Public Health England

The PHE Knowledge strategy

Consultation responses

About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

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Introduction

PHE launched a draft version of its Knowledge strategy: Harnessing the power of information to improve the public's health in October 2013. This document summarises the healthy response we received from the public health community and beyond and highlights key areas where our strategy will be altered.

A key commitment in our strategy, one that was strongly supported by respondents, was around openness. In keeping with the strategy itself, this response will also make available all comments submitted in a suitably de-identified manner.

Responses were received on the Knowledge strategy by 70 organisations or individuals across a broad spectrum of organisations. We were extremely pleased to receive such comprehensive feedback and extend our thanks to those stakeholder groups and partners who were able to respond.

Public Health England - Departmental responses	11
Public Health England - Personal responses	13
Local authorities	12
Local government - Personal responses	5
Voluntary/ Third sector	13
National organisations/ bodies	8
Professional bodies	3
Other	5
Total	**70**

Fig 1: Responses to the knowledge strategy by organisation

Respondents were, on the whole, clearly pleased to have a strategic vision articulated for public health knowledge, intelligence, information and data services. In addition for broad and specific support for points made in the strategy were a host of perspectives and suggestions for improvement.

The PHE Knowledge strategy was constructed around the eight priorities for knowledge articulated by John Newton on the formation of PHE. The responses received have made it clear that, whilst all eight priorities are still relevant and necessary, four are fundamental to a cycle of knowledge whilst the other four describe important but specific techniques, methodologies or disciplines. In trying to describe our approach to all eight priorities, some readers found the document repetitive and found it difficult to follow a thread.

The next iteration of the Knowledge strategy will follow a narrative around the knowledge cycle, describing knowledge as a continuum from data, through synthesized information, intelligence and knowledge to inform action.

The key points made, alongside our response are highlighted below. Although all comments have been reviewed, not all are represented in the following summary.

Comments on the Knowledge Strategy

Comments on the executive summary, introduction and vision

1. Cross system working – a theme in many responses was around the concern that national bodies run the risk of duplicating effort and wasting resources resulting in a confusing proliferation of tools and services. The final version of the strategy will clarify this developing situation as much as possible. PHE is committed to eliminating duplication of effort and will work with NHS England, CQC, Monitor, the HSCIC, ONS, NICE, DH and others to ensure national roles and responsibilities are increasingly clear.
2. Specific topic areas of interest – several respondents raised concerns about the lack of mention of specific public health topics. The document is not intended to be a public health strategy, but a knowledge strategy to support public health. As such these omissions are intentional, although we will make sure we address inequalities and protected characteristics in the next iteration.
3. Stakeholders – there were some concerns raised about audience and intended beneficiaries of the strategy. We are encouraged that respondents wish to be more included. The next iteration of the strategy will make it clear that, wherever possible throughout the document, beneficiaries of services and products will be all those with an interest in addressing the public health agenda, even those outside of traditional public health roles. It will also be explicit around the importance of the local authority public health intelligence teams as the front line for locality based public health intelligence. We will also reiterate the commitment to doing things locally and only centrally when it makes most sense.
4. Standards and openness – we noted and appreciated the strong support for striking a balance between proscriptive standards and an environment that supports innovation and the commitment to open software, tools and ideas. We will address these ideas in a little more detail alongside concerns over privacy in the next version of the strategy.

Comments on Priority 1: Understand and meet the needs of users, particularly local government and local NHS

5. Advocacy – in areas where PHE does not have control, we have a duty to listen to colleagues, understand their requirements and articulate them in a way that is most likely to further the public health agenda, eg data access or interactions with other organisations
6. Data access – there was a tremendous response from, in particular, colleagues in local government asking PHE to grant or otherwise support access to data, at the record level and identifiable if necessary, at no cost and addressing systemic information governance issues. Although the situation is far from completely

resolved, things are getting clearer all the time and the final version of the strategy will highlight our progress to date in outline.

7. Local interactions – we were pleased to see respondents request a “one system” approach between services offered by PHE and the local authority public health intelligence team. We will make this clearer alongside a clarification of internal PHE structures and their responsibilities.
8. Workforce development – there was strong support for PHE’s role in terms of workforce development for public health professionals and other partners. We have taken on board the advice offered and will act on it.

Comments on Priority 3: Work with others to build and manage linked datasets that are safe and available for use

9. Data linkage – some respondents were concerned about the potential for too much data linkage, others are concerned that we have not said we will link by default. We will be clearer about our legal support and will discuss the potential to link with datasets outside traditional health boundaries.
10. Information Governance – other than IG concerns around dissemination of data locally, there were three other areas raised we will address:
    a. Impact of the EU data regulation
    b. Consent – how we support patients opting out of providing data
    c. More detail on the IG Management framework

Comments on Priority 4: Bridge the current gap in the translation of knowledge into action

11. Use of tools and technologies to promote communications – knowledge products are no use if they are not consumed. We received a large amount of support around tools and technologies to promote the consumption of knowledge products which we will investigate and play back for us all to take advantage of.
12. Indicators – it was clear that respondents, whilst pleased about the concepts PHE has proposed in terms of the development and support of tools to present data and information, felt we could improve on the offering. We will present the requirements for these tools clearly in the next iteration of the strategy incorporating the need for reduced duplication between organisations, accessibility of underlying data and presentation of quality metrics.
13. Evaluation – we will include greater reference to services/ activities which are not technology based, ie our role in the evaluation of evidence and synthesis of knowledge.
14. Evidence production – there was support for following a “NICE style” evidence production pathway and we will reiterate our commitment to working with NICE to achieve the aim of translating knowledge into evidence.

Comments on Priority 5: Build and develop health intelligence networks

15. Specific networks – there was some consternation about “cherry-picking” three new intelligence networks in the strategy. The general approach, involving groups of stakeholders and experts from outside PHE was supported, and will be developed into an approach for networks more broadly. The next iteration of the strategy will clarify our support of national topic-based networks, underpinning networks and local area networks. We are committed to avoid duplication of existing intelligence networks.

Comments on Priority 6: Extend the use of surveillance to inform health responses

16. Gaps – the comments on this chapter were mostly confined to gaps, areas which are not well supported at the moment. The next iteration of the strategy will highlight our approach to identifying and addressing these gaps.

Comments on Priority 7: Connect people to share experience

17. Networks – there was keen support to our approach around sharing, collaboration and the use of networks to support this. We have noted the proposed additional topic-specific and underpinning collaborative areas and will explore our role in supporting these in the final version of the Knowledge strategy.
18. Sharing activities – the strategy described a number of tools and techniques we will support that encourage sharing and collaboration and we welcome respondent’s additions to this list. We will describe a more complete approach in the final version of the strategy.
19. Making things better – we received a number of comments, primarily from PHE staff, around corporate tools to support better working eg survey tools and document management support. The final version of the strategy will give an outline as to what tools will be corporately supported as well as committing to supporting interoperable systems, shared standards and taxonomies.