**Event: UK Statistics Authority Health & Care Summit**

Held on **Friday 8 July 2015** at Etc Venues Conference Centre, 1 Drummond Gate, London SW1V 2QQ.

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| [Welcome and Key Note Address Ed Humpherson](#_Welcome_and_Key) Ed passed on Sir Adrian Smith’s (Deputy Chair of the UK Statistics Authority) apologies. Sir Adrian, who had been invited to chair the morning, was unable to attend due to another appointment. Ed explained that this meant he would be in the odd position of introducing himself.  Ed said he saw the Summit as a key milestone in the Authority’s drive to improve health and care statistics with the aim of maximising their public value. The Summit offered, he explained, an exciting opportunity for producers and users to shape the landscape for English health and care statistics together. Setting out the Summit agenda, Ed said there would be time to reflect and value the best of the current landscape, envision what might result from making the changes needed, and engage about what should happen going forward. The vision was for an improved system providing high quality statistics underpinning better decisions inside and outside of public administration.  Ed recalled that in the run-up to the Summit he had been encouraged by the support received from leaders of the health and care system, as noted in the [Health and Care Round Table event](https://www.statisticsauthority.gov.uk/publication/health-and-care-statistics-in-england-the-statistics-authoritys-direction-of-travel/) held in February 2016. The Summit, he was sure would provide a further platform for producers and users to discuss meeting the challenges in delivering on the direction of travel arising from the Round Table. Signposting to what would happen after the Summit, Ed said that Authority staff attending would listen carefully to people’s ideas, thoughts and opinions. He would publish his own reflections regarding the Summit on his blog on the Authority’s website and would present an update on the Authority’s direction of travel regarding these statistics alongside the blog.  He hoped participants would enjoy the day. Keynote Address from Ed Humpherson Ed summarised what the Authority is looking for in good health and care statistics. He referred to the high-level principles underpinning the Code of Practice for Official Statistics - meeting the highest standards of trustworthiness, quality and public value.  Ed explained that while the day would focus on English health and care statistics, Scott Heald, Associate Director from Public Health and Intelligence (PHI) in Scotland, would be offering his perspective of the statistical leadership challenges in Scotland. He said that it was his view that there are no border controls over the challenges facing the respective health and care analytical teams in the different administrations. He emphasized the tremendous opportunities for us to learn from each other saying he saw the day as giving particular focus on the opportunities for raising the public value of health and care statistics.  Ed described what he perceived as a nascent data eco-system, influenced by emerging technologies such as big data and data science. This emerging data eco-system was coalescing for example around: the needs expressed in [Dame Fiona Caldicott’s very recent report on](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535170/NDG_consultation_A.pdf) Data Security, Consent and Opt Outs; the work of the National Information Board; the increasing value derived from National Minimum Datasets; and Department of Health (DH’s) Intelligent Transparency agenda. The Intelligent Transparency Agenda draws support appears from both by the health family (DH, National Information Board (NIB) etc), and the Authority with perhaps different perspectives. The health family's perspective is principally on data - to make the health and care system run efficiently, to have resources in the right places, to identify/share best practice etc. The Authority’s perspective is mainly on the interplay between data and Official Statistics - aggregated data - in order to support choice, to enhance organisational and political accountability, and to shine a light on the nation's health and to compare ourselves within the UK and internationally.  Ed emphasised the Summit’s positive forward-looking approach to the changes needed given that the people understood and largely accepted what the problems were. He summarized that the call for action as being to fully exploit the opportunities and meet the challenges head on. He said that he hoped the day would:   * appreciate the organisational processes that have been working well * envision how together stakeholders, users and producers could build upon these processes to work even better * plan, prioritize and signpost to the ways that the proposed design would be deployed   Ed explained that the Authority’s role going forward would be:   * helping to shine a light on the processes that are working well, * being ambitious for the eco-system to fulfil its potential, * providing a platform for this developing narrative * advocating and championing the new approaches, using its regulatory powers prudently in shaping a fully functioning efficient and effective data eco-system |
| **[Address from John Pullinger, National Statistician](#Address_from_John)**  John said that mobilising the power of data to make better decisions required faster, more finely grained and more targeted information with a view to answering the questions that matter to decision makers. He observed that the data revolution was offering us new tools to draw out rich insights and allowed us to make sense of things that would have been almost beyond comprehension only a few years ago.  Acknowledging that the Summit focussed on health and care, John thought that the recent review by Sir Charlie Bean about the measurement of the economy was material to the topics under discussion at the Summit. The Chancellor had asked the review to investigate three questions:   1. What were the statistics needed to measure the modern economy? 2. How well did the existing statistics match up to that? 3. What mechanisms did we need to match the demand to the supply?   John took the view that Sir Charlie Bean’s recommendations from March this year resonated with the needs for radical change to health and care statistics, explaining that the recommendations translated into a vision of :   * The statistical system moving from a product to a service orientation * Delivering on a more joined up approach, delivering a coherent picture without a user having to navigate the complexities of the producer’s environment * Creating better access to data alongside tools to create richer insights using those statistics * Investing in capability [….] through better skills and a mindset of curiosity   John observed that a major transformation had been taking place in order to deliver this vision but underscored the many ways in which the production of health and care statistics needed to change going forward. He made reference to a series of Assessment Reports authored by the Authority’s Regulatory team of English Patient Outcome Statistics, following recommendations in the Francis Review, which demonstrated the unrealised potential from these statistics.  John noted the many positive signs of good progress, citing for instance work ongoing across the UK to connect the information needs of the four nations, however he acknowledged that the biggest challenges were in England. DH, Public Health England (PHE), HSCIC/NHS Digital, Care Quality Commission (CQC), ONS had fully committed themselves to creating a coherent, logical, efficient and clear system of health and care data, statistics and analysis. Three improvement themes were being pursued, based on user views, with aspirations for better:   * coordination and engagement * data and analysis * presentation   John said that he and his Statistics Authority colleagues would listen carefully to everything people said at the Summit in order to respond vigorously after the event. |
| **[User Perspective from Hugh Pym, BBC](#User_Perspective_Hugh)**  As the BBC’s Health Editor, Hugh related his experiences of finding and using health and care statistics. Referring to the tight deadlines he and his colleagues worked to, he made a comparison between the certainty of the release arrangements for ONS’ economic statistics with the more uncertain arrangements for the release of health statistics. He commented on how difficult it was to find out when some statistics were going to be released. He made a plea to make statistics available at least on a quarterly basis with fixed published release arrangements, noting that this also protected statisticians from being accused of political bias. He gave an example from October 2015 when the Monitor and the Trust Development Authority were accused of delaying their performance and financial reports until after the Conservative Party Conference to avoid awkward questions being asked during the conference. While he personally did not think the accusations had been stood up, he commented that the absence of a forward schedule and the discipline of following that schedule jeopardised the publics’ trust in these organisations’ impartiality.  Hugh and his journalist colleagues often found they were unable to compare health statistics across the four nations. The reasons for this lack of coherence could be down to different classifications, definitions or time periods over which the statistics are measured (or all three). He called for standardised statistics in key areas. He cited particularly the yo-yoing of the arrangements for the frequency of the release of Accident and Emergency (A&E) Waiting Time Statistics in England and in Scotland. In Scotland where A&E Waiting Time statistics had been published monthly, it had been decided recently to publish them weekly. In England the obverse occurred, where they had been publishing A&E statistics weekly, and recently decided to publish them monthly. He said he would prefer standardised monthly A&E Waiting Times and Waiting List statistics. He had some praise for ONS's presentation of its statistics, but felt that NHS England drew attention to those features of the health statistics that they wanted to emphasise, which meant that he had to dig into the data himself to get a full picture. He noted the political sensitivities associated with DH's weekend mortality statistics, and mentioned that a leading clinician had questioned the validity of Hospital Episode Statistics (HES) data that underpinned the weekend mortality statistics. His priority would be for more information about mental health resources, both at an aggregate level and what each Clinical Commissioning Group (CCG) actually spent money on. In response to a question from the floor, he alluded to an ongoing discussion among his colleagues about the desirability of focusing more on solutions-based journalism - an approach to reporting highlighting answers to problems, as opposed to stories focusing on the issues themselves.  **[User Perspective from Juliet Whitworth, Local Government Association](#User_Perspective_Juliet_Whitworth)**  Juliet gave a user’s perspective from the point of view of what some Local Authorities thought, was working well with health and care statistics and what they felt could be improved. Juliet said that local government members she had spoken to thought the quality of health and care statistics was good and were an example of what worked well. For what could work better, those same members were looking for improvements in:   * co-ordination / alignment / ease of use / flexibility of outputs / better use of existing data / access to data / speed of data / minimise data burden / co-ordination of policy / communicate with users   Juliet said that engagement between local government bodies and statistical producers could benefit the respective parties through both gaining a greater understanding of issues and the ability to act on them; better integrated commissioning and delivery; better forward planning and through using the data in more innovative ways. |
| **Pitch & Post Session # 1 Chris Roebuck, Statistics Head of Profession, HSCIC-** establishing a stronger portfolio of National Statistics  Chris introduced the headline results from HSCIC’s first ever all-publications consultation. There had being over 260 responses (38 per cent individuals, 62 per cent orgs) suggesting changes to what is presented in 31 publications. There were also proposals to alter the scope of 8 publications, reduce the frequency of 10 publications and stop 6 publications. The consultation had proposed minimal change in respect to 43 publications. HSCIC would be publishing its formal response to the feedback in September this year.  Chris presented some usage statistics - the most downloaded HSCIC National Statistics were the Hospital Episode Statistics and the results of the Health Survey for England (just under 21 thousand and 15 thousand downloads per annum respectively). Of HSCIC’s suite of Official Statistics, the statistics from the Quality Outcomes Framework (QOF), Patient-led Assessments, Maternity Statistics and A&E Statistics were the most downloaded (the QOF being the highest with over 35 thousand downloads per annum). However, some National Statistics see very small numbers of downloads. The inter-quartile range of downloads for National Statistics was between 2 and 6.5 pa and for other Official Statistics is just over 1 to 3 pa. These results highlighted some significant differences in use when measured using the publications download metric. In his pitch Chris asked for feedback from participants on:   1. Whether, as users, they differentiated between National Statistics and other Official Statistics 2. What made for a strong National Statistic? 3. Whether national importance should feature more prominently in determining National Statistics status? 4. Where there is a diversity of datasets on a theme, with different customer demand, should HSCIC be looking for a National Statistic covering this “family?” Even cross-organisational?   Observations on these questions from participants included:  Q1 Summary  A number of users who responded to the question did not perceive much difference between National Statistics and other Official Statistics. There was a view that the most important attribute of the statistics was the value they had in use, not whether they carried the National Statistics designation. There was some feedback that those who perceived a difference attributed this to differences in quality between National and Official Statistics, although producers said they saw the difference as being more to do with the integrity of processes and the publication of metadata. Of those that made distinctions between National and Official Statistics, some thought it was to do with the topic of the statistics (Official Statistics were perhaps more experimental, where the method is not as tried and tested). Others saw National Statistics as being of a higher order of trustworthiness and some that these statistics were produced over a longer time-period alongside trend analysis. Some saw the classification of Official Statistics are denoting any statistics from an official producer. Some participants thought users were more concerned with accessibility and reliability than designation status. Comments fed back included that users just wanted the data and were less concerned about provenance.  Q2 Summary  What participants thought made strong National Statistics were high levels of value and quality with a good links to user bases. Producers should clearly set out the limitations of National Statistics. The latest publication of National Statistics should be easy to find in a central location with clear links to both archived historic data and to the current underpinning data for the statistics. Some participants felt that National Statistics accreditation should go beyond statistical releases and attach to associated infographics, charts, and articles. There was a clear expectation that National Statistics were trustworthy and free from political bias. Some participants expected National Statistics to answer not only national questions but allow the drilling down to address issues at lower levels of geography. Tried and tested methodologies were associated with National Statistics status. One person commented that National Statistics should represent the single source of the ‘truth’.    Q3 Summary  Participants were divided about whether more consideration should be given to the national importance of a statistics in determining whether it was designated as a National Statistic. Some agreed that national importance was a key attribute and others thought that local importance should be the determining factor. One noted that some of the statistical releases spoken about at the Summit had not been Official Statistics (such as weekend mortality) and asked how the Statistics Authority would make sure that information beyond Official Statistics would be released in an orderly manner?  Q4 Summary  There was a mixed response to the question-many liked the idea of a National Statistic representing a family but were less sure how it would work in practice. Some asked what problem narrowing the range of National Statistics was trying to solve. Some saw the concept of a family of statistics as offering an opportunity to create stories - go beyond health and care to be cross cutting - linking for instance to poverty and access to services. Participants pointed out that from a user perspective it did not matter which organisation produced the statistics.  Other points discussed  Some participants fed back that they did not think that NHS Digital and other Official Statistics producers are the right organisations to produce info-graphics, and commentary. Some thought there should be much less commentary, but much improved access to basic data. There was enthusiasm among some participants for collaboration between Official Statistics producers and other organisations to combine different types of specialist expertise to produce insightful output. However, there was a degree of support for NHS Digital to control access to a single care statistics portal. There was reference to data access issues with specific reference to Hospital Episode Statistics (HES). Finally there was a degree of support for the Code of Practice for Official Statistics to be applied in the future, to published analyses of all types. |

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| **Pitch & Post Session # 2 Stephen Buckley, Head of Information, Mind -** engagement between the voluntary and community sector and statistics producers  Stephen described Mind as a mental health charity with a network made up of around 150 independent charities, delivering direct support to around 400,000 people each year. He characterised Mind as a campaigning organization wanting to see change in the world. Stephen detailed some of Mind’s recent campaigning successes as well as their current campaigns. He mentioned that the recommendations of the mental health taskforce had identified a black hole in data about how quickly people were able to access services, what sort of care they had received and what outcomes they had been experiencing- all seen as vital to good care. Consistent and reliable data in mental health still lagged behind other areas of health. While some good information was available, it was not co-ordinated or analysed usefully  Stephen cited Mind’s key sources of data:   * Adult Psychiatric Morbidity Survey * Mental Health Services Monthly Bulletins * Prescription Cost Analysis Data and HSCIC prescription publications * ONS bulletins – especially suicide registrations * PHE Fingertips * FOI requests to local authorities   Specific gaps in Mind’s understanding include:   * patchy data on under 18s (though expanded data set seen as helping here) * the capability of categorising data by demographic * data more about services than people * data that were difficult to interpret for charities and community groups – how to bring it to life   In his pitch Stephen asked:   * what, in the context of ‘living a long life’, could help turn quality-assured data into tangible mental health information? * how might that mental health information be translated into working practices?   Discussion focused on: *Leadership and accountabilit*y. It needed to be clear who was leading the provision of mental health information. This point needed to be resolved before people could make any progress.  *Data*  By looking at the available data, it was easy to ask and subsequently answer the questions set out. People need linked data sets, as information needs to flow for users to get anything tangible out of statistics / data. Data needed to be linked outside of health and care as well to get anything meaningful (e.g. to prisons data/statistics). Furthermore, the value of data outside government was discussed – how could this be captured and shared in a way that added to the whole picture. Some participants’ thoughts that it was particularly important for non-statutory services that connected with communities under-represented in statutory service provision to be able to feed in to the overall data picture.  This discussion referenced the National Data Guardian’s “[Review of data security, consent and opt-outs](https://www.gov.uk/government/publications/review-of-data-security-consent-and-opt-outs)”. It was noted that the Department of Health had opened a [consultation](https://www.gov.uk/government/consultations/new-data-security-standards-for-health-and-social-care) on this review, which was to close on 7 September 2016 – any feedback was being welcomed.  *Funding*  Going forward we should learn from good examples that exist already – we didn’t need to reinvent the wheel. However, a real challenge was presented when funding stopped for projects that were already working well, especially at the local level.  *Information needed for decisions*  It was important to keep sight of the needs of decision-makers? What did they see as valuable? Producers needed to go beyond user testing, for example using focus groups, and discovery sessions to ask what was valuable. Yet, people needed practicality and pragmatism when addressing these points.  *Collaboration*  There was a need to challenge any silos/structural barriers that prevented collaboration. Furthermore, it was important to build up organisational relationships, as it was not efficient to build up new partnerships purely reliant on personal relationships. |
| **Pitch & Post Session # 3 Jamie Jenkins, ONS** collaboration enabling coherence  Jamie set out a [map of the health statistics landscape](https://www.statisticsauthority.gov.uk/wp-content/uploads/2016/03/Annex-B-Health-Statistics-Landscape.pdf). He noted how easy it was for different producers to work in silos. However, when producers within the system collaborated the results could be impressive. Jamie cited the example of statistics on deaths from ‘legal highs’. Conversations with Home Office, had identified a need for historical data on deaths through ‘legal highs’. ONS worked in collaboration with the policy departments to quality assure the analysis. The analysis would help the review of the Psychoactive Substances Act. Another example of the value of collaboration for the purpose of coherence were statistics on Cancer Survival, where working across policy departments ensured indicators met current and future demands. The parties collaborating included ONS, DH, PHE and NHS England. Jamie pointed to one further example namely a spike in mortality in 2015 where ONS and PHE collaborated on the analysis. Looking forward Jamie saw collaboration opportunities on alcohol and smoking related death statistics.  Jamie sought input from the group on:   1. What benefits should ONS and third parties expect from collaborations / partnerships and what might be the best way to structure these? 2. How could ONS best nurture collaboration between teams across government or within ONS so it became commonplace?   Discussion focused on:  Q1 summary  People saw access to data as one of the primary benefits of collaboration. Adopting greater consistency of approaches as part of the initial collaboration helped make future collaboration easier. Another benefit was that collaboration helped engender greater consistency between National Statistics and other data and statistics. Collaborative work often focused more on answering questions rather than merely publishing numbers (participants noted that standard statistical products could be data rich but narrative poor). People viewed statisticians as often too far removed from those asking the questions and collaborative work helped bring statisticians closer to those with information needs. A further benefit discussed was the opportunity that collaboration offered for aligning priorities.  Q2 summary  How collaboration could be nurtured. People thought that collaboration needed to be seen as an essential part of the statistician’s role and higher management should make it a priority. Participants saw the importance of involving users in the collaboration to prioritise their needs alongside involving and working with the Press Office to finalise priorities. One of the tensions that statisticians needed to manage to nurture collaboration was balancing the needs of groups who mainly wanted aggregate national data versus those who wanted local data. To exploit the most-immediate opportunities for collaboration and get the most benefit, those working in a collaboration needed to give as full a picture as the statistics could sustain as well as supply examples of the successful use of the insights generated. To realise the benefits of collaboration there needed to be an area where the relevant data could be published together not at different sites  Questions raised by participants as part of the discussion of this topic included;   * who owns this agenda- the UK Statistics Authority, DH or both? * how would collaboration make a difference to the Statistics Value Chain? |
| **Feedback from Challenge Workshoplead by Anita Charlesworth and Helen Patterson *-****Improve the quality of Official Statistics by presenting statistics that are coherent and enhancing public value by providing greater insight*  Anita and Helen used the example of ONS’ [UK Health Accounts](https://www.ons.gov.uk/releases/ukhealthaccounts2014)  as a case study looking at improving the presentation of statistics such that they were coherent and provided greater insight. Helen explained some of the features of Health Accounts in the UK:   * measure healthcare expenditure * analyse expenditure by:   + mode of financing (government, out-of-pocket, insurance …)   + provider organisation (hospital, residential home, ambulatory…)   + type of function (curative/rehabilitative, long-term, preventive, administration…) * standardised definitions (System of Health Accounts 2011) – OECD, Eurostat, WHO * are now produced by all countries in the European Economic Area and nearly all OECD member states, including the UK from May 2016 * are currently at a whole UK-level * include health-related social care   The statistics, published for the first time in May this year, provided insight into healthcare expenditure as a proportion of Gross Domestic Product (GDP) for 2014 but did not attract much profile on their release. ONS were interested in encouraging the wider use of these statistics but recognised the challenges of raising awareness around ‘accounts statistics’ and issues related to the definition of healthcare and terminology around analysis categories. To address these challenges ONS was (or would be):   * front-loading key information about statistics in publications to ensure they were understood * briefing in DH and devolved administrations * blogs – British Medical Journal and Health Foundation * making International comparisons * linking to healthcare efficiency work * conducting a workshop with key stakeholders   ONS designed the case study of UK Health Accounts to prompt questions around- what else could be done to raise the profile of these statistics and ensure that relevant parties could understand their potential uses. Beyond ONS’ existing relationships, how could ONS open channels of communication with a wider group of users in order to help it understand how they could develop these statistics to serve users’ needs? How could the health accounts and productivity statistics be used together to provide an analysis of the efficiency of the UK health system? Additionally, beyond the links with productivity***,*** how could ONS establish and help to exploit statistical cross-overs where health accounts could be analysed in conjunction with other health statistics?  Participants in the workshop proffered the following:   * Show case studies of how others use data * Engage others as advocates – two way engagement * Consider what the key questions around health accounts might be both from a pro-active and reactive side policy perspective * Use the power of story-telling for stimulating debate * Track users – engage with them, ask them what they use the statistics for * Consider how to balance the tension regarding the quality / robustness of granular data to allow the highest levels of insight whilst providing adequate caution to users. * Linkage -consider how this data could be linked to social care data to provide insight into the potential for more integrated health and care packages and reflect on how HSCIC’s data and accounts data could be linked * Publish as a CSV file – with tidy datasets. [Please note that CSV files were published by ONS for the “[UK Health Accounts, 2013 to 2014](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/datalist?sortBy=release_date&filter=user_requested_data)”on 3rd August 2016, as a result of this feedback]. * Clarify responsibilities for communications alongside creating a communications strategy as a help to journalists. As part of that strategy- get to know and work with data journalists * Look at the breakdowns by disease areas (programme budget data breakdown) – (NB: there is a separate EU project – Healthcare expenditure by disease and condition (HEDIC) looking at this. The UK through DH has been involved as an observer. Theoretically, there should be harmonization between HEDIC and the UK health accounts, but ONS would not have any UK data for this in the near term). * Consider an engagement strategy with other OECD countries who produce and use these statistics and the data and with people who produce similar data for other sectors.   **Feedback from Challenge workshop****lead by Scott Heald** *Foster greater trust in Official Statistics through creating strong and visible statistical leadership and coordination*  Scott offered personal reflections on what works well in health statistics in Scotland and more broadly in Official Statistics across Scotland. He gave the example of all 3 Heads of Profession – Scottish Government (SG), PHI [publishing under the Information Services Directorate (ISD) brand] and National Records of Scotland working together and additionally considered what they could do better. For example in engaging users - how could they adapt to reducing funds, do more with less, change how they did things; open data etc. He also considered why their users felt that PHI was a "trusted brand". He saw the benefits of cross-Scotland working as making a positive impact on staff development, engagement, infrastructure etc and posed the question to workshop participants whether this could work for England? Scott talked about PHI’s links with SG, where there were very few issues regarding processes, pre-release, and breaches of the Code. He discussed whether staff "rotating" between the principal Scottish Health statistics organisations worked well. One of Scott’s key themes was the importance of leading through their staff, encouraging and building on their ideas and enthusiasm. In structural terms, he mentioned that PHI split Data Management and Analysis Functions and explained why he thought that worked well. Finally, Scott identified that PHI keep separate leadership between "managerial" and "statistical". Scott posed three challenge questions for the workshop participants to ponder:   1. How could producers maintain and enhance the professionalism and objectivity of statistical outputs? 2. How best could the leaders of the health and care system promote a publicly trusted statistical voice for health and care statistics? 3. Who was best placed to provide leadership in an environment of multiple organisations producing health and care statistics   Feedback from the workshop groups included:  Q1 summary  Publish guidelines for example around the necessary statistical tests for different outputs; influence the culture of producing organisations through encouraging producers to follow both the spirit and the letter of the Code of Practice; encourage short visual outputs and narratives, (long outputs are of less interest to the media). Participants discussed the risks to professionalism and objectivity inherent in adopting new techniques such as data visualization. There was a need to exercise caution that data visualizations themselves do not paint a distortive picture. Scott gave as an example the data visualization treatment of some teenage pregnancy statistics in Scotland that would have detracted from the main message of the narrative had it been used in the publication – in this case, a simple graph told the story and was used in the publication. The group discussed the need for ensuring professionalism - how did professionals achieve constant reflection- how do they know they were doing things right?  Q2 summary  There was a strong theme of working up from a local to a national level. This would involve providing more local level data, but working as part of a wider group of statisticians, NHS Board information analysts and local authority information analysts linking up across the piece. There was advocacy for local network case studies and bringing in local data (Maximum Data Sets) towards generating a national picture. PHI has staff working locally in NHS Boards and in local authorities, currently up to 50 people working in local teams providing an analytical service for first time as well as working alongside designated information leads in health boards. Some participants said they thought leaders within the NHS do not care about the stats- the main priorities of leaders within the NHS and Local Authorities is not the stats. There was some discussion about how we get engagement with leaders (through, for example, demonstrating the power of the data). People saw communications as an important enabler with the idea that producers get a BBC person or media person to test their communications. The importance of communications skills was emphasised. Participants emphasised how important it was that they were at the decision-making table. Participants were interested in Scotland’s Official Statistics Board and that statisticians were empowered to set that up. Scott identified some of the benefits of the leadership approach as having one place to go for example in IT and gave examples of efficiency through collaboration. However, Scott also emphasised in Scotland not everything is exemplary. For example, getting agreement on priorities with stakeholders, for example SG, has been a lengthy process.  Q3 summary  Participants contrasted what they saw as a simpler delivery model in Scotland with the models in England. In the latter, there were 28 statistics producers; very few had a strong concept of the Code of Practice (Code) and National Statistics. Motivating them to meet the Code’s standards and apply the Code’s Principles more widely for their statistics in general was seen as a significant challenge. Participants saw the importance of linking things better and bringing data together. They also identified the dangers around the loss of data (and the messages they tell) through frequent organisational change. Participants identified PHI as best placed to provide leadership in Scotland. Participants were interested in the effects of “rotating” staff between producers. People identified the potential for linking across health and education. The simpler delivery model in Scotland had contributed to the perception among users (not least within the NHS) of PHI being a ‘trusted brand’. PHI, while independent of SG, was an integral part of the NHS in Scotland and this had appeared to help with integrating information provision with the decision-making processes. |
| **Feedback from Challenge workshop****lead by Kate Sweeney and Andy Baker** *Promoting collaborative engagement and strengthening strategic partnerships.*  Kate and Andy explained how PHE and Local Authorities worked together on public health intelligence. They explained the respective roles of PHE and Local Knowledge and Intelligence Services (KIS). The latter KIS provides:   * expert analysis for the local public health system to help understand and address key public health priorities * ad-hoc analysis and requests service, benchmarking to inform business planning and local prioritisation of public health action * local support for users of key technical tools and products including GIS and Return on Investment tools * proof of concept pilots and other local projects to test new and innovative approaches including the use of new data sources   Local KIS provides training and professional workforce development - developing capacity and capability of the wider public health workforce, with a specific focus on health intelligence. Local knowledge transfer involves active dissemination of national PHE Knowledge and intelligence resources, supporting their local use and gathering feedback on their value.  Andy set out the West Midland’s Local KIS ‘Plan on a Page’ and positioned Coventry within that regional plan. Kate and Andy spoke about the West Midlands Public Health Intelligence Network, which they characterised as a strong network to build from post NHS transition but facing the challenges of the “unknown”. There had been changes in membership over time which had had the effect of making it a more active and influential network. PHE provided the facilitation of Local KIS and was developing its role.  The common themes for collaboration between PHE and Local KIS were:   * relationships across different professional bodies and establishing mutual benefit * things can be complex and messy – and it’s important to understand what the shared principles are * there are issues around trust and timeliness in the use and re-use of information   The key question in respect to the challenge of promoting collaborative engagement and strengthening strategic partnerships had been:   * how could leaders of the health and care system promote collaborative engagement and strengthen strategic partnerships to deliver change for users and citizens?   Kate and Andy’s workshop looked at what appeared to be working well and identified:   * jointly funded posts * the ability for PHE to identify and share best practice * direct links and personal relationships perhaps due to the mutual dependency and benefits   In terms of transferability, participants agreed that there was a need to do something for topic areas with all the partners joined up. People saw as identifying where the experts for a particular topic were as an essential activity as well as finding ways to share and communicate their expertise. Participants felt that it was important to create transparent processes and to have standard operating procedures. This would make the sharing of data and the coding of that data easier.  Participants spoke about the impact of establishing a combined authority ‘Analysis Group’ as a forum to share and improve methods across Local Authorities (LA). They saw this as key to replicating the benefits from one LA to others. PHE had skills that were not necessarily available at a local level so these groups were ways of transferring knowledge. They saw the positive influence of the face-to-face exploration and presentation of data. Participants saw the presentation of data in such a way that it inspired action as a significant challenge, made even harder by the volume of CCGs that need to react.  The ideas and thoughts of participants had been recorded as part of PHE’s learning. An important conversation that took place during the workshop was about data sharing and public concerns (in the context of the Caldicott Review). There was evidence that there were real concerns about sharing beyond direct care. Participants agreed that they needed to understand what those concerns were before trying to promote benefits and build trust.  The discussion between the participants acknowledged the value of Public Health Intelligence in Local Authorities. Participants took the view that PHE provides a good umbrella service providing useful tools to help LAs. PHE was seen as having the capability of identifying where PHI analytical expertise within LAs lay and thus could help focus resources to the places where such expertise needed to be developed.  Some participants said that in future they would appreciate the development of comparative tools and saw the benefit of feeding back their experience of using national tools at a local level. Some emphasized the importance of local level / local area research in reaching users and understanding their needs  Some questions that participants debated but did not have time to come to conclusions included:   * could PHE use the political muscle behind devolution to influence at national level and remove barriers etc * how did the structure work in terms of collaborative working (HSCIC/PHE/ONS) at national level on a topic basis? |
| **Feedback from Challenge workshop****lead by Linda Whalley** *delivering greater public value through setting a cohesive strategic direction for statistics that keeps pace with the changing landscape and cuts across organisational boundaries*   * what could the leaders of the health and care system do to cut across organisational boundaries and set a cohesive strategic direction for statistics that kept pace with the changing landscape, while maintaining independence and objectivity for the statistics? * how could leaders of the health and care system promote collaborative engagement and strengthen strategic partnerships to deliver change for users and citizens?   Observations:   * publishing the data and statistics is itself valuable, * data to make decisions, that then bring value * raising public awareness, understanding, knowledge * accountability and transparency * greater value is achieved through publishing ‘actionable’ data and insight analysis for example addressing unwarranted variation (but users needed to know what 'good' looks like for example around unwarranted variation to action this) * value sometimes takes a long time to manifest itself. Examples cited were the use of environmental data and impacts on health. Non-health data were also identified as being useful e.g. employment, environment, housing. * new work measuring wellbeing, looking at place. Devolution and new care models. * producers, stakeholders and users could do more to focus on benefits of statistics through the design stage   **COHESIVE STRATEGIC DIRECTION** *involves*   * collaboration implies that the output is greater than the sum of the inputs (links to the value question too) * reconciling different interests (political, policy, management information, performance reporting, truth unto power etc). Linked to public value as balancing the different interests can sometimes be challenging (schizophrenic even) e.g. trust * linking datasets * use of data from other (non health and care) sources * strategic sense-making. Testing hypotheses, given different interests and likely different contextualisation * influencing voice with senior leaders – not just with the analyst community but with system and policy leaders also. Get better connection across and into policy-making. * must champion the value of data and statistics. The Code itself delivers public value   **KEEPING PACE** *implies*   * changing landscape includes Government itself * freeing up time and resource. Balancing reactive and proactive. Only do what has value (e.g. frequency of publications - if trends are only discernible every five years, only calculate every five years) * technology and tools * keep up with the questions being asked too. Don't constrain in silos. |
| **Closing remarks from Ed Humpherson**  Ed said that he and other Authority staff had been listening carefully throughout the day so that the Authority can follow up effectively. He articulated five important ways that the Authority would follow up to the momentum and energy generated through the Summit. It would:   1. create a note setting out the key strategic issues and publicise among those attending who can then be the key ambassadors for taking forward initiatives to tackle these strategic themes back in their own organisations 2. support the drive to address these issues 3. reconvene the Round Table and play back the proceedings from the Summit 4. liaise with main statistics producers and ask them to create action plans, which would have the status of voluntary enhancements. Over time the Authority will monitor progress against these action plans and consider regulatory action if progress is insufficient or too slow 5. invite people to reconvene in a year’s time to take stock; the planning for that would start later this year. |
| **Reflections on the day and closing remarks- John Pullinger**  John reflected on five common themes that he had taken from the day:   1. Users had provided many examples of simple, quick things that would enhance their experience of using these statistics. Improvements that producers, people in the room, could implement. The day had also clearly described what is working well. 2. Contributors had signaled the strategic need for clear and enhanced leadership, both statistical leadership and from the leaders within the health and care system. Developing the eco-system that Ed described would be a collaborative endeavour not just between producers and users but also with champions [for the power of data and insight] and with the influencers. At various times people spoke about the need for statisticians to have a seat at the [decision-forming] table if they were to make a significant difference. One of the tasks ahead is to nurture and develop relationships with such champions and influencers; opportunities might arise in England with changes in government with new Ministers. The work of the NIB would undoubtedly be influential; the Authority and others in the room could help it with its important work. The NIB for example was looking to address the gaps in good statistics in Social Care and Mental Health, which people had referred to often during the day. 3. The Summit had underscored the importance of data linking to gain greater insight –with opportunities to link health data, for example to education data and to transport data, to supply answers to important questions. Several times people spoke about shifting the balance from a focus on the national picture to ensuring that producers balance this by adequately addressing local information needs.   4. Many contributors powerfully articulated the benefits from implementing these enhancements. The work producers were doing to flex their service offering to the needs of different audiences was an example of good design and of not going down a route of either / or – either data only or interpretation and analysis. Some users need the insight and interpretation and these users complement those who want the data alone. A significant benefit of enhancing the data and metadata would be the capability to arrive at coherent results using the same data, the replication of results.  5. The final recurring theme had been that for innovationto be beneficial people would need to embrace change. Many spoke of the leadership through our people. We have brilliant people and we should be investing in them as well as ensuring they know they have a mandate to innovate. All the benefits from the various innovations and processes whether happening now or in the future shaped by the discussions during the day would come when people have a mandate to innovate –then collectively all of us will deliver it . |