Information to Improve Public Health

Cancer Outcomes Conference 2012
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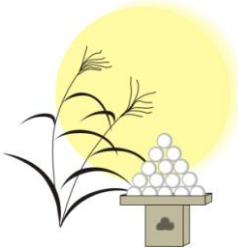
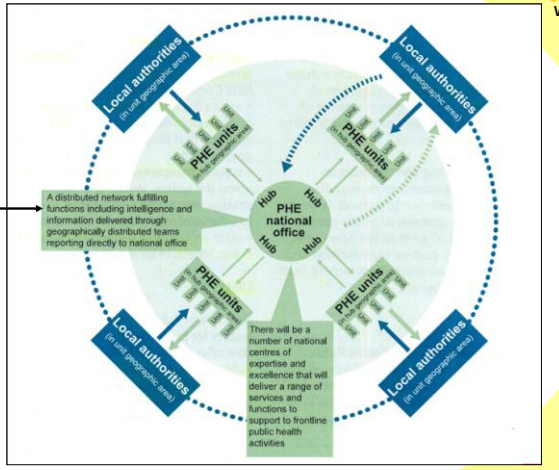
Outline

- Public Health England Operating Model
- Opportunities
  - Public health intelligence
  - What is available now?
  - What could we do together?
- Challenges
  - Transparency vs confidentiality
- Conclusions



PHE - Operating Model

Network of 'Evidence & Intelligence Teams' 70% national and 30% local work supporting local PH staff, health & wellbeing boards, clinical commissioning groups, DsPH in local authorities



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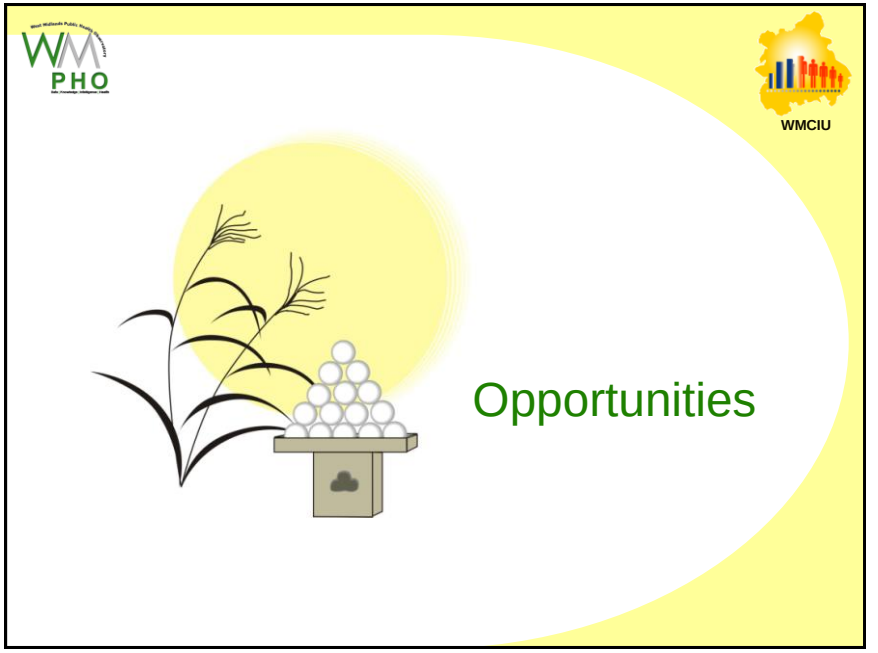
Network Teams

- Will be accountable to 'PHE National Office'
- Will carry out
  - Replicated functions – same function performed according to a single service specification by each team agreed with 'PHE National Office' e.g.
    - cancer registration,
    - screening QA visits
  - Distributed lead roles
    - Roles carried out for whole of England by a single team e.g.
      - NCIN cancer lead roles
      - National Obesity Observatory
      - Child Health and Maternity Information
    - Integrated work programmes, which could be
      - within a single function – NCIN and cancer registry work programme, move to single national cancer registration database
      - across functions – PH Outcomes Framework Indicators, joint projects with e.g. PHO, HPA, NTA, cancer screening QARC


PHO
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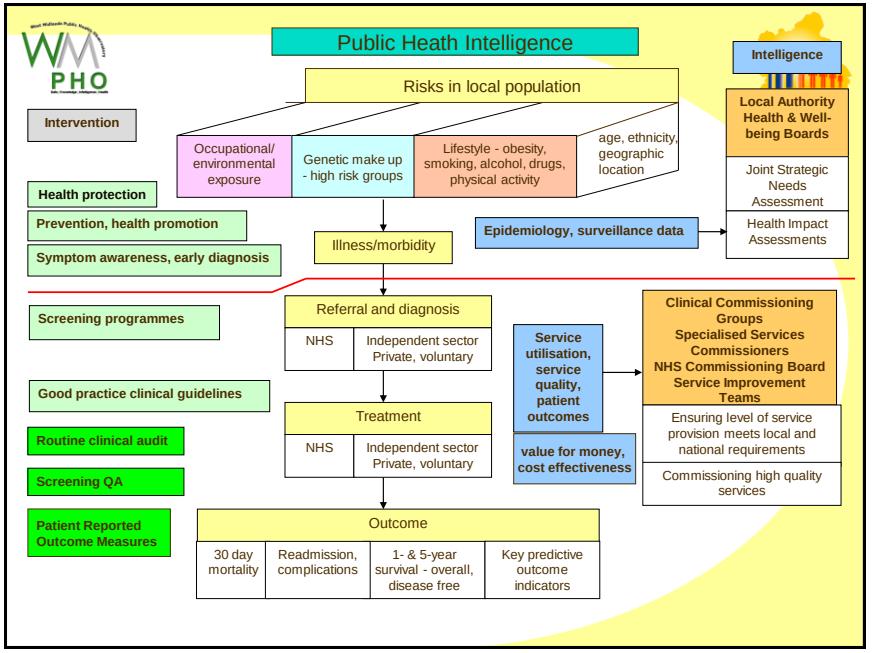
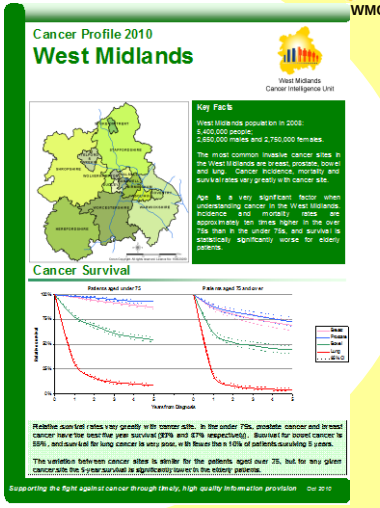
Opportunities


PHO
Public Heath Intelligence
Intelligence
Risks in local population
Intervention
Occupational/ environmental exposure
Genetic make up - high risk groups
Lifestyle - obesity, smoking, alcohol, drugs, physical activity
age, ethnicity, geographic location
Local Authority Health & Well-being Boards
Joint Strategic Needs Assessment
Health Impact Assessments
Health protection
Prevention, health promotion
Symptom awareness, early diagnosis
Epidemiology, surveillance data
Illness/morbidity
Screening programmes
Referral and diagnosis
NHS
Independent sector Private, voluntary
Service utilisation, service quality, patient outcomes
Clinical Commissioning Groups
Specialised Services Commissioners
NHS Commissioning Board
Service Improvement Teams
Good practice clinical guidelines
Treatment
NHS
Independent sector Private, voluntary
value for money, cost effectiveness
Ensuring level of service provision meets local and national requirements
Routine clinical audit
Screening QA
Commissioning high quality services
Patient Reported Outcome Measures
Outcome
30 day mortality
Readmission, complications
1- & 5-year survival - overall, disease free
Key predictive outcome indicators

What is available now?

Local Authority Health Profiles



Health Profiles - deprivation

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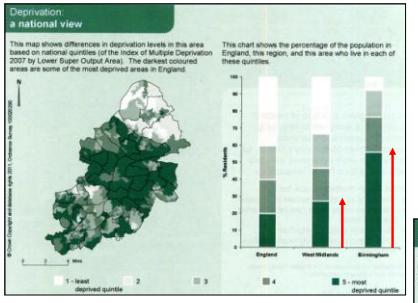
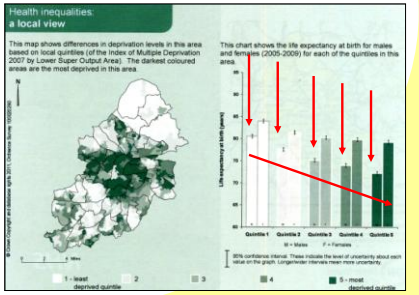


- The West Midlands is a relatively deprived region
- Birmingham is one of the most deprived local authorities in England



- Life expectancy in Birmingham is lower in the most deprived quintile
- Life expectancy is lower in males in all deprivation quintiles

Deprivation – cancer incidence

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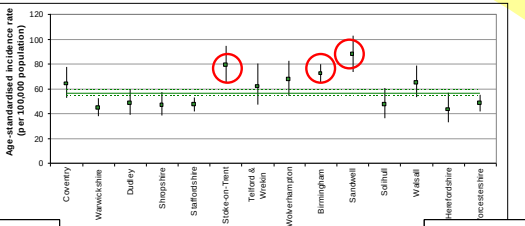
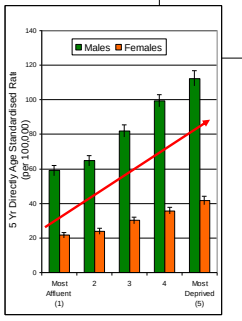
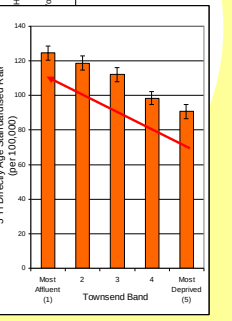
Lung cancer



Breast cancer



- Lung cancer incidence increases with deprivation
- Unusually, breast cancer incidence is higher in the most affluent groups



Health Profiles - ethnicity

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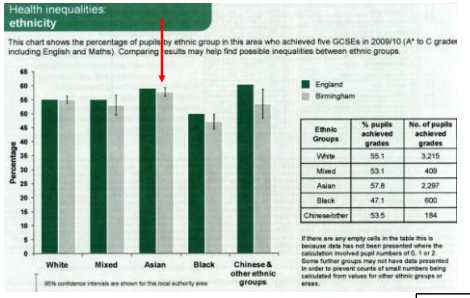
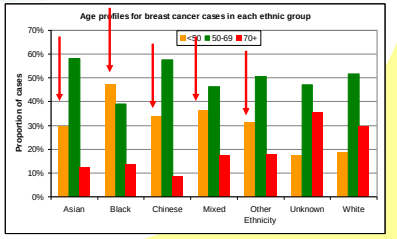


Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	55.1	3,215
Mixed	53.1	409
Asian	57.8	2,297
Black	47.1	600
Chinese/other	53.5	184

- In Birmingham a higher proportion of Asian pupils achieved 5 GCSE A* to C grades

- In the West Midlands women in ethnic minority groups diagnosed with breast cancer are younger



Social and Health Care Benchmarking

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ADASS / AQuA whole system quality and efficiency locality benchmarking summary table

	Population aged 65 and over	(a) Non-elective admissions aged 65+ per 1000 pop 65+	(b) Non-elective bed days aged 65+ per head of 1000 pop 65+	(c) Non-elective re-admission rate within 28 days aged 65 and over	(d) Non-elective Re-admission rate within 90 days aged 65 and over	(e) No of delayed transfers of care aged 18+ per 100,000 pop	(f) Proportion of people aged 65+ discharge direct to residential care	(g) Permanent admissions to residential/ nursing care aged 65+ per 100,000 pop 65+	(h) Proportion of local authority ASC spend on aged 65+ on res/nursing care	(i) Proportion of all deaths which occur at home - aged 65 and over
Source System	poppi.org.uk	SUS	SUS	SUS	SUS	UNIFY	HES & TIS	NASCIS	NASCIS	ONS via NHS NW
Data range	2010 est	Jan10 - Dec10	Jan10 - Dec10	Jan10 - Dec10	Jan10 - Dec10	Feb-11 bed days	Jan10 - Dec10	FY 2009/10	FY 2009/10	Jan10 - Dec10
Locality		Less is better	Less is better	Less is better	Less is better	Less is better	Less is better	Less is better	Less is better	more is better
Blackburn	18,100	297	2319	24.7%	40.6%	88	1.7%	1,110	59%	18.5%
Blackpool	26,900	291	2674	22.7%	39.5%	264	1.3%	945	53%	18.1%
Bolton	41,300	213	1966	19.6%	33.8%	249	1.5%	760	43%	17.6%
Bury	28,700	252	1937	22.5%	38.2%	138	1.3%	840	59%	18.8%
Cheshire E	68,400	237	2059	21.2%	36.2%	279	4.6%	790	51%	16.1%
Cheshire W & C	59,100	237	2084	22.7%	38.3%	158	4.1%	800	53%	17.4%
Cumbria	59,700	190	1723	21.1%	36.7%	190	2.0%	730	55%	20.3%
Halton	17,000	347	2728	25.5%	42.1%	118	1.8%	995	58%	20.7%
Knowsley	23,500	323	2633	24.1%	40.2%	138	1.5%	900	54%	22.6%
Lancashire	205,500	247	2246	23.4%	39.1%	296	1.3%	900	54%	18.1%
Liverpool	63,300	353	3053	23.8%	39.5%	176	2.5%	905	59%	19.9%
Manchester	59,400	341	3753	24.6%	40.9%	208	2.5%	635	42%	18.6%
Oldham	32,500	283	2224	24.5%	40.8%	92	2.8%	875	54%	15.8%
Rochdale	30,100	287	2140	25.6%	41.6%	158	1.4%	815	53%	19.2%
Salford	33,400	330	2661	22.9%	39.0%	224	1.2%	930	56%	16.7%
Sefton	55,900	261	2271	21.5%	36.9%	120	2.3%	855	62%	20.1%
St Helens	30,100	271	2268	22.8%	38.1%	141	1.1%	810	46%	19.3%
Stockport	59,100	268	2614	22.3%	38.2%	326	2.7%	795	41%	17.4%
Tameside	33,500	264	2650	21.9%	36.9%	68	3.4%	655	50%	15.9%
Trafford	34,900	262	3005	22.7%	38.8%	416	2.0%	670	51%	19.0%
Warrington	31,200	283	2613	25.0%	39.3%	14	4.2%	650	60%	18.2%
Wigan	49,500	287	2651	24.4%	41.8%	223	1.9%	830	55%	17.4%
Wirral	58,600	270	2363	23.4%	38.3%	22	4.5%	955	63%	18.8%

AQuA Advancing Quality Alliance

Benchmarking order

Best 1-6
7th-12th
13th-18th
19th - 23rd

DRAFT FOR DISCUSSION ONLY

Data still to be verified with local partnerships

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Partners of adass adult social services

What could we do together?

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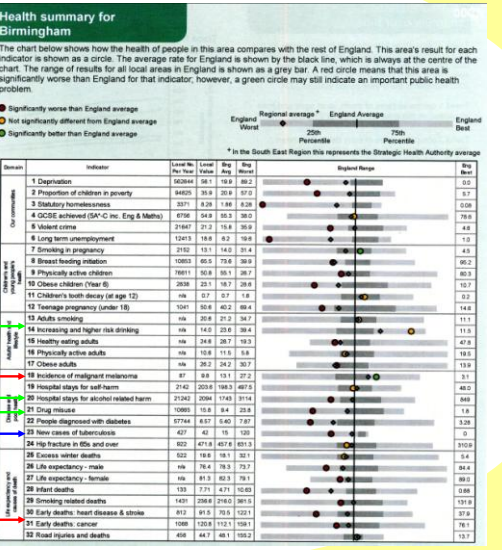
Health Profiles

From the HPA

From the NTA

From cancer registries



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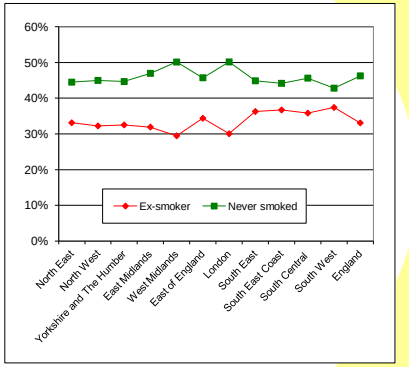
Cancer registries and PHOs

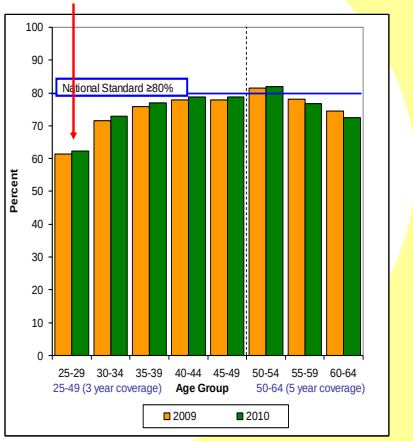
- Link smoking cessation with lung cancer incidence and mortality
- Do the areas with the highest smoking quit rates have the biggest decreases in lung cancer incidence?



Cancer screening QA, PHOs and HPA

Low uptake in women aged 25-29

- Link sexually transmitted disease and teenage pregnancy rates with cervical screening uptake
- Target health promotion campaigns to encourage high risk young women to attend their first invitation when they are 25
- Link HPV vaccination rates with cervical cancer incidence rates to monitor effectiveness of vaccination

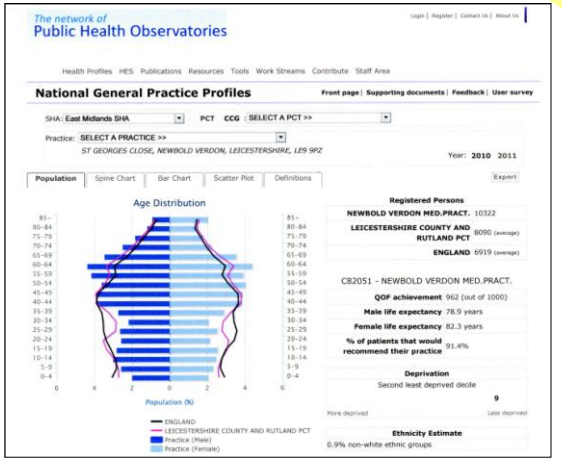


Challenges

Data Transparency

- Transparency and release of open data throughout the health and social care sector are to be driven forward in line with the policies set out in the Coalition agreement and the Public Data Principles agreed by the Public Sector Transparency Board
- Information Strategy includes plans to:
  - release large routine public service datasets to analysts
  - provide support for individuals and organisations to obtain fast, easy access to health and social care data
  - give access for service users to their own data and records
  - provide user feedback to services

GP Practice profiles - PHOs



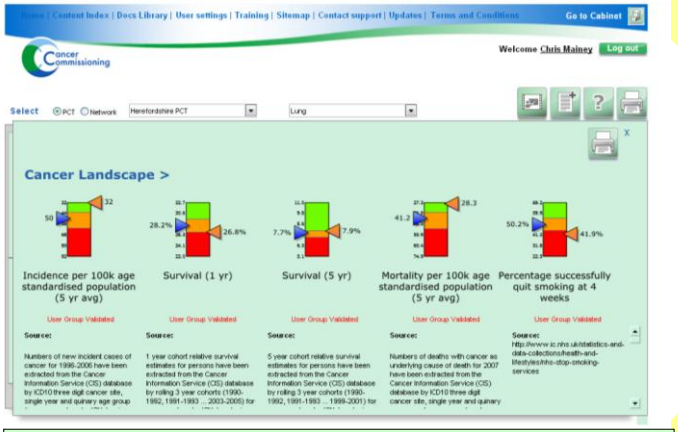
Available on the internet

UKACR Guidelines

Guidelines governing the release or publication of *potentially* identifiable data

- As a general rule, the following categories of data should be regarded as potentially identifiable:
  - Individual records even if they do not include variables, such as names, full postcodes, and dates of birth which would make them obviously identifiable
  - Tabular data, based on small geographic areas, with cell counts of fewer than five cases/events (or where counts of less than five can be inferred by simple arithmetic) – hereafter referred to as "sparse cells"
  - Tabular data containing cells that have underlying population denominators of less than approximately 1,000
  - Tabular data relating to diagnoses/ treatments at provider level, with cells containing counts of fewer than five cases/events

Transparency vs confidentiality



Cancer Commissioning Toolkit - Includes GP Practice profiles

Only available to registered users via N3 connection

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Conclusions

- There is much to gain from the 'sender organisations' working more closely together within Public Health England to provide evidence and intelligence
- Information Governance issues will need to be resolved if equivalent data are to be made available for all types of disease to PH staff working in local authorities and within PHE
- The release of large routine public service data sets as part of the Transparency Agenda means that commercial organisations and community interest groups may be 'in competition' with PHE to provide the intelligence required by local authorities and commissioners to improve the Public's Health

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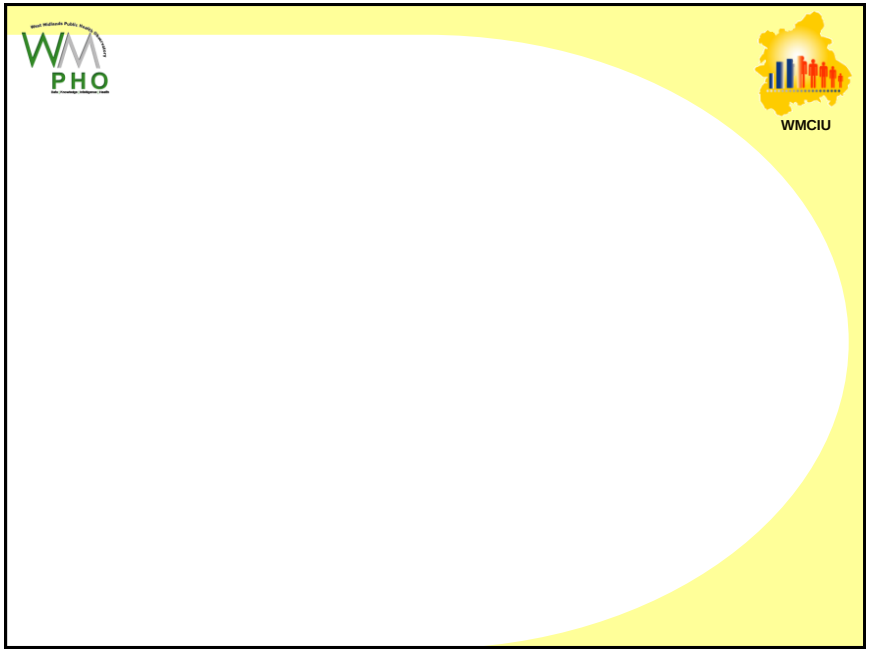
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