

# Consultation response

## The King's Fund's response to *Healthy Lives, Healthy People* and associated consultations on the Public Health Outcomes Framework and Funding and Commissioning Routes

31 March 2011

The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

This is an overall response and reflection on the White Paper *Healthy Lives, Healthy People* (Department of Health 2010) and the associated consultations on the outcomes framework and commissioning and funding mechanisms. We welcome the opportunity to respond to the Department's proposals in the spirit of improving them further and in mitigating the risks that are currently present.

We have addressed certain issues in more detail where we feel we can constructively add value to the debate. The White Paper has a core focus on inequalities in health. We believe that the role of the NHS in reducing inequalities is as critical as the role of the public health system. In our consideration of inequalities we therefore also make recommendations for the NHS.

Others are better placed to respond to other more specific issues, particularly on workforce, training and health protection issues.

### Summary

The King's Fund welcomes the key principles behind the White Paper and some of the reforms it proposes. However, we have serious concerns about elements of the reforms themselves, their overall coherence and how they will be implemented in practice at the speed and in the context in which they are being undertaken.

We welcome:

- the political commitment to put public health and actions to reduce inequalities in health, centre-stage both nationally and locally
- the intention to ensure the Department of Health becomes the 'Department of Public Health, Inequalities and Social Care' as opposed to being dominated by the management of the NHS

- the mature approach that the White Paper sets out in terms of government's understanding that responsibility for public health lies with individuals but also the wider social and economic context in which they live. There is therefore a legitimate role for government to enable healthier choices but also, where appropriate, to seek to change the social and economic conditions in order to promote public health.
- the move to local government responsibility for public health and the outcomes framework that, in the long run, should lead to a much more coherent approach to action on the wider determinants of people's health.

We have major concerns about several aspects of the proposed reforms which put the laudable ambitions at significant risk. In particular:

- the timing of the reforms in the context of major organisational change in the NHS and local government and severe budgetary pressure on the NHS and on local authorities
- the level and proposed allocation of resources for public health including their size and scope
- the overall balance of policies, duties and power relationships between the NHS and local authorities
- the balance of accountabilities, incentives and levers in the new system including the over-reliance on what will inevitably be a small incentive payment to drive through improvements in public health locally
- the lack of clear accountability for outcomes in the new system, and the over-reliance on public transparency of the public health outcomes framework as the prime accountability mechanism
- the lack of population health responsibility of GP consortia beyond the duty of caring for unregistered patients and the risk that primary care's role in public health will be marginalised
- the technical challenges of coordinating local work and supporting data flows on public health with the loss of co-terminosity between local government and primary care trusts (PCTs).

We make recommendations that will hopefully address some of these issues. Annex 1 includes our answers to the specific questions proposed in the consultation on the public health outcomes framework.

The government – genuinely in our view – wants to focus on improving public health outcomes through devolving more power to local decision-making. But we feel that these proposals, when seen as a whole, do not follow through on the logic of this philosophy. We are not for or against ring-fencing per se, but a more local and outcomes focused system is less consistent with ring-fencing than one based more narrowly on the delivery of specific services. A fully outcomes-focused system with less ring-fencing and the greater local innovation and choices that allows must then be coupled to strong accountability for outcomes through Public Health England, since the budget is drawn from national taxation.

The proposed system is does not look like this. Rather, the budget remains ring-fenced and accountability is fragmented, weak and is not tied to success on the Public Health Outcomes

Framework. Instead, local areas are to be rewarded for success on the PHOF through what will be a small financial reward, the health premium. It is striking that there is no countervailing accountability or penalty for lack of success. This implies an astonishing confidence in the power of the premium and trust in the system that without penalties or accountability performance will not slide.

The Department has a significant opportunity to alter their proposals to increase the likelihood of meeting the stated ambitions for public health and health inequalities. We also believe amendments to the Health and Social Care Bill are needed to increase accountability and alignment between the NHS and local authorities with regard to inequality reduction.

In the transition to the new system the Department needs to ensure that it helps the system to prepare and remains focused on delivering. It is closing its highly regarded National Support Teams, when their capability is urgently required to help with the move to local authority control and to ensure that the NHS continues to focus on public health issues. It should look again at such decisions.

## **The key issues**

The government's proposals would mean responsibility for public health and health protection will in future be divided between local authorities, Public Health England and the NHS Commissioning Board and GP consortia, each of which will take major roles. Local authorities will principally be responsible for local health improvement, Public Health England for health protection evidence and information and the NHS Commissioning Board screening and other primary care activities, much of which will be delivered by the GP consortia.

Given the ambition to improve public health and narrow inequalities in health there are four critical questions to be asked of the reforms:

- will public health have the right resources to do the job?
- where will accountability lie for outcomes nationally and locally?
- will the levers and incentives in the system stack up into a coherent whole?
- will the right information be available and cut-up in the right way to do the job well?

We discuss these issues and challenges below.

## **A: Resources and their allocation**

### ***Will the new system have the right resources?***

The government proposes that a ring-fenced public health budget is paid for from the Department of Health's funds and allocated to local authorities. We discuss the issue of the ring-fenced budget, in relation to the package of reforms as a whole, in a later section.

Whether the reforms will be supported by the appropriate level of resources is a defining question. In comparison to the delivery of medical care, 'public health' is notoriously difficult to measure since the drivers of population health are so broad. The Department has attempted to measure how much is spent on public health for the first time in order to work out how much of that total spend to transfer to Public Health England and local authorities and to then allocate locally.

Estimates of this total vary, some estimates put this at around £4 billion to £5 billion, 5 per cent or less of overall NHS spending in England. This is based on several pieces of

information including work by Health England (Butterfield et al 2009) and regional estimates from the North West. However, the remit of Public Health England is broad and these estimates may be off the mark. Nonetheless, given the scale of the public health and health inequalities challenge, outlined in the evidence paper published alongside *Healthy Lives, Healthy People*, we are seriously concerned that public health will be underfunded at the outset. The National Audit Office expressed similar concern in their recent report on inequalities in health (National Audit Office 2010).

**R1. We recommend that the Department estimates the scale of the public health budget on a proper assessment of need and not solely on basis of estimates of what is currently being spent. The optimal spend is likely to be significantly greater than allocated.**

The public's health is affected by wider economic events and choices, including the balance of broader public sector spending and economic growth. We are therefore concerned about the scale and allocation of public service cuts in terms of their impact on public health. Although not conclusive there is evidence to suggest that government social welfare spending (excluding health) is seven times as powerful in terms of its impact on mortality rates as changes in GDP (Stuckler et al 2010). At a local level it is also clear that recent government spending cuts have been sharper in areas which have higher deprivation (Taylor-Robinson and Gosling 2011).

**R2. In order to promote public health and reduce inequalities in health, major government decisions over public service spending cuts and allocations need to be subject to proper Health Impact Assessments and at a national level assessed by the Sub-Committee on Public Health.**

Clearly, the workforce is a critical part of the resources for public health. We recognise that others are better placed to make substantive comments on the public health workforce. However, we note that the training, quality and leadership of the public health workforce will be critical to the success of these reforms and that the Department needs to ensure that it supports its development.

The workforce for public health should not be seen as restricted to the relatively small professional public health workforce. There are now 1.4 million employees in the NHS in England, an increase of over 25 per cent since 2000. Every one of those employees has the potential to be a champion for public health, in their day jobs and as importantly in their families and communities. Millions more work in local authorities. Health and local authority leaders need to use this incredible and often ignored capacity. For example, Yorkshire and Humber Strategic Health Authority introduced the policy of 'Making every contact count' (NHS Yorkshire and the Humber 2011) which aims to view every contact in the NHS as an opportunity to offer advice and support to improve health and offer training to a range of NHS staff. As well as integrating well-being into the NHS, these types of programmes have the potential to be cost-effective, using marginal interventions with an existing workforce.

**R3: We recommend that the Department, with others, develops a strategy to release the massive untapped potential in local authority and NHS employees to become active in promoting and delivering improvements in public health.**

***Will the resources be in the right places?***

It is not clear how many of the resources will be held and used nationally by Public Health England but it is likely to be significant, given the need to fund health protection issues,

commission many services nationally and fund the prevention payments for the Quality and Outcomes Framework in primary care (see section on incentives).

The remainder will be allocated to local authorities and the Department is consulting on how it should do this. It says nothing about the allocation of NHS resources. In truth, despite the importance of the public health budget, it will be dwarfed by the size of the resources going into the local NHS. The NHS has a critical part to play in public health improvement and inequality reduction, particularly through the role of primary care. The NHS budget therefore needs to adequately reflect the role of the NHS in public health and inequalities reduction.

The Advisory Council on Resource Allocation (ACRA) is continuously developing approaches to the correct allocation of NHS resources. In recent years it has been asked to reflect that one of the core objectives of the NHS is to tackle avoidable inequalities in health. This objective will remain if the Health Bill retains – and extends – the proposed duty on the NHS Commissioning Board and GP consortia to have due regard to tackle inequalities in health care access and outcomes.

In 2010/11 the allocation formula included a weighting of 15 per cent for the health inequalities element of the formula, this will be reduced to 10 per cent in 2011/12 (Gainsbury 2011). In terms of the resource impact this is likely to be more important – once implemented through pace of change policy – than the changes to the public health allocation formula.

**R4: We urge the Department to fully assess the impact on public health and inequalities of the decision to reduce the weight on deprivation in the NHS allocation formulae.**

The public health allocation system will be new. We support the Department's decision to ask ACRA to develop a formula for the allocation of the public health budget.

Our core concern is that the public health allocation adequately reflects the distribution of inequalities in health, especially given the possible implications of recent decision about the NHS allocation formulae. We recognise that in order to avoid destabilising changes in services there must be a pace of change formula (as with the NHS) but public health action needs to focus on inequality reduction, especially within local authority areas for instance between wards, and allocation formulae should reflect that.

**R5: We recommend that the public health allocation formula reflects both within and between area inequalities in health outcomes in terms of morbidity, quality of life and life expectancy.**

We are concerned that the current intention seems to be for the allocation formula to be based on a 'one-shot' strategy and for all future changes in allocations (beyond up-rating for prices) to be based on achievements that are rewarded through the health premium. While the intentions behind this are good – rewarding success rather than failure – this is far too crude and risks consigning parts of the country to a vicious spiral of underfunding for public health which cannot be broken out of. It is well known that parts of the country, particularly those associated with larger inequalities, are subject to population churn, which is a significant factor in determining performance on area-based outcome measures. As a minimum this needs to be factored into either up-rated allocations or the basis of the health premium, ideally the former.

**R6: We recommend that in its allocation formula for public health the Department revises its current position of only up-rating allocations for prices.**

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**It must also include broader elements outside the control of local authorities, such as population churn, so that areas are appropriately funded for public health.**

## **B: Accountability and governance**

Accountability and governance will be as critical in the new system as funding. The current system of public health accountability is complex, fractured and unclear. We welcome the clarification of some roles in the system. However, there continues to be a lack of clarity about accountability for outcomes in the new system especially at local level – we judge this to be the greatest risk to the success of the reforms.

### **National Accountability and governance**

#### *The Public Health Sub-Committee*

We welcome the establishment of the Sub-Committee on Public Health and its status as a decision-making body. There is now a powerful mechanism at the heart of government to lead on the contribution of other government departments to public health. The Department should make the most of this opportunity by using it to help ensure that the policies of those departments that will contribute the most to public health.

**R7: We strongly recommend that the Sub-Committee on Public Health develops its role to include: being a formal body assessing the health impacts of major government policies; promoting the use and implementation of Health Impact Assessment across government policy-making; and promoting the development of tools and techniques that will measure the cost-effectiveness of interventions on health in sectors outside healthcare.**

#### *Duties on inequalities in the Health and Social Care Bill*

The commitment to duties on the NHS Commissioning Board and GP consortia to tackle inequalities in health in the Health Bill is a major step forward. This is the first time major health bodies have had such an explicit duty. We expect the Secretary of State and, in its turn, the NHS Commissioning Board to use these to drive the role of the NHS in reducing inequality, in concert with the existing Public Sector Equality Duties. However, to be successful they need to be stronger, and similar duties need to be instituted for local authorities.

We welcome the new duty on the Secretary of State that in exercising his or her functions in relation to the NHS (s)he must have regard to the need to reduce inequalities in access to care and in the outcomes from that care. This is the first time that such an explicit duty has been assigned to the Secretary of State, or organisations (s)he is responsible for. This 'due regard' is potentially a powerful lever for the Secretary of State to use with the NHS Commissioning Board to reduce inequalities in access and outcomes from patient care. We also welcome the allied duties on the NHS Commissioning Board itself and commissioning consortia.

However, we question whether this duty is either strong enough or comprehensive enough and there is no detail in the Bill, *Healthy Lives, Healthy People* or associated consultations on how it will be implemented. There is a risk that the new health care and public health system with its greater emphasis on competition, choice and freedom – for providers, as well as

patients – will lead to a greater variation in service levels and outcomes and potential ‘cream skimming’. These duties should be an important lever in the system to prevent this.

Currently, the duties refer only to the role of the health care system in respect of patient care. While this is clearly important, the NHS as a provider, a commissioner, a major employer, purchaser and integral member of the local health and wellbeing board has a much broader role in shaping broader health outcomes of the public, in addition to simply treating patients. Despite the organisational changes which will place the budget and core responsibility for public health intervention with local authorities, the NHS directly and indirectly shapes population health outcomes as well as delivering care services, as the largest local employer and economic entity in many areas, it directly affects the wider determinants of health by its actions. The proposed duties on inequalities are therefore a missed opportunity, in being too narrow.

The risk of GP consortia and the NHS Commissioning Board reverting to a default position of interpreting the duties on inequality as purely an access to care issue for patients, is underlined by the definition of ‘*health services*’ in the clauses in the Bill relevant to inequalities as ‘*services provided as part of the health service*’. This ignores the power that any NHS body, or any organisation acting as a provider to the NHS, has in terms of its broader actions beyond direct provision and access to services that could impact on inequalities.

There are some proposed duties that reduce this risk. In particular, the duty on the NHS Commissioning Board ‘to encourage’ commissioning consortia to work closely with local authorities in arranging the provision of services, and the requirement that consortia must consult the health and wellbeing board on their commissioning plans. However, it seems more desirable and straightforward to require commissioning consortia to have due regard to these issues, rather than expect the local authority and health and wellbeing board to intervene as a policeman. A direct duty will be more effective in bringing about the required cultural changes and objectives amongst consortia than relying solely on checks and balances through health and wellbeing boards. There is a strong case for making this explicit through the legislation.

**R8: In order to maximise the role of the NHS in narrowing inequalities in health we urge that the government widens the duty on inequalities to include the contribution of the NHS to broader health outcomes.**

It is not clear from the Bill – at least to us – whether GP consortia will have a direct duty to improve the health of the population in their area. While the duty to provide services for non-registered patients is welcome, there is an opportunity to place a duty on consortia to become guardians of population health, as well as providers of care in response to the presenting needs of registered patients. This will help ensure that GP consortia take their public health duties seriously as they engage with the new health and wellbeing boards. Otherwise, GP consortia may default to focusing on issues of access to care.

**R9: We recommend that the government extend GP consortia’s proposed duties to provide health care for non-registered patients, to broader population health duties.**

Despite our concerns about the strength and comprehensiveness of the duties on the NHS ‘side’ it is more worrying that despite the current Secretary of State’s public view that he sees an improved public health system as the major route to the reduction of inequality in health outcomes, there is no specific mention of inequality reduction in any of the clauses that refer to the new public health system in the Bill. It is well known that much well-

meaning public health intervention actually acts to increase and entrench inequalities since the wealthier and more educated are often in a position to respond more quickly and more deeply than those with more difficult lives and circumstances. It is therefore critical that the legislation makes it clear that part of the *raison d'être* of the changes and their fundamental aim is to specifically reduce inequalities in health outcomes. Where possible changes to the Bill, in wording and meaning, should be aligned between the NHS and local authorities duties so that it is clear they jointly have the same interests and expectations in terms of inequality reduction.

**R10: We urge the government to be more explicit in the Bill about the role and expectations of local authorities around tackling inequalities in health and align them with the expanded duties we suggest for the NHS Commissioning Board and GP consortia.**

The health and social care system is currently very poor at understanding and mapping the use of services by different groups. Relevant codes are poorly recorded in administrative records which makes assessment against existing Public Sector Equalities Duties difficult. Changing the Bill will make little difference unless local public services take these duties seriously, which includes collecting appropriate information.

**R11: We recommend that the Bill introduces a mandatory duty to record, unless individuals object, the equalities characteristics of users of health and social care services.**

#### *Public Health England*

Public Health England will be a key player in the new system, in its direct role in terms of health protection and emergency preparedness and its broader role as producer, collator and disseminator of evidence and developer of the outcomes framework. It will also have important commissioning responsibilities that will include relationships with the NHS Commissioning Board. It is therefore a complex organisation with a multitude of roles in the system. However, these roles have not been sufficiently set out in the consultation questions to really 'test out' its proposed functions.

**R12: We recommend that the Department consults further – publicly – on detailed functions and governance of Public Health England as it begins to shape its role.**

There are arguments for Public Health England to be independent of government. On balance, however, we feel that it needs to be part of government in order to wield the influence it needs to on public health. However, it also needs to be accountable to the public, not only the Secretary of State. The Chief Medical Officer's privileged and unique position as a professional, independent voice from within government will be an important guarantor of independent thinking and advice. However, further independent assessment of Public Health England's activities will help to reassure those that fear that independence of public health advice to government is at risk from its establishment as part of the Department of Health.

**R13: We recommend that Public Health England has a charter setting out clearly its objectives and an annual and independent assessment is published assessing its performance.**

Public Health England can be a powerful and driving force for inequality reduction. The government needs to be explicit that this is one of its core aims and set up independent scrutiny to ensure it is doing so.



**R14: We recommend that in Public Health England's charter is includes the explicit reduction of inequalities as part of its founding objectives and that this is independently assessed and reported on annually.**

#### **Local level accountability and governance**

Health and wellbeing boards are to be established in upper-tier local authorities and are intended to promote joint working between the NHS, social care and public health services in local areas. They will undertake local joint strategic needs assessments with the local NHS and following this joint health and wellbeing strategies. GP consortia will be legally required to participate in health and wellbeing boards and to 'have regard' to their joint health and wellbeing strategies in developing their own commissioning plans.

It is currently proposed that local authorities' responsibilities will include: prevention and treatment of obesity; prevention and treatment services to address drug and alcohol misuse; smoking cessation services; sexual health services (excluding contraception); mental health promotion and mental illness prevention; and school health programmes including school vaccination programmes. They will also have a role in supporting Public Health England in carrying out what have been the Health Protection Agency's functions around control of infectious diseases and protecting the public against other environmental health hazards.

Directors of Public Health will sit solely within local authorities. They will be jointly appointed by the local authority and Public Health England (on behalf of the Secretary of State). They will be officers of local authorities and as such subject to their management structures and ultimately accountable to their chief executive. They will also be professionally accountable to the Chief Medical Officer who will be located within Public Health England.

#### *Health and wellbeing boards*

We welcome the intention to create statutory health and wellbeing boards and the early implementer programme that are piloting them.

We suggest that the core membership of the health and wellbeing boards is largely sound; however, we think the link between housing and health has been underexplored throughout the public health strategy and outcomes framework documents, as well as the role of environmental health officers. Other areas too are important to consider including leisure services and transport.

**R15: We recommend that the roles of housing and environmental health in particular should be explored further in terms of mandatory membership of health and wellbeing boards.**

We have major worries over whether health and wellbeing boards will have the power to really drive local public health strategy and to ensure that all partners play their full role. It is all too easy to see how health and wellbeing boards will simply become 'talking shops' rather than bodies with system leadership, commissioning power and accountability at their core.

We are particularly concerned about whether the boards will have sufficient engagement from and influence with GP commissioners (see The King's Fund's response to the consultation paper on *Local Democratic Legitimacy in Health* (The King's Fund 2010a)). It is not clear, for example, what influence decisions by the health and wellbeing boards on prioritisation of treatment areas as part of the joint strategic needs assessments (JSNA) would really have on resource allocation decisions by GP consortia, which will hold the vast majority of funds for health care.

Boards will need to identify priorities through the JSNA and then work on local strategies for priority needs such as frail elders, the homeless and isolated individuals who may not be accessing health care, where it is critical that care needs span the whole pathway from prevention through to acute care. This will need the engagement and support of GP consortia as providers and commissioners and identification of care pathways that cross responsibilities.

**R16. We recommend the government considers placing a duty on GP consortia to promote the health of their local population, this will ensure closer engagement with the health and wellbeing boards and increase the coherence of care for socially excluded groups.**

What is clear is that as the early implementer sites will be facing all these questions and issues as they develop. This is a major opportunity to support them, to learn from each other and to evaluate so that mistakes are not perpetuated when the system goes live. To do that requires planning and support from the centre.

**R17: Health and wellbeing board experience needs to be documented, evaluated and further supported so that the key governance in the local public health system has the best chance of success once the reforms go live.**

*The Director of Public Health*

Directors of Public Health will be officers of local authorities and as such subject to their management structures and ultimately accountable to their chief executive. They will also be professionally accountable to the Chief Medical Officer, who will be located within Public Health England. If the Secretary of State considers a Director of Public Health may be failing in their duties, they can require the local authority to review their performance, investigate whether failures have occurred, consider any steps the Secretary of State requests of them and report to the Secretary of State on what action is to be taken. A local authority must also consult with the Secretary of State before removing a Director of Public Health from their post.

The role of the Director of Public Health is critical to the success of local systems management and their position needs to reflect that. As such, we argue that the resources and authorities these individuals have over other parts of the system should be increased.

We reiterate the messages from *Leading Together Better* (IDeA 2009) that '*there needs to be widespread understanding of what success looks like for ... appointments, partnership working and for health and wellbeing processes and programmes*'. We also believe Directors of Public Health need to have clear lines of upward support from Chief Executive Officers, Public Health England, NHS Commissioning Board, and the Chief Medical Officer, with clear understanding of the levers at their disposal to manage the local system.

IDeA's assessment of the success of Joint Directors of Public Health (IDeA 2008) suggests that there are different ways in which the Director of Public Health role can play out in local areas. Given the importance of this role in local system management, we would encourage further exploration of the ways the role can play out successfully, and enshrine mechanisms and levers into local agreements that will allow for Directors of Public Health to operate successfully in the inherently complex accountability environment.

Although we support the move to local authorities, the move must not isolate the skills and expertise that a large number of public health specialists have in clinical care and clinical service design. The roles and skills of these professionals must be maximised since they will

be critical in ensuring coherence and alignment between the public health activities of local authority, GP consortia, acute sector services and the NHS more generally.

**R18: We recommend that the Department reconsiders the role and status of Directors of Public Health and the wider team in the system, and are given clearer guidance on how they can use the levers and incentives at their disposal.**

*GPs, as commissioning consortia and providers of public health*

GPs are important providers of services that improve public health. The vast majority of us will see a GP in any given year, their public health role is crucial in helping us to stay well, helping us to change our health behaviours and in ensuring long-term conditions are managed to prevent and delay further problems. As the previous government's health inequalities target regime recognised, primary care has a fundamental role in reducing inequalities in health. Indeed in the short run, it is through primary care that inequalities in life expectancy can be improved fastest through secondary prevention and optimal control of blood pressure, cholesterol and diabetes, as reflected in the Department of Health's intervention tool (London Health Observatory 2010). GP consortia will also have a critical role in ensuring that secondary care fulfils its role.

We have outlined how currently it seems that health and wellbeing boards' leverage over GP consortia will be light as currently set out. This will be compounded by consortias' stronger lines of accountability to the NHS Commissioning Board both directly and through the Commissioning Outcomes Framework. In order to counterbalance this we think it makes sense that there is a greater public health presence in GP consortia's decision-making.

**R19: We recommend that the government considers how it will ensure there is sufficient public health expertise input into GP consortia's decision-making.**

If the NHS Commissioning Board taking its new duties on tackling inequalities seriously it will improve the chances that GP consortia will as providers be narrowing inequalities in outcomes from NHS care. One good sign of this will be how the Commissioning Outcomes Framework is designed to tackle inequalities including appropriate linkages with public health. So far the impact of the Quality and Outcomes Framework on public health and health inequalities has been limited, and GPs perceive their role to be limited (Dixon *et al* 2011, forthcoming). A cultural change will be required in order for consortia to be active in tackling health inequalities, and the Commissioning Outcomes Framework will need to put strong incentives in place. Consortia will need to be held to account and rewarded for delivering on a high-level set of outcomes the health of the population. Without these incentives and broader duties on tackling inequalities in health – as we recommend above – they will be less motivated to engage with their local health and wellbeing boards in a meaningful way.

**R20: We recommend that the NHS Commissioning Board is publicly transparent in its reporting of how it is holding GP consortia to account for tackling inequalities in health including their actions to reduce inequalities in health as part of the Commissioning Outcomes Framework and their alignment with the priorities of local health and wellbeing boards and the Public Health Outcomes Framework.**

*The Public Health Outcomes Framework*

We strongly support the concept of an outcomes framework for public health. We also think that its domains represent the reality of public health: from health protection through to the

wider determinants of health, behaviour change and the final outcomes in terms of morbidity, quality of life, life expectancy and infant mortality. Our response to the specific questions from the outcomes consultation is attached as appendix 1.

The intention is to reduce the number of indicators in the outcomes framework. This runs counter to the declared intention for more public transparency of outcomes. Rather local areas and populations should have access to the widest array of comparable information that the centre can provide from which they can choose their priorities and understand how they compare with other, similar areas. We recognise the burdens and costs of data collection will need to be taken into account in terms of new collections.

**R21: We recommend that the Public Health Outcomes Framework is not limited to a small number of outcome measures. This runs counter to the declared intention to increase public transparency. Rather the set should be widened so that local areas have more choice over the areas they wish to focus on and publically track their achievements against peers over time.**

There are many additional indicators that could be included, as above we feel that there should be no artificial limit on this. Overall, we believe there is a reasonable balance; however, we would stress the inclusion of more indicators that are related to individual and community 'well-being', public mental health and wellness. Positive wellness models and assets-based approaches are recognised as being increasingly important as well as deficit and illness-based models of public health.

**R22: We recommend that the outcomes framework includes more indicators that reflect well-being, community as well as individual outcomes, and asset-based approaches to public health.**

All areas – rich or poor – suffer from inequalities in health, but the information to track this is currently poor and incomplete. While local areas to some extent do this themselves there is a lack of comparable information across England. If the outcomes framework is to be successful in increasing the health of the poorest fastest it has to be complemented by within-area measures as well as local authority level information. There is a clear role for Public Health England at the centre to help this process.

**R23: We recommend that Public Health England commits to investing in and supporting improved within-area measurement of key indicators in the outcomes framework.**

The roles of health and wellbeing boards, GP consortia and the Director of Public Health are currently unbalanced in our view as we have set out above. In a more balanced system with good relationships and clearer accountabilities the outcomes framework could be a major mechanism for improvement in public health locally. However, the proposed role of the Public Health Outcomes Framework is too narrow and is restricted to be simply a tool for public transparency.

The presumption is that public accountability will flow purely from public transparency of the Public Health Outcomes Framework is flawed. No organisation or group of organisations (for instance the representatives of the health and wellbeing board) will be held responsible by Public Health England for ensuring improvements in the outcomes in the framework. This is left entirely to local discretion. In 'good places', helped by co-terminous boundaries, common vision and good leadership the outcomes framework will be a catalyst for positive change. In other places, where none of these factors are in place, the outcomes framework is in danger of being ignored. This means that no-one is in the end accountable for the outcomes that are

meant to flow from the billions of pounds that will be spent by local authorities on public health.

Although the Secretary of State reserves the powers to remove the Director of Public Health there appear to be no plans for Public Health England to actually design an explicit mechanism that will guide such a course of action, or actions short of it, in relation to overall performance, or 'failure' on the Public Health Outcomes Framework.

**R24: The Department considers seriously and consults further on what Public Health England's response will be to 'failure' on the outcomes framework given citizens' health and billions of pounds of taxpayers' money is at stake.**

This is in contrast to how GP consortia are expected to be held account for their contribution to the NHS Outcomes Framework through the Commissioning Outcomes Framework. It is expected that the Commissioning Outcomes Framework will be accompanied by strong accountability so that the NHS Commissioning Board can demonstrate to the Secretary of State that the outcomes in the NHS are being delivered efficiently. This imbalance in accountability for outcomes means that GP consortia will respond first to the Commissioning Outcomes Framework and the NHS Commissioning Board. In order to tackle this Public Health England needs to develop similar commissioning frameworks for public health, seeking to align and influence the NHS Outcomes Framework. This alignment and accountability problem between the frameworks puts integrated working and public health at significant risk.

**R25: We recommend that Public Health England follows the lead on the design of the NHS Commissioning Outcomes Framework and works with commissioners and stakeholders to develop commissioning outcomes guidance and frameworks for public health, seeking to align with and influence the NHS Commissioning Outcomes Framework.**

We welcome the seeming intention to measure progress against outcomes by the equality characteristics and by within-area inequalities where possible. We believe that this needs to be replicated across the outcomes frameworks. For example, recent research suggests that future efforts to tackle health inequalities should focus on deprived practices, regardless of the area in which they are located (Dixon *et al* 2011, forthcoming). By addressing within-area inequalities, every GP consortia and local authority will then be seen as responsible for tackling inequalities across the country not simply in the traditional areas of high urban deprivation associated with the previous government's Spearhead approach.

**R26: We recommend that that all outcomes frameworks, and associated commissioning frameworks, aim to measure improvement on within-area inequalities reduction.**

We reiterate our message from our response to the NHS and social care outcomes frameworks that for the Public Health Outcomes Framework to be effective, the three outcomes frameworks need to be as aligned and consistent as possible to create incentives for the NHS, public health and social care to work across pathways and integrate care where necessary. Over time we suggest that indicators across the frameworks are developed that fulfil the following.

**R27: We recommend that over time the Department develops indicators in the outcomes frameworks or supporting commissioning frameworks where appropriate that:**

- **use indicators along whole care pathways with public health components where relevant (eg, obesity as per standards set by the National Institute for Health and Clinical Excellence (NICE))**
- **include measures of the quality of integrated, co-ordinated care, which can impact on quality of life and patients' experience of services but may not translate directly into 'hard' outcomes**
- **make local organisations accountable for the same, system-level measures to foster co-operation which health and wellbeing boards, and associated strategies, will seek to achieve**
- **further explore the potential for outcomes focused on specific groups of the population (particularly those experiencing health inequalities).**

### **C: Incentives and performance management**

The new system reflects a major philosophical shift in policy, from a belief in performance management and substantial central support to one of incentives, information and local decision-making. We support the increased emphasis on the latter but question whether this will deliver the step-change in public health and inequality reduction that is envisaged.

#### **The health premium**

The Department has signalled that the health premium's role is to incentivise improvement in health, and areas will be rewarded for doing so. On one level, this can be criticised, like the Quality and Outcome Framework has been, that it turns the pursuit of inequality reduction into a money chase rather than as a primarily cultural and professional goal, backed up – as we argue for – with strong accountability and duties.

Nonetheless if a health premium is to be the only way that local authorities are able to increase their overall pot relative to others (given the current proposals on allocations for public health discussed above) it will be important to them. All the indications are, however, that the premium itself will be small.

The Department clearly recognises this in that they have been clear that it will be attached to a 'small number' of indicators from the outcomes framework – otherwise it would become vanishingly small and have no impact as an incentive. If it is to be any sort of incentive at all, it is clear to us that it needs to incentivise the most pressing public health concern in virtually all local authorities, and that is within area inequalities. The Community Health Profiles (Association of Public Health Observatories 2011) show that every area has substantial inequalities, be they Spearheads or Kensington and Chelsea, and this is the problem that most urgently needs to be tackled.

The current thinking behind the premium reflects this focus on inequalities which is welcome but how this is done is critical. There is also a tension between a 'technically right' solution and one which is transparent enough for local authorities to understand what they need to do in order to qualify for payment. The current model is for a reward payment based on relative between area performance on a small number of indicators in the outcomes framework, with larger payments for more disadvantaged local authorities. This is a transparent approach that recognises that local authorities with high deprivation have further to go and will find it more costly and harder to do so. This, on the surface, seems reasonable, especially if the indicators

concentrate on the primary drivers of inequality, such as tobacco control – as has been signalled in the recent *Tobacco Control Plan* (Department of Health 2011).

However, this runs the risk of local authorities focusing solely on the ‘easy wins’ in their communities, helping people from wealthier areas, who are easier and cheaper to reach in order to hit qualifying criteria, rather than poorer communities where social norms are harder to crack. It also runs the risk of focusing on the short term, rather than investing in the wider determinants of health. In short, it could simultaneously improve population health and widen inequalities within local authorities.

There is also a need to ensure that local authorities are stretched, that is, that the premium is designed so that they are not incentivised to do only the minimum to meet the payment threshold in year, this implies some form of tapering. Population health churn also needs to be taken into account to reduce the likelihood of misattribution of outcomes to actions.

The design of the formula therefore needs to balance these competing demands in a way which is as simple and transparent as possible and unlikely to lead to perverse actions. Our overall view on this is that if the incentive payment truly is to reflect the desire to reduce inequalities in health, then its design needs to focus on a combination of within-area inequality reduction in final outcomes and short-run shifts in the known major causes of inequalities that the local authority can influence. This implies that within-area smoking rates and within-area life expectancy improvements are the leading candidates for inclusion in a relatively simple formula that sends a signal to local authorities that what is most important is that they reduce their within-area inequalities and they balance long-term and short-term actions to do this.

**R28: If the Department is to implement the health premium immediately, it should be used to reward reductions in within-area life expectancy variation and within area variation in smoking rates or alternative approaches that incentivise a balanced approach to action on inequalities.**

**R29: The premium mechanism should also involve a tapering mechanism so that local authorities are rewarded for stretch achievement and underlying population factors are taken into account.**

However, due to the complexities and high chance of perverse outcomes we feel it is too early to commit to a health premium at this stage. The Department needs time to test out alternative approaches, both in terms of retrofitting on what would have happened on past data if approach A, B or C had been adopted and on piloting approaches. This, in the long run, will ensure that the premium works in achieving its objectives.

**R30: We recommend that the Department tests out alternative approaches and pilots them before committing to an approach.**

### **Other payment mechanisms**

We welcome the development of tariffs for smoking cessation (as outlined in the Tobacco Control Plan). This will help to put public health on an equal footing with other interventions and make it more straightforward for commissioners and encourage the development of better measures of outcome.

However, tariff development in public health is complex and we would wish to ensure that individual-based tariffs for specific behaviours (such as tobacco cessation tariffs) are not the only currency developed. In particular, it is well known that health behaviours cluster and

that it can be more difficult and costly to help some groups and individuals to change their health behaviours than others. This argues for tariffs that both take into account multiple behaviour changes and that reflect differences in ability to produce change. If these are not developed it may lead to perverse incentives for 'easier' and cheaper patients to be targeted, with possible impacts on inequalities.

**R31: Tariff development in public health needs to reflect the underlying differences in systematic costs and success rates of changing multiple behaviours and in changing behaviours for different types of individual.**

We encourage the development of alternative funding mechanisms for those organisations that contribute to improvements in public health further 'upstream'. This is a role that the voluntary and community sector have a particular role in. Some, particularly the larger national bodies, will be boosted by the development of individual-based public health tariffs, being able to provide services to patients as part of public health or more broadly integrated care pathways. However, many voluntary and community sector organisations that provide valuable insight and support to vulnerable individuals and groups that are not directly reflected in behaviour change or individual level health outcomes. Individual-level tariff-type payments are not an appropriate payment mechanism for these organisations and they may be put at a systematic disadvantage in the absence of alternatives.

**The role of the Quality and Outcomes Framework**

As the National Audit Office and the Marmot Review have stated, the Quality and Outcomes Framework (QOF) can be used more innovatively to reward GPs for improving population health and reducing inequalities.

Our understanding is that at least 15 per cent of the current QOF value is to be devoted to public health and primary prevention indicators from 2013. We also understand that this funding will come from Public Health England's budget and so represents a diversion from the ring-fenced allocation rather than an additional sum from primary care funds. A sizeable proportion of Public Health England funding will be directed to GPs and away from local authorities. As Public Health England will also be responsible for funding some other elements of QOF such as those relating to immunisation, contraception, and dental public health, we are uncertain about what proportion of public health funding will be routed to GPs.

Driving improvements in public health via QOF is appropriate, but must not be overstated, and in particular should not be assumed to be a key driver for reducing health inequalities. Overall, the evidence to date about impact of QOF on reducing suggests that differences in performance between practices in deprived and non-deprived areas are narrowing. However, our research shows there is weak evidence as to the impact of QOF on health inequalities (Dixon *et al* 2011, forthcoming). If QOF is to play a stronger role in tackling health inequalities in primary care, each new QOF indicator should include explicit evidence about its role in reducing health inequalities. If this evidence is unavailable, NICE should recommend areas of research to improve the evidence base on the role of general practice in reducing health inequalities.

**R32: The Department should include explicit evidence of how new indicators in QOF will reduce inequalities in health**

**Performance management and support**

It is clear from our discussion under local accountability and incentives that we believe that the new system is at significant risk of relying on too few levers to drive the improvement



that is being asked of it. We support more use of incentives but the system cannot rely on them alone, especially in the absence of strong and clear accountability.

It is well known that poorly specified targets and the performance management that goes alongside them can be perverse, narrowing activity and leading to undue concentration to the detriment of other important areas. However, the previous government's focus on inequalities and public health through the Public Service Agreement (PSA) and associated target has been widely accepted as helping to focus critical action locally on public health and inequalities reduction. The Health Select Committee in 2009, while accepting that the inequalities PSA target was stretching and ambitious recommended it be continued (Health Select Committee 2009). The inequalities PSA target was arguably one of the very few, if any, in the last government that was outcomes focused and, since it was a broad outcome, left lots of local leeway for innovation and differences of approach.

Our view is that the fact that the prime reason the previous government's PSA target was not met was not that it wasn't possible, but that the Department did not performance management it adequately. Despite it being a PSA indicator it was translated into a tier 2 vital sign, reflected with less strong performance management from the centre than for priorities such as waiting times. By the end of the period, the Department had good evidence of how primary care in particular could reduce inequalities in life expectancy but did not choose to give it the priority in terms of performance management it required. Our recent inquiry into quality of care in general practice (Goodwin *et al* 2011) shows just how much variation there still is in general practice. In order to narrow inequalities in health, the Department needs to consider performance managing to reduce the most serious variation, particularly in access to secondary prevention such as control of diabetes, cholesterol and hypertension that directly affect life expectancy.

We remain extremely concerned that a system that has no clear accountabilities, and that relies on public transparency of information and small incentives payments, will not be strong enough to meet the stated ambitions of the new public health system. The Department needs to look again at the lessons from the previous government's approach to public health and take the strengths into the new system.

**R33. The Department needs to reconsider its approach to performance management and support on public health. A balance of incentives and performance management and support are more likely to be successful than relying on one or another alone.**

## **D: Information, evidence, tools and support**

Getting the resources right and in the right place and the correct balance between system responsibilities, accountability and incentives are important. But none of that will be relevant if the system does not have the right underlying information, evidence, tools and support to help it function.

### **Will the system have the right information?**

Without accurate, up-to-date information on public health trends and outcomes, the system will not function. We support the proposals to develop a central public health intelligence and dissemination function. There are obvious benefits to be had in central standard setting and economies of scale and scope in a central intelligence function.

We have already welcomed the Public Health Outcomes Framework; our responses to the specific questions in the outcomes consultation are at annex 1. We also welcome the

The King's Fund response to *Healthy Lives, Healthy People* and associated consultations on the Public Health Outcomes Framework and Funding and Commissioning Routes

intention to eliminate duplication and streamline the intelligence function. However, this is not synonymous with a general reduction in information streams. There is a worrying trend in this in health and across government. We agree with the UK Statistics Authority that the move of the NHS Information Centre to cut, with immediate effect, the contribution it makes to the General Lifestyle Survey conducted by the Office for National Statistics is wrong (2011). As Sir Michael Scholar has said,

*'The decision by the NHS Information Centre will... result in the immediate discontinuation of long-established national statistics on smoking, drinking, health conditions and use of health services... the move would seriously undermine the UK's ability to monitor key trends affecting public health.'*

The government has to protect these vital sources of information on long-term trends if it is to know whether the strategy is being successful or not. It is a dereliction of duty not to do so. This is not an isolated case and we raised concerns in our response to the Department's Outcomes framework consultation (The King's Fund 2010b) that there is an unseemly rush with little or no consultation to strip back data collection in the NHS, and in local authorities. We are not opposed to this, as long as these are good decisions taken after due consultation. Clearly, in many cases this is not happening. Similar moves have been taken to discontinue the Department of Health's support for the NHS satisfaction questions in the British Social Attitudes Survey.

**R34: The Department has to ensure that the system has the right information for transparency, to guide actions and be the basis of accountability.**

#### **Local intelligence functions and information across boundaries**

Public Health England can provide information, evidence and benchmarking from the centre. However, there is a critical need also for a local intelligence function and capability. It is not clear who will perform this function with the abolition of PCTs and the absorption of Public Health Observatories into Public Health England.

Directors of Public Health will be supported by a team with specific public health and commissioning expertise, a positive commitment in the White Paper. Key questions however remain to be answered: will PCT capacity be transferred to local authorities? How will information be made available at GP consortia level and how will this map to local authorities to support JSNAs and equity audits? How will the transfer of data, intelligence and systems from quangos such as the Health Protection Agency be assured?

We have major concerns about the impact of increasingly fragmented boundaries between NHS and local authority organisations due to the creation of GP consortia. One of the achievements of the previous government was to move towards more co-terminous boundaries and data flows between local authority and PCT boundaries which improved the chances of joint working and removed the excuses for not doing so.

The boundary changes that are a consequence of 'free' clustering of GPs into consortia present massive challenges to the use of information to support accountability and governance in the new system. Most NHS and public health data flows are mapped to statutory boundaries that may not align with the future boundaries of GP consortia; it is unclear whether or not it will be possible to reconfigure relevant data sets to these new boundaries. The same is true of Office for National Statistics population denominators that are used in the construction of many public health indicators.

The use of public health data by GPs is critical but announced changes in policy present challenges. For example, GP consortia will have new responsibilities for unregistered populations, but it is unclear how information will be tracked for these transient populations. The extension of choice of GP beyond patients' area of residence will also create challenges for information flows based on practice lists or geographically defined practice populations.

**R35: The Information Centre should prioritise mapping data to GP consortia boundaries and local authorities to ensure that the public health intelligence function supporting the health and wellbeing boards and GP consortia are fit for purpose.**

#### **Evidence**

We welcome the proposal that Public Health England will promote information-led, knowledge-driven and evidence-based public health interventions, supporting national and local public health efforts. However, given this role for Public Health England in 'developing the evidence', we question what the fit and overlaps with NICE's role will be. It is important that Public Health England's work is aligned with NICE's work developing the quality standards that will support the NHS Outcomes Framework.

**R36: The Department needs to clarify the respective roles of Public Health England and NICE in developing the evidence base for public health and how this aligns with NICE's work on the quality standards supporting the NHS outcomes framework.**

The public health community in England, and the UK more broadly have an enviable international track record in mapping, understanding and assessing how public health has developed and changed, and how certain groups are left behind.

With notable exceptions – such as the cost-effectiveness of smoking cessation; the relationship between work, unemployment and health; and the Department of Health's health inequalities intervention tool – public health research has been less successful in making a strong case for the cost-effective interventions that will make a difference in the short, medium and long term. This is understandable given the complexity of many public health interventions and their long-term pay-offs. Nonetheless, it is essential that commissioners – wherever they may be in the system – are armed with this information when they make their decisions.

There have been signs of change, Health England, commissioned by the Department, has produced a very relevant body of work, although this has now ceased (Health England 2010). The National Institute for Health Research's Public Health Research Programme is welcome. There is also the need to translate this work into usable evidence locally for practitioners and commissioners; Public Health England is ideally placed to do this setting expectations of the NIHR's Public Health Research programme for instance.

**R37: We recommend that Public Health England's initial research focus should be on the dissemination and translation into practice for Directors of Public Health and commissioners of what is known to be effective and cost effective.**

#### **Support**

The Department of Health needs to ensure that the baby is not thrown out with the bathwater as its central discretionary funding is squeezed. For example, the National Support Teams for health inequalities has been cheap, highly influential and effective, as the National

Audit Office has shown. This, and other National Support Teams, are being wound up as part of the Department's work to cut central spending. We urge the Department to think again about this, or be very clear about how the capability, learning and resources that have been developed will not be lost in transition before Public Health England needs to reinvent them again.

Alongside the activity behind that target – which has recently been assessed by the Public Accounts Committee – was a highly focused and evidence-based programme of work that sought to increase the implementation of secondary prevention in primary care (eg, statins prescribing, hypertension, diabetes and cholesterol control) that would rapidly reduce inequalities in life expectancy when targeted at high-risk groups. It is not clear under this Bill where the responsibility for such evidence-based intervention would lie and how it is to be ensured that this strategic focus continues.

**R38: We recommend that the Department looks again at its decision to wind up the National Support Teams, they are ideally placed to support the new roles in the system with practical, tailored and evidence-based information.**

## **E: Ring-fencing and coherence of the reforms**

One of the headlines of the reforms on public health has been the decision to ring-fence the public health budget at local authority level. The issue of ring-fencing is not straightforward – whether it is appropriate or not needs to be seen in the context of the vision of the reforms and how they stack up in terms of overall coherence. The decision to ring-fence is therefore the last decision that should be made, rather than the first.

There are good arguments for ring-fencing including the well-known tendency for public health budgets to be raided when finances are tight – this has happened in the NHS and there is no reason to suppose it wouldn't happen in local authorities, unless other levers prevented it. Ring-fencing is important for accountability purposes, since the Secretary of State for health is essentially transferring NHS resources to local authorities and requires assurances that these funds are spent on 'public health'. Our understanding is that these funds also count towards the government's commitment to increase funding in the NHS in real terms, ring-fencing is important politically. There is therefore a logic, from the Department's perspective, for the ring-fence.

However, this is out of step with government policy as a whole. Public health is also a conceptually broad topic. It can be defined by its workforce, their functions, organisations, and services provided or by its determinants, intermediate or final outcomes. The White Paper itself uses all of these ways to talk about public health. The definition inevitably and rightly becomes broader as the focus is more towards outcomes, as many factors including the wider determinants of health are critical in achieving them. This explains why many in local government are against ring-fencing since, in their view, they should be left to pursue outcomes in whatever way is most effective locally. There is also a logic to this argument; if the outcomes are what really counts, then ring-fencing is unhelpful since it ties resources to services that might not be the most effective way to achieve those outcomes.

The tension in the government's position is obvious. It has developed a public health outcomes framework and wants the system to become progressively more focused on outcomes rather than processes or specific services. The outcomes framework also reflects this tension, in that it is not truly just an outcomes framework, having within it process measures and intermediate outcomes. The current position is therefore halfway between an

outcomes-focused system and a more traditional service based on one where resources fund services not outcomes.

A full outcomes-based approach is inconsistent with a ring-fence, but the corollary of the local innovation that that would lead to is much stronger accountability in a nationally tax-funded system, through Public Health England, in a way akin to which the NHS Commissioning Board seems to be following. This would also ensure that the innovation was truly focused on public health and inequality reduction and not simply to backfill existing functions in local authorities. Ring-fencing is clearly more consistent with a defined system based on specific functions and services that have to be delivered, rather than outcomes per se. This approach is also present in the White Paper with the delineation of specific responsibilities, duties and functions flowing to different places nationally and locally.

There is then no right or wrong answer to whether the public health budget should be ring-fenced or not at local authority level. The decision needs to be guided by the vision for the system and how the reforms stack up. The current system does not appear coherent. There is the welcome development of the outcomes framework but no hard accountability for the outcomes in it, many of which are not public health outcomes per se. But there is also the complex web of responsibilities for specific services that are being parcelled off to different parts of the NHS and local authorities, Public Health England and the NHS Commissioning Board. We therefore do not have a defined position on the issue of ring-fencing, but we do ask the government to clarify the coherence of its reforms and its ultimate vision for public health.

**R39: We recommend that the Department clarifies its long-term vision for public health and then decides on whether ring-fencing is the most appropriate way to support that vision.**

### **The biggest risks during transition**

We believe that the biggest risk with the reforms lies in the areas of accountability as set out above. If that and other important issues were addressed there remain problems that need to be mitigated in transition.

#### *Wider public service budget cuts*

The shift of public health to within local authorities comes at a time of widespread financial cuts to the public sector. We are very concerned that local authorities will make deep cuts to programmes that support the wider determinants of health as they attempt to tackle budget shortfalls.

Some have argued that the Department of Health lacks an independent voice to speak up for public health, and that Public Health England needs to be that voice. We agree that Public Health England and the Department need to speak up and analyse the effect of budget cuts elsewhere in government. There is too little evidence on this issue. However, we feel that on balance Public Health England needs to be inside government, making the case through representations to the Sub-Committee on Public Health where it is more likely to be effective in the long run.

**R40: We urge the Department to rapidly commission and publish a report on the public health impacts of budget cuts so that local populations can see the impact of decisions on their health.**

#### *Stopping things that are effective*

We are concerned that the disruption of transition will stop things that are proven to be effective. This applies to organisational capacity and capability and some of the national capability that will be left to depreciate.

Public health departments in PCTs have built up a detailed understanding of the needs of local communities. PCTs will need to support GPs to understand those needs and to help them to start thinking systematically about the health of the population as well as the needs of individual patients. We are concerned that public health capacity will become isolated from PCT clusters in transition which will be detrimental to public health. Directors of Public Health should be supported by the rest of the PCT to remain part of the wider transition discussions until such a time as the clusters cease to exist (provided they do). This will facilitate the transition into the new partnership arrangements that will be needed between local authorities, GP consortia and the wider health service.

We are also concerned that during this period of transition organisations and interventions that are cost effective and have proved their value will be discontinued. The Department of Health's National Support Teams provided high-quality, evidence-based support to local PCTs as we have highlighted above. They were associated with the previous government's focus on performance management and PSA targets in public health and health inequalities. However, their approach and tools are as relevant, if not more so, to local authorities and GP consortia in the new system and they provide an important bridge between primary care and local authorities. The National Audit Office praised the inequalities National Support Team for its work and effectiveness with primary care. It is our understanding that they and the other public health National Support Teams are being disbanded on 31 March.

#### *Health Inequalities widen further*

Although we welcome the focus on inequalities in the White Paper, the Bill and the health premium it is clear that we do not consider the reforms, as they are, to be powerful enough to match the ambition.

In our wider analysis of the NHS reforms, we have already highlighted concerns that the move to GP commissioning consortia, and the implementation of any willing provider policy, may exacerbate health inequalities. Our concerns are set out fully in our submission to the Health Select Committee enquiry into commissioning, and will be published as part of their considerations shortly.

We think the department should seek to understand, across the system, where there are risks of health inequalities expanding, as a matter of priority. There will have been a number of responses to individual White Paper consultations that have highlighted concerns about health inequalities— it is unclear whether all of these messages are being collated across the system. The Department can work with relevant organisations to designate specific roles and responsibilities about managing this risk, especially during the transition. For example, we would welcome that efforts to extend choice in the NHS are monitored in partnership with Public Health England and local public health intelligence to measure the impact of implementing this policy on health inequalities.

**R41: We recommend that the Department sets up a mechanism to monitor the risk to inequalities in health widening in the transition with a remit to propose change through the Department's processes and across government through the Sub-Committee on Public Health.**

## References

### **Appendix 1: Response to *Healthy Lives, Healthy People: transparency in outcomes, proposals for a public health outcomes framework***

#### **Overview**

We focus on three issues below, developing our arguments in the main body of this response and then go on to address the specific consultation questions.

#### **Accountability**

As our overall consultation response outlines, we are seriously concerned about local and national accountability for outcomes in public health in the new system. Accountability through the Public Health Outcomes Framework is assumed through public transparency. This is unlikely to be strong enough, particularly in the context of budget cuts that could mean that without some form of direction outcomes on public health could slide.

The outcomes framework specifies the indicators – but not what constitutes acceptable levels of performance – both in terms of improving public health and reducing inequalities, and in terms of accountability for the public health budget. The only mechanism outside public transparency is the health premium, which rewards good performance; there is no equivalent mechanism for poor performance.

Implicit in the three purposes of the framework set out in the consultation is that there are some thresholds of ‘acceptable performance,’ but this is not expressed. The Department needs to work with stakeholders to develop its vision for accountability, in which the Public Health Outcomes Framework should play a part.

## **The number of indicators**

More broadly, again as we have stated in the response, there is little rationale for limiting the indicator set for the Public Health Outcomes Framework if local areas are to be able to prioritise their actions across the huge sweep of public health. Given the breadth of what public health encompasses, there is a risk that reducing down to a core indicator set will disincentivise local authorities from taking a broader approach by considering other indicators as well.

We support the proposal to publish the indicators in one central location to a common format – for reasons of quality assurance, timeliness and cost-effectiveness. But this does not have to result in limiting the numbers and range of indicators, which would be a regressive step – given the wide range of indicators published in the Compendium currently, for example, which is one of the largest and internationally unique set of public health indicators.

The proposals say that the large indicator set will be reduced to a core set in order to reduce burden of data collection and reporting on local authorities. Many public health data sets do not require local authorities to submit data – for example, the Office for National Statistics data on mortality and cancer registration are not collected by local authorities. They are analysed in concordance with local authority boundaries and the data is made available, but the data collection burden on local authorities is not great.

For the other data sets that do require local authority collection and reporting, we recommend that data should be judged on its merits on a case by case basis, and whether its availability enhances the potential for positive action.

The central question that the Department, and Public Health England, need to ask is not, 'how can we reduce the burden of data collection?', but rather 'is this information important for public health?' If a data set is shown to add value, it should be collected. And for data to be useful, it generally needs to be comparative – ie, available for all areas.

We strongly support having a more broad-based and comprehensive approach to compiling, disseminating and using public health information, and would see a narrowing vision as a backward step and damaging to public health.

## **The NHS in the Public Health Outcomes Framework**

As we also raised in our overall response, the NHS has a greater role in public health, prevention and tackling health inequalities than indicated by the public health outcomes framework, and as lacking in the NHS Outcomes Framework.

GPs have direct contact with the bulk of the population, including those most at risk from a public health and inequalities perspective. They are therefore well placed to offer advice and services and this has been recognised in part in the Quality and Outcomes Framework, for example, by the inclusion of smoking and obesity measures.

But the role of the NHS goes beyond what is suggested in paragraph 35 of the consultation that,

*'The NHS has a clear role in premature mortality amenable to healthcare, whilst public health's role is to reduce premature mortality through preventative approaches.'*

In fact, many of the indicators in domains 3 and 4 of the Public Health Outcomes Framework are relevant to the work of GPs. The risk of this segregation is that GPs and the NHS as a



whole may not engage actively in those areas and with those indicators that are not asterisked as shared with the NHS, when in fact there is a critical value in them doing so.

**RA1: We recommend that further work is completed by the Department to map out more completely the synergies between public health and primary care and to put in place more robust sanctions and levers to encourage working and integration at the interface between the NHS and public health.**

## Questions for consultation

***Question : 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?***

As we have outlined in our overview response, greater joint accountabilities, at least for GP consortia and local authorities, for outcomes, data sharing, and partnership working, will facilitate the development of effective local partnerships.

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

Yes.

We recommend adding another criterion:

*'Is the indicator statistically meaningful at the proposed spatial level (eg local authority) – specifically, is the indicator reliably measurable at local authority (and Output Area) level, or is it likely to be affected by small number problems so that variations between areas and/or over time are subject to random statistical variation?'*

For example, many of the mortality indicators in Domain 5, including hospital admissions for injuries in children, will at local authority and Output Area level amount to very small data figures (unless data is pooled over several years, which results in a lag in terms of assessing performance), and especially if some indicators are to be produced quarterly – eg, teenage conception and low birth weight rates. These issues arise at PCT level, and will be exacerbated at local authority level because of the larger number of local authorities (the former governments infant mortality Public Service Agreement (PSA) target is an example).

The Marmot Review discusses some of these measurement issues and challenges in detail (Marmot *et al* 2010).

The indicators and data therefore need to be carefully reviewed on a case-by-case basis in terms of the numbers of likely events, and the scope for meaningful analysis at local, regional, national levels. The health premium should not be attached to any indicator until it has been checked for reliability and measurability at the local level.

***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?***

First, by ensuring that (at least some) indicators are measureable by dimensions that reflect inequality. The indicators will of course enable monitoring of geographical and therefore proxy socio-economic inequalities – this must be extended to within-area level if inequalities are to be tackled across all local authorities. One of the weaknesses of the previous government's previous approach to inequalities was that it focused only on a subset of local authorities, when all have large gaps in life expectancy between the most and least disadvantaged. The Public Health Outcomes Framework needs to be able to measure this.

Second, the indicators should also, where data allows, be disaggregated by other dimensions of inequality. We therefore welcome the proposals to disaggregate the data by inequality and

equality strands. However, small number and disclosure issues will constrain what can be published locally at a disaggregated level. The indicators therefore need to be reviewed to see which can be disaggregated at local level, and which can only reliably be disaggregated at a regional, or national level, to form a sensible framework.

Third, GP consortia should be made fully aware of and accountable for their joint responsibility in addressing inequality and equality issues. As we have outlined in our overview response, we believe that the duties on inequalities outlined for GP consortia need to be strengthened in the Health and Social Care Bill.

Fourth, in this context, we are very concerned that NHS organisations have not, to our knowledge, been forewarned to amend ethnic coding in datasets, where appropriate, in accordance with the revised ethnic codes used in the 2011 Office for National Statistics census of the population which apply across government departments. NHS organisations should have been issued a Data Set Change Notice (DSCN) by the Information Centre to implement this change in their information systems. Without this update, it will not be possible to monitor ethnic inequalities in access to and outcomes of services, nor will the Department of Health and commissioners and providers be able to comply with the requirements of the Equality Act 2010. Given the time lag in implementing Data Set Change Notices once they are issued, we consider this an issue of utmost urgency.

Fifth, as we have set out in our main response, the health premium needs to be focused on within-area inequality reduction, otherwise it risks widening them. We propose in our main response that the premium is driven by within area life expectancy and tobacco control gaps – this is relatively simple and will ensure that local authorities focus on both long and short-term drivers of inequalities.

Sixth, in order to drive inequality reduction and equality promotion there do need to be some levers and performance drivers for both local authorities and GP commissioning consortia. Beyond the health premium, there are no proposals for how this can be addressed. Given that it is relatively untested – as we set out in our overall response – the health premium should be piloted or otherwise tested in order to assess its impact, particularly on inequalities. We further consider that some indicators should be prioritised for performance monitoring in the context of inequalities, and should apply to *all* local authorities, in order to signal the importance of this issue, maintain the progress that has been made in tackling inequalities over the last decade, and signal that inaction is not acceptable.

Finally, we note that the indicator '*Take up of the NHS Health Check programme by those eligible*' could be more explicitly targeted towards tackling health inequalities, otherwise this service could be offered more frequently to those accessing services or those who are healthier, when there is great potential to tackle inequalities through this programme. Incentives in public health could work more effectively if they are awarded for engagement with those who are typically 'more difficult to engage with'.

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

We agree about the need for joint accountability. But there are risks in specifying some Public Health Outcomes Framework indicators as 'joint' that there is little incentive for other partners, eg, GP consortia, to engage with other dimensions of public health.

GPs can, for example, engage in the wider determinants such as school health, benefits, housing, etc. As paragraph 35 says:

*'There is a strong case for explicitly recognising the shared responsibility of public health and the NHS to reduce rates of premature mortality. The NHS has a clear role in premature mortality amenable to healthcare, whilst public health's role is to reduce premature mortality through preventative approaches.'*

This is a rather arbitrary distinction: the synergies between the NHS and public health are overlapping and multifarious. GPs have the potential to play a powerful role in local communities: they are highly respected, have contact with many of those most vulnerable to ill health, and have influence and authority. Their new enhanced role as commissioners strengthens what they can do locally, including influencing some wider determinants and preventive approaches to reducing premature mortality etc.

The reforms should be expanding GPs' horizons (especially since many GPs are reluctant to engage with public health and inequalities) and not setting arbitrary boundaries that may provide GPs with little motivation to engage. Please also see our inquiry into Improving Quality in General Practice (Goodwin *et al* 2011) for our recommendations that GPs have significant duties and responsibilities for public health and inequalities.

We would suggest that the three frameworks (NHS, public health and social care) are the starting point for moving towards a single framework in future that reflects the extent of the overlapping needs and responsibilities between the sectors.

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

Taken on its own, yes. In particular, we welcome the inclusion of the wider determinants. There is some overlap in terms of the indicators for domains 3 and 4, where the distinction in terms of choice of indicators seems somewhat arbitrary.

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

We recommended in our overall response more community-based and 'place' indicators, well-being indicators and those reflecting asset-based approaches to public health, to reflect the important role that people's communities play in public health and that positive well-being is also an important goal of the public health system.

We also consider there should be more indicators on risk factors and intermediate outcomes – eg, cancer registrations as a marker of cancer incidence – prevalence of other killers – eg, cardiovascular disease.

There are limitations to measuring hard outcomes only (as in Domain 5), notably that there is often a long lead-lag time to outcomes – eg, smoking and cancer incidence and mortality – so there is a need to measure – eg, smoking cessation services and cancer incidence. The same applies to risk factors for (eg, hypertension) and prevalence of cardiovascular disease. Risk factor control now is imperative for future outcomes, but the impact won't show for some years.

The Marmot Review signals that where there are hard outcome goals, there is also a need to have intermediate indicators on interventions that can help to deliver those outcomes. Whether these are a part of the outcomes framework itself is a difficult decision. They could be seen as important markers of likely success as opposed to final outcomes and be part of

tracking and monitoring data rather be seen as the ultimate objectives. Public Health England could take a role in designing such supporting frameworks that local areas can use to assess progress towards final outcomes.

**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?**

We think there needs to be clarity about the purpose of the indicators. If the indicators are not to be used to for performance management (as stated), what is the rationale for reducing the number? Given the breadth of what public health encompasses, there is a risk that reducing down to a core indicator set will disincentivise local authorities from taking a broader approach by considering other indicators as well. We support the proposal to publish the indicators in one central location to a common format – for reasons of quality assurance, timeliness and cost-effectiveness. But this does not have to result in limiting the numbers and range of indicators, which would be a regressive step (given the wide range of indicators published in the Compendium currently, for example, which is one of the largest and internationally unique set of public health indicators).

Also, if local authorities and other local partners are to use these indicators for JSNAs and routine population monitoring that covers the diverse needs of local populations, they need a broad repertoire of indicators.

If there is to be a core indicator set, the remaining indicators should also be published somewhere. It would be a regressive step for there to be less public health information in the public domain in future than to date.

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

No response written

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

See response to question 2.

**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)**

The indicators to be incentivised need to be selected carefully so as to ensure that:

- they are based on reliable data sources and cannot be 'gamed'
- the lead time to impact is taken into consideration
- they can be reliably measured at local level and are not subject to statistically random variation because of small numbers (see response to question 2)
- they do not induce unintended consequences, eg, a focus on selected aspects of public health at the cost of others
- they do not result in patchy engagement, resulting in some local authorities that are not on trajectory losing the motivation to tackle inequalities.

Given this, and our view that the over-riding purpose for the health premium should be inequalities reduction we have proposed that within area life expectancy and tobacco control are the two leading indicators for inclusion.

**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?**

We welcome the sharing of indicators (and therefore presumably accountability) between the NHS and public health outcomes frameworks. But we think this should extend beyond one domain. For example, population vaccination coverage in Domain 1 should be shared with the NHS, as GPs play a key frontline role in this.

Other indicators where the NHS/GPs have a key role because they are in direct contact with at risk groups and can influence lifestyle choices:

- domain 3: smoking prevalence (smoking-related indicators are for example incentivised in QOF and GPs are well placed to promote smoking cessation services); obesity in children; drug treatment
- domain 4: low birthweight, breastfeeding, diabetes prevalence, screening uptake, early diagnosis of cancer
- domain 5: the NHS has shared responsibility for deaths from chronic liver disease, but why not for hospital admissions for alcohol-related harm in domain 3? All the indicators in domain 5 should be shared with the NHS.

The risk of specifying narrowly which indicators are shared and which are not is that GPs could take an unduly narrow focus on what constitutes their role in public health. To a large extent, this is the result of having separate strategies and frameworks for public health and the NHS, but the impact can be reduced by broadening the role of the NHS with greater shared responsibility with local authorities for indicators and domains. We believe this principle also extends to social care, and the sharing of indicators between social care and public health.

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

Overall, the life course is covered well, and we welcome this approach.

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