Department of Health

Government Response to the House of Commons Health Committee Report on Public Health Post-2013 (Second Report of Session 2016-17)

December 2016

Cm 9378

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by Command of Her Majesty

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Introduction

The Government is grateful for the Health Committee's interest in the public health system and for its thoughtful and positive report. The Department of Health and Public Health England set out their accounts of the development of the public health system since 2013 in their separate written submissions to the inquiry. This response to the Committee's report, prepared by the Department in consultation with PHE and NHS England, addresses directly each of its recommendations. PHE's and NHS Digital's joint response to the issues raised in Annex 1 of the Committee's report is appended.

Government response to recommendations

Funding

1. Cuts to public health are a false economy. The Government must commit to protecting funding for public health. Not to do so will have negative consequences for current and future generations and risks widening health inequalities. Further cuts to public health will also threaten the future sustainability of NHS services if we fail to manage demand from preventable ill health.

The Government fully appreciates the importance of protecting and improving public health. It also believes that taking action to reduce the deficit and promote economic growth is vital to the long-term health of our economy and to all of the public services that it supports.

The duty on local authorities (LAs) to improve the public's health involves more than delivering a set of narrowly-defined services from a ring-fenced grant. Instead LAs need to address all the determinants of public health – a 'place-based' approach, that can bring together funding streams from local government, central government and the NHS.

This is a core principle of the Government's strategy: that the making and delivery of policy across the whole of the public sector can be harnessed for the good of the public's health, without significant extra costs (and often with a significant return on investment). There are examples of this principle in practice in central government and the NHS later in this response.

The 2015 Spending Review outcome made available £16 billion of funding for local authorities in England over the next five years. It followed two years of real terms growth in funding in 2013/14 and 2014/15. The ring-fence around the grant remains in place for this financial year and the next, as does the requirement for LAs to use their grant with regard to the need to reduce inequalities in health.

The Secretary of State, Public Health England (PHE) and NHS England also share a statutory duty to address health inequalities. The NHS Five Year Forward View clearly recognises the importance of preventing ill health, and central government continues to set the national agenda – for example through the diabetes prevention programme and childhood obesity plan, or in local Sustainability and Transformation Plans (STPs).

2. We recommend that the Government sets out how changes to local government funding and the removal of ring fencing can be managed so as not to further disadvantage areas with high deprivation and poor health outcomes. We plan to return to review the variation in funding and outcomes.

The Government agrees, and will publish and consult on key aspects of the changes as they develop. The introduction of full business rate retention (BRR) for LAs by the end of the Parliament, and the proposed ending of the ring-fence for the public health grant, will fundamentally alter the way that LAs are funded. Officials from the Department of Health (DH), PHE, the Department for Communities and Local Government (DCLG) and HM Treasury are already working together, and with stakeholders including the Local Government Association (LGA) and the Association of Directors of Public Health, on both these reforms.

Systematically improving public health and addressing unnecessary variation

3. We recommend that local authority directors of public health should be required in their statutory annual reports to publish clear and comparable information for the public on the actions they are taking to improve public health and what outcomes they expect to achieve, and to provide regular updates on progress. While public health priorities may be different for different areas, which is entirely appropriate, they should be presented in a standardised format, and underpinned by a benchmarking framework that allows for informed comparison and challenge. The Chief Executive of Public Health England, in his capacity as accounting officer, should publish an annual report drawing together and analysing local progress towards agreed plans.

The Government agrees that it is essential to have available robust information that allows comparison and challenge, and believes that the 2013 reforms were a major step forward for the transparency of the public health system. DsPH are required to produce annual reports (and LAs are required to publish them) but the Government does not agree that it is currently necessary to impose a standard format. DsPH should be free to be creative and innovative, as well as informative, in their reporting on local priorities.

The Government does agree that LAs should identify their own local needs and priorities, and that anyone should be able to benchmark any LA's progress against a standard set of indicators. The Public Health Outcomes Framework (PHOF) remains the principal tool for defining long-term ambitions for the whole public health system. It does not set targets but does help LAs to define their own priorities. The PHOF was refreshed (after consultation) and republished in May 2016, setting out 66

diverse, comprehensive and measurable indicators of public health. PHE continues to monitor and publish comparable data for each indicator for every LA in England. The PHOF has the status of 'statutory guidance' for LAs – that is, they must have regard to it.

PHE also produces an annual report, and the 2015/16 edition included chapters taking an overview of the health of England and summarising how all PHOF indicators had improved, worsened or remained stable over the year.

4. We also reiterate the recommendation of our recent report on the impact of the Spending Review on health and social care that the Government should set out clear milestones of what it expects public health spending to achieve, and by when.

The Government agrees that it is responsible for establishing clear national strategies for public health that complement and incorporate local action. This is an extract from the Government's response to the Committee's recent report:

"In terms of objectives and milestones, the Public Health Outcomes Framework (PHOF) – refreshed after public consultation and republished in May 2016 – will continue to provide the most important mechanism for transparency and accountability across the whole public health system… The PHOF's two overarching priorities have remained constant and clear since its original publication in 2012:

- *increased healthy life expectancy; and*
- *reduced differences in healthy life expectancy between communities and groups.*

The PHOF will be reviewed again in 2019…

LAs lead locally on population health improvement, but to do that effectively they must work in conjunction with their local partners, including Clinical Commissioning Groups. The NHS and LAs are working together now, with other local stakeholders, to develop place-based, multi-year Sustainability and Transformation Plans (STPs). These aim to improve the sustainability and support the transformation of the health and care system by addressing the challenges set out in the NHS Five Year Forward View, including the upgrade in prevention.

NHS England, NHS Improvement and PHE have worked with other key bodies to set out a single framework for STPs that has a clear focus on prevention. PHE has provided evidence to DsPH and STP teams to help them develop bold and practical plans for preventing ill health. PHE assesses draft plans and supports their further local development.

In June all 44 STP footprints incorporated prevention in their draft plans, and about 90 per cent of all plans actively prioritised preventative action. Most included action to prevent mental health problems, reduce smoking and alcohol consumption, tackle obesity or prevent cardiovascular conditions.

While many of the most innovative and effective opportunities to improve health can be realised by local agencies working in partnership, the Government has been clear that it will not shy away from its responsibility to take strong national action where this is necessary and supported by evidence.

For example, tobacco use remains one of the leading causes of inequalities in healthy life expectancy. Building on our clear track record on protecting children from the harmful effects of tobacco, the Government is committed to publishing a new tobacco control plan…"

Since giving that response the Government has launched its childhood obesity plan[1] – supported by schools and the NHS – which will help children and families to make healthier choices and be more active, while the NHS diabetes prevention programme is now delivering an evidence-based behavioural change intervention for people at risk of developing type 2 diabetes. By 2020 the programme aims to support at least 100,000 people every year. The Government also remains committed to publishing a new tobacco control plan.

[1] HM Government (August 2016) *Childhood Obesity: A Plan for Action*

Politics and evidence

5. Benchmarking standards for all local authorities' prescribed public health functions should be introduced, which should be transparently monitored to enhance accountability and provide reassurance that these functions are being maintained at an appropriate level.

LAs' statutory duty in primary legislation is to take the steps that they believe are appropriate to improve the health of their populations. Some specific LA public health functions are prescribed in regulations but most, including drug and alcohol misuse services, are not. The Government agrees that both prescribed and non-prescribed functions should be transparently monitored and in almost all cases they are, principally – but not only - through PHOF outcomes data. The ending of the public health grant will make transparency even more important in driving improvement and assuring accountability, but this is not the same as setting national benchmarking standards - the Government believes that LAs should define and account for their own ambitions in the context of their local Joint Strategic Needs Assessments.

However, PHE can and does offer targeted support where outcomes data suggests potential problems. For example, in 2015/16 PHE Centres provided tailored support to a number of LAs with low drug and alcohol treatment recovery rates, helping 40 to reverse downward trends.

Only two of the prescribed LA functions do not lend themselves to the regular collection of quantitative outcomes data: promoting local health protection plans and advising NHS commissioners. For these PHE makes other arrangements for monitoring, including direct communication with DsPH.

Boundary issues and fragmentation

6. The outstanding issue of who is responsible for commissioning PrEP for HIV needs immediate resolution, and we recommend that NHS England and DH clarify the position without delay.

The Government welcomes the fact we now have clarity on the legal position from the Court of Appeal following its judgement on 10 November. The ruling made it clear that NHS England has the ability, but not the obligation, to fund PrEP. The Government understands that NHS England now plans to formally consider whether to fund PrEP.

7. Where boundary issues are identified around responsibilities, PHE should set out the options for them to be addressed in the best interests of patients and the public and ensure that they are resolved without further delay.

The Government agrees that further restructuring would not be helpful, but acknowledges that the system is still maturing. While most boundary issues are resolved locally, the Government also recognises that – exceptionally - there can be a need for national intervention where there is evidence of a significant problem.

For example, in 2013 it became apparent that there were differences of opinion locally about how responsibility for the four tiers of obesity services should be shared between LAs and clinical commissioning groups (CCGs). In response PHE and NHS England set up a joint group that proposed a clear division of responsibilities[2], and PHE is working to provide national guidance for commissioners and providers including service specifications as part of a whole system approach, supporting local STPs.

Leadership for public health at a national level

8. National system leadership is important to signal clarity of purpose and commitment to the local system when it comes to improving health and wellbeing. In order to demonstrate where national leadership for public health lies, and to avoid confusion and the risk of giving conflicting advice to the local system, the Government should produce a clear statement of who does what in respect of the main system leaders, namely, the Department of Health, Public Health England and NHS England.

The Government has been clear that the ultimate responsibility for the comprehensive health service as a whole, which includes LAs undertaking their public health functions as well as the NHS, rests unequivocally with the Secretary of State. PHE exists to exercise many of the Secretary of State's duties and powers (especially those relating to the protection of health) and to provide expert, evidence-based guidance to the whole health and care system – including LAs and the NHS. NHS England's formal public health commissioning responsibilities are set out in the annual 'section 7A' agreement between it and the Secretary of State, and its wider responsibilities for prevention and health improvement are addressed in the NHS Mandate. The Government looks to PHE as the main source of support for local government, especially for DsPH, and PHE continuously strives to strengthen that relationship.

[2] PHE, NHS England (March 2014) *Report of the working group into joined up clinical pathways for obesity*

However, the 2013 reforms deliberately avoided placing hard borders around the different components of the public health system – that would risk opening up stretches of no man's land between them as priorities evolve and new threats to health emerge. Instead the reforms encourage partnership and close collaboration between parts of the system, which requires a degree of overlap between what the different national players may legitimately do.

This should not be a cause of confusion - it is for those players to find the most effective ways of working together flexibly in the prevailing circumstances, which will inevitably change over time. The Government continues to believe that this arrangement is necessary and that in most circumstances it works well, but accepts that, in what is still a young system, there is some settling down to be done in establishing a full and mutual understanding of roles and responsibilities.

The Government will therefore continue to support and facilitate integrated working across the system, partly through the work that the Committee's report acknowledges. It agrees that clarity of purpose is important and takes full responsibility for maintaining that through a steady focus on the core long term objectives of the PHOF and the 2010 White Paper *'Healthy Lives, Healthy People'*.

9. Embedding health in all policies is important at both national and local level. But while there is evidence of progress locally, there is less evidence of such an approach becoming embedded across Government departments. We urge the Government to take bold and brave action through its life chances and childhood obesity strategies in order to improve public health and reduce health inequalities.

10. A Cabinet Sub-Committee on Public Health is unlikely in itself to be the answer to securing more effective joined-up policy to improve health and wellbeing. We consider instead that the strengthened cross-departmental working which is required is more likely to be achieved by vesting responsibility for providing political leadership for public health at a national level in a Minister in the department responsible for coordinating cross-departmental work, the Cabinet Office. We recommend that a Minister in the Cabinet Office be given specific responsibility for embedding health in all policies across Government, working closely with the Minister for Public Health in the Department of Health.

The Government agrees that protecting and improving the nation's health and wellbeing is a job for central government as a whole, together with a wide range of national and local partners. It also agrees that a Cabinet sub-committee is not the most effective way to achieve that unity. However, the Government is clear that the role of the Parliamentary Under Secretary of State for Public Health and Innovation includes promoting health in all policies, not just those that are the direct

responsibility of DH. Creating a second Ministerial post with similar duties would run the risk of duplication and inconsistency.

DH's annual remit letter to PHE sets out Ministers' expectations for the crucial role of PHE in informing and supporting the development of policy across government, and sets out a number of specific areas where this role will be particularly important in the year ahead. The National Audit Office's 2014 report into PHE[3] also recognised the importance of this aspect of PHE's responsibilities and called for it to strengthen its capacity for cross-Whitehall influencing. In response PHE has developed a cross government engagement strategy and has begun to build constructive relationships with a range of government departments. For example:

- work between the Department of Transport (DfT) and PHE to support walking and cycling. Duncan Selbie, PHE's Chief Executive, and Phillip Rutnam, the Permanent Secretary of DfT, wrote jointly to all LA chief executives, DsPH and chairs of Local Economic Partnerships to highlight a £20 million DfT fund for sustainable transport initiatives and the support that PHE and DfT can offer to local communities; and

- PHE's work on the Government's sports strategy – *Sporting Future* – together with the Department of Culture, Media and Sport and Sport England, ensuring consistency with the recommendations of PHE's *Everybody Active, Every Day* guidance[4] and showcasing examples of good practice.

11. Since Public Health England was established, the interface between it and the DH has lacked clarity. We therefore urge the Government to review the relationship between the DH's Public Health Group and PHE. The 'tailored review' of PHE which DH is currently carrying out offers a good opportunity to do so.

The relationship between DH and PHE is established in PHE's framework agreement and in the annual letter from DH Ministers setting out PHE's remit. However, the Government agrees that, three years on from PHE's establishment, it would be helpful to review and optimise the relationship. As the Committee recognises, the tailored review of PHE and the restructuring of DH taking place now provide a timely opportunity to do so in ways that draw on the assets and strengths of both organisations.

The tailored review issued a public call for evidence and is analysing the 133 responses it received. DH expects to publish the review's findings and

[3] NAO (December 2014) *Public Health England's grant to local authorities*
[4] PHE (October 2014) *Everybody active, every day - an evidence-based approach to physical activity*

recommendations around the turn of the year and will set out the arrangements for implementation then.

12. Likewise we urge NHS England and PHE to clarify how the two organisations are seeking to pool their expertise and resources around public health in order to ensure that the local health system feels adequately supported and not conflicted by confusing messages or requirements.

The Government agrees that NHS England and PHE must continue to work collaboratively and in tandem, and shares the Committee's recognition of the diabetes prevention programme as an example of that collaboration in practice. The NHS has an integral role to play in the prevention of ill-health, reflected in the NHS Five Year Forward View. To help deliver that role the Department of Health's arm's length bodies (ALBs) have established a Prevention Board, chaired by the PHE chief executive, bringing together expertise from PHE, NHS England, local and central government and the third sector. PHE has also worked closely with NHS England on the development of the NHS planning guidance nationally, on the resulting production of STPs locally, and in the development of key STP metrics focused on prevention.

The two work closely together in many ways, at national and local levels – for example, in drawing up the annual 'section 7A' agreement setting out which of the Secretary of State's public health functions NHS England will undertake on his behalf. The agreement sets out specific services to be commissioned by NHS England and the outcomes they should achieve. NHS England is accountable to the Secretary of State for how well it performs – for example, in driving improvements to screening and immunisation services NHS England benefits from the support and expertise of embedded PHE teams to make sure that local health systems are adequately supported. PHE also has staff embedded in NHS England to support specialised commissioning and oral health services.

NHS England and PHE frequently issue joint communications and exchange staff to work on other areas of shared interest such as the NHS Five Year Forward View or the joint tuberculosis strategy[5], and work closely on key initiatives like the diabetes prevention programme, the voluntary, community and social enterprise sector strategic partners programme, and antimicrobial prescribing – where the collaboration has contributed to a reduction in antibiotic prescribing.

The Government expects – and will encourage - further fruitful relationships to develop across an even broader range of subjects as PHE and NHS England mature as organisations.

[5] PHE, NHS England (January 2015) *Collaborative Tuberculosis Strategy for England 2015 to 2020*

Access to data

13. Our inquiry has identified numerous problems with access to data for public health professionals, which is creating barriers to effective joint working. We are pleased to note that efforts are now ongoing within Public Health England to address these problems.

14. Public health teams need to be able to access data in patients' interests. We were told by PHE's chief knowledge officer that a change in policy was needed to remove the current restriction that all linkage of health and social care data can only take place centrally, within NHS Digital (HSCIC). We recommend that the Department of Health review these barriers.

15. Some areas have managed to access the data they need, and others have not. Some areas also lack the capacity to analyse their data. A co-ordinated national support programme is needed to ensure that until data is easily available to local authorities, all areas at least understand what data they are able to access, and how they can do so.

16. PHE identified two types of data public health specialists are having difficulty in accessing—access to population healthcare data, and access to operational data about the services they commission. Annex 1 to this report contains a compilation of the concerns public health professionals have raised to this inquiry regarding access to data, and we ask PHE and NHS Digital to provide a response to us on each point raised. We will revisit this issue to check progress in six months' time.

The Government is committed to ensuring that health and care data is held securely so that it can be used for statutory and lawful purposes (including public health purposes), and in line with the wishes of patients and service users. To protect and improve the health of individuals and the nation, and reduce the cost of healthcare while improving quality, we must continue to exploit the full potential of data, ensuring that data sharing and linkage practice is fully in line Government policy.

The Government does not believe that *all* linkage of health and social care data must only take place within NHS Digital - the intention is that the *main* linkage of national data should happen within NHS Digital, so that it stays the main national data collection body. This limits the number of organisations that hold large volumes of identifiable NHS data, and potentially reduces the need for such data to be widely disseminated in ways that increase risks.

There has been variation in access to data and NHS Digital has been working to address this, for example through a streamlined on-line Data Access Request Service. LAs by their nature do not have the same access to NHS data as staff working in the NHS. Indeed, there is currently no legal power for NHS Digital to provide to LAs some of the identifiable data mentioned in the report's Annex 1 .

The Government acknowledges that, in some cases, this may have affected LAs' ability to discharge certain aspects of their public health functions. However PHE and NHS Digital have made good progress in providing more than half of LAs with anonymised health service activity data. NHS Digital is engaging directly with the Association of Directors of Public Health to understand how best to meet the needs of all LAs within the legal framework. LAs should already be aware of what data NHS Digital can provide and how they can obtain it, and of the legal limitations which apply, but the Department of Health will ask NHS Digital to ensure that is the case and that regular updates are provided. Through the implementation of *Personalised Health and Care 2020*, its framework for the better use of data and technology, the Department is progressing new technologies to make anonymised data sets more available and capable of achieving the benefits that previously required the sharing of personal identifiable data .

Dame Fiona Caldicott, the National Data Guardian for health and social care, recently undertook a review of data security and patient consent for data sharing. The Department has undertaken a public consultation which concluded on 7th September 2016 and is due to respond shortly. It is important that decisions on data sharing policy and linkage are fully aligned with Dame Fiona's recommendations, and therefore the Government will respond more fully to the Committee's recommendations in this area once its response has been prepared for publication .

In considering the response, the Government needs to ensure that any system within health, public health and social care that holds and links data meets the highest standards of data security, with appropriate and rigorous assurance and testing, and that this will be harder to achieve in a distributed data model.

The Government understands that PHE and NHS Digital have a regular and established engagement arrangement on data sharing. They have prepared a joint response (appended to this document) to the specific points raised in Annex 1 of the Committee's report .

The public health workforce

17. Trends in the public health workforce can be adequately monitored only through the speedy introduction of the promised database. This is particularly

important given the potential impact of reduced spending by councils on public health staffing.

The Government agrees on the value of a minimum dataset for the public health workforce. DH is continuing to work with NHS Digital, PHE, Health Education England and others to develop the dataset. This is a complex process but the department hopes to test it in 2016 with the aim of introducing it across the system in 2017.

18. Barriers to workforce mobility must be removed, and we are concerned that this issue has not been resolved three years after the transfer of public health responsibility to local authorities. We will review progress in six months.

This is not just an issue for public health staff – the relevant provisions apply to movement across the public sector as a whole. The Government will continue to work with PHE and the LGA to monitor the impact on the public health workforce of the current arrangements, and to look at how the mobility of public health professionals can be supported to make sure that LAs and PHE have access to the skills they need. Meanwhile PHE, the LGA, the Association of Directors of Public Health and the Faculty of Public Health have collaborated to produce guidance[6] recommending that employers make every effort to recognise past service. For example, LAs can voluntarily recognise past service with an NHS body for benefits such as annual leave, sick leave or maternity leave.

19. As the Government develops its proposals for reform of professional regulation, it needs to ensure that it has a coherent, straightforward and evidence-based approach to the regulation of public health specialists. We recommend the Department of Health review its current policy in order to protect the public.

The Government remains committed to reform of the regulation of health and (in England) social care professionals, and to the principle of proportionate regulation. It is working on how it might go further than the simplification and consistency changes recommended by the Law Commissions - there are opportunities for better regulation, greater cost efficiency and increased autonomy for the professional regulators to help them respond more quickly to changing ways of delivering healthcare.

The purpose of professional regulation is to protect the public by ensuring that everyone practising a health profession does so safely. Regulation needs to be both

[6] LGA et al (August 2014) *Public Health in the 21st Century: organising and managing multidisciplinary teams in a local government*

proportionate and effective, imposing the least cost and complexity while securing safety and confidence for the public. Statutory regulation can be a solution where significant risks to users of services cannot be mitigated in other ways, but it is not always the most proportionate or effective means of assuring safe care. The Government is currently considering how to assess whether statutory regulation for healthcare professional roles is appropriate, and this will inform decisions on the level of regulatory oversight needed for roles including public health specialists.

Case study: Health protection

20. Health protection is a critical public health function, and more work needs to be done at a national level to support local areas to deliver a seamless and effective response to outbreaks and other health protection incidents. This work should begin with an audit of local arrangements, including a review of capacity in provider trusts, and the development of a national system to collate and disseminate lessons learned from incidents. We will review PHE's progress on this work in six months' time.

The Government agrees that health protection is of critical importance and that all parts of the system must work effectively together to protect the public's health. PHE has convened a group comprising the key national bodies from the NHS and local government to design a new and comprehensive assurance exercise to address the full range of issues, including the specific areas highlighted by the Committee. PHE will be happy to update the Committee on progress.

Case study: Health in all policies

21. We urge the Government to be bold, and make good on its commitment to health in all policies, by enshrining health as a material consideration in planning and licensing law.

As the Committee notes, one of the principal reasons for giving public health functions back to LAs was the opportunity they give DsPH to influence a much wider range of local policy-making. The Government's policy of devolving more responsibilities to LAs and combined authorities will extend that range still further, but any additional regulation of businesses needs to be considered carefully and firmly based on evidence.

DCLG's National Planning Policy Framework is already clear that LAs should take account of the need for healthy communities in their planning policies and decisions. Local planning authorities should work with DsPH, local NHS organisations and other partners to achieve this.

LAs can and do already take public health considerations into account where they link to the existing licensing objectives - for example alcohol-related injuries, the wellbeing of children and the prevention of crime and disorder, and the Government acknowledges the damage to health attributable to alcohol. There are difficulties, though, that would need to be worked through around causal links between harm to health and specific premises in order for a new health objective to be effective. We will consider carefully the findings of PHE's work to develop the local data collection and analysis of evidence, to inform the future consideration of how a health objective might the licensing objectives operate in the licensing system.

In response to local authority interest and their role as a 'responsible authority' under the current licensing objectives, PHE has also developed an analytic support package to support the use of health data in licensing decisions, which will help local authorities promote alcohol licensing objectives. PHE will publish an evaluation of that work.

The role of the NHS in public health

22. The system of enhanced public health accountability must be extended into the NHS, forming part of a broader national strategy to systematically and demonstrably implement the radical upgrade in public health called for in the Five Year Forward View.

23. The NHS has an important role to play in prevention, and developing the skills of its workforce to deliver preventative advice as part of routine care is central to that. We will follow up progress on this issue when we next review the public health system.

The Government agrees strongly that the NHS has an important role to play in prevention and that improving and protecting the public's health requires action across the whole health and care system. It also agrees that the whole system should use the same key measures of public health.

PHE, NHS England and the other Five Year Forward View ALBs have asked LAs and the local NHS to develop place-based, multi-year STPs in 44 areas. Their aims are to improve patient care, improve health and wellbeing, and ensure financial stability, and they offer another opportunity for local partners to co-design and develop a common vision for preventative services. The NHS and partner organisations are exploring how best to target investment towards early and preventative actions that can tackle unhealthy behaviours (such as diet, alcohol consumption and smoking) and reduce complications (including amputations in people with diabetes).

NHS England has developed Commissioning for Quality and Innovation (CQUIN) payment incentives for preventing ill health arising from risky behaviours or anti-microbial resistance, and for promoting health and wellbeing among NHS staff. The prevention CQUIN rewards NHS providers to train their staff to offer effective advice to patients who drink excessively or smoke.

The CCG Improvement and Assessment Framework includes a number of key public health measures and is an important way of monitoring improvement in maternal smoking, child obesity, diabetes, falls and health inequalities, along with the public health elements of the Quality Outcomes Framework in primary care.

Department of Health
October 2016

Public Health England

NHS Digital

A joint response to the issues raised in Annex 1 of the Health Committee Report on Public Health Post-2013 regarding access to data

The current position

NHS Digital and Public Health England (PHE) are working to ensure that the health and care system has access to the data and intelligence it needs to discharge its responsibilities. Both organisations have separately reported previously to the Committee about the actions being taken to improve the way we do this, both separately and in partnership. For example, we are continuing to:

- Publish more data that complies with the Information Commissioner's Office standard for anonymisation of data, so that anybody can access and use it;
- Make it easier for organisations to apply for data through the NHS Digital Data Access Request Service (DARS) and the PHE Office for Data Release (ODR). This ensures that data is only shared where there is an appropriate legal basis, for a purpose that benefits the health and care system, and only where the appropriate security safeguards are in place. NHS Digital has recently launched an online application service, which has improved turnaround of requests even further;
- Improve our relationships with, and service offer to, key stakeholders who rely on data from NHS Digital and PHE, so there is a better understanding of stakeholder requirements;
- Introduce, with the Department of Health and NHS England, new system-level governance arrangements so that we have top-level collaboration and decision-making on priorities and investment decisions. A new Digital Delivery Board, chaired by the Chief Clinical Information Officer for the NHS, is being established to oversee the investments and the work commissioned, including the portfolio of work to deliver the commitments under the National Information Board's Paperless 2020.

The executive teams of PHE and NHS Digital meet regularly to consider the strategic data access issues affecting the national and local public health system. At the most recent meeting, a number of actions were agreed that consolidate our collaborative approach to addressing these challenges, including:

- Running a series of regional workshops with local authority public health colleagues in order to get a better understanding of their data access requirements, and explore the options for resolving them;
- Meeting with the Information Commissioner's Office about the use of anonymised data and compliance with the ICO's code of practice;
- Refreshing the Memorandum of Understanding that is in place between NHS Digital and PHE to cover the timely and efficient transfer of data between the two organisations to support the statutory responsibilities of each;
- Opening up a conversation about the Data Services Platform, a new service that NHS Digital is commissioned to design and deliver to support the National Information Board's Paperless 2020 commitments. NHS Digital is working with PHE and local authority public health

representatives to capture the data access requirements of the public health system, and to support the arrangements PHE has put in place to support the local public health intelligence function.

- Regular meetings have commenced between NHS Digital and local authority directors of public health and the Association of Directors of Public Health, so that NHS Digital can engage directly with local authorities' needs and concerns.

Public Health England

NHS Digital

Response to Health Committee report Annex 1 – supplementary information about problems with access to public health data

The transfer of directors of public health and their teams out of the NHS and into local authorities in April 2013 had profound implications for the access of the English local public health system to key health data sets and information services. Under current legislation and national policy, there is no legal basis for local authority public health teams to process confidential information without patient consent or the alternative legal basis provided by Section 251 of the NHS Act 2006.

This means that NHS Digital and PHE are unable to provide local authority public health teams with access to patient identifiable data to support the discharge of their statutory health improvement duty of local authorities, or their wider public health responsibilities. Anonymised data can be provided in accordance with the ICO anonymisation code of practice, and both NHS Digital and PHE have implemented new processes for local authorities to apply for access to the national data sets NHS Digital and PHE control. However, both NHS Digital and PHE recognise that further improvements are needed to make sure that timely and efficient access to the data and information services highlighted to the Health Committee are addressed wherever possible.

	What data?	**Why is access needed?**	**Data holder**	**Why access is currently problematic**	**Was there access pre-2013?**	**Joint PHE/NHS Digital response**
11.	Mortality data (PCMD) including cause of death	1 Suicide audit 2 Identifying mortality rate for CVD in most and least deprived quintiles 3 Identifying leading causes of death (and compare to England)	Health and Social Care Information Centre (now NHS Digital)	N3 access no longer available IGLevel 2 toolkit not in place in our LA	Yes (public health mortality file). We could link postcodes to IMD data too.	a) Data controller: NHS Digital for national data b) Access conditions: Death registration data is made available to NHSD by the Office of National Statistics (ONS) and is subject to the provisions of the Statics and Registration Services Act 2007. NHSD has delegated authority from ONS to manage the process for third-party data access to mortality data on the basis of agreed procedures to process and assure

						applications for access to this data. One of the requirements set out by ONS is for each applicant to complete an IG Toolkit assessment. There is also a separate application form and agreement which is specific to ONS. c) Current access: The NHSD procedure for providing local authority public health teams with access to PCMD changed in early 2016/17. There have been some delays in granting access to the data under this new procedure. Bridging arrangements have been put in place to ensure ongoing access to the data for those local authorities previously granted access, and a standard application template is now available for use by all local authority applicants. d) Future plans: It is expected that local authority access to PCMD will be managed through the current application process for the foreseeable future.
1.	Anonymised hospital activity data	Hospital activity data (inpatient, outpatient and A&E) would be used to contribute towards the Joint Strategic Needs Assessments and would be a key component in informing the Public	Health and Social Care Information Centre (now NHS Digital) / Commissio ning	PHE have sourced Hospital Episode Statistics (HES) on behalf of Local Authorities from the HSCIC. However, this was done with little consultation with local	This information was readily available to PH teams in Primary Care Trusts.	a) Data controller: NHS Digital for national data b) Access conditions: Current legislation and national policy does not permit local authorities to process confidential hospital activity data without patient consent or

		Health advice to Clinical Commissioning Groups.	Support Units	teams who generally do not have the resources to warehouse and manage the dataset as it covers the whole of England. A web-based national system, similar to the Primary Care Mortality Database (PCMD) would be a more efficient solution and reduce duplication across the country.		other legal basis. NHSD is only able to lawfully provide local authorities with access to anonymised HES and where local authorities can demonstrate compliance with the ICO code of anonymisation. c) Current access: NHSD currently makes HES available to local authorities in three forms: i. anonymised data extracts via DARS; ii. online access via the HDIS interrogation tool; and iii. published aggregate statistics. PHE is funding for 2016/17 the provision by NHSD of an anonymised HES data extract service available to all local authority public health teams. A standard application template has been produced by PHE and NHSD for use by all local authorities wishing to access this service. Some local authorities have encountered issues in managing the large volumes of HES data being made available in extract form. Support is being provided where possible though the PHE local knowledge and intelligence service teams, and by NHSD by supporting local authorities to enter into partnerships with those able offer
13.	HES data for one year free of charge to LA PH teams	PHE indicated that they would provide access. May or may not be useful	Health and Social Care Information Centre (now NHS Digital)	Means completing data sharing framework through H&SCIC and a further (different) data sharing agreement which identifies need for N3 or IG Level 2 toolkit.	PCT Information Team would have had access to secondary care data and we would have been able to put in information request if required. Local CSU is not so accommodating	
10.	Hospital Episode Statistics – Inpatient, Outpatient	To monitor patterns of disease and support and improve the local	Health and Social Care Information	Whilst permission has been granted for local authorities to access this	Yes – via Secondary Uses Service	

	and Urgent Care	responsiveness, effectiveness and value for money of commissioned public health and NHS services. It is also used to support the statutory 'core offer' of public health advice and support to local NHS commissioners, the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and other functions of the Health and Wellbeing Board. It is more specifically used to undertake longitudinal analyses of patterns the incidence and prevalence of health risks and diseases, demand and access to treatment services, health outcomes monitoring, and support the programme of health needs assessments, health equity audits and health impact assessments within local area.	Centre (now NHS Digital)	data the process has been problematic. Current arrangements for public health access to pseudonymised HES data are due to close on the 31st of August 2016, with no clarity around a future arrangements for local authority public health access and any associated costs leaving local authority public health teams in limbo and unable to access this information in the longer term. Due to the delays outlined above the short-term access our Council will have will amount to less than three months limiting the ability of the Public Health team to fulfil its statutory obligations or plan for the use of this information to improve health and wellbeing locally in the longer-term.	data feeds within Primary Care Trusts.	the necessary capability and capability. d) <u>Future plans</u>: For 2017/18 onwards, PHE and NHSD are collaborating on a joint proposal to the new Digital Delivery Board to secure funding in order to maintain the HES data extract service over the longer-term. NHSD and PHE are also working with local public health teams to: i. increase awareness of the different HES data options that are available, and work with directors of public health to understand how best to meet their requirements; ii. produce standard templates that explain the legal basis for accessing and using record-level data so that it is easier for local authorities to navigate their way through the NHSD application and approval process; and iii. explore ways that NHSD might extend the HDIS service to help local authorities for whom the HES data extract service is not the best solution to meet their requirements; and iv. provide local training and

						support to local authority public health analysts to help them extract maximum value from the anonymised HES data that is available to them.
7.	Anonymised mental health services data	Mental health service data (MHSDS/MHLDDS, IAPT) would be used to contribute towards the Joint Strategic Needs Assessments and would be a key component in informing the Public Health advice to Clinical Commissioning Groups.	Health and Social Care Information Centre (now NHS Digital) / Commissioning Support Units	The CSU have advised that only commissioners with Accredited Safe Haven status (ASH stage 1) are able to receive data and that although MHMDS is pseudo data they have to treat it as though it is 'clear' due to its sensitive nature.	Data sets have evolved and developed but what information did exist was readily available to PH teams in Primary Care Trusts.	a) Data controller: NHS Digital for national data b) Access conditions: Current legislation and national policy does not permit local authorities to process confidential mental health data without patient consent or other legal basis. NHSD is only able to lawfully provide local authorities with access to anonymised MHMDS/MHLDDS and IAPT data and where local authorities can demonstrate compliance with the ICO code of anonymisation. c) Current access: This data is available to local authorities who can apply for access to anonymised data through the DARS service. The standard NHSD data access charges apply. e) Future plans: As is the case with HES data, PHE and NHSD are collaborating on a joint proposal to the new Digital Delivery Board to secure funding to increase the data and information services provided to local authority public health teams.
16.	Mental health treatment data	As above	MH trust	As above	Yes	

						NHSD is also working with local public health teams to increase awareness of the different mental health data set options that are available, and with directors of public health to understand how best to meet their requirements.
2.	Anonymised cancer incidence data	To identify hotspots of cancer incidence within the local authority. This information would contribute towards the Joint Strategic Needs Assessments and would help inform targeted interventions.	Public Health England	PHE will not provide access to anonymised data at record level, which means Local Authorities have to submit individual requests each time we need to data in a slightly different way & PHE have to calculate the rates themselves, which they have limited capacity to do.	The information was much easier to access prior to 2013.	a) Data controller: Public Health England b) Access conditions: Current legislation and national policy does not permit local authorities to process confidential cancer registration data without patient consent or other legal basis. PHE is only able to lawfully provide local authorities with access to anonymised cancer register data. c) Current access: PHE and NHSD routinely publish a wide range of indicators, reports and information tools based on the cancer registration data set – such as the publicly-accessible CancerData website (www.cancerdata.nhs.uk), the Indicator Portal (http://digital.nhs.uk/article/450/Indicator-Portal-Collection) and the restricted-access CancerStats website (nww.cancerstats.nhs.uk) – which are aimed at both public and professional audiences. Local authorities can also apply for
4.	Anonymised cancer survival data	Hospital activity data (inpatient, outpatient and A&E) would be used to contribute towards the Joint Strategic Needs Assessments and would be a key component in informing the Public Health advice to Clinical Commissioning Groups.	NWCIS/NCIN	NWCIS are currently undertaking a piece of work looking at cancer survival at a national and local level, but this may take some time to come to fruition and we using relatively old data when discussing how well our residents are doing post diagnosis. We have received data on request (takes some time) from	This information was much easier to access prior to 2013.	

				NWCIS since 2013, but it is limited due to the confidentiality issues that arise in allowing access to personal data.		access to anonymised data extracts through the PHE Office for Data Release. d) Future plans: As is the case with HES data, PHE and NHSD are collaborating on a joint proposal to the new Digital Delivery Board to secure funding to increase the data and information services provided to local authority public health teams. PHE is continuing to work with local authorities through the new Cancer Networks to ensure that cancer registration data is being made available to support the identification of local public health priorities and the commissioning of effective treatment services.
12.	Cancer stats at a local level e.g. survival rate at 5 years	Public health surveillance. Continuing to monitor what we have had in past	National Cancer Intel. Network?	It is not published at a lower level (e.g. CCG or LA)	Yes, via H&SCIC Indicator Portal	
19.	National screening programme data	As above	PHE	<blank on HSC report>	Yes	a) Data controller: Public Health England b) Access conditions: Current legislation and national policy does not permit local authorities to process confidential screening programme data without patient consent or other legal basis. PHE is only able to lawfully provide local authorities with access to anonymised screening data. c) Current access: PHE routinely publishes a wide range of indicators and reports based on the screening programme data sets. Local

						authorities can also apply for access to anonymised data extracts through the PHE Office for Data Release.
15.	Child health information – that is, all data held within the child health information system, including immunisation	This would help us to: I) monitor population health trends II) enhance support provided to the NHS via the 'Core Offer' III) conduct more insightful needs analysis to inform commissioning interventions which promote public health IV) identify escalating health issues and particularly for screening programmes, fulfil requirement of the Director of Public Health to provide assurance on screening	NHS England	Information governance rules and also the fact that we do not commission these services, this means it is hard to convince partners to share the data, resulting in lengthy bureaucratic processes to try and get data, if at all.	Yes	a) Data controller: NHS Digital for national data b) Access conditions: Current legislation and national policy does not permit local authorities to process confidential child health data without patient consent or other legal basis. NHSE and NHSD are only able to lawfully provide local authorities with access to anonymised child health data and where local authorities can demonstrate compliance with the ICO code of anonymisation. c) Current access: There is a particular complexity to be addressed here because the legal basis for accessing the data for commissioning purposes is different to the legal basis for its use for public health purposes. Local authorities can request access to child health data through the DARS service. However, through discussions with local authorities, it has become clear that few are aware of this. NHSD is therefore: i. producing standard templates for local authorities to use to support

						their applications; and ii. engaging with local authorities to raise their awareness of this and seek volunteers to pilot the applications through the DARS processes. d) Future plans: Future national and local reporting of child health will be via child health information systems into the Children and Young People's Health Services Data Set (CYPHS) provided by NHSD. The first publication from CYPHS was at the end of September 2016. NHSE is presently leading the development of a national child health information strategy, which is due to be published before the end of 2016/17.
18.	Maternity data	As above	NHS Trust	Information governance makes it almost impossible to share health related identifiable data for so called 'secondary usage purposes' and it's not always straight forward to do this for primary patient care purposes. Even when sharing using pseudonymised data as proposed in our example above it is very difficult to	Yes	a) Data controller: NHS Digital for national data b) Access conditions: Current legislation and national policy does not permit local authorities to process confidential maternity data without patient consent or other legal basis. NHS Trusts and NHSD are only able to lawfully provide local authorities with access to anonymised maternity data and where local authorities can demonstrate compliance with the ICO code of anonymisation.

				share data. This is despite regulations that suggest using pseuodomymisation for secondary usage sharing purposes is possible		c) Current access: The Maternity Services Data Set (MSDS) commissioned by NHSE and provided by NHSD is now in place, and work is ongoing to build the coverage and quality of the data collected. NHSD is now publishing regular reports from MSDS and making the data available via the DARS service. d) Future plans: As is the case with HES data, PHE and NHSD are collaborating on a joint proposal to the new Digital Delivery Board to secure funding to increase the data and information services provided to local authority public health teams. NHSD is also working with local public health teams to increase awareness of the maternity data sets that are available, and with directors of public health to understand how best to meet their requirements.
8.	Breastfeeding initiation data	Monitor breastfeeding initiation rates across the borough and be used within the Joint Strategic Needs Assessment and Early Years performance data.	NHS Trusts	Local data flow – Local hospitals used to supply data to local PCT Business Intelligence Teams. However, when PCTs were abolished this data was no longer available to some Public Health teams. NHS England were publishing	This information was readily available to PH teams in Primary Care Trusts.	a) Data controller: NHS England b) Access conditions: Current legislation and national policy does not permit local authorities to process confidential breastfeeding data without patient consent or other legal basis. NHSE is only able to lawfully provide local authorities with access to anonymised data

				the data until Q1 2015/16, but no data has been released since.		and where local authorities can demonstrate compliance with the ICO code of anonymisation. c) Current access: The previous national reporting by NHS England of breastfeeding initiation has now ceased. Future reporting will be through the Maternity and Children's Data Set commissioned by NHSE and provided by NHSD. Data collection has commenced but work is continuing to build coverage and quality. As a consequence, there currently is no national reporting of breastfeeding at this time; NHS England is working to develop an interim reporting solution. d) Future plans: Future reporting will be through the Maternity and Children's Data Set.
3.	Vaccination and Immunisation uptake data	To identify uptake of vaccination and immunisation across the borough, and assist with fulfilling the Public Health role around assurance for various aspects of health protection. Some data is available at CCG or GP Practice level, but this is insufficient for population monitoring, targeting areas of low uptake and	NHS England	Direct access to the information has not been agreed and standard data flow has not been established. Vague 'IG' concerns have been cited as reason data cannot be provided.	The information was much easier to access prior to 2013.	a) Data controller: NHS England b) Access conditions: Current legislation and national policy does not permit local authorities to process confidential vaccination and immunisation data without patient consent or other legal basis. NHSE is only able to lawfully provide local authorities with access to anonymised data and where local authorities can demonstrate compliance with the ICO code of

		preventing outbreaks.				anonymisation. c) Current access: PHE is currently working with NHS England to implement a new national children and young people data set that will improve the level of access of local authorities to information on vaccination and immunisation in children aged 0-5. It is currently expected that this new data set will be rolled-out over the next three years.
9.	Reporting at administrative scales (county, district and ward). Service provision needs individual level data from the National Drug Treatment Monitoring System (NDTMS).	To consider the characteristics of people in substance misuse treatment in the county to order to inform needs assessments and commissioning decisions. To assess whether locally commissioned substance misuse treatment services are meeting the needs of service users.	Public Health England (PHE)	PHE have concerns over the provision of individual level data because of confidentiality. The only personal information that was ever previously provided was age, gender, ethnic group and partial postcode.	Yes, via the regional NDTMS team	a) Data controller: Public Health England b) Access conditions: The patient consent model for NDTMS does not allow PHE to provide the potentially identifiable data collected on the users of drug and alcohol treatment services to local authorities. c) Current access: PHE already publishes non-identifiable activity and performance reports for the local drug and alcohol treatment service commissioners. Local authorities can also apply for access to anonymised NDTMS data extracts through the PHE Office for Data Release.
17.	GP records	As above	GPs/ CCG	As above	Yes	a) Data controller: GPs for local data; GPES requesting organisation for the GP Extraction Service (GPES)

						b) Access conditions: Current legislation and national policy does not permit local authorities to process confidential primary care data without patient consent or other legal basis. However, local authorities are able to access GP practice data by acting as a data processor under contract to the NHS but such arrangements would need to be agreed at a local level. c) Current access: Patient-level data held in GP systems is available through the NHSD-provided General Practice Extraction Service (GPES). NHSD has begun to fulfil requests for GP data. Unfortunately, GPES currently is operating at near-full capacity so further work would be required to provide local authorities with access to anonymised GP data through this system. d) Future plans: As is the case with HES data, PHE and NHSD are collaborating on a joint proposal to the new Digital Delivery Board to secure funding to increase the data and information services provided to local authority public health teams. NHSD is also working with local public health teams to increase awareness of the GP data that is

						available, and with directors of public health to understand how best to meet their requirements.
5.	Demographic information available via an extract from the NHS Patient Register	The data provides a postcode level population denominator, based on GP registrations; essential for calculating rates for non-standard geographies, it assists with the production of local level (ward, SOA) population estimates, and apportion data as appropriate. It also enables us to calculate GP Practice level rates, deprivation scores, etc. and has in the past strengthened responses to ONS consultations on national population estimate methodologies. The GP Patient Register has also been used in the past (with appropriate ethical approval) to undertake population wide epidemiological surveys of health-related behaviour and risk factors. Results of which have been used locally to set priorities and target	NHS England	Public Health has not been allowed access to a full non-anonymised version of the GP Register. Individual or postcode level information has not been agreed.	This information was readily available to PH teams in Primary Care Trusts.	a) Data controller: NHS England b) Access conditions: Under current legislation and national policy, local authorities are prevented from being provided with postcode level demographic data as this is defined as identifiable patient data. c) Current access: Access to the Patient Demographic Service (PDS) is managed by NHSD, which publishes a range of national health population statistics and indicators which local authorities can access via the Indicator Portal: (http://digital.nhs.uk/article/450/Indicator-Portal-Collection) d) Future plans: As is the case with HES data, PHE and NHSD are collaborating on a joint proposal to the new Digital Delivery Board to secure funding to increase the data and information services provided to local authority public health teams. NHSD is also working with directors of public health to understand more about their requirements for demographic data.

		resource. In addition, information held on the Patient Register could potentially help with specific pieces of work; a recent example being identifying new entrants to the UK to assist with latent TB screening.				
6.	Access to patient postcode across all datasets	As a general point that applies to all datasets, the absence of patient postcode on data that LAPH teams can access impedes local analysis. Without a postcode, many data records/local data cannot be allocated to defined local areas or new electoral ward boundaries, meaning rates for local areas cannot accurately be calculated.	Various	Full postcode is classed as person identifiable data and has not been made available to LAPH teams since transition	This information was readily available to PH teams in Primary Care Trusts.	Access conditions: Current legislation and national policy does not permit local authorities to process full postcodes without patient consent or other legal basis as this is defined as identifiable patient data. Local authorities are able to apply through DARS where they believe they have a legal basis to use full postcode; higher geographies can also be requested as part of data extracts that are classified as anonymised.
21.	Out of Area service recharges	Only first part of the postcode provided and IG sited for not sharing data. Not possible to prove that this resident has used the service	Various providers	As above	Yes	Access conditions: This issue is insufficiently clearly presented to respond to other than in general terms. Postcodes are classified as a patient identifier, so any data request (regardless of its source) which includes the requirement for full postcode is considered to be for patient identifiable data as so requires a legal

						basis.
14.	Data from STEIS – NHS incident reporting system	---------- ---------- ---------- -	----------	---------- ---------- ----------	---------- ----------	a) Data controller: NHS England b) Access conditions: Access to the STEIS serious incident report system is managed by NHS England.
20.	Ability to link data	In addition to the previous examples, this enables us to provide a much more detailed analysis. For example, by linking mortality data to maternity data we have been able to demonstrate locally increased risk of infant mortality generated by the following factors; age of mother, smoking, late booking in pregnancy and obesity. We have recently enquired about sharing pseudonymised (non-identifiable) mortality data for the purpose of linking to hospital and social care data, a project which could add tremendous insight into understanding the potential interventions points for health and social care, to improve outcomes for the patients	Various including local providers, HSCIC, ONS, CSUs, Councils, other government departments	Information governance makes it almost impossible to share health related identifiable data for so called 'secondary usage purposes' and it's not always straight forward to do this for primary patient care purposes. Even when sharing using pseudonymised data as proposed in our example above it is very difficult to share data. This is despite regulations that suggest using pseuodomymisation for secondary usage sharing purposes is possible.	Yes	a) Access conditions: Where patient identifiers are required to accurately link data sets current legislation and national policy prevents local authorities from doing so without patient consent or other legal basis. b) Current access: Bespoke linked data sets are available to local authorities in an anonymised form through the DARS service. The standard NHSD data access charges apply. c) Future plans: As is the case with HES data, PHE and NHSD are collaborating on a joint proposal to the new Digital Delivery Board to secure funding to increase the data and information services provided to local authority public health teams. NHSD is also working with local public health teams to increase awareness of the different linked data set options that are available, and with directors of public health to understand how best to meet their requirements.

		and reduce premature death. However, the current information governance regime makes this almost impossible to do without spending months seeking assurance from ONS to be able to share this data.				

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