



Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

UK Faculty of Public Health response to *Healthy Lives, Healthy People: Transparency in outcomes - proposals for a public health outcomes framework*

Introduction

About the UK Faculty of Public Health

The UK Faculty of Public Health (FPH) is the leading professional body for public health specialists in the UK. It aims to advance the health and wellbeing of the population through three key areas of work: health improvement, health protection and health services. In addition to maintaining professional and educational standards for specialists in public health, and providing practical information and guidance for public health professionals, FPH advocates on key public health issues, influencing policy change at the highest level, and working closely with policymakers, professionals and the public to make a positive difference to people's health and wellbeing.

What is public health?

Public health is the science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society¹. There are three domains of public health: **health improvement** (including people's lifestyles as well as inequalities in health and the wider social influences of health), **health protection** (including infectious diseases, environmental hazards and emergency preparedness) and **health services** (including service planning, efficiency, audit and evaluation). All three domains need to be addressed

¹ http://www.fph.org.uk/what_is_public_health

actively by the public health system if the public's health and wellbeing are to be protected and improved.

FPH has also responded to all consultations around the public health white paper, *Healthy Lives, Healthy People – our strategy for public health in England*. These are available at: www.fph.org.uk

Key messages

- Making changes to improve the health of a local population requires thorough understanding of current issues that need addressing. This is possible only if reliable information on morbidity and mortality, including modeling of future scenarios for impact and efficacy, is readily available.
- The implementation of the white paper recommendations could result in disruption of existing data flows and the loss of analytical expertise. Arrangements for maintenance and ongoing development of surveillance and monitoring systems, including the associated information technology, need urgent clarification.
- There is serious risk to provision of existing information if for example funding for public health observatories is not guaranteed.² This may lead to gaps in surveillance and monitoring, directly affecting the ability of public health specialists to produce trend data in population health and health inequalities and identify emerging communicable disease threats.
- The document aims to set out a new strategic outcomes framework for public health at national and local levels, moving away from targets and performance management. However, process measures should not be abandoned completely as some allow adverse outcomes to be predicted and intervention to be made at an earlier stage. For example, improvements in outcomes such as life expectancy involve a significant time lag.
- The loss of national targets potentially has mixed implications. Whilst it may remove the perverse incentives of targets, it is important to ensure that the quantity and type of information that is actually collected is fit for purpose.

² Wilkinson A. Funding threat to public health training. *BMA News*, 3 March 2011

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?

The key to this lies in ensuring that partners are asked to work towards similar outcomes. Ideally a single health and well-being outcomes framework should be used by all healthcare, social care and public health commissioners and providers. Failing that, the separate frameworks should have as many common indicators as possible.

The outcomes framework alone will have little impact on joint working in the absence of other levers to encourage this. We offer here some examples of related risks and their mitigation.

General Practice

The involvement of GPs in public health can do much to address health inequalities, improve quality of care and protect the health of their population. However, there are large challenges to be overcome in achieving this. GPs are culturally focused on the patients that they see, rather than the populations that they serve. Furthermore, proposed changes to allow choice of registration with GPs may make this phenomenon worse as GPs will have a broader population coming from outside their usual 'catchment' area. They will have to address the needs of not only of those presenting to them, but also the needs of those disadvantaged groups – and others who do not present to primary care. GPs recognise that they need the expert input of their public health colleagues in ensuring, in particular, these hard-to-reach groups are considered in service planning and the commissioning of appropriate services.

The Quality and Outcomes Framework (QOF) has had a distorting effect on clinical priorities for GPs. When surveyed, FPH members were equivocal about whether arrangements would prove sufficient to incentivise GPs to address better the wider health needs of their population. The role GPs currently play in delivering many public health interventions could become less of a priority once they are required to take on additional commissioning roles. The abolition of Primary Care Trusts (PCTs) will result in no obvious link between GPs and local authorities, apart from nominal representation from consortia on local Health and Wellbeing Boards. We would thus endorse the recent recommendation by the Public Accounts Committee that

accountability frameworks should be strengthened to encourage GPs to contribute towards health and wellbeing priorities.³

Health Protection

Currently, there is good liaison and cooperation between different branches of the health protection service and excellent links between the local, sub-national and national levels. These need to be preserved and developed in the new national public health service.

There is a difficult balance to achieve between a top-down approach led by central government and complete autonomy at the local level. There is a danger that if strategic direction is left to local partners, then priorities may be distorted by special interests, leading to a duplication of effort and resources. Strong leadership at a sub-national level is required to ensure that local partnerships are responsive to local need, but also act in a coordinated and collaborative way.

Recommendations:

- The additional population based QOF indicators do not provide sufficient motivation alone for GPs to shift their historical focus from that of the individual to the population.
- Accountability frameworks should be strengthened to enhance this and encourage joint working.
- Mechanisms need to be put in place to preserve the excellent national, sub-national and local links in health protection.
- Accountability in PHE must be clear, as well as requiring strong sub-national leadership if we are to continue the coordinated and collaborative working that currently exists in health protection.

Consultation question 2: Criteria used to determine public health indicators

The following criteria are being used to determine indicators for public health:

1. *Are there evidence-based interventions to support this indicator?*

³ House of Commons Committee of Public Accounts. *Tackling inequalities in life expectancy in areas with the worst health and deprivation*. London: Stationery Office, 2010

The Government should commit to evidence based policy-making, taking into account the full range of interventions for which there are evidence, including regulation, legislation, taxation and subsidy.

2. *Does this indicator reflect a major cause of premature mortality or avoidable ill health?*

This is a reasonable criterion

3. *By improving on this indicator, can you help to reduce inequalities in health?*

Equity should be a key principle underpinning the public health outcomes framework. However, the inequalities agenda seems to feature more prominently in the criteria than is currently reflected by the proposed indicators.

4. *Will this indicator be meaningful to the broader public health workforce and to the wider public?*

There a need for clarity on what the proposed outcomes framework is trying to achieve. Whilst it is important for the public to be able to make informed choices, for example about health care, it is also critical that the outcomes framework includes sufficient information to enable:

- local agencies to determine local priorities
- commissioners to determine whether a provider is meeting all their contractual obligations and
- independent analyses to be carried out, to generate evidence to improve practice in the future.

5. *Is this indicator likely to have a negative/adverse impact on defined groups (groups sharing a characteristic protected by equalities legislation)? (If yes, can this be mitigated against?)*

This is a reasonable criterion

6. *Is it possible to set measures, SMART objectives against the indicator to monitor progress in both the short and medium term?*

The complexity of measuring outcomes has not been fully acknowledged. This is particularly the case with health inequalities, which are complex and multi-faceted, and judgement against SMART criteria is unhelpful.

7. *Are there existing systems to collect the data required to monitor this indicator; and*
 - a. *Is it available at the appropriate spatial level (e.g. local authority)?*
 - b. *Is the time lag for data short, preferably less than one year?*
 - c. *Can data be reported quarterly in order to report progress?*

As outlined above, there is a danger to current robust systems of surveillance and monitoring, and the potential need to consider the use of interim measures, given that there is often a significant timelag in achieving health improvements.

In order to effectively tackle health inequalities, indicators may need to be measured at levels lower than top-tier local authorities, for example at the middle layer super output area (MSOA), so that potential reward money can be filtered to the appropriate population groups, and used for their intended purpose rather than consumed within other areas.

Consultation question 3: How can we ensure that the outcomes framework and health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

The indicators need to address inequalities more explicitly and to include some that are specifically targeted at disadvantaged groups. However, the concept of a health premium acknowledges that areas with existing inequalities face some of the greatest challenges in improving health. The basis on which this is awarded is crucial though. The premium may not reduce health inequities if it is paid retrospectively to areas that have made progress in health improvement as some areas may have insufficient funding to start making progress from the start. This approach may end up widening health inequalities, as progress is more likely to be made in more affluent areas with poorer areas being penalised. In addition, the total budget for the premium must be at least as big as the health inequality adjustments in council and Department of Health (DH) resource allocation formulae, otherwise inequalities may widen.

The white paper states that the DH will ask the Advisory Committee on Resource Allocation (ACRA) to support the development of its approach to allocating resources to local authorities. The DH should refer to the recent review of the health inequalities elements of the NHS weighted capitation formula led by Professor Steve Morris from UCL, commissioned by ACRA.⁴

⁴ Morris, S. et al. Research on the health inequalities elements of the NHS weighted capitation formula. Final report. 2010. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_122620.pdf

Recommendations:

- On the basis of the findings of the research led by Professor Steve Morris, we suggest that the underlying principles of the proposed health premium should be clearly delineated, that the methods used to calculate it justified and its potential impact on health inequalities assessed before it is implemented.

Consultation question 4: Is this the right approach to alignment across the NHS, adult social care and public health frameworks?

The NHS currently plays an important role in improving health, and this should be maintained. There is however a risk of confusion and duplication from the development of three separate outcomes frameworks for the NHS, public health, and adult social care. Whilst this acknowledges that professionals from different sectors are working together to achieve shared outcomes, the Government must ensure consistency across these frameworks. However, this should not be used as a reason to reduce the number of public health indicators as these are important for providing comparable data across localities, countries and also in monitoring individual organisational performance and progress.

Recommendations:

- We suggest that the development of three separate outcome frameworks risks duplication. Careful examination must be made to ensure they do not result in duplication or competing priorities.
- The number of public health indicators should not be reduced to such a level as to make meaningful comparisons impossible.

Consultation question 5: Do you agree with the overall framework and domains?

The five key domains in the proposed outcomes framework seek to reflect national, local and community level public health actions. Together they encompass two of the three domains of public health – health improvement and health protection – but the health services domain of public health which is concerned with service planning, efficiency, audit and evaluation is largely absent from both the draft outcomes framework and the public health white paper, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*. Clarification is required regarding the difference between some of the domains, as there currently appears to be repetition and confusion about where some indicators should be placed. For example, the distinction between ‘Domain 3 (Health improvement)’ and ‘Domain 4 (Prevention of ill health)’

seems unnecessarily artificial, particularly as there is some overlap between the two: non-accidental injury (NAI) in children aged 5-18 year olds appears in Domain 3, whilst NAI in the under 5s is placed in Domain 4. Similarly, cycling participation is included in Domain 2, but physical activity is included in Domain 3.

In order to achieve better integration across domains, health protection issues could also be incorporated in the health improvement agenda. For example, indicators on chlamydia diagnosis rates (Domain 4) or mortality rate from communicable diseases (Domain 5) could be categorised as health protection.

Recommendations:

- The health services domain should be included within this framework as it is a key part of public health.
- Further work needs to be carried out to remove the current duplication and overlap within the domains.

Consultation question 6: Have we missed out any indicators that you think we should include?

Although one of the key aims of the outcomes framework is to narrow health inequalities, there is virtually no mention of inequalities in the proposed indicators. There is also minimal explicit mention of issues associated with disadvantaged groups eg. drug misusers, asylum seekers and refugees, homeless people or prisoners.

We note also the inclusion of only a small proportion of positive indicators, such as cycling participation, physical activity, prevalence of healthy weight, social connectedness and mental wellbeing. More outcomes should also be focused on positive rather than negative events, and none of the currently positive indicators should be lost in a move to reduce the overall number of indicators. Given the emphasis on improving the overall health and wellbeing of the nation, additional mental health indicators should also be included, for example, excess mortality in the mentally ill, mental health in older people and a measure of mental health wellbeing, such as the Warwick-Edinburgh Mental Well-being Scale.⁵

⁵ <http://wrap.warwick.ac.uk/543/>

It is essential that sufficient information is collected to facilitate rigorous evaluations that improve practice and inform future commissioning decisions. This may include interim process measures to allow adverse outcomes to be predicted and intervention to be made much earlier for outcomes where there may be a time lag after an intervention. For example, within Domain 3, simply measuring smoking prevalence in adults is unlikely to provide commissioners with sufficient information to determine whether or not their services are effective. It would go against the grain of the proposed framework, which seeks to reduce the data burden on local authorities, if they then had to take steps to collect more detailed information themselves. Similarly, the proposed framework only measures the rate of hospital admissions for alcohol-related harm. Hospital admissions represent only the tip of the iceberg of harm, and this measure alone would not allow commissioners to either assess need in their local population or the success of local interventions.

In the health protection domain, there should be indicators for sexually transmitted infection and blood borne viruses including HIV/AIDS. For example, there could be indicators for reducing the incidence of syphilis and gonorrhoea; increasing testing and treatment referral rates for hepatitis B and hepatitis C, especially among injecting drug users and prisoners; and reducing the proportion of people with HIV/AIDS who do not know they are infected.

Recommendations:

- Careful examination should be undertaken to ensure that any indicators do not result in an additional burden on local authorities.
- More outcomes should be focused on positive events rather than negative, and the inclusion of more mental health indicators.
- Rigorous evaluation of the existing evidence on proposed indicators should take place to ensure they result in improvements rather than harm.
- Indicators relating to health inequalities do not feature prominently, despite the stated aims of the framework to focus on these, this issue should be redressed.
- Several additional health protection indicators should be included.

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

Please see our previous comments about ensuring that the outcomes framework generates sufficient information to enable rigorous evaluations to be undertaken in order to improve practice and inform future commissioning decisions. Given the concerns about the level of detail within the proposed indicators, great caution should be taken in carrying out any ranking exercise.

Consultation question 8: Are there indicators here that you think we should not include?

No. As previously noted, there appears to be repetition and confusion about where some indicators should be placed.

Consultation question 9: How can we improve indicators we have proposed here?

Indicators may need to be measured at levels lower than top-tier local authorities, for example at the middle layer super output area (MSOA), so that potential reward money can then be filtered to the appropriate population groups and used for their intended purpose rather than consumed within other areas.

It is also vital that indicators generate meaningful information that can be used to undertake evaluations and inform future commissioning decisions. Some of the proposed indicators are currently very broad, and additional information would be required so that the data can be used to direct public health action. For example, in Domain 4, it is proposed to report 'Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed.' Unless this information is reported at the level of individual tumour types, the data is meaningless in terms of future preventive work. Additionally, because of potentially small numbers of certain cancer types, the information may be misleading if presented at a local level. Additionally in Domain 4, 'screening uptake (of national screening programmes)' will also require the information to be reported by programme, in order for public health specialists to make use of this information.

The high level vision set out in both the outcomes framework and the white paper is "to improve the health of the poorest, fastest". Acknowledging concerns raised previously about the risk of

incentives widening inequalities, it is unclear whether or not the incentives aligned to this vision will be awarded for improvement on the indicators, or for achieving a specific threshold or value relative to other areas. In order to encourage local authorities to continue existing work to reduce health inequalities, it is crucial that improvement is rewarded, but also that appropriate support mechanisms are in place for those areas struggling to improve.

Additionally, there may be a need for local flexibility in the measures. For example, some areas of London have very high rates of infant mortality. One of the indicators usually used in this context is the level of breastfeeding. However, in many of these areas breastfeeding rates are very high, because of local ethnic mix, so this measure does not provide useful information that can help local partnerships address the problem of infant mortality.

There needs to be a better evidence-base behind the proposed indicators. This will require closer involvement of universities and academic partners from a range of disciplines, including health economics and behavioural science. This in turn is likely to require much closer integration with research funding strategies, particularly those developed by the National Institute for Health Research and the Research Councils.

Recommendations:

- Indicators may need to be measured at tiers below top-tier authorities
- Several indicators as currently specified will not generate meaningful information that will result in population health gains and would suggest that these be revisited in light of the existing evidence.
- Several indicators as currently specified will result in a widening rather than reduction in health inequalities
- Overall, the evidence-base behind some of the proposed indicators is weak and this should be reviewed.

Consultation 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.)

As noted previously, a system of incentives may widen health inequalities if progress is more likely to be made in more affluent areas. Additionally, incentivising only certain indicators may encourage local authorities to focus on these outcomes at the expense of others.

Consultation question 11: What do you think of the proposal to share a specific domain on preventable mortality between the NHS and the public health outcomes frameworks?

We acknowledge the important role that the NHS currently plays in improving the health of the public: there is increasing evidence that health care can make a considerable contribution to population health. The concept of ‘amenable’ mortality offers a way to measure this contribution, and to compare relative performance over time. However, measures at an aggregate level are limited as they do not indicate which elements of the health system are performing sub-optimally. For example, cancer mortality rates cannot be used as a quality measure for individual NHS providers because it would be impossible to assess the respective responsibility of different providers along the care pathway. Indeed, whilst such indicators have a valuable part to play in observing changes in performance over time, they were never intended to be more than an indicator of potential weaknesses in health care that can then be investigated in more depth.^{6,7}

Caution should be used when considering the value of such indicators and would propose that only those deaths than can be prevented by contemporary interventions should be included. The AMIEHS project (Avoidable Mortality in the European Union: towards better Indicators for the Effectiveness of Health Systems) is due to report soon. This project seeks to develop a set of avoidable mortality-based indicators that can be used in future surveillance of the performance of health systems in Europe.⁸ These measures could usefully be incorporated into both the public health and NHS outcomes frameworks.

The NHS is also integral to achieving several other outcomes in the proposed Outcomes Framework, beyond preventable mortality. For example, in health protection, immunisation and TB control services are provided by the NHS but are supported by public health services through surveillance, incident management, etc. There are similar relationships for activities related to promoting sexual health or preventing healthcare associated infections. It thus makes sense to share some domains.

⁶ Holland W. Avoidable death as a measure of quality. *Int J Qual Health Care* 1990; 2(3-4):227-233.

⁷ Nolte E, McKee M. *Does health care save lives? Avoidable mortality revisited*. London: Nuffield Trust, 2004.

⁸ <http://amiehs.lshtm.ac.uk/>

Recommendations:

- Measures resulting from the AMIEHS project could usefully be incorporated into both the public health and NHS outcomes frameworks.

Consultation question 12: How well do the indicators promote a lifecourse approach to public health?

There is a reasonable attempt to include a range of indicators across the lifespan. However, as with inequalities, this needs to be more explicit. It may require a more multi-dimensional approach to the indicators rather than relying on the domains alone.