Department of Health

October 2015

Transfer of 0 to 5 children's public health commissioning to local authorities

Data and information factsheet 2: data sharing

Data throughout refers to top-level indicators

1) Introduction

From 1 October 2015 all local authorities will provide services for children aged 0-5 years in their local areas as part of their public health function. It is important that we collectively try to understand and track performance of those services both before and after the commissioning responsibility transfers to local government. This factsheet offers support on data sharing between local authorities, local authorities and providers, local authorities and Clinical Commissioning Groups (CCGs), local authorities and Commissioning Support Units (CSU's).

Data sharing is necessary to enable the reporting of indicators and outcomes data, which is essential for the effective commissioning and monitoring of service provision. This includes the quarterly reporting of health visiting indicators to Public Health England, which commences in Q1 2015/16

This fact sheet has been produced at request of some local areas to developing information sharing arrangements. Other areas already have such arrangements in place and this factsheet is not intended to replace any such arrangements

2) Purpose of Data Sharing

The purpose of this factsheet is to support the regular sharing of aggregated information. This will assist local authorities in their submission of data to Public Health England. This data sharing could consist of data transferred once or on an ongoing basis, as agreed by the parties involved.

3) Benefits

Data sharing is intended to help local authorities to obtain standardised information from 0 -5 year service providers that will be beneficial in a number of ways:

The data will demonstrate a baseline position of service provision for the local authority in relation to mandated and other services from the acquisition of 0-5 year commissioning responsibility

This data will help you secure standardised information to demonstrate improvements in commissioning, the future local planning of service provision and enable you to benchmark against registered and residential populations to detect trends in 0-5 year old's public health

Securing a regular flow of aggregate information (data not limited to one person, but data that is tracked across time, organisations or some other variable) could be helpful in supporting the performance monitoring of services on an ongoing basis and inform the annual review of contracts.

4) Requirement for and Benefits of Data Sharing

Data sharing between local authorities, local authorities and providers, local authorities and Clinical Commissioning Groups (CCGs), local authorities and Commissioning Support Units (CSU's) is required to:

Aid future planning of service provision

Gain as clear a picture as possible before the transfer, as well, as how things then develop after the transfer

Compare local performance with other parts of the country

Secure standardised information to demonstrate improvements in commissioning

Enable benchmarking across populations to detect trends in 0-5 year olds public health

5) How data can be shared

Providers may be sharing data on the indicators and outcomes data to local authorities in one of two ways. Either by;

Lead local authority model where the provider reports on all children who have received their services to the lead local authority who commissions those services, but the report is segregated for multiple local authorities based on the residence of the child. The commissioner then shares the provider activity report with their neighbouring local authorities.

Or alternatively by;

Distributed model where the provider assigns all children who have received their services to the local authority where the child lives. The provider then reports this information about activity directly to each local authority for their own residents.

Each local authority will then have the information to be able to construct the overall picture for their residents. The nominated lead for each local authority will then report their local authority data to Public Health England via the central web-based data reporting system.

Information received for these indicators will be in aggregate format and will not be identifiable and therefore consent is not required.

6) Roles and responsibilities for each organisation

Data should only be shared between organisations as necessary for them to be able to fulfil their reporting responsibility:

Providers to report to local authorities on the services they have provided to children resident in the local authority area..

Local authority to local authority to in delivering the lead local authority model

CSU and CCG's on service provision to local authorities

Each organisation who agrees to share the aggregated data in an agreed format and process will also agree to:

Transfer and store data securely

Not share data with other parties without explicit consent – unless other statutory requirements apply.

Not to publish or disclose data without prior discussion

Allow information audit in case of breaches or potential breaches of security, which could compromise confidentiality.

The information shared must only be for the purpose requested

Freedom of information requests should be dealt with by each individual organisation in line with their internal processes and procedures.

Each organisation should appoint a single point of contact who will work together to ensure the processes of data sharing is adhered to.

Remember that data protection legislation is not a barrier to sharing information but provides a framework to ensure that information is shared appropriately

Data sharing should be entered into for sharing information as required or permitted under data protection and any other relevant legislation.

There should be no requirement to share identifiable data with a local authority commissioner, but if there is, local agreement needs to be established and it is the responsibility of both partners to ensure that this is appropriately managed.

7) What data is required to support commissioning of 0-5 year children's public health services?

The indicators will include coverage of the five reviews described in legislation as universal health visitor reviews. It also contains information about health outcomes, as described in the Public Health Outcomes Framework, where the data for the indicator flows directly from health visiting activities. It is understood that these indicators are the main indicators outlined within local contracts.

Indicator name	Indicator definition	Aggregate data items for collection

Mothers receiving antenatal visit	Mothers who received a first face-to-face antenatal contact with a health visitor at 28 weeks or above	Number of mothers who received a first face-to-face antenatal contact with a health visitor at 28 weeks of pregnancy or above
% New birth visits < 14 days	Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days by a Health Visitor	Total number of infants who turned 30 days in the quarter who received a face-to-face NBV within 14 days from birth, by a health visitor with mother (and ideally father)
		Total number of infants who turned 30 days within the quarter
% New birth visits > 14 days	Percentage of face-to-face NBVs undertaken after 14 days, by a health visitor	Total number of infants who turned 30 days in the quarter who received a face-to-face NBV after 14 days from birth, by a health visitor with mother (and ideally father)
% 6-8 week Review	Percentage of children who received a 6-8 week review by the time they were 8 weeks	Total number of infants, due a 6-8 week review by the end of the quarter, who received a 6-8 week review by the time they turned 8 weeks
		Total number of infants due a 6-8 week review by the end of the quarter
% breastfeeding at 6-8 weeks	Percentage of infants being breastfed (fully or partially) at 6 to 8 weeks.	The number of infants recorded as being totally breastfed at 6-8 weeks
		The number of infants recorded as being partially breastfed (receiving both breast milk and formula) at 6-8 weeks
		The number of infants being recorded as not breastfed at 6-8 weeks
% 12 month reviews < 12 months	Percentage of children who received a 12 month review by the time they turned 12 months	Total number of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months

		Total number of children turning 12 months during the quarter
% 12 month reviews < 15 months	Percentage of children who received a 12 month review by the time they turned 15 months	Total number of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months
		Total number of children turning 15 months during the quarter
% 2-2½ year reviews	Percentage of children who received a 2-2½ year review	Total number of children, due a 2-21/2 year review by the end of the quarter, who received a 2-21/2 year review by the time they turned 21/2 years.
		Total number of children aged 21/2 years in the quarter.
% 2-2½ year reviews using ASQ-3	Percentage of children who received a 2-2½ year review using Ages and Stages Questionnaire (ASQ-3).	Total number of children due a 2-21/2 year review by the end of the quarter for whom the ASQ-3 is completed as part of their 2-21/2 year review
		Total number of children who received a 2-21/2 year review by the end of the quarter