Healthy Lives, Healthy People: Transparency in Outcomes
Proposals for a Public Health Outcomes Framework

Response by the Association of Directors of Adult Social Services (ADASS)

The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of responsibilities for housing, leisure, library, culture, arts, community services, and increasingly, Children Social Care within their Local Authority.

ADASS members are jointly responsible through the activities of their departments for the well-being, protection and care of their local communities and for the promotion of that well-being and protection through the use of direct services and the co-ordination of, and liaison with the NHS, voluntary agencies, private companies and other public authorities, as well as close working with the relatively newly transferred posts of Directors of Public Health, now set within Local Authorities.

ADASS members have leadership responsibilities in Local Authorities to promote local access to services and to drive partnership working to deliver better outcomes for local populations. They participate in the planning of the full range of council services and influence Health Service planning through formal and informal partnership arrangements.

ADASS welcomes the opportunity to contribute to the Department of Health consultation on the “Healthy Lives, Healthy People: transparency in outcomes proposals for a public health outcomes framework”.

Questions for consultation

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

- Ensure duties are placed on each partner to work together.
- Clarity of responsibility and accountability in delivering outcomes.
- Recognition of the diversity of local geographies.
- Jointly agreed care pathways must be in place for the preventative elements to be prioritised by GP Consortia.
- The outcome framework indicators must be truly reflective of jointly commissioned projects or pathways, collectable locally and trackable at least on a quarterly basis.
- The pathway concept is vital to joint commissioning to bridge the transition between separate commissioning arrangements for different age groups. Whilst good for ensuring accountability the differing commissioning arrangements such as those proposed for the healthy child programme may negate a joint family based approach and a life course approach.
- Opportunities to bring together the respective agencies in collating, validating and analyzing performance data for the new geometries especially in this dynamic period in the next few years to ensure a consistent approach.
- GP Consortia, Public Health England and Local Authorities will be able to work together if they jointly contribute to the health and wellbeing strategy arising from the JSNA.
- Ensure the Health and Wellbeing Boards have the responsibility to bring commissioners together at local level to account for the achievement of shared outcomes.

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

The six themes identified in the Marmot report that will reduce impact on health inequalities needs to be included i.e. giving every child a good start in life, enabling children and young people to maximize their capabilities, fair employment and good work for all, healthy standards of living for all, healthy and sustainable communities, ill health prevention.

Improving care pathways and service specifications to achieve the desired outcomes should be the priority.

Typically health and wellbeing outcomes fall into short term results such as can be seen from smoking cessation to longer term 5-10 year changes. There will need to be a balance in selecting outcomes for health and social care that are statistically worse than national rates. The priorities for young people in each local area are already established within children's plans.

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?

The greatest source of inequalities begins before the age of three according to the Marmot report. Local Authorities will be accountable for reducing these inequalities yet commissioning for this age range will be the responsibility of Public Health England (PHE). It will be vital to ensure that PHE is accountable to Health and Wellbeing Boards locally to ensure they too are accountable for the outcomes.

The health premium is easily devolvable based on the numbers of people living in the areas of greatest deprivation but subtler inequalities due to age, gender and ethnicity and disability require detailed understanding of how health services are utilized or not. Whilst predictive risk software if used by all consortia at a population level would be desirable in the long term practice profiles can be used in the short term - but only for the Quality and Outcomes Framework (QoF) data for those aged 16+
Child health record systems would need to be substantially improved to provide assurance for the under 16s.

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

Yes, a whole integrated system approach is correct. However, there is a need to recognise the differential pressures on the three frameworks as a consequence of differential government's priorities. This will provide an additional challenge to the whole integrated system.

Outcomes - no mention of Police/Probation.

Clinical evidence base of what works in public health and health outcomes is stronger and that this could relegate priorities in Adult Social Care.

Whilst improving data is a key priority sharing the outcomes in such a way as to ensure individual patient confidentiality will be key and improving web based data entry to ensure that many partners can overcome the diversity of datasets will be critically important.

Patients may be concerned that the results of commissioning sexual health programmes could lead to personal information being available to commissioners in local authorities who are not be clinicians. Current data sharing agreements relate to the need to share data for safeguarding purposes only and general health data does not fall into this category. The law would have to be changed for termination of pregnancy data to be made available to Local Authorities and strict data sharing protocols in place.

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

The domains in the framework partially map to the themes of the Marmot report which tackle inequalities but could be strengthened.

The first domain is poorly defined and the work on sustainable communities must be improved.

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

- The Marmot report notes that there should be a national indicator for childhood development at age 3.
- Additional QoF health and wellbeing indicators have yet to be defined
- There is a significant gap for domain 1 – for example clostridium difficile is monitored routinely as an indicator of joint working between Local Authorities, care homes, hospitals and GPs which should be included.
- Sustainable development indicators are published nationally and already collected by crime and disorder partnerships.
- Nothing on alcohol – only mortality.

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?

Agree with the approach as there are 63 indicators stated currently.

The answers depend on what your commissioning role is:

- If you are a GP Consortia – work on improving care pathways to reduce admissions and secondary care costs.
- If you are a Local Authority –health and wellbeing improvement, education and employment for vulnerable groups together with the reduction of crime and disorder will remain priorities.
- If you are Public Health England – population behaviour change and early interventions.

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

- Housing overcrowding is theoretically invaluable but the data can only be collected via the census once every ten years. Until a more robust indicator is devised it will be difficult to quantify.
- The air quality data cited in domain 2 is not solely attributable to the outcome.
- Local data quality investigations show that unintentional injuries and accidents are poorly coded and actually represent the impact of respiratory conditions on admissions.
- There is no national agreement about the indicator we will use for children aged three. E.g. The Family Nurse Partnership collects the Ages and Stages Questionnaire but this is not accepted by early year centres or schools. The early years foundation measures at school entry are collated too late according to the findings of the Marmot report and local Head Teachers.

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

- By choosing data that is causally linked to health outcomes rather than associated due to deprivation.
- Through this consultation and by supporting more national web based interfaces to allow teams from different providers to enter a common dataset.

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 determinants of health and wellbeing which give the biggest quality of life returns, reduce inequalities and lifetime costs to the health, education, social care and criminal justice system i.e. • Employment /volunteering for vulnerable groups. • Access to housing for vulnerable groups. • Educational attainment for vulnerable groups at key stages of transition. • Mental health interventions as set out in the Royal College of Psychiatrists position paper 4 (2010) e.g. parenting and family based programmes. • Population wide behaviour change to increase physical activity, reduce obesity and the harms from alcohol and substance misuse.
Question 11. What do you think the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?
It is useful to have indicators to prevent early deaths from smoking, obesity and a range of communicable diseases.
Question 12. How well do the indicators promote a life-course approach to public health?
Is there an alignment between commissioning responsibility, activity and outcomes? It would be sensible to use the same heading outcome measures identified in the Marmot report as many local teams have identified how their services will perform against these. The work done by the Marmot report to identify possible indicators based on the life stages is not replicated well under these headings. There is an excellent summary in the Appendices of the Marmot report which could be used.