

Local public health intelligence

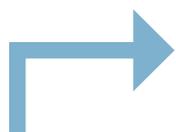
Factsheets

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	For Information
Gateway Reference	18033
Title	Factsheet: local public health intelligence
Author	Department of Health / Public Health England Transition Team
Publication Date	27 September 2012
Target Audience	Directors of PH, Local Authority CEs
Circulation List	
Description	A factsheet detailing local government requirements for public health intelligence capacity and services and outlining steps that need to be taken to secure such capacity and services including addressing IT and information governance architecture issues.
Cross Ref	Public Health in Local Government Factsheet
Superseded Docs	N/A
Action Required	N/A
Timing	N/A
Contact Details	Knowledge and Intelligence team PHE Transition Team Wellington House 133-155 Waterloo Road SE1 8UG 020 7210 4850 http://healthandcare.dh.gov.uk/
For Recipient's Use	

Summary of local public health intelligence



Upper tier and unitary local authorities in England¹ will soon have a new statutory duty to improve the health of their populations.

Subject to approval by Parliament, they will also have responsibilities to provide public health advice on healthcare services to NHS clinical commissioning groups and to provide information and advice with a view to ensuring that plans are in place to protect the health of their population from outbreaks of infection or environmental hazards.

Local authorities will need to use the best available health intelligence in order to fulfil these significant new public health functions.

This factsheet summarises these health intelligence requirements and describes issues that local authorities will need to address with their partners to establish effective health intelligence support, including:

- access to relevant health and social care data and evidence
- provision of specialist health intelligence skills and capacity
- governance of any confidential information used for health intelligence.

To maintain access to existing and future available health intelligence products and services, local teams will need to:

- have appropriate IT infrastructure and information governance arrangements in place, including N3 connections, NHSmail email accounts, and log-ins to relevant evidence repositories (eg 'Athens')
- ensure skilled health intelligence staff are based within the local authority and/or develop a business model for securing this input from partner organisations
- make arrangements with local NHS organisations for provision of relevant data and information from local NHS systems
- consider whether confidential personal data is required for specific purposes and identify the legal basis for access to, and controls around the use of, such data.

Public Health England will actively support this work by engaging with local authorities to develop an effective knowledge and intelligence service and by leading on or contributing to relevant national policy and delivery.





Public Health England will provide evidence and updates on how England measures up against the Public Health Outcomes Framework, and will provide standardised, benchmarked information that local authorities may choose to use in their joint strategic needs assessments and health and wellbeing strategies.

Access to NHS data for local authority staff is an essential part of the service clinical commissioning groups require from commissioning support groups and any costs incurred by the commissioning support groups in providing it need to be covered by the clinical commissioning groups, not the local authorities.

Public Health England will work closely with the NHS Commissioning Board to promote effective joint working at local level between local authorities, clinical commissioning groups and the new commissioning support units².

Public Health England will encourage sharing of information and practice across the local system, promoting uptake of new initiatives where these are found to be effective, and developing a repository of best practice for public health.

¹ In England, there are a mixture of single-tier (unitary) and two-tier authorities. In areas covered by two tiers, the upper tier will usually be known as the county or shire council and the lower tier as the district, borough or city council. Unitary authorities may have adopted any of these names (www.hmrc.gov.uk/manuals/ctmanual/ctm40860.htm). When we refer to local authorities in this document, we are referring to upper tier and unitary authorities only.

² Commissioning support units are currently being designed to offer support to clinical commissioning groups, including on service redesign, market management, procurement and contract negotiation. They will also offer information services in many cases including monitoring, analysis and risk stratification. (www.commissioningboard.nhs.uk/files/2012/09/fact-comm-support.pdf).

Actions

Throughout this series of factsheets you will find text boxes summarising the key actions arising from each section. These are intended to help local areas plan for and implement a successful transition.

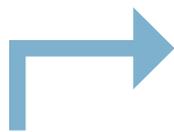


Produced: September 2012

Gateway reference: 18033

© Crown copyright 2012
Produced by the Department of Health
www.dh.gov.uk/publications

Local government's new public health functions



From April 2013 local authorities will have a key role in improving the health of their local population, working in partnership with clinical commissioning groups, and others, through health and wellbeing boards in their localities.

They will be responsible for commissioning and collaborating on a range of public health services and for advising the commissioners of local NHS services.

Local authorities will need to ensure they have appropriate health intelligence and evidence input needed to discharge these new duties effectively.

Health and wellbeing boards are being established by local authorities in partnership with NHS clinical commissioning groups and others. The boards will be responsible for preparing comprehensive joint strategic needs assessments and joint health and wellbeing strategies, and will have a role in commissioning plans take those assessments and strategies properly into account.

These important new responsibilities in local government will join existing roles that substantially influence the health of local people, for example environment, housing, economic development and regeneration, education and care services.

Local authorities will therefore be able to improve significantly the health of their local populations, as measured by the Public Health Outcomes Framework. The factsheets on public health in local government give further details of the specific public health functions that are transferring from the NHS to local authorities.

These new functions will rest with councils as a whole but will be supported by specialist public health staff transferred into local government, including specialist leadership from directors of public health supported by their teams, including, in many cases, some public health intelligence staff.

Beyond upper-tier and unitary local authorities, local partners such as district councils, NHS and voluntary agencies, and local businesses will make significant contributions to local health and wellbeing strategies.

Public Health England will also work closely alongside local authorities both as the national leadership body for public health (including working with Councils on the joint appointments process for directors of public health) and as an active partner in local initiatives, where appropriate³.





While many responsibilities for public health transfer from the NHS to local authorities, healthcare commissioning responsibilities are transferring to new NHS clinical commissioning groups and the NHS Commissioning Board.

The business intelligence functions supporting these commissioning responsibilities are, in the main, transferring into new commissioning support units or other NHS bodies. It is important that the contribution these and other intelligence functions were making to public health in the NHS is recognised and secured within the new arrangements.

Requirement for health intelligence in local authorities

To deliver their public health functions, local authorities will need to obtain and use relevant data and evidence to both inform their public health advice to the NHS and to shape their own strategic health activities.

Depending on local circumstances this work may best be organised 'in-house' by the local authority, or it may be a commissioned service – purchased partly or wholly from other bodies, such as collaborative models with other local authorities.

In addition, commissioning support units may assist in providing data on behalf of clinical commissioning groups, to assist local authorities in providing public health advice to the NHS.

Access to an effective and robust local health intelligence function will be essential for local authorities to discharge their new duties effectively.

Many of the new health functions in councils will critically depend on the use of data and evidence, including strategic leadership for health, developing health and wellbeing strategies and publishing director of public health annual reports.

Local clinical commissioning groups will also ask the local authority to undertake specific tasks to support local NHS commissioning.

Examples of work that might require sophisticated use of data and evidence include:

- developing and using the joint strategic needs assessment and the joint strategic assets assessment to inform commissioning or service delivery plans for local authorities and for clinical commissioning groups
- developing and interpreting neighbourhood, locality and/or local GP-practice profiles
- identifying vulnerable local populations, marginalised groups and describing local health inequalities, and supporting equality and diversity analyses
- offering public health advice on the commissioning cycle, including understanding local performance and key drivers against indicators set out in the Public Health Outcomes Framework, the NHS Outcomes Framework and the Commissioning Outcomes Framework
- supporting clinical commissioning groups in interpreting and understanding data on variation in levels of service use in both primary and secondary care





- assisting in developing evidence-based care pathways, service specifications and quality indicators to monitor patient outcomes
- preparing the director of public health's annual health report
- providing critical evidence appraisals to support development of clinical prioritisation policies for both populations and individuals.

A number of specialist intelligence staff will transfer to local authorities from the NHS, bringing with them significant and relevant experience and expertise.

It will be important for councils to consider whether the health intelligence capacity and capability available to transfer in from the NHS will be sufficient to discharge new public health responsibilities, especially because:

- health intelligence capacity is highly

variable around the country, both in existing public health teams and in local authorities

- Although many councils already employ information and intelligence staff to support existing duties, such as in housing, planning and the environment, the specialist nature of health intelligence means it is unlikely all existing council teams would be able to fully absorb new public health responsibilities
- health intelligence expertise is also highly sought after and some staff may choose to move toward a commissioning support unit-type organisation and to focus on the business intelligence aspects of their role.

³ The most obvious example where Public Health England will be working in direct support locally is in health protection, but increasingly Public Health England will support health improvement responsibilities while the local strategic leadership function remains with councils.

Actions

- Local authorities will wish to understand local requirements for health intelligence.
- Local authorities, along with clinical commissioning groups and commissioning support units as appropriate, will wish to agree a resource and business model for health intelligence.

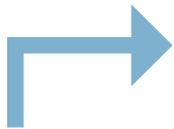


Produced: September 2012

Gateway reference: 18033

© Crown copyright 2012
Produced by the Department of Health
www.dh.gov.uk/publications

National organisations providing health intelligence resources



Many existing datasets, and health intelligence products and services, will continue to be available from April 2013 from a range of national providers, as they are now.

This includes, for example, the public health compendium⁴ – a suite of population health indicators for national and local level information – and the local health profiles⁵ – providing reports and maps on public health data in many cases down to small area level.

Other sources include:

- national general practice profiles⁶
- indices of deprivation⁷
- a range of local authority data that can be accessed through neighbourhood statistics⁸.

A number of tools exist for the economic evaluation of interventions, such as Programme Budgeting Benchmarking Tool, Patient Programme Budgeting Atlas, Spend and Outcome Tool (SPOT), Reported Outcome Measures Tool (PROMT), Inpatient Variation Expenditure Tool (IVET), NHS Comparators⁹, the NICE Return on Investment Tool and health impact assessments¹⁰.

The “Right Care programme” has produced health investment packs that are a useful introduction to the above

economic assessment tools¹¹. In the future, Public Health England will provide a comprehensive list and set of links for tools available to support local health intelligence functions.

Under the national strategy for information in health and social care¹², large-scale datasets will increasingly be available under the principles of transparency.

This will add to the existing suite of datasets available, primarily from the Health and Social Care Information Centre, through NHS connections (outlined below) such as:

Open Exeter

- Primary Care Mortality Database (PCMD)
- Bowel Cancer Screening System (BCSS)

Exeter/Mconnect

- Master Patient Index

Primary care data

- Quality and Outcomes Framework (QOF)/Quality Management Analysis System

National N3 connection websites

- ePACT (provides information on prescriptions)
- National Cancer Information Service





- Immform (records data on uptake of immunisation programmes)
- National Child Measurement Programme (NCMP)
- NHS comparators.

A wide range of data required for health intelligence will therefore be accessible at the local level, although local expertise and capacity will still be required to extract and use relevant data, or to commission another body to do so.

In order for local authorities to consider their own needs for health intelligence support it is necessary for them to understand what support will be available from other agencies.

Many of the relevant national organisations are also in transition meaning it is not yet possible to provide a definitive list of products and services.

However, the following sections identify areas where these organisations are likely to contribute toward meeting local health intelligence requirements.

Public Health England

A specification for the contribution that Public Health England will make to local public health intelligence is being developed in partnership with local authorities and other partners in the health system.

On the basis of a refreshed and integrated view of the functions of its predecessor bodies, Public Health England will be able to provide a range of tools, indicators,

atlases and profiles, alongside education and training opportunities, to support local authorities across the whole range of their health responsibilities, including providing advice on healthcare services to clinical commissioning groups and health protection.

Health intelligence capacity within local authorities will be needed to request, use, interpret, and build upon these nationally available tools and service to provide the bespoke intelligence needed by both local authorities and clinical commissioning groups.

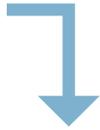
These products will be based initially on the Public Health Outcomes Framework¹³ and will include updated versions of the Local Health Profiles series and the NHS Atlases of Variation.

Public Health England will also provide easy access to a range of catalogued evidence resources and examples of good practice that, together with the statistical resources, will help local authorities to establish and address the public health priorities in their area.

For example, Public Health England will be working closely with National Institute for Health and Clinical Excellence (NICE) and other partners to provide integrated summaries of evidence, public health guidance and local statistical information to guide commissioning for local areas.

Public Health England will not in general provide record-level data services, as that function is expected to come from other sources, for example the Health and





Social Care Information Centre (HSCIC), commissioning support units and other providers.

However, Public Health England and, in due course, the HSCIC, will provide data and information directly to local authorities in business areas where Public Health England continues to be the primary data collector (health protection surveillance, drug and alcohol treatment, and disease surveillance such as cancer).

Public Health England will also provide a responsive ad hoc intelligence service to local authorities and the local NHS, accessed via the Public Health England centres and within available resources.

This service could be enhanced where local authorities or NHS commissioners require it through locally negotiated arrangements. These would need to include appropriate cost recovery, for example where Public Health England is contracted to provide a quality observatory function to the local NHS.

Public Health England intends to build on the successful model of the National Cancer Intelligence Network to establish additional multi-agency topic based intelligence networks in areas where such intelligence can drive improvements in outcomes, for example in child and maternal health, or vascular disease.

Further guidance will be developed on these before Public Health England is established in April 2013.

Health and Social Care Information Centre

The national Information Strategy clarifies the role for the re-formed HSCIC as the national repository for health and social care information.

HSCIC will be responsible for collecting, securely linking and making available a wealth of data in safe, anonymised formats to those who need it.

Public health teams in local authorities will be able, as at present, to access a wide range of aggregate data on the health outcomes of their population.

Increasingly, they will also be able to draw upon an expanding range of linked datasets, for example, to support the commissioning and delivery of local public health services.

Office for National Statistics

Data on births and deaths will be available to local authorities directly from ONS for health and statistical purposes.

This has been enabled by clauses 284, 285 and 287 in the Health and Social Care Act (2012), which amend section 42 of the Statistics and Registration Service Act 2007.

At present the HSCIC has a service level agreement with the ONS to provide births and deaths data to the NHS.

HSCIC and ONS are working together to consider how best to meet local authorities' needs for these data.





It is likely that deaths data will be provided via access to the PCMD (see page 1 of this document). ONS and the HSCIC are in discussion about the provision of births data.

In addition ONS will continue to supply data for the public health compendium¹⁴ and provide the ONS Vital Statistics tables. ONS is not expecting to contract individually with local authorities for the provision of births and deaths data.

National Institute for Health and Clinical Excellence

NICE will continue to provide access to a broad range of public health evidence and advice through NHS Evidence.

This content will also be made available through the Public Health England website.

NICE is currently working with local government to produce tailored summaries of evidence of effective public health interventions based on NICE guidance for local use, as well as a portfolio of public health guidance.

Local authority staff engaged in providing public health advice on healthcare services to the NHS (clinical commissioning groups or the NHS Commissioning Board) will be able to obtain access to evidence and information databases and resources purchased on behalf of the NHS including access to full text copies of articles free of charge using Athens login identities.

NHS library services have agreed to continue to administer public health staff accounts following their transfer to local authorities.

Public health staff who already have an Athens account should update their organisation details¹⁵. Public health staff who do not have NHS Athens accounts should register online¹⁶.

Any applicant/user who needs help applying for or changing an account should contact their regional administrator¹⁷.

⁴ <https://indicators.ic.nhs.uk/webview>

⁵ www.localhealth.org.uk

⁶ www.apho.org.uk/pracprof

⁷ www.communities.gov.uk/publications/corporate/statistics/indices2010

⁸ www.neighbourhood.statistics.gov.uk/dissemination

⁹ all accessible at www.networks.nhs.uk/nhs-networks/health-investment-network/key-tools/#programme-budgeting-benchmarking-tool

¹⁰ www.apho.org.uk/default.aspx?QN=P_HIA

¹¹ www.rightcare.nhs.uk/index.php/tools-resources/health-investment-packs

¹² www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134205.pdf

¹³ www.dh.gov.uk/health/2012/01/public-health-outcomes

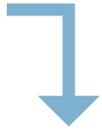
¹⁴ <https://indicators.ic.nhs.uk/webview>

¹⁵ www.library.nhs.uk/myaccount.aspx (login required)

¹⁶ <https://register.athensams.net/nhs/nhseng>

¹⁷ www.evidence.nhs.uk/nhs-evidence-content/journals-and-databases/nhs-athens-administrators





Actions

- Local authorities will wish to understand national partners' roles and responsibilities, especially as firmer plans emerge over the rest of 2012/13.
- Public health teams will need to apply for Athens accounts in accordance with the instructions in this factsheet.
- Public Health England, NICE, ONS and HSCIC will need to keep local authorities and public health teams informed as plans emerge for 2013/14.
- Local authorities will need to alert any unmet requirements for data and information to Public Health England and to consider how best they can be met either nationally or locally.

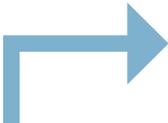


Produced: September 2012

Gateway reference: 18033

© Crown copyright 2012
Produced by the Department of Health
www.dh.gov.uk/publications

Access to the data and information required to support the new roles of local authorities



Local arrangements for health intelligence

Local authorities and their partners will wish to agree arrangements for health intelligence functions that best meet local needs.

This will include considering roles and responsibilities for councils, clinical commissioning groups, and commissioning support groups in relation to holding, analysing and interpreting data to support public health and healthcare commissioning functions.

Recent guidance from the Department of Health has already advised directors of public health to “agree arrangements on public health information requirements and information governance”¹⁸ and to ensure that there are “plans in place to ensure access to IT systems, sharing of data and access to health intelligence in line with information governance and business requirements during transition and beyond”¹⁹.

Local authorities may choose to provide public health intelligence in different ways, for example, by employing in-

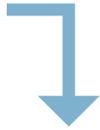
house public health intelligence teams, by collaborating across a number of local authorities, purchasing all health intelligence functions from a third party, or by agreeing a shared function with local commissioning support groups.

For their part, clinical commissioning groups are required, under section 14W of the NHS Act 2006, inserted by the Health and Social Care Act 2012, to “obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in – (a) the prevention, diagnosis or treatment of disease, and (b) the protection or improvement of public health.”²⁰ They will therefore need to agree with local authorities how that public health advice will be delivered²¹.

The guidance issued by the Department of Health proposed using memorandums of understanding to establish a framework for relationships between the local authority based public health teams and clinical commissioning groups.²²

As part of this process, commissioning support groups will be able to engage





with local authorities and the public health team specifically to establish what each part of the future system will provide²³.

In the past, NHS employed health intelligence staff obtained data on local health services mostly from within their own organisation using data sources available via N3-based systems.

The conversion, collation, cleaning, validation, linking, analysis, interpretation and dissemination of results would in most cases be an in-house NHS activity.

Common practice was for these data to be shared between public health intelligence staff and health care commissioning teams.

Very few of such secondary care data management functions are transferring to local authorities. They are considered to be primarily a support to the business intelligence functions that commissioning support groups will undertake in the future.

The cost of information and intelligence support to secondary care commissioning was excluded in the process used to estimate the public health budget that would transfer to local authorities.

However, the public health funds will include the costs of data collections for services that will be commissioned or provided by local authorities.

In future, commissioning support groups are expected to have a role in data management, with some commissioning

support groups also taking on responsibility for data analysis on behalf of clinical commissioning groups.

This means that the resource to conduct data management functions described above, that public health teams in the NHS have relied upon to date, and that will be needed in future by local authorities, is likely to transfer to either commissioning support groups or clinical commissioning groups.

Local authority-based public health intelligence teams will therefore need a detailed business plan, developed in agreement with their local clinical commissioning group(s), describing their work programme for health intelligence provision.

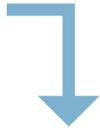
This will allow the local authority to identify the level of support they will require and to form an agreement with the clinical commissioning group about how this support will be resourced.

Role of the NHS Commissioning Board

The Commissioning Board Intelligence for Commissioning programme has developed a framework for health intelligence and a suggested IT architecture to support it²⁴.

The framework, or Commissioning Intelligence Model, is a consolidated view of the different types of commissioning intelligence requirements needed to support evidence-based commissioning decisions for the NHS.





The IT architecture underpinning the Commissioning Intelligence Model relies on large regional data warehouses, or data management integration centres (DMICs).

Data management capabilities would be provided by these specialist integration centres across the country, in support of local commissioning support groups which, in turn, will be able to provide support to clinical commissioning groups, using a single integrated commissioning data model.

These structures are not yet in place, meaning that interim solutions may be required to ensure that local authorities are able to access the NHS data where they wish to do so through DMICs.

Financial arrangements: who pays for what?

Clinical commissioning groups, in many cases, as the primary customers of commissioning support groups, will need to ensure that their local authority partners receive the data and services they require in order to provide an effective public health advice service for healthcare commissioning.

This is particularly important where locally specified datasets are not available from national sources, such as the Health and Social Care Information Centre.

Provision of data management services for secondary care services is not generally covered by the public health grant to local authorities (unlike the advice function, which is).

In most cases, the transfer of resource to commissioning support groups includes much of the generic data management and broader business intelligence functions required to support the specialist health intelligence functions transferring to local authorities.

Where local authorities wish to access NHS data from commissioning support groups this will almost always be for the purpose of advising on population healthcare issues. It will form part of the public health advice service they are required to provide to clinical commissioning groups.

Access to those data for local authority staff is an essential part of the service clinical commissioning groups require from commissioning support groups and any costs incurred by the commissioning support groups in providing it need to be covered by the clinical commissioning groups, not the local authorities.

Local authorities may wish to commission additional data management services non-NHS data and in some cases it may be possible for commissioning support groups that are hosted by the NHS Commissioning Board to provide these services.

Public Health England will develop its own business model, aligned with those in place for clinical commissioning groups, commissioning support groups and local authorities.

It will describe a tiered potential contribution, allowing different organisations to supplement their own





capabilities by engaging Public Health England to provide additional services.

Some intelligence tasks are generic and best done nationally (eg benchmarking or tasks requiring specialised inputs such as health economics or modelling).

Others are only locally relevant or rely heavily on local knowledge and are best carried out locally (eg cluster investigation).

In general, it will reduce total costs if Public Health England and other national agencies undertake commonly required tasks in the first category and make the results available to local organisations.

Access to record-level data

Local authorities will need access to a wide range of information and intelligence to fulfil their health functions.

Strategic functions will largely be based on the use of aggregated data, or other forms of record-level data that are effectively anonymised. However, other important functions may require access to identifiable record-level data.

Examples of the uses of aggregate data include the development of joint strategic needs assessments, and making comparisons with other local areas on public health outcomes or other measures to assess priorities for action.

For instance, locally specified analyses of information on pregnancies, terminations and under-18 conception rates would most likely be needed to allow local authorities to commission appropriate

sexual health services for their local population.

It may be essential to access the underlying record-level data to perform and interpret analyses but not necessarily to use the intelligence to support commissioning.

Underlying data may also be needed to link data from different sources, such as linking housing data with hospital emergency attendances, to provide a basis for work on the social and economic determinants of health, or to link events over time to assess outcomes.

Local authorities may arrange for another agency to perform such analyses, or data linkage, on its behalf.

Councils should already be very familiar with the legal requirements for handling sensitive personal data. Any organisation doing so must be clear about the legal basis on which they are accessing and using those data and ensure they have the appropriate information governance protocols in place for the particular type of data access they require.

¹⁸ Integrated Approach to Planning and Assurance between DH and the NHS for 2012/13, p18

¹⁹ Public health transition planning support for primary care trusts and local authorities, p14

²⁰ Health and Social Care Act 2012, section 26

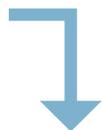
²¹ Clinical Commissioning Group Authorisation Draft guide for applicants, p13 (criterion 1.3)

²² Healthcare Public Health Advice Service to Clinical Commissioning Groups, p14 onwards

²³ Developing commissioning Towards Service Excellence 021111, p44

²⁴ Commissioning Intelligence Report for Clinical Commissioning Groups v0.20
www.commissioningboard.nhs.uk/2012/02/03/commissioning-intelligence-report





Actions

- Local authorities will wish to understand clinical commissioning group requirements for public health advice and the health intelligence functions needed for this.
- Local authorities will wish to develop memoranda of understanding with clinical commissioning groups to establish arrangements for the advice service to clinical commissioning groups including for necessary data and intelligence support.
- Local authorities will wish to engage with clinical commissioning groups and commissioning support units, forming agreements as appropriate, on health intelligence staff access to data, funded by the clinical commissioning group as part of the public health advice service.



Produced: September 2012

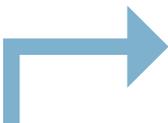
Gateway reference: 18033

© Crown copyright 2012

Produced by the Department of Health

www.dh.gov.uk/publications

Information governance in relation to local authorities and their new roles in health



Legal basis for use of patient- identifiable data

Any use of personal data, especially if it is sensitive personal data, must be supported by a legal basis for the use of those data.

In practice, the legal basis normally depends on the use of data by a legitimate body for a legitimate purpose, where the purpose requires use of those data in that form.

Examples of a valid legal basis for use of person-identifiable data include:

- a. Where explicit consent has been obtained and recorded from the patient or service-user.
- b. The processing of confidential information on “communicable disease and other risks to public health” by the Health Protection Agency is supported by Section 3 of The Health Service (Control of Patient Information) Regulations 2002²⁵.
- c. Permission to process confidential patient information has been obtained from the National Information Governance Board under Section 251 of the National Health Service Act 2006²⁶.
- d. The activity may be part of direct patient care and patients would

reasonably expect their data to be used for this purpose by this organisation.

e. There is an overriding public interest in the use of such data for this purpose (for example in an emergency) and such use is necessary.

It has been recognised that the current processes for safeguarding personal data are complex and may not always achieve the desired balance between protecting privacy and enabling use for public and individual benefit.

Some significant reforms and reviews are therefore currently in train:

- a. The Department of Health has commissioned a review of information governance from the current chair of the National Information Governance Board (NIGB), Dame Fiona Caldicott, to consider the balance between protecting patient information and sharing it to improve patient care. Any changes to the legal framework for information governance in health and care settings will only be considered in light of the Caldicott review, which is due to report later in 2012/13.
- b. The NIGB will be abolished from April 2013, when new arrangements will come into place for advising the Secretary of State for Health on applications to access patient identifiable data (commonly



referred to as “Section 251 applications”). c. Under the Health and Social Care Act 2012, the Health and Social Care Information Centre (HSCIC) is required to produce a code of practice covering the collection, analysis, publication and dissemination of confidential information relating to the commissioning and provision of health and social care services in England. The code will build on existing legislation, standards and professional codes of conduct relating to the management, use and disclosure of confidential information, and provide a clear set of guidelines on the sharing, protection and legal disclosure of confidential health information²⁷. It will apply both to NHS organisations and local authorities and is expected to be published before the end of 2012.

To enable public health teams based in local authorities to provide population health advice there must be an appropriate information governance architecture in place agreed with local partners. Where required, this architecture will allow public health teams to receive, store and analyse patient identifiable and record-level data.

However, aggregate or anonymised data will be sufficient to meet most public health intelligence requirements, and confidential information should only be accessed in instances where this is absolutely necessary and there is no practical alternative.

The new HSCIC will, in due course, provide access to a wider range of de-identified and linked datasets, which will meet many of the needs of local authorities. In terms of local data,

commissioning support units and data management integration centres provide a possible future option for local authorities to obtain record-level data.

If local authority-based public health intelligence teams are going to handle record-level or other patient-identifiable NHS data they will need to demonstrate compliance in with level 2 of the Hosted Secondary Use Team/Project version of the NHS IG toolkit, and the presence of a “safe haven”²⁸ arrangement.

Local authorities already working with the Social Care Delivery, Local Authority or other versions should contact the IG toolkit helpdesk (0845 3713671); exeter.helpdesk@nhs.net) for advice on how their current assessment may be extended to cover their new public health responsibilities.

Public Health England will work with partners including the HSCIC during 2012/13 to develop a national checklist for information governance arrangements at the local level, which local teams may use to inform local agreements.

IT architecture: the boxes and wires and what goes down them

The most widely used secure network within the health sector is the NHS National Network, known as N3²⁹, while most primary care trust-based public health staff use its secure email system NHSmail for transfer of sensitive data.

Public health intelligence teams based in local authorities are likely to need to be connected to N3 in order to fulfil their function.





This would only not be required if the authority was very extensively supported by a health intelligence function in another organisation.

Limited access to essential data because of the lack of appropriate IT architecture (N3 connectivity in particular) has been identified as a formal risk by the Public Health England Programme Board.

N3 is intended to provide connectivity to an organisation formally recognised as “delivering health services”, and at least 40 local authorities in England have already arranged access to N3 on this basis.

A local authority wanting to connect to N3 has to go through a process known as “Information Governance Statement of Compliance”. This is the process by which organisations enter into agreement with NHS Connecting for Health for access to its services, including the NHS National Network (N3).

The terms and conditions of access are set out in the IG Assurance Statement, which is a required element of the IG toolkit³⁰.

Alternatively, connection between local authorities and the NHS can occur through the Government Connect Secure Extranet, or GCSX. This is a wide area network (WAN), which enables secure interactions between connected local authorities and other Government Secure Intranet (GSI) connected organisations³¹.

The Government has also developed a “Public Service Network” (PSN) strategy. PSN is a “secure private internet” for the public sector – it is like the internet but with the security that the government requires³².

The rationale is that most departments, agencies, local authorities, police authorities etc have their own network. At least 2,000 networks exist, connecting around 5.5 million public sector workers over hundreds of sites.

The aim of PSN is to work with these bodies to rationalise and standardise the networks. Ultimately all public sector networks will be connected, and each government department should already have an established roadmap for implementation. In London 11 boroughs have added the N3 service to their London PSN infrastructure.

IG toolkit completion remains a requirement for whoever wishes to access confidential data.

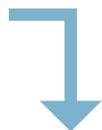
Finally, an alternative possibility is for individual health workers to request a virtual private network (VPN) token to access N3. A single user VPN enables access to the N3 network via the internet³³.

There are therefore a number of options for gaining access to N3 from a local authority base. None is completely straightforward, and it is imperative that local authorities that have not done so address the issue of access to N3 as soon as possible.

NHSmial

NHSmial is the national email and directory service available to NHS staff in England and Scotland. Accredited to Government – RESTRICTED status, it is the only NHS email service secure enough for the transmission of confidential patient information.





The Department of Health information strategy has stated³⁴: "All e-mail communication about our care must be appropriately secure and protected. Work will continue to improve access to and use of NHSmail within the NHS, and social enterprises and other qualified providers of care services, as part of their commissioning contracts with the NHS, will be given access to a limited number of NHSmail accounts. Similar incentives for social care will be made available that make the process and cost of connecting social care providers, local authorities and other care providers via secure electronic communication easier, cheaper and less bureaucratic."

The use of NHSmail relies on a number of features: role-enabled access; appropriate administrative support including funding; the holding of certain software licences; and compliance with information governance requirements:

- a. Role-enabled access: NHS staff are enabled to apply for an email account with NHSmail on account of their employee status. Connecting for Health in general agrees to the use of NHSmail by non-NHS organisations provided that the business purpose is health.
- b. NHSmail service is provided centrally free-of-charge, although there may be a requirement for local administration as part of ordinary IT management.
- c. Specific software licenses are also required to use NHSmail eg Windows Server 2003 and Exchange Server 2007 client access licences purchased under the Microsoft PSA09 agreement³⁵. Connecting for Health is enquiring whether existing licences can be transferred to the local authority.

d. Information governance requirements: see above.

A number of public health intelligence teams who have already transferred to local authorities have maintained access to their NHSmail accounts.

²⁵ www.legislation.gov.uk/ukxi/2002/1438/contents/made

²⁶ www.legislation.gov.uk/ukpga/2006/41/contents

²⁷ See Department of Health. NHS Information Governance - Guidance on Legal and Professional Obligations, 2007 (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079616)

²⁸ A "safe haven" in this context is defined as the agreed set of administrative arrangements that are in place within the organisation to ensure confidential personal information is communicated safely and securely. (www.connectingforhealth.nhs.uk/systemsandservices/infogov/igfaqs/safehaven/view)

²⁹ N3 is the National Network for the NHS. It provides a broadband network, supporting IT infrastructure, networking services and sufficient, secure connectivity and capacity to meet current and future NHS IT needs. With the exception of specific applications information is unencrypted when transmitted within N3. Confidentiality of sensitive information in transit over N3 is not assured, and Department of Health guidelines stipulate that patient-identifiable data must be kept confidential. It is the data owners' responsibility to ensure appropriate controls are in place to secure data in transit. Connection and router are both supplied and managed by the N3 Service Provider (N3SP). www.connectingforhealth.nhs.uk/systemsandservices/n3

³⁰ www.connectingforhealth.nhs.uk/systemsandservices/infogov/igsoc/non-nhs

³¹ www.buyingsolutions.gov.uk/services/Communications/GSi

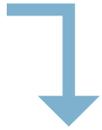
³² www.cabinetoffice.gov.uk/resource-library/public-services-network

³³ <http://n3.nhs.uk/ProductsandServices/N3Connectivity/ConnectAnywhere%28remote%29.cfm>

³⁴ <http://informationstrategy.dh.gov.uk>

³⁵ www.connectingforhealth.nhs.uk/systemsandservices/nhsmail/using/third





Actions

- Local authorities will wish to understand whether and what need there is for access to confidential data by health intelligence teams for defined purposes.
- The Public Health England Transition Team is working with the Association of Directors of Public Health to develop a list of examples in which directors of public health may need access to confidential data.
- Public Health England will work with partners including the HSCIC during 2012/13 to develop a national checklist for information governance arrangements at the local level, which local teams may use to inform local agreements.
- For confidential data access, local authorities will need to meet the Information Governance Toolkit level 2 in having a safe haven architecture.
- Local authorities will wish to consider how to connect to N3 and to establish NHSmail accounts for all local authority staff engaged in public health commissioning (which may be broadened to social care in time).

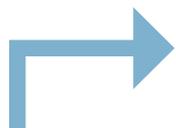


Produced: September 2012

Gateway reference: 18033

© Crown copyright 2012
Produced by the Department of Health
www.dh.gov.uk/publications

Summary of actions



- Local authorities will wish to understand local requirements for health intelligence.
- Local authorities, along with clinical commissioning groups and commissioning support units as appropriate, will wish to agree a resource and business model for health intelligence.
- Local authorities will wish to understand national partners' roles and responsibilities, especially as firmer plans emerge over the rest of 2012/13.
- Public health teams will need to apply for Athens accounts.
- Public Health England, NICE, ONS and HSCIC will need to keep local authorities and public health teams informed as plans emerge for 2013/14.
- Local authorities will need to alert any unmet requirements for data and information to Public Health England and to consider how best they can be met either nationally or locally.
- Local authorities will wish to understand clinical commissioning group requirements for public health advice and the health intelligence functions needed for this.
- Local authorities will wish to develop memoranda of understanding with clinical commissioning groups to establish arrangements for the advice service to clinical commissioning groups including for necessary data and intelligence support.
- Local authorities will wish to engage with clinical commissioning groups and commissioning support units, forming agreements as appropriate, on health intelligence staff access to data, funded by the clinical commissioning group as part of the public health advice service.
- Local authorities will wish to understand whether and what need there is for access to confidential data by health intelligence teams for defined purposes.
- The Public Health England Transition Team is working with the Association of Directors of Public Health to develop a list of examples in which directors of public health may need access to confidential data.
- Public Health England will work with partners including the HSCIC during 2012/13 to develop a national checklist for information governance arrangements at the local level, which local teams may use to inform local agreements.
- For confidential data access, local authorities will need to meet the Information Governance Toolkit level 2 in having a safe haven architecture.
- Local authorities will wish to consider how to connect to N3 and to establish NHSmail accounts for all local authority staff engaged in public health commissioning (which may be broadened to social care in time).