Supplementary written evidence submitted by Ros Jervis, Service Director - Public Health & Wellbeing, Wolverhampton Council (PHP0114)

1. Data requirements to support the Public Health Intelligence function

I came away from the session feeling concerned that I had not fully demonstrated the difficulties my team were facing trying to access data. Our panel discussions led, in my opinion, to the view that the establishment of 'Safe Havens' were the solution to this problem. However, it has not been possible to progress or even discuss a Safe Haven status as Local Authority Public Health (LAPH).

The Public Health Intelligence (PHI) function in my team is totally dependent on access to credible and reliable data to inform current population health and assist in planning for future health needs. Prior to the implementation of the Health and Social Care Act 2012 public health had access to individual record level data which allowed detailed analysis of various issues by condition, geography, age, gender and ethnicity. Access to a unique identifier such as the NHS number further enhanced the public health intelligence function, providing the ability to link data from different sources to provide greater insight into local areas of concern.

However, access to data has been significantly disrupted since public health transitioned out of the NHS. Whilst national factsheets¹ have outlined the essential requirements necessary to establish effective PHI support, there still remain three main outstanding issues:

a. Information Governance

Public Health Access to Data - Advisory Note² states that there is authorised access to confidential patient information for risks to public health under existing legal provisions. However, there is variable application of Regulation 3 that supports this access.

The need to comply with Information Governance (IG) requires establishment of a legal basis to share data that was previously available, and if received, this data can only be used for the specific reason detailed within the agreement. This stifles the proactive analysis of current and emerging issues as there is often a significant time delay in getting these agreements through process and a further time lag in receiving the data. Subsequently, the requirement to seek another agreement for additional usage of this data restricts the innovative work produced from data linkage.

Public health requires the same access to data that was available prior to transition to the local authority. A national mandate to re-establish access to data required to address public health risk and communicable disease, within an overarching information sharing agreement between public health and the NHS, would resolve this issue. This type of agreement would also enable the Director of Public Health to effectively scrutinise and challenge local screening and immunisation performance, an issue that of course led to such lively discussion at the evidence session of the Health Select Committee Inquiry.

b. Establishment of N3 connection

Remote access to NHS data via N3 connectivity ceased when public health transitioned into Local Government. There have been local organisational difficulties re-establishing this connection despite ensuring the appropriate IT infrastructure and IG measures are in place to support this function. A national mandate to establish an N3 connection between public
health and the NHS should resolve this issue.

c. Pseudonymisation

Pseudonymised data would enable secondary use of data without compromising patient confidentiality and a national pseudonymisation process would support delivery of the public health intelligence function. Whilst there has been a review of data pseudonymisation by the Health and Social Care Information Centre\(^3\), there appears to be no definitive recommendation for this process. A national pseudonymisation tool would support access to and sharing of data.

\(^1\)Department of Health (2012) Local Public Health Intelligence


\(^3\)HSCIC (2014) HSIC Data Pseudonymisation Review-Interim Report
2. Notification of performance data and incidents to support the Director of Public Health (DPH) role of scrutiny, challenge and assurance for health protection services

With the transfer of public health functions to the Local Authority, the DPH was given the responsibility to scrutinise, challenge and seek assurance that there are robust plans and processes in place to manage health protection incidents and outbreaks.

The DPH also needs to ensure that health protection services, such as screening and immunisation services, are robust, meeting targets and are safe and effective.

This statutory function is, in most areas including Wolverhampton, discharged through a Health Protection Committee, chaired by the DPH. The experience within our area is that whilst aggregated figures are generally available on how well a Local Authority area is performing as a whole, for example childhood immunisations, there is no data provided at a level below this, i.e. ward level or GP practice level. The only occasion when we have received data at this level is for seasonal influenza vaccination by GP practice, which was released after months of agreeing an Information Sharing Agreement. It is therefore, very difficult to understand the variations in performance and what may be the cause of variation and limits the ability of the DPH and their team to scrutinise such services.

In addition to performance data, very few incidents are reported to the Health Protection Committee for screening and immunisation services. In the past three years one immunisation incident has been formally reported to the DPH which is a major contrast to the number of reports received prior to transition. There have been reports of screening service issues, which the public health team were made aware of through attendance at individual local programme boards and formal Care Quality Commission inspections, however, these incidents have not been formally notified to the DPH. As a consequence we are not assured that we are fully aware of performance and quality and incidents.

Incident reporting needs to be supported by formal arrangements to describe the authorisation for sharing information and data between the main commissioners (NHS England, CCG, Public Health England (PHE) and LAPH) in a sensible, timely manner.

3. Notification of incidents in commissioned services

As a commissioner of public health services from both NHS and non-NHS providers, we require all providers notify us with the details of any incidents and that robust Route Cause Analysis (RCA) is undertaken when appropriate. However it is evident that this is not constantly happening for a number of reasons.

The challenges facing public health in relation to contract incident assurance, is due in the main to our inability to access the national STEIS system. This nationally recognised system enables providers to report and manage incidents in line with the National Serious Incident Framework. Access to the STEIS system was previously available to public health via PCT Governance functions; however since transfer into the Local Authority authorisation has been removed. We would consider the development and implementation of an additional reporting system for Local Government a waste of resource and duplication.
In some areas Public Health teams have made arrangements with local Clinical Commissioning Groups (CCG) to receive incident reporting on their behalf, however this relies on CCG capacity and is only relevant for providers based within the CCG footprint. These sort of arrangements are even more difficult to arrange in circumstances where the provider is based in another CCG area. By way of example we commission our drug and alcohol services through an organisation based outside of Wolverhampton. As they have no systematic means of reporting incidents to us they report any incidents to their local CCG. We recently made arrangements for this CCG to share all reported incidents involving our residents since transfer in April 2013, this brought 14 historical serious incidents to our attention.

We would welcome a national work stream to provide some real focus on this issue and help provide clarity in relation to roles and responsibilities for incident management and develop effective assurance arrangements for all relevant stakeholders including LAPH services, CCGs, NHS England and PHE.

18 May 2016