**Annex to Enclosure PHE/16/49**

1. **Vaccination coverage statistics**

1.1. NHS England teams, supported by PHE screening and immunisation staff, are responsible for commissioning and local performance management of immunisation programmes, including those that are delivered in general practice (pre-school and adult elderly programmes) and those provided in schools (human papilloma virus, meningitis, adolescent booster) and other settings (e.g. influenza vaccination in pharmacies).

1.2. Local Authority (LA) public health teams are responsible for scrutiny of these programmes rather than performance management, and also commission related services to promote child health more broadly such as health visitors and school nursing. Clinical commissioning groups (CCG) have no formal role, but as they are responsible for the quality of GP services, CCGs have a legitimate interest in immunisation performance.

1.3. Coverage statistics are obtained by combining various record level data flows including from schools, primary care and local Child Health Information Systems (CHIS). The Immunisation, Hepatitis and Blood Safety team in Public Health England collates aggregate data returns. Currently, PHE can only provide vaccination coverage estimates at Local Authority/CCG level for most of the routine childhood vaccines. In contrast, GP based collections for adult vaccines, or for the newer childhood vaccines (including rotavirus and MenB) are collated at GP practice level. No individual-level data is available at national level.

1.4. Directors of Public Health are concerned that current arrangements do not allow them to take a sufficiently active role in promoting vaccination uptake, for example by working with GP practices with low vaccine coverage or by investigating patterns of vaccination uptake (for example in relation to deprivation). DsPH are entitled to their own *ImmForm* accounts where they can view GP level data for selected programs, including some childhood programmes (such as MenB or rotavirus). Current contractual arrangements do not however allow GP level data to be shared with Councillors, although they would be allowed to see ward based uptake data. The Chair of the Health Select Committee is personally very concerned about this issue.

2. **What are the options to improve the situation?**

2.1. The immunisation team in Public Health England are in discussion with their technical partners (*Immform*, PRIMIS) to commission practice level coverage statistics for the key childhood vaccines not already covered. This requires an investment by PHE over 3 years to extend the capability of *ImmForm*.

2.2. By 2019, NHS England expects to have implemented the new Children and Young People's Dataset which would provide record-level data including immunisation status for resident children. This would be accessible to local authorities and PHE for analysis. There is no additional cost to Local Authorities or PHE for this solution although there would be an analytical requirement. Colleagues in PHE understand that this approach may not be fully functional by 2019 and that additional arrangements may be required.

2.3. By 2020 a master digital child health record is anticipated and is currently being tested by NHS England. This would give further information and functionality for example by allowing linkage with other data at record level.

## 3. Who needs to do what?

- PHE will be commissioning *ImmForm* to provide practice level aggregate data on childhood vaccinations
- PHE needs to ensure that NHS England and NHS Digital prioritise the new child health dataset and master child health record

## 4. Screening uptake statistics

There are 11 national screening programmes:

- NHS abdominal aortic aneurysm (AAA) programme
- NHS bowel cancer screening (BCSP) programme
- NHS breast screening (BSP) programme
- NHS cervical screening (CSP) programme
- NHS diabetic eye screening (DES) programme
- NHS fetal anomaly screening programme (FASP)
- NHS infectious diseases in pregnancy screening (IDPS) programme
- NHS newborn and infant physical examination (NIPE) screening programme
- NHS newborn blood spot (NBS) screening programme
- NHS newborn hearing screening programme (NHSP)
- NHS sickle cell and thalassaemia (SCT) screening programme

4.1. Screening uptake data come from a variety of collection systems reflecting the diverse nature of the programmes and the settings involved. PHE's screening division collates these sources and produces aggregate statistics for publication. Considerable work is required to be done by NHS England, NHS Digital and PHE to produce reports for different geographies e.g. PHE Centres, NHS England local offices and local authorities. In some cases, for example antenatal screening programmes, performance statistics are only available at provider level.

4.2. Screening uptake statistics are currently published on the following sites:

| Web link | Geography | Reporting period |
| --- | --- | --- |
| PHOF | Local authority | Annual |
| Screening KPIs | Provider, CCG, local screening programme | Quarterly, Annual |
| Official stats – breast screening | Local authority | Annual |
| Official stats – cervical screening | Local authority | Annual |
| National GP profiles | Practice level | Annual |

4.3. PHE screening division staff and relevant colleagues in NHS England are aware of the need for more frequent and timely local coverage statistics. This would allow local identification of good practice, benchmarking, rapid assessment of local improvement activities, and more active management of provider performance. The data needed are already available to commissioners of NHS screening programmes within NHS England local offices and to PHE employed staff in the commissioning teams.

## 5. What are the options for improving the situation?

5.1. An MoU has recently been agreed to facilitate data sharing between NHS England and PHE. This clarifies the fact that PHE is allowed, under the rules governing Official Statistics, to share more timely statistics with local authority colleagues for management purposes (i.e. to improve service quality).

5.2. Under the terms of the MoU NHS England can share such data with PHE Regions and Centres, Local Authority Directors of Public Health, CCGs and voluntary organisations. There are important data security and confidentiality terms in the agreement that need to be met, for example that they prohibit the publication of the data (or disclosure in a public meeting) in advance of official publication.

5.3. In addition to the data shared as part of the MoU it is possible for local authorities to make a special request to either PHE or NHS England for data for specific purposes.

## 6. Who needs to do what?

- PHE needs to ensure that the MoU is fully implemented for all screening programmes across the country.

- PHE is working with Directors of Public Health to specify and develop a user interface to provide access to the statistics and to publicise the ad hoc request service.
- NHS Digital, through its management of the Information Governance Toolkit, to support local authorities in their responsibilities for information governance standards. PHE to continue to support this dialogue.

## 7. Access to Hospital Episode Statistics and Birth and Mortality Data

7.1. Hospital Episode Statistics (HES) and birth and mortality data are traditionally considered to be essential for monitoring the health of the population and the effectiveness of local health care.

7.2. National policy is to centralise the processing of personal confidential data in NHS Digital, the national data repository for health and care. Against this needs to be balanced the requirements of LAs to access the data and information services they need to discharge their statutory health improvement duty and wider public health responsibilities.

7.3. Currently anonymised HES and birth and mortality datasets are provided by NHS Digital. Local authorities must apply for access through NHS Digital's independent Data Access Advisory Group (DAAG), which assesses the local authority's requirement for the data and ability to ensure that it is handled safely and securely (including anonymised data). The DAAG is expert in information governance and data security but does not have specific public health expertise. A new process for local authorities to access record level data was introduced in early 2016. Presently, only a minority of authorities have had their applications approved but there is evidence that NHS Digital is now improving its application processing times.

7.4. For HES data, over 80 local authorities have contacted NHS Digital for access to the anonymised HES extract service. PHE is currently paying for the provision of this service by NHS Digital, but has stated that it does not expect to continue to pay. Thirty-four local authorities have active agreements in place, and a further 40 are progressing through the application process. However, some local authorities have experienced lengthy delays in having their applications reviewed by NHS Digital and in receiving data once they have had approval from DAAG.

7.5. Some local authorities have reported a number of difficulties in using the record level anonymised HES extracts including: uncertainties over ongoing funding; new and sometimes unclear application processes; difficulties in meeting information governance assurance requirements; lack of sufficient IT infrastructure and information management expertise to host large and

complex data sets; and a lack of clarity on the ways that local authorities can collaborate to benefit from economies of scale and improved skill mix.

7.6. Local authorities vary considerably in terms of the size of their health intelligence function, which impacts directly on their ability to manage and extract value from what is a very large and complex record-level data set.

7.7. In addition, local authorities cannot currently link local authority-held identifiable data, for example on social care or housing status, with health care data. This means they cannot analyse the combined pattern of local service use or investigate the health and care experience of particular groups such as those living in social housing. They are not allowed access to the identifiable health data – which requires a clear legal basis in order to comply with data protection legislation – to undertake the linkage themselves. NHS Digital does not yet provide a linkage service adequate to meet the potential demand. Some authorities have developed ways round this based on legacy arrangements with local NHS bodies.

7.8. Another issue that has been reported by local authorities is the difficulty of getting access to general practice registration data on resident populations. In the past this was available in aggregate form from the Open Exeter system. It is not clear how this information can be provided now.

7.9. Since the origin of vital statistics in the nineteenth century, birth and death data have been provided confidentially to DsPH for their residents. ONS collate and code the registration data and provide it to NHS Digital. DsPH now need to apply individually to NHS Digital for access to the records for their residents each year whereas in the past it was available direct from ONS. At the moment only a handful of authorities have received their births and deaths data under these new arrangements.

7.10. Public Health England has been working with NHS Digital to try to ensure that data and information services are provided that meet the public health requirements and priorities of local authorities. PHE's Local Knowledge and Intelligence Service (LKIS) has regular meetings with heads of intelligence in local authorities and is currently delivering a series of regional workshops in partnership with NHS Digital on local data access. However many local authorities would say that they are still not getting access to the data they require.

## 8. What are the options to improve this?

8.1. Further work could include:

- agreeing with NHS Digital an approach to the ongoing provision of data and information services to local authorities;
- developing an online portal tailored to the needs of local authorities which would allow easier access to a wide range of data including those data held by NHS Digital (this would require investment);
- continuing to develop health intelligence staff in local authorities so they can make the most of the data available;
- developing an agreed core data requirement for local authorities and minimal obligations in respect of information governance;
- providing a route for local authorities to raise concerns about data access.
- working in partnership with NHS Digital to scope solutions which facilitate data linkage between local authority-held and NHS-controlled health datasets, including "remote data labs";
- providing a data linkage and analytical support service to local authorities (delivered by PHE LKIS; this would also require investment);

## 9. Who needs to do what?

- PHE to work with local authorities to agree a core data requirement (with appropriate information governance conditions) for every authority
- NHS Digital to continue to engage with local authorities and DsPH in particular to understand and meet their needs for data, including providing access to anonymised HES extracts for those that can analyse them or another level of service for those that cannot.
- NHS Digital to provide a more streamlined approach to providing access to births and deaths data for DsPH.
- PHE LKIS to continue to support and develop public health intelligence capability and capacity in local authorities.