

Response to queries: information sharing in helping to achieve the 2017-19 national CQUIN Indicator 4, 'Improving services for people with mental health needs who present to A&E'

This response has been compiled by NHS England's Adult Mental Health team to address numerous queries from local partners who are working hard to implement the 2017-19 national CQUIN Indicator 4, 'Improving services for people with mental health needs who present to A&E'. It has been approved by data sharing and privacy experts in NHS England's Information and Transparency Group. Its purpose is to help staff in acute and mental health providers, and commissioners, to understand the positive approach to information sharing and information governance required to enable them to successfully achieve the CQUIN's aims in the context of the relevant legal and policy frameworks.

It is by no means exhaustive and local partnerships need to work together to work through the implications, details and challenges.

Key extract from [the CQUIN Indicator Specification document](#):

'Central to the CQUIN is the recognition that information sharing practices within the NHS itself and beyond need to improve, particularly for patients with mental health needs, in order to improve their experiences of care and outcomes. The issue of missed opportunities to share information in the interest of patient safety has also been raised by coroners on many different occasions following suicides and other serious incidents, with misplaced concerns about patient confidentiality often cited as a contributory factor. The information sharing practices encouraged by the CQUIN support the Caldicott Review's assertion that the duty to share information can be as important as the duty to protect patient confidentiality, and that health and social care professionals should have the confidence to share information in the best interests of their patients.^{1 2} Information sharing agreements where they are not already in place should be expedited.³ (pp. 52-3)

Key principles:

- The ultimate aim of the CQUIN is to ensure that people are receiving the most appropriate care for their needs. This includes identifying unmet mental health needs and tailoring interventions accordingly.
- The nature of the CQUIN means that patient-level data is used to improve the direct care of patients. The Health and Social Care (Quality and Safety Act) 2015 actively puts a duty on organisations to share information for direct care. Sharing for direct care can take place across departmental and organisational boundaries.

¹ Caldicott review: information governance in the health and care system:

<https://www.gov.uk/government/publications/the-information-governance-review>

² NHS England, A Quick Guide to Sharing Patient Information for Urgent & Emergency Care:

<http://www.nhs.uk/NHSEngland/keogh-review/Documents/160203-qcick-guide-Sharing-Patient-Information-for-Urgent-Care.pdf>

³ The Information Governance Alliance (hosted by NHS Digital) and the Centre of Excellence for Information Sharing have produced helpful resources:

<http://systems.digital.nhs.uk/infogov/iga/resources/infosharing> & <http://informationsharing.org.uk/our-work/learning-good-practice/> & <http://informationsharing.org.uk/our-work/resources/>

- Rule 2 of the Health & Social Care Information Centre (now NHS Digital) publication, [A guide to confidentiality in health and social care \(September 2013\)](#) states that 'Members of a care team should share confidential information when it is needed for the safe and effective care of an individual'. Information should therefore be shared on a need-to-know basis and always in the best interests of the patients. For the purposes of this CQUIN, 'care teams' are effectively multi-disciplinary virtual teams working with patients across traditional departmental and organisational boundaries.
- The key Caldicott principle to note for this CQUIN is principle 7 from [the 2013 Caldicott 2 guidance, Information: To share or not to share? The Information Governance Review \(March 2013\)](#): that the duty to share information can be as important as the duty to protect patient confidentiality.
- Chapter 3 from the guidance (which applies across both health and social care) provides further specific helpful advice, for example:
 - 'The Review Panel found a strong consensus of support among professionals and the public that safe and appropriate sharing in the interests of the individual's direct care should be the rule, and not the exception.' (p. 37)
 - 'For the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual.' (p. 38)
 - 'The Review Panel concludes that organisations should pay closer attention to the appropriate transfer of information when people cross organisational boundaries.' (p. 46)
 - 'The Review Panel concludes that a registered and regulated professional's primary concern must be for the health and wellbeing of the individual to whom they are providing direct care and...the presumption should be in favour of sharing for an individual's direct care.' (p. 47)
 - 'The Review Panel concludes that for direct care, when a professional is satisfied the recipient has a legitimate relationship with the patient, and that the recipient understands any particular issues or conditions that apply, the information can be shared with the individual's implied consent. The recipient then becomes responsible and accountable for that information in a professional capacity.' (p. 47)
 - 'The Review Panel also concludes that organisations employing health and social care professionals must support the safe and effective sharing of personal confidential data for direct care between professionals and staff with a legitimate relationship to an individual.' (p. 47)

Sharing data and information between teams operating in acute hospital Emergency Departments

- To maximise the benefit of this scheme to patients, selecting the cohort of patients identified as having the highest number of A&E attendances and who could benefit from a specialist mental health assessment and subsequent interventions does not need to be limited to patients who have previously been referred to the acute hospital liaison mental health (aka liaison psychiatry) team.
- A liaison mental health department functions as an integrated department in an acute hospital alongside other specialties. Liaison mental teams provide care for the same patients as the rest of acute hospital staff and at an organisational level this should be reflected in joint operational policies and service level agreements.

- Given that the department of liaison mental health directly delivers clinical care in the Emergency Department, they are not a third party but part of the acute hospital operating on-site, and a positive approach to internal information sharing should therefore be adopted, especially in the context of this CQUIN, the primary aim of which is to improve care for certain patients.
- It should be borne in mind that for the phase of the CQUIN which requires collaborative care planning, provider staff will need to obtain explicit consent from patients, as patients need to be involved in the co-production of plans. Where onward referral is necessary from an acute hospital department such as the liaison mental health team to an out-of-hospital service such as a community mental health team, the process for obtaining patient consent is necessary in the usual way. The wishes of those patients who do not consent to be involved should be respected and they should not be included as part of the cohort. As a result it is important that provider staff carefully and sensitively explain the purpose of this scheme to patients, emphasising the express purpose and opportunities to improve their care.

Sharing data and information between acute and mental health providers, and other NHS organisations

- Linking or cross-referencing different datasets (e.g. A&E HES and MHSDS) to understand which patients who attend frequently are known to both acute and mental health services, and then selecting those who the data suggests could benefit from tailored interventions, is an equally legitimate and potentially complementary approach if sound information governance principles are followed⁴. Where patients are already under the care of mental health services and more than one organisation is already involved in the patient's care (e.g. an acute trust following the patient's attendance at A&E), then there is a positive duty for mental health provider staff and acute provider staff to share relevant clinical information as set out in the [GMC's Good Medical Practice guidance](#) – in these circumstances consent is implied and the patient should be informed. This is further clarified in [the GMC's guidance on delegation and referral](#). Where onward referral is proposed to an organisation which is not already involved in the patient's care, explicit consent must be sought from the patient.
- Secondary uses of existing patient-identifiable data are unlikely to be possible without the explicit consent of the patient. Where it is deemed impracticable for this to be sought, the data can still be used in a pseudonymised form. This is data that does not directly identify an individual, but usually has one strong identifier such as the NHS number so that those people with access to IT systems can re-identify the patient. This process of re-identification must be done by someone with a legitimate relationship to the patient. Consent will be required for any data required to be linked to primary care – unless the patient is currently open to an acute hospital liaison mental health service, access to their GP medical records will require the patient's written authorisation. In cases where there is doubt, professionals from other different NHS organisations (e.g. primary care, ambulance, NHS 111) should seek advice from their Caldicott Guardian. It is equally important to recognise that information sharing between professionals and patients is necessary to enable shared decision making.

⁴ NHS England has obtained approval from the Confidentiality Advisory Group to allow personal data to be used for Risk Stratification, for both case-finding and commissioning. Each requires a slightly different approach.

Sharing data and information between the NHS and non-NHS organisations (e.g. the police, local authorities, voluntary sector organisations)

- Areas should already be able to draw on existing local work undertaken to date on information sharing agreements by local Mental Health Crisis Care Concordat partnerships, which have been in place since 2015. Most multi-agency sharing is done on a consent basis. Other services and organisations involved in local CQUIN schemes as named above will be expected to consult with their own Caldicott Guardians.
- Care plans, once co-produced with the patient and if the patient is content, should be copied/circulated to all involved professionals. Care plans can be attached to the patient's Electronic Patient Record where possible.
- The Information Commissioner's Office (ICO) has produced guidance on Privacy Impact Assessments (PIAs), which helps partners to find collectively-agreed solutions to both issues of gaining patient consent and other local concerns held by partners. See <https://ico.org.uk/media/for-organisations/documents/1595/pia-code-of-practice.pdf>.
- The PIA is tool for identifying risks to privacy, which can therefore help to highlight what actions may need to be taken to mitigate those risks and by whom. It is also an opportunity for partners to develop relationships, work collaboratively to understand the cultural benefits to partners and build their understanding, confidence and trust in each other which ultimately underpins any successful information sharing practices.
- The Centre of Excellence for Information Sharing have produced materials which partners can use to work some of the issues around information sharing for people with mental health problems, particularly those experiencing a mental health crisis: <http://informationsharing.org.uk/policy-areas/health/>. Along with providing a raft of materials, including [draft information sharing agreements](#) (which should be informed by PIAs); the Centre have also published a thematic report that highlights the key cultural factors that impact on information sharing across all policy areas: <http://informationsharing.org.uk/news/cc-themes/>.
- The NHS RightCare team have produced a resource pack on '[Setting up a High Intensity User service](#)', including [a sample information sharing consent form](#), which may be useful.
- The Information Governance Alliance (IGA) and Healthcare Quality Improvement Partnership (HQIP) have recently published [a guide describing how IG laws and principles apply to the use of personal data in local or regional multi-agency healthcare quality improvement studies](#). This may also be useful.

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