Transparency in Outcomes, proposals for a Public Health Outcomes Framework

Response from PHAST- Public Health Action Support Team.
A social enterprise, Community Interest Company (not for profit).

Annex A: Questions for consultation

Question 1. How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

There should be a clear statement of responsibilities, incentives and accountabilities within the new system so that organisations work together effectively. It will also be important to ensure those whose responsibilities cover non health aspects of the new well-being agenda are engaged. The indicator framework itself should provide a sensible balance between nationally agreed standardised indicators to allow for comparisons across organisations, and also provide for local flexibility to address local issues. Inclusion of indicators that are relevant to 'partners' and not pure 'health' is important. For example the London Health Commission (LHC)/London Health Observatory (LHO)/ Regional Public Health Group/Greater London Authority (GLA) devised a set of 10 indicators to review inequalities and health strategy delivery across London. These included 'wider' indicators such as unemployment, school attainment, air quality, road traffic casualties as well as life expectancy and infant mortality rate. These ensured 'engagement' of the wider partners as they could 'recognise' their contribution to health.[1] Indicators where data was already collected were used.

Question 2. Do you feel these are the right criteria to use in determining indicators for public health?

The criteria are generally good and it is encouraging they refer to inequalities However, it is also important to be thinking of outcomes for the future and what would be the ideal outcomes/ measures. There is a risk that the last criterion (7) " are there existing systems to collect the data...." is limiting. We also need to consider what would be 'ideal' outcome measures and consider setting up systems to collect such data where this is practicable and affordable. Relying on criteria 7 may only allow a 'static' not progressive approach.

[1] Health in London: Review of the London Health Strategy High Level Indicators. 2002/2003/2004 et seq. GLA 2002 and series.

Other criteria to consider are:

a. That the figures are large enough for effective local monitoring and action
b. The absence of certain indicators does not create perverse incentives or distort public health priorities within the system
c. There should be indicators that provide a clear link between local action and outcomes.
d. Indicators should encourage the engagement of the wider partners and particularly across the LA, to address the social determinants and life course. (see answer to Q1).

It will be important to ensure as much consistency as possible between indicators used here and in other parts of health and well being work (eg such as Joint Strategic Needs Assessment-JSNA).

Question 3. How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

Local organisations will need ready access to the evidence of what works to reduce inequalities, and in a form that can be easily transformed into local action. Gaps in the evidence base should be addressed as a high priority, potentially through NICE and NIHR funded research. It is difficult to see how a 'short term' health premium will help towards long term objectives of better health and well being. The 'short term' indicators need to be those that relate robustly to the long term outcomes desired.

Question 4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

There are ways in which the framework could be improved:

As presented (in the question above), children's outcomes are missing. There is a thread running through the consultation documents that 'aligns' NHS/Public Health with adult social care. This could result in a lop-sided system in which children's care, social and wellbeing outcomes are viewed separately.

The overarching 'health protection' referring to 'major emergencies' is a narrow focus. For example Climate Change and its impact on health is the major PH issue of this century, the use of the phrase 'emergencies' appears to refer merely to 'acute' issues.

The 5 domain approach misses opportunities between them.. eg climate change - mitigation in wider determinants- domain 2 - such as active travel/ walking and cycling has benefits in domains 3 4 and 5 via reducing obesity, increasing health and reducing carbon emissions. The interrelationships should be recognised.

The framework should not detract from the NHS's role in improving public health. The 'NHS' part of the framework could read 'healthcare' with 'NHS' being the delivery mechanism for both improved health care and public health. Some public health interventions can improve healthcare outcomes in the short term as well as the long term. Similarly health care interventions can be provided in such a way as to benefit patient care, outcomes and reduce carbon emissions as is being developed by the Green Health Care approach.[2] These interrelationships should also be acknowledged.

It is good to see 'inequalities' specifically referred to in each domain but it does not capture para 39 'improve the health of the poorest fastest'

Question 5. Do you agree with the overall framework and domains?

The outcomes framework needs to cover the three areas of Public Health spelt out in the white paper. It is not clear whether the outcomes framework will fully cover the third public health domain of

health services – including planning, efficiency and effectiveness, audit and evaluation

The link to this area needs to be explicit

Question 6. Have we missed out any indicators that you think we should include?

(Also response to Q8 and Q9)The overall selection of indicators looks sensible but they should be road tested and subject to an independent evaluation. It will be important to ensure there are no perverse incentives in the Public Health System that inadvertently downgrade important work as a result of what is excluded. This is particularly important in the delivery of the Marmot recommendations. It is possible the work done already on the Joint Strategic Needs Assessment could help frame the overall set and identify how best to use and develop such information. Consistency of definitions with other areas where indicators or targets are used is important so that local organisations are not using different indicators to monitor the same or similar things.
The recent approach to indicators in London is shown in the recent report "Fair London, Healthy Londoners?" and is recommended. The LHC/LHO/GLA/Marmot team have developed a set of six indicators looking at inequalities and health both London wide and locally (LAs). They reflect the Marmot review priorities and the life course approach adopted in the public health white paper. Indicators cover life expectancy, healthy (disability-free) life expectancy, wellbeing (perceived social support and mental wellbeing), readiness for school, young people not in education, employment or training (NEET) and income status. [3]. These indicators cover both traditional 'health' indicators and those of wider social determinants. The latter will engage suitable partners for delivery.

[2] Campaign for Green Healthcare. www.greenhealthcare.org
[3] London Health Commission. 'Fair London, Healthy London?'. GLA March 2011.

Question 7. We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?

There is no harm in having a wide range of indicators in such a complex area, particularly if the data are readily available. They also provide local flexibility both to compare themselves with others nearby, or with comparable populations and to identify particular priorities for their population

Question 8. Are there indicators here that you think we should not include?

See response to Q6

Question 9. How can we improve indicators we have proposed here?

See response to Q6 and Q1.

Question 10. Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)

It is difficult at present to see how use of indicators can readily incentivise improved health and well being, which is a long term objective and takes years to manifest itself in positive results. The only way you can easily incentivise in the short term is by encouraging *processes* or 'interim outcomes' where there is strong evidence that they improve outcomes in the longer term and are cost effective**.** Further work to relate evidence of longer term outcomes to interim /short term indicators and processes is needed. This could be achieved via NIHR and the proposed School of Public Health Research.

Question 11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

A good idea, but there might be more areas where the two can share objectives. Public Health interventions in the NHS are of importance and can make healthcare more efficient and effective(eg stopping smoking in advance of an operation has been shown to be of benefit both in efficiency and outcomes) as well as the 'health services' domain of public health(see response to Question 5.

Question 12. How well do the indicators promote a life-course approach to public health?

The indicators cover the different parts of a life course, although possibly older age groups are less well covered than others. An important aspect is to ensure the indicators are the right ones which, based on research, can have a demonstrable effect on improving the health and well being of the worse off as people progress through life. Indicators need to link to the Marmot Review life course and 'causes of the causes'. See answer to Q6 and Q1.

PHAST would be pleased to discuss further with you the points in this response. We believe we have a unique perspective as the only public health focussed social enterprise and can bring valuable experience to bear on these proposed changes. Please see also PHAST responses to the consultations on 'Healthy Lives, Healthy People: the strategy for public health in England' and to the Funding and Commissioning routes for public health.

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