- GPs are made aware of what children's centres offer, and receive simple maps of what services are available in each location.
- Senior managers ensure extensive and high quality training for staff at all levels on basic IT systems and software packages; promote better understanding and availability of new technology and what is possible e.g. I-pads and remote access backed up with good accessible call centre advice.
- Senior managers promote the development of key working and support for individual

practitioners taking on a key working role as integral to the effective management of integrated service provision if the needs of families with complex additional support needs are to be met.

- Senior managers highlight the positive and negative impact on the lives of families resulting from good and bad exchange of information at operational level in any training developed.
- They highlight to early years staff the consequences for health colleagues if information they have been told in confidence leaks out.
- They provide a model contract for children's centre staff which includes confidentiality requirements, and Code of Conduct on confidentiality to which children's centre staff sign up.
- They promote the concept of the 'team around the child' by making this a shared accountability/family contract to work together on a single issue with a family, that individual staff involved sign.
- They promote shared multi-agency training.
- They ensure that staff implement local agreements - for example use of children's centre registration form and consent at the first health visitor home visit.
- They build information sharing into staff PDRs/ appraisals.
- They develop a single local record keeping system (electronic or paper) for use by both health visitors and Family Support Workers.

## **Good practice in information sharing in the early years A factsheet for children's centre and other early years setting leaders**

### **Information sharing works best where you:**

- Include information sharing policies and procedures in induction and regular staff updates.
- Build information sharing into staff supervision, PDRs/ appraisals.
- Involve parents in providing training, to share their perspective on information sharing.
- Use staff meetings, inset days, away days to provide....
  - Opportunities for teams to get to know each other as individuals.
  - A clear understanding across the team of the roles and unique challenges of different professional groups and the protocols/cultures they work with.
  - Discussion about challenges of being part of the community you work with and clarity about the definition of confidentiality.
  - Opportunities to agree terms of reference that staff sign up to in regard to attendance at regular team meetings to discuss families' needs.
- Develop a children's centre registration form which defines for parents the core multiagency centre 'team' and allows them to provide consent for information sharing of non-sensitive information about a child's development and health within that team.
- Firm up the concept of the 'team around the child' by making this a shared accountability/family contract to work together on a single issue with a family, which individual staff involved sign.
- Find ways to talk to and engage GPs in what the children's centre offers.
- Promote the development and use of standard parent-held Family File, where families wish to use this.
- Where families are less able to hold and share information themselves, use key working to

support them.

- Recruit bilingual staff into many different roles, train them to qualified interpreter status and place these staff on a staff bank with additional enhanced pay when they are called away from their post and used to interpret for colleagues

## Appendix A – Information sharing task and finish group

<b>Members</b>	<b>Job title</b>
<b>Jean Gross CBE – Chair</b>	Former Communication Champion for Children and Young People
<b>Phil Walker</b>	Head of Information governance policy. Informatics Directorate DH
<b>Sue Robb</b>	Head of Early Years, 4Children - DfE Strategic Partner
<b>Ann Crichton OBE</b>	Chair of the Children's Centres Leaders Reference Group
<b>Bernadette Duffy</b>	Head, Thomas Coram Centre
<b>Maria Luscombe</b>	Associate Clinical Director Children's Services/Head of Paediatric Therapy, NW London Hospitals Trust
<b>Dr David Low</b>	National Clinical and Lead Paediatrics Designated Doctor for Safeguarding Sandwell & Consultant Paediatrician SWBHT
<b>Elizabeth Andrews</b>	Early Support
<b>Jane Williams</b>	Head of Children, Young People & Family Services, South Warwickshire NHS Foundation Trust
<b>Jackie McCormick OBE</b>	Sure Start Children Centre Locality Manager West Northumberland
<b>Nicola Amies</b>	Director of Early Years, Bright Horizons Family Solutions. Expert Panel member on Tickell & Nutbrown Reviews
<b>Judith Mace</b>	Manager, East Lancashire Health Improvement Services, Lancashire Care NHS Foundation Trust
<b>Liz Elsom</b>	Divisional Manager Early Years & Childcare, Ofsted
<b>Sally Jaeckle</b>	Head of Early Years Services, Bristol Local Authority
<b>Fiona Smith</b>	Adviser in Children & Young People's Nursing, Royal College of Nursing
<b>Jenny Cleary</b>	Head of Midwifery, Whittington Health
<b>Tracy Jackson</b>	Early Years Strategic Lead, Stoke on Trent
<b>Penny Kenway</b>	Head of Early Years, Islington Council
<b>Clare Sandling</b>	Starting Well Policy Lead, Department of Health
<b>Patrick Branigan</b>	Sure Start and Quality, Department for Education

# Appendix B Summary of current regulations and guidance on information sharing, and recent developments

## Current regulations and guidance

In 2008 the Government published revised information sharing guidance<sup>2</sup> – which aimed to support good practice in information sharing by offering clarity on when and how information could be shared legally and professionally. The guidance was developed in consultation with a range of practitioners, national organisations and representative bodies and consisted of a package of materials which included:

- *Information Sharing: Guidance for practitioners and managers* Essential guide as it details how those working with client information should make decisions about information sharing.
- *Information Sharing: Pocket guide* containing a summary of the key decision making consideration
- *Information Sharing: case examples* which illustrated best practice
- *Information Sharing: training materials* available for local agency and multi-agency training
- *Information Sharing: Further guidance on legal issues* which provided a summary of the laws

The guidance focused on making case-by-case decisions about sharing personal information and **did not deal** in detail with arrangements for “bulk” or “pre-agreed” sharing of personal information between IT systems or organisations.

To help address this gap in March 2010 this guidance was supplemented by specific guidance for the early years *NHS Services and Children's Centres - how to share information appropriately with Children's Centre Staff*<sup>3</sup>. The jointly produced DH and DfE booklet set out the framework for information sharing between all practitioners based at a children's centre, so that information could be shared appropriately. It focused particularly on sharing information relevant to delivering effective health services delivered through a children's centre and included some case studies of children's centres which had taken steps to improve information sharing.

The guidance notes that children's centres and health services will generally be working with two kinds of information;

- anonymised or aggregated information

Anonymised or aggregated information (where an individual is **not identifiable**) is not subject to the Data Protection Act and hence can be shared. An example of this is population data on local needs drawn from the joint strategic needs assessment.

- data where an individual is identifiable.

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<sup>2</sup> DfE and DCLG (2008) Information sharing: Guidance for practitioners and managers <http://education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-00807-2008>

<sup>3</sup> <https://www.education.gov.uk/publications/standard/Integratedworking/Page1/DCSF-00301-2010>

Where an individual is **identifiable**, there is a need to distinguish what is classified as ‘pre-planned or bulk information’ and ‘case-by-case information’ as different rules apply. Prior to sharing pre-planned or bulk information, such as information that identifies pregnant women in a locality, an Information Sharing Protocol (ISP) can be agreed, provided that a Privacy Impact Assessment (PIA) confirms that it is appropriate to share this level of detail. **According to the Data Protection Act, consent need not be sought for bulk transfer of information on live births (including name and address) as long as the transfer is to a public body and is for an important public interest purpose.** The fact of a live birth is in the public domain, moreover, so it is not confidential.

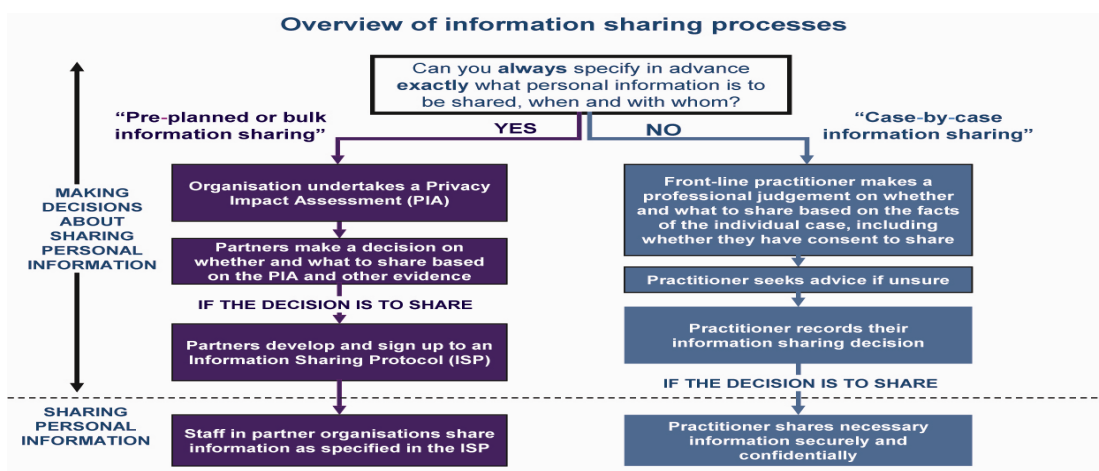
- Examples of this bulk data sharing include the receipt of new (live) birth data (i.e. information on children born within an area and their parents), and data on children under five and their parents new to a local area. The provision of such bulk data by local health services enables children’s centres to contact parents and make them aware of the services available directly.

In case-by case situations, information can also be shared. A record of consent must be kept to prove that parental/carer permission has been requested and given and to justify the decision to share information.

- Examples include sharing information on specific family circumstances and child development issues that help services provide appropriate support services. In some cases there are child protection and safeguarding issues that trigger the need to share information across services. Consent is not always required in these circumstances, especially where a child is thought to be suffering from or likely to suffer from significant harm.

It is helpful to look at the information sharing process in the form of a decision flowchart. Looking at the left side of figure 1, the information is anonymised or aggregated in a manner that does not allow an individual to be identified. It is not subject to the Data Protection Act and it can be shared, with appropriate security. Looking at the right side of the figure 1, the proposed sharing relates to personal information, i.e. information that identifies an individual.

**Figure 1 Information sharing process**



Information which is not confidential may generally be shared where that is necessary for the legitimate purposes of preventative work. Where information is confidential, however, and consent is refused, that should be respected, unless in the practitioner’s

professional judgment on the facts of the case, the public interest justifies the sharing of information. There may also be cases where practitioners are justified in sharing confidential information without consent in order to make decisions on whether to share further information or take action.

### **Recent developments**

The passing of the Health and Social Care Act in 2012 has brought further changes to the law on information sharing. The Act (modification of the NHS Act 2006, section 270 and the Statistics and Registration Service Act 2007, section 42) states that record-level births and deaths data can be provided to the NHS Commissioning Board, Clinical Commissioning Groups and Local Authorities. There is still an information governance clearance process involved, but this process of sharing bulk data does not require consent. It is understood that work is currently under way to clarify what this means through further regulations.

In 2012 DH produced *The Power of Information - putting all of us in control of the health and care information we need*. This strategy document sets out an ambition that information 'be used to drive integrated care across the entire health and social care sector, both with and between organisations'. Another ambition is that information should be 'recorded once, at our first contact with professional staff, and shared securely between all those providing our care - supported by consistent use of information standards that enable data to flow (inter-operability) between systems while keeping our confidential information safe and secure.' There is a commitment to developing interface standards, by no later than 2015, to ensure inter-operability of systems within health and across health and social care. For the patient, implementation of the strategy will mean that 'my doctors, nurses and other professionals will be even better at communicating', and 'I will not have to tell my medical or care history over and over again', and 'NHS and other care services will share the information about me with all those who need to look after me (with my appropriate consent), will protect my data and respect my confidentiality.' The document notes that 'all our health and social care data should, wherever it is held, use the NHS number as the default patient identifier by 2015...local authorities are committed to working with health colleagues towards much better integration of our health and care information and working towards consistent use of NHS numbers.' It recommends the use of mobile devices and technologies to make access to IT-based information systems easier for staff in community settings. It notes that there will be specific informatics requirements associated with the transfer of public health functions to local authorities: 'these include helping local authorities to collect data that was previously collected by the NHS, for example child height and weight surveillance data to track child obesity.'

The document further notes that 'The NHS Futures Forum received a clear message that **not** sharing information has the potential to do more harm than sharing it', and that there was a need for greater clarity over the circumstances in which it is in our interest for personal health and care information to be shared. The independent review led by Dame Fiona Caldicott into the balance between keeping protecting confidential health and care data and sharing that data securely was published in April 2013. That report and the Government's response, published 12 September 2013, make clear the duty on health and care teams to share confidential information - legally, safely and appropriately - when it is needed for the safe and effective care of individuals.

See <https://www.gov.uk/government/publications/caldicott-information-governance-review-department-of-health-response>



A final highly relevant development is the Child Protection – Information Sharing (CP-IS) project, announced by the Department of Health in December last year. CP-IS will enhance national IT systems in emergency departments and other unscheduled health care settings, to include information from local authorities on children who are subject to a child protection plan or are looked after. CP-IS will be developed and rolled out over the next five years, with first wave sites in Lancashire and London expected to go live in early 2014.

# Appendix C - A model for information sharing

## A suggested model for information sharing across agencies for children 0-5

