Written evidence submitted by the Health Statistics User Group  
(PHP0040)

Executive Summary

1. This memorandum focuses on the public health intelligence function

2. Public health intelligence is a key public health function requiring a skilled workforce.

3. The function has suffered since 2013 as a result of the Health and Social Care Act, particularly in terms of problems with data access. These have undermined its ability to provide the information required to support the public health function more widely

4. The Act has had an adverse effect on the public health intelligence workforce and consequently on the effectiveness of public health In particular, there has been a loss of staff with key skills.

5. Current cuts in public health spending and planned further cuts will further undermine a function which has already been adversely affected by the changes made under the Health and Social Care Act.

6. We urge the Committee to support our recommendations to protect and develop this area in the future.

1. Background

1.1 The Health Statistics User Group (HSUG) was established to represent all users of health and health services statistics and to bring together users and producers of statistics. Our activities are aimed at maintaining and improving data quality, data access, and the use of health and health services statistics. The group is independent, but, along with other groups representing users of statistics, we are affiliated to the Statistics User Forum, hosted by the Royal Statistical Society. Our membership includes professionals working in a wide range of organisations including NHS organisations, central and local government, universities and non-governmental organisations.

1.2 We welcome this inquiry into the impact of the Health and Social Care Act on public health, as we share the widespread concerns on this subject. In this memorandum, however, we focus specifically on the impact of the Act on the public health intelligence function.
2. Public health intelligence and the delivery of public health functions

2.1 The effectiveness of all aspects of the public health function depends crucially on reliable and detailed information and evidence. This is needed in order both to understand current health issues and to identify priorities and actions to improve health and reduce inequalities. This combination of information, methods and evidence to inform and guide public health decision making is generally described as public health intelligence.

2.2 Although this activity has a longer history, over the past decade public health intelligence has become recognised as a specialism, within the specialist spectrum of multi-disciplinary public health activity, but providing an essential underpinning to the public health function in general.

2.3 Before the implementation of the Health and Social Care Act 2012, public health intelligence was provided largely from within the NHS by primary care trusts, strategic health authorities and regional public health observatories. Under the Act, this was transferred outside of the NHS, with most activity being transferred to local authorities, while public health observatories were absorbed into Public Health England, with some activity being retained within NHS trusts. As we show below, this has had adverse effects on both public health intelligence and the workforce which provides it.

2.4 In local authorities, public health intelligence staff provide information to Clinical Commissioning Groups, key members of the Health and Wellbeing Board and a wide range of partner organisations in addition to public health colleagues within the local authority. This is described in fuller detail below.

2.5 Information required for public health intelligence is derived from a wide range of sources such as surveys, primary, secondary and tertiary health care data, and social care data. To inform the relationship between health and other factors, it needs demographic information including data from birth and death registration and wider economic and social data such as area deprivation scores.

2.6 Although public health is concerned with populations rather than individual patients, data at an individual record level are often required to enable appropriate analysis to be undertaken, such as by specific medical condition, small geographic areas, age, gender, ethnicity and where possible other ‘protected characteristics’ as defined in the 2010 Equality Act. Further, added value can be obtained by linking information from different sources, for example by linking health and social care data, to gain deeper insight about our vulnerable populations than is possible from a single data source.

2.7 In summary, public health intelligence is a vital part of the public health function which requires a highly and specifically skilled workforce with access to relevant information and evidence at a detailed level.
3. The effectiveness of local authorities in delivering the envisaged improvements to public health

3.1 The implementation of the Health and Social Care Act 2012 adversely impacted on the delivery of public health intelligence in a number of ways. These include responsibilities and role of public health intelligence, access to data, and organisational issues. The adverse impact on the public health intelligence and skills is discussed in Section 4. Much of the discussion is focussed on the local public health function where our members have made us aware of some of the more significant effects.

The responsibilities and role of public health intelligence

3.2 Preparatory work leading up to implementation of the Act, with its creation of new organisations, such as Clinical Commissioning Groups, helped to define the role public health intelligence would be expected to perform post 2013. The following documents were relevant and should be of interest to the committee:

Public Health Intelligence worksheets (published September 2012)

Frequently Asked questions on PHI (December 2012)
http://www.apho.org.uk/transition

Public Health England’s contribution to LAs and the NHS(August 2013)

Healthcare Public Health Advice to CCGs(June 2012)

3.3 These documents broadly set out the following areas for public health intelligence under the Act as being:

a) The ‘traditional’ role of local public health intelligence in supporting the Director of Public Health’s mandatory role of monitoring and surveillance of health issues locally; often public health intelligence has a vital role in the production of the Annual Public Health Report and increasingly in other required functions;

b) Intelligence required by the Health and Wellbeing boards including the statutory requirements for the Joint Strategic Needs Assessments, and the Pharmaceutical Needs Assessment, as well as other health needs
assessments and health equity audits;

c) Intelligence supporting the commissioning of local public health services such as sexual health, substance misuse, smoking attributable mortality, and smoking rates, for targeting cost effective services appropriately;

d) Intelligence support as part of the Health Care Public Health Advice to Clinical Commissioning Groups (The ‘Core offer’). Often this involves sharing intelligence functions with the Clinical Commissioning Group to ensure the best commissioning of health services to serve the resident population;

e) Provision of input to health aspects of strategic local authority objectives and targets

f) Closer working with services within local authorities such as education, social services, housing and environment to provide integrated intelligence across different LA departments providing an overview of how to reduce health inequalities which are often related to wider determinants of health (taking advantage of the close working within local authorities).

3.4 The extent to which public health intelligence has been able to support this wide range of responsibilities should be considered in the light of the impact of the Act and is set out below and in Section 4

**Impact on access to data**

3.5 There have been difficulties in accessing data generally across the health sector as the new arrangements have made it more difficult for health analysts to obtain data which are sufficiently detailed to fulfil their function. This has had a particular impact on those in local authorities.

3.6 Some of this is due to the requirements for Information Governance compliance to be demonstrated by the local authorities before access can be granted. This is a complicated area and new to many authorities. When public health was in the NHS there were arrangements for staff to access data securely, for example by using a secure ‘N3 connection’ to the NHS network. Most local authorities did not have these arrangements. While we support the requirement for maintaining patient confidentiality we find the approach to data access under the Act to be very restrictive and impractical. Its result has been to stifle and dilute important health analysis and research because health service data are not readily accessible.

3.7 The transfer of the public health function from the NHS to local authorities in 2013 created a number of obstacles to data access for public health intelligence. In particular:

a) As described in fuller detail below, many public health teams lost key staff during the transfer, as a result of which valuable knowledge and skills were often lost and either not replaced or have taken time to rebuild.
b) With public health outside the ‘NHS family’, many data provider organisations have been reluctant, or have found it difficult, to afford access to data. Also, new organisations such as the Commissioning Support Units were established to support Clinical Commissioning Groups but had no responsibility to support local authority public health. Building relationships with new organisations is still important but was impeded as the transfer from primary care trusts was imposed without the preparation and foundations needed to enable local public health intelligence teams to access the data they required to be able to fulfil their role. With a smaller public health intelligence capacity, local public health teams have not always had the capacity to rectify these situations unaided.

c) Restrictions on data access have reduced the potential for local data linkage, thereby losing opportunities to employ this powerful technique to provide fuller information to support prevention. Evidence that could provide information on the health needs of our vulnerable populations, and could inform appropriate interventions in particular situations such as excess winter deaths, or ‘troubled families’, can no longer be linked with other relevant information.

d) In some local authorities these issues have been overcome but, in most, difficulties remain. This has resulted in a variable quality and fragmented public health intelligence service.

3.8 Data quality and completeness are being compromised as a result of the requirement to remove records of people who have opted out of allowing their data to be used outside the NHS from data provided to all users. NHS England did not offer the public the opportunity to distinguish between the purposes for which their data were to be used, and many people who opted out were concerned about commercial uses of their data. This will have a detrimental impact on the use of data for research and public sector purposes, which enjoy considerable public support.

3.9 If public health intelligence cannot access the data it requires to fulfil its function, or if this access is too onerous, then key health issues cannot be addressed. Simple and secure means are needed to improve access to data by trusted analysts. Accredited analysts working in local authorities require the same access to data as previously in the NHS. Analysts had been trained in the appropriate handling of personally identifiable information, confidentiality, and the anonymising of information in order to publish data without disclosure of sensitive or confidential information. This aspect of a public health professional’s training has been undermined by the Act.

4. The public health workforce
4.1 While skills required by public health intelligence overlap to some extent with analysts in other areas, public health has a particular population health focus and requires professionals with specific skills.

4.2 Public health analysts need the generic analytical skills which are likely to be shared with other local authority analysts. These include advanced data manipulation and analytical skills, including knowledge of appropriate statistical methods and technical skills including statistical analysis and advanced use of database, spreadsheets, statistical software and geographical information systems.

4.3 For public health intelligence, many further specific skills are needed. These include:

a) A thorough knowledge and understanding of a wide range of relevant data and evidence sources, including their content, how to access them, their quality, their relative strengths and weaknesses and how to use these to produce relevant information and make inferences about public health outcomes and trends.

b) Knowledge of epidemiology and epidemiological methods to enable them to construct appropriate designs for analysis and produce results which are meaningful for public health.

c) An understanding of the public health context, including why data are needed, how to measure health services, outcomes and health needs, including how best to meet those needs.

d) Knowledge of health economics. This can be achieved either by recruiting a health economist or by providing additional training to an existing member of the team.

**Effects of the Health and Social Care Act on public health intelligence workforce and skills**

4.4 The Act created a number of problems for the public health intelligence workforce:

a) In the transfer to local authorities the public health function lost many experienced staff. This happened partly through salaries not being preserved or protected in the transfer, as was done for medically qualified public health consultants. This created severe shortages in public health teams, and thus impacted on their ability to use intelligence and evidence effectively. Posts are often vacant or filled on a temporary basis, with subsequent losses of organisational memory.

b) Pay bandings and career paths that were established only a few years earlier were no longer recognised, as a result of which some senior public health intelligence posts were undermined, and posts were lost in re-organisation.
c) Numbers of analysts in public health teams vary, but in many local authorities, there is just one public health intelligence post in a team. In this case, a sole analyst is unlikely to possess the full range of skills set out above leaving many public health teams with a skills shortage. Sole analysts can find all their time taken up with ad hoc requirements for data and intelligence and as a result larger projects such as data improvement or gaining better access do not get done. Continuity problems can arise when sole analysts leave or are absent;

d) It is important to plan to have strategic and professional oversight of the intelligence function, and this is less likely in the new arrangements, particularly if there is only one analyst.

e) Analysts can become isolated with no prospect of a career path. In turn there are few opportunities to find ‘training slots’ for new analysts at the start of their career.

f) There has been considerable fragmentation with public health analysis now being spread across local government, the NHS and the Public Health England, which is now part of the Civil Service. This inhibits public health intelligence professionals from moving between organisations due to the adverse impact on their employment terms and conditions, and this prevents them from developing a broad knowledge of health information and intelligence generally.

4.5 All of these issues have undermined much of the good work done previously to develop a strong public health intelligence workforce which has matured professionally and organisationally since 2003, and which will require investment and time to recover.

4.6 The Committee should be aware that the independent Centre for Workforce Intelligence, in its report on the public health knowledge and intelligence workforce, http://www.cfwi.org.uk/publications/public-health-knowledge-and-intelligence-a-study made a number of recommendations to preserve the public health intelligence function, including:

a) Offering clearer guidance to local authorities on the appropriate skills and professions they need in their public health knowledge and intelligence teams.

b) The establishment of a professional network for this workforce which encompasses all employers

c) Creating initiatives to increase workforce mobility between local authorities, Public Health England and the NHS.

d) Resolving issues impeding access to NHS data by local authorities.
Organisational issues

4.7 The transfer of the public health intelligence function to local authorities has raised organisational issues within authorities. Arrangements vary with some authorities bringing together analysts from different functions into one central team whilst others keep the public health analysts within their own team. There are advantages and disadvantages of a central approach. A single team can cover a wider range of skills, can provide management and professional oversight, and will also provide better cover in case of absence. On the other hand, the incorporation of a public health analyst into a central generic team may not take account of the wider professional public health role described in paragraph 4.3 and over time they may be deskillled.

4.8 We do not advocate a particular organisational model, but are concerned that the financial pressures and uncertainties placed on local authorities and separately on public health lead to the risk of a reduction in public health intelligence capability and capacity. We urge that irrespective of the solution adopted in individual local authorities:

a) The specific professional knowledge, skills and experience required for public health intelligence are acknowledged, supported and remain available.

b) Public health should continue to be responsible for prioritising the work of the public health intelligence function. Matrix relationships and representation of public health intelligence on multi-disciplinary boards in local authorities seems to work very well, when there is capacity within public health.

c) The job descriptions devised for Agenda for Change are revised to take account of the changes in employing organisations and then mapped onto local authority pay scales.

5. Public health spending.

5.1 The changes made under the Health and Social Care Act have already had an adverse impact on the public health intelligence function, resulting in loss of skilled staff needed to do the work required. We are very concerned about the impact of current cuts in public health spending and the prospect of further cuts as they will further undermine the effectiveness of the public health intelligence function.

6. Conclusion

6.1 We urge the Committee to acknowledge the importance of public health intelligence as an integral part of the public health function and recognise the specific skill-set required.
6.2 We ask the Committee to acknowledge this by calling on the Department of Health to:

a) Redress the impact of the Health and Social Care Act on the analytical function, notably its adverse impact on access to data and improved access to data in public health and in the health system more widely.

b) Implement the recommendations of the Centre for Workforce Intelligence set out in paragraph 4.6.

c) Ensure that the public health intelligence function is well defined and able to recruit, train and retain appropriate staff to deliver public health intelligence in the future, in particular to publish guidelines for local authorities and other employers defining the role of public health intelligence and the skillset required.

d) Ensure that current and future financial constraints and the devolution agenda do not dilute the public health intelligence function further in local authorities and ensure that their future plans include training and recruitment to build capability to deliver an effective service.

6.3 We would be pleased to discuss these issues with the Committee as required.

14 December 2015