Healthy Lives, Healthy People: Transparency in Outcomes Framework
A consultation on proposals for a Public Health Outcomes Framework

Response from Yorkshire & Humber Regional Health Trainer Hub

Yorkshire and Humber Regional Health Trainer Hub is funded by the Department of Health to support, develop and embed Health Trainer Services across the 14 districts in the Yorkshire and Humber Region.

In 2004, the public health white paper, 'Choosing Health: making healthier choices easier' gave a commitment that from 2006, NHS Health Trainers would be providing help, motivation and practical support to individuals in their local communities.

Health Trainers reach out to people who are in circumstances that put them at a greater risk of poor health and suffer the greatest health inequalities. They work with them to assess their health and lifestyle risks, helping build their motivation to change. They have facilitated behaviour change and provided advice, motivation and practical support to individuals in their local communities since 2006, initially in Spearhead areas and now right across the country.

In 2008 the Department of Health reaffirmed their commitment to the provision of a national Health Trainer Service, stating that "Amongst other initiatives the Department of Health will roll-out Health Trainers to every community, and extend their reach with an additional network of volunteer health champions who will operate as an outreach team facilitating uptake of health trainer services and other interventions, as appropriate," (Health Inequalities: Progress and Next Steps. 2008).

During the development of health trainer services much progress has been made in measuring healthy outcomes and quantifying the impact of the intervention on individuals and in terms of the organisational cost benefits.. A great deal can be learnt from our experience of working closely with individuals and communities to coproduce better outcomes and we are glad to see co production as an underpinning principle of the outcomes framework. Our comments which we set out below are driven by our experience of what works and doesn't work for people in communities.

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

The OF should be written in a language that is understandable by all sectors, not just by health professionals, to enable local partnerships to work effectively. It is particularly important that both GP consortia and local authorities take responsibility for delivering the OF and that local communities are engaged from the planning stage onwards.

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

We do agree that these are appropriate criteria to use, however we would like to suggest the addition of the following:

- Indicators should be measurable to at least middle layer super output area (MSOA) and GP Consortia level
- Evidenced based interventions need to be adopted which specifically address the inequalities gap or there is a real danger than health improvement programmes will increase the gap. Health trainers are one such evidence based intervention.
- The Health Trainer Programme has developed a sophisticated Data Collection Recording System (DCRS) which measures behaviour change, and from which reports can be drawn when needed at whatever level demanded (i.e. district, GP practice, locality). It could be extended to use for behaviour change programmes generally, thus reducing the costs of data collection which was identified as a risk in the HIA.

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?

Health inequalities would be more appropriately addressed if some indicators reflected different levels of attainment i.e. using a physical activity example, the health premium could be linked to encouraging people to moving on from where they are now – to an improved position for example a positive behaviour change from being sedentary (inactive) to being more active (i.e. moving from being active on zero days per week to one day per week, one to two etc) in order to capture changes in those with the lowest levels of inactivity.

To make a difference to inequalities at a district level, proven health improvement interventions which are often small, need to be scaled up.

The health premium needs to be carefully designed so that it doesn't have the effect of disproportionately rewarding improvement in those populations which are easier to reach and change, rather than those that are harder to reach and slowest to change.

To address particular health inequalities the indicators need to be measured to the level where inequalities are identified i.e. at levels lower than top tier local authorities, in wards that are often disguised by more affluent neighbouring areas when larger geographical areas are considered; potential reward monies (or similar) can then be filtered to the appropriate neighbourhood/ population groups and used for its intended purpose rather than consumed within other areas.

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

Although there are separate Outcome Frameworks for the NHS, public health and for social care, it is positive that, where outcomes depend on integration and alignment, indicators are replicated across the three frameworks, or complementary indicators are included. It is important that there are shared reporting arrangements and that all parties benefit from incentives. The OF stresses the importance of coproduction in the development of the indicators – our view is that this principle should be extended to the setting of local indicators and delivery plans – and that this joint approach should in itself be an indicator.

We hope this will promote joint working and service integration enabling local partnerships and the communities they serve to work well together. While we welcome indicators being replicated across the three outcomes frameworks to promote service integration, we believe more will be needed to ensure integrated working across the NHS, public health and social care. It is essential that the new GP Consortia take on board their new responsibilities fully and recognize that improving health and reducing health inequalities is a key strategic priority.

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

Yes we agree with the framework and domains, although there does seem to be some repetition and overlap which could create confusion. Making progress on outcomes will depend in large part on there being the resources to implement interventions on a sufficient scale to make an impact.

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

There is an emphasis in the OF document on coproduction as a valued approach in setting the national indicators – we believe that coproduction is equally essential during the planning and delivery stage and suggest that evidence of coproduction (including with local communities) in setting and negotiating local indicators and in planning delivery should in itself be an indicator.

Some of the indicators that have been suggested (e.g. prevalence of healthy weight in adults and percentage of adults meeting the recommended guidelines on physical activity) have been used by CLES in evaluating the Big Lotteries Regional Health and Well Being Programmes on a large scale. This has proven to be very problematic with districts struggling to collect information of this nature from people participating in activities to improve health and lifestyle. This is in part because the evaluation effort becomes totally disproportionate to the level of intervention. Evaluation is often seen as intrusive by communities and can damage the relationship which has developed.

It is important that we distinguish between research, evaluation and audit and adopt the model used almost exclusively in all other areas of health delivery, where we follow evidence based practice and audit on a regular basis to be assured of quality. Combining this approach with self reported wellbeing across the key areas of healthy eating, physical activity, smoking, mental health and well being will deliver better results.

We very much welcome the indicator of self reported wellbeing in Domain 3 and would suggest that measures already used in the DCRS (see above) could be used to capture this information. Our experience is that it is better to measure a self reported positive shift in behaviour (e.g. improvement in healthy eating, increased physical activity, improved well being) than to seek to collect quantitative data in a routine manner, for the reasons indicated above.

Using positive behaviour change data we are also able to assess the value for money to the NHS, and other public sector bodies of investing in prevention work. This ability to attribute a monetary value to the work is extremely valuable.

We would also suggest that signposting data is a useful indicator of people being appropriately referred to appropriate services.

We suggest that it would be helpful to include an indicator set on self management of some key conditions, e.g. diabetes. These indicators could include self reported self management, positive behaviour change, HbA1cs, and service utilisation. There is some robust randomized control trial research from the Elisabeth Bruyere Institute and McMaster University in Ottawa which shows that early intervention work around blood pressure monitoring and CVD awareness can reduce hospital admissions for CVD by 9% which is hugely motivating to all involved in delivering the intervention.(BMJ Feb 2011.L.Chambers)

We would recommend inclusion of an indicator of the level of community engagement as well as social connectedness as an indicator of social capital, as there is clear evidence that both help produce better health outcomes (eg see NICE guidance)

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?

- Self reported well being – including positive behaviour change
- Social connectedness
  (Both these indicators underpin all the others and are important throughout the life course)
- Take up of the NHS Health Check programme by those eligible
- Prevalence of recorded diabetes
- Physical Activity indicator: Percentage of adults meeting the recommended guidelines on physical activity (5x30 minutes per week) better framed as making a positive behaviour change to take up more exercise.
- Healthy Weight indicator: Prevalence of healthy weight in adults and children – Better framed as a positive behaviour change to improve healthy eating.
- Health related quality of life for older people

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

No, although we think some should be core, and others negotiated locally.

Question 9
How can we improve indicators we have proposed here?
- Do not lose self reported well being indicator – it underpins all the others
- Add an indicator on community engagement
- Include self reported positive behaviour change in key areas of healthy eating, physical activity, mental well being, alcohol and smoking.

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)

Agree that incentivizing indicators will encourage local authorities and GP Consortia to focus in that direction but the danger is that to incentivise some will downgrade others. Which

indicators to select could perhaps be negotiated with each district through the Health and Well Being Board

In addition, we suggest that those that are incentivized for everyone, should be the overarching indicators, particularly the indicator on reducing the gap in life expectancy and healthy life expectancy between communities.
In addition, our preference would be to incentivise indicators of self reported well being and community engagement as they underpin all the other indicators.

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 agree that this would be helpful

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

We agree that a life-course approach has been addressed to some extent, although not fully, due to the lack of detail around some indicators.

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