This paper has been submitted on behalf of Public Health, City of Wolverhampton Council in response to the request for written evidence in relation to the Public Health post 2013 Inquiry.

Recommendations

A: Access to data

- Seamless access to data without the need to produce purpose specific information sharing agreements to deliver the public health function
- National, standardised pseudonymisation process to support data linkage to inform local public health intelligence and commissioning of services

B: Public Health Funding

- A review of the proposed public health funding formula to prevent a disproportion reduction in funding in areas experiencing the highest levels of deprivation
- Establish a process to ensure that public health funding is allocated to meet current and future population need to prevent increasing poor health outcomes and widening health inequalities

C: Fragmentation of Health Protection

- A review of roles and responsibilities of all agencies involved within the remit of health protection, including expert advice, strategic approach, development and implementation of plans and incident management both in health care settings and the wider community
- Clarification of these roles and responsibilities and establish a pathway where information is shared
- Agree roles, responsibility and funding for incident response and management

D: Health Improvement Services

- Review of the fragmentation of relationship with NHS on public health
- Improved integration of Screening and Immunisations Programmes
1. Access to Patient Identifiable Data

1.1 Despite the publication of the Public Health Access to Data – Advisory Note\(^1\), public health staff employed by the local authority are still struggling to access data.

1.2 The Advisory Note clearly states that there is a legal position to share patient identifiable data (PID) for ‘communicable diseases or other risks to public health’. An interpretation is provided of what constitutes a risk to public health. However, when data is requested for these purposes, requests are denied or there is a ‘requirement’ to complete a laborious purpose specific information sharing agreement (PSISA) to establish the basis for receiving the data.

1.3 Although the Advisory Note states that there are not restrictions on the use of pseudonymised/anonymised data, this data format does not allow for the effective monitoring of contracts, identification of population needs and effective commissioning.

1.4 It is not possible to produce PSISA for every issue within public health that requires PID to support delivery of the public health function.

1.5 Seamless access to data would overcome these problems alongside a national standardised pseudonymisation tool to allow data linkage to inform local public health intelligence.

2. Public Health Grant Allocation

2.1 The Advisory Committee on Resource Allocation (ACRA) proposed public health grant funding for 2016/17 consultation document\(^2\) has raised some grave concerns regarding the future delivery of the public health function.

2.2 The public health grants for 2013/14 and 2014/15 were based on recommendations the ACRA target formula and historical spend data. Whilst the proposed formula for 2016/17 appears, on the surface, to be a logical and sensible approach, there are hidden impacts associated with application of this methodology.

2.3 Whilst the formula includes a new formula for substance misuse, sexual health services and a new component for children’s 0-5 services, it does not explicitly incorporate the Index of Multiple Deprivation (IMD).

2.4 The consultation document displays the change in funding as a percentage of the weighted population expressed as a rate per 100,000 population. The rationale

\(^1\) [http://www.hscic.gov.uk/media/11797/Public-Health-Access-to-Data-Advisory-Note-April-13/pdf/Public_Health_Access_to_Data_Advisory_Note.pdf](http://www.hscic.gov.uk/media/11797/Public-Health-Access-to-Data-Advisory-Note-April-13/pdf/Public_Health_Access_to_Data_Advisory_Note.pdf)

for this method is not provided and appears disingenuous as it portrays the changes in funding to be smaller than that which would be experienced in reality.

2.5 The consultation document claims that, using the weighted population method, 80% of areas would experience a change of less than 5%. However, a review of the percentage change in the share of the weighted population against potential percentage change in funding indicates that 15% of LA’s are set to lose 20% or more of their funding and a staggering 53% of LA’s are set to lose 5% or more.

2.6 When these findings are matched against the latest deprivation score, a slight but significant correlation with deprivation is highlighted, with the poorest areas experiencing the greatest reduction in funding (see figure 1).

*Figure 1: Correlation of Local Authority funding change against Index of Multiple Deprivation*

2.7 Furthermore, analysis of the average change in funding by deprivation quintile highlights the disproportionate negative impact of the proposed formula, with more deprived Local Authorities experiencing the greatest reduction in public health funding (see table 1).
Table 1: Comparison of percentage change in funding by Index of Multiple Deprivation

<table>
<thead>
<tr>
<th>IMD quintile</th>
<th>Average of % change in funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>00.0-19.9</td>
<td>-8.5</td>
</tr>
<tr>
<td>20.0-39.9</td>
<td>-7.6</td>
</tr>
<tr>
<td>40.0-59.9</td>
<td>-1.5</td>
</tr>
<tr>
<td>60.0-79.9</td>
<td>7.2</td>
</tr>
<tr>
<td>80.0-100</td>
<td>14.8</td>
</tr>
</tbody>
</table>

2.8 The November 2015 Spending Review and Autumn Statement further compounds the in year reduction in public health funding by imposing an additional 4% year on year reduction in funding. It appears that no consideration has been given to sustaining delivery of, not only the mandated public health function, but the discretionary services that contribute to achievement of mandated public health services.

2.9 Unless there is a concerted effort to future-proof the public health function by ensuring that there is sufficient funding to support delivery, there will be increasingly poor health outcomes and widening health inequalities.

3. Fragmentation of Health Protection

3.1 Since the movement of Public Health into Local Authorities there have been many positives including improved collaborative working with Planning, Housing, Social Services and Environmental Health departments in an attempt to bring about real change in terms of Health Protection.

3.2 However with this move, Public Health has no longer been regarded by some as integral to, or part of, the NHS family. This has led to numerous difficulties including the sharing of and access to data on health protection incidents, engaging with other NHS services, and understanding each organisation’s role and responsibility for the wide array of health protection issues within their boundary.

3.3 It has also led to examples where either work has been duplicated or rather alarmingly where there are gaps in work required. This is no more evident than when a health protection incident occurs requiring a local, coordinated response, either medical or otherwise. Whilst these are often well managed in acute trusts there are considerable variations in coordinating responses with primary care settings, criminal justices services, education sector and others.

3.4 Alarmingly there have been examples where potential significant public health issues in the community have resulted in more time being expended on ascertaining whose responsibility it is, who is to resource it, accessing key information and whether there is the relevant experience and knowledge within that organisation to respond rather than responding.
3.5 This has raised concerns and confidence that health protection incidents are not being reported, monitored or learnt from.

4. **Health Improvement Services**

4.1 Since the move of public health into local authorities, there has been considerable variation in the level of close working between NHS partners and public health. This relationship is under increasing threat as budgets shrink, and the NHS focuses ever more on efficiency savings, as opposed to prevention, as a way to maximise value in NHS budgets.

4.2 The main services that are commissioned by local public health teams include sexual health services, drug and alcohol services, health visiting and school nursing, and a range of healthy lifestyles services, including health checks. These are all services that require close working relationships with local health commissioners and providers, and indeed much of the evidence based work these services provide results in substantial savings to the NHS. Reductions in these services are likely to reduce the savings the NHS will see in the future, and have serious detrimental impacts on the health of communities.

4.3 In addition, there are a range of services that CCGs and NHS England commission which would benefit from closer, collaborative working with public health teams, to ensure they are evidence based, focus on early intervention and are underpinned by the recognition that the NHS cannot afford not to invest in prevention. Some examples of this include diabetes services, CVD services, and musculo-skeletal services. There is a need to ensure much greater integration of public health and NHS commissioning.

4.4 As the Screening and Immunisation Programmes are now managed by PHE, based with NHS England, there is a lack of engagement and involvement with local public health teams. This has included a lack of sharing of data on local uptake of screening and immunisations, due to issues raised over information governance. On the other hand there seems to be an expectation that local public health teams will resource local campaigns and work to increase uptake of screening and immunisation, which would rely on access to local data.

4.5 In addition the Director of Public Health has a statutory responsibility to ensure scrutiny, challenge and assurance for health protection programmes, including screening and immunisations. Whilst mechanisms have been set up to do this at a local level, there is still a paucity of evidence of incidents and detailed uptake of programmes.

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