RTPI
mediation of space · making of place

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Department of Health, Room G16
Wellington House
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Email response sent to: publichealthengland@dh.gsi.gov.uk

Dear Sir or Madam,

Response to Consultation: Healthy Lives, Healthy People: transparency in outcomes, proposals for a public health outcomes framework

Thank you for the opportunity to respond to the above consultation. The Royal Town Planning Institute (RTPI) is the largest professional institute for planners in Europe, representing around 23,000 spatial planners. The Institute seeks to advance the science and art of spatial planning for the benefit of the public. As well as promoting spatial planning, the RTPI develops and shapes policy affecting the built environment, works to raise professional standards and supports members through continuous education, training and development.

This response has been formed drawing on the expertise of the RTPI Environmental Planning and Protection Network's Healthy Communities Interest Group.

Enclosed is the RTPI's response to the consultation.

If you require further assistance, have any queries relating to the enclosed or require clarification of any points made, please contact the Policy and Practice Team on 020 7515 1913 or email catherine.middleton@rtpi.org.uk.

Yours faithfully,

Matt Thomson
Head of Policy and Practice

Introduction

The RTPI supports and welcomes the production of a unified set of indicators. It is crucial that the indicators are embedded across local authorities and health partnerships in the proposed new system and that they help establish a new paradigm in addressing public health, which we interpret is the Government's intention.

The outcomes framework should facilitate the integration of policy and interventions vertically (among Government, local authorities and other stakeholders) and horizontally (between stakeholders in the Health and Wellbeing Board and local authorities). To be successful in this challenge, the framework needs to give practical expression and effect to the holistic and cross-cutting nature of the social determinants of health model. In this model, public health is not the sole domain of the public health profession, but falls to all sectors of society. The social determinants model gives the greatest insight into causes of ill health and inequality, and into those interventions that are likely to be most efficacious.

Spatial planning, the management of the environment to promote sustainable development, is thus a key area of policy and intervention which has an as yet unrealised potential for protecting and promoting public health. This perspective is, we believe, strongly aligned with the social determinants of health model.

Delivering safe, healthy and attractive places to live are key objectives of spatial planning. We believe that the health and wellbeing of a community must be considered at all stages of the planning system. In this way planning can deliver sustainable development that effectively meets the needs of all sections of the community.

The RTPI's initial proposals to the pre-consultation phase of the National Planning Policy Framework (NPPF) have emphasised that the NPPF should be structured around the key issues or themes on which the government intends to deliver through planning, and that these should go beyond the traditional remits of narrow physical planning to address issues such as health.

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?

As Local Authorities will be leaders in promoting public health it is vital that the outcomes framework is mainstreamed across the whole of the Council and acts to guide all its functions, thus effectively reflecting the social determinants model. If it is constrained or contained within 'public health', or the Health and Wellbeing Board and Strategies, or simply linked to adult social and children's services, the full synergies will not be achieved.

The GP consortia need to have ownership of the outcomes along with third sector stakeholders. In two-tier authorities it is vital that the District Councils also have ownership, and that it drives their corporate work across spatial planning, environmental health and parks and open spaces.

The outcomes framework ought thus to provide one means of integrating diverse activities, policies, services and interventions in order to achieve the maximum synergy. Only in this way will the scope of the social determinants of health model be brought to bear on the public health and priorities will be able to be set as between prevention, promotion and clinical intervention in the most cost effective options.

The costs and benefits, including the health premium, need to follow the outcomes framework. The costs of interventions in the built environment or in housing for instance could lead to cost reduction in healthcare. The costs and benefits therefore need to be allocated in way that is equitable.

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

These are a sound basis for developing an outcomes framework but the list fails to adequately stress the importance of prevention in avoiding the major causes of ill health and disease. Healthy environments could thus be an outcome.

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 key is to ensure that the outcomes framework fully reflects the social determinants of health and hence supports a focus on 'the causes of the causes'. It should act to shift the bias away from traditional public health models to a more holistic approach. It should be robust and yet flexible and intelligent enough to reflect the long term nature of the reduction in inequality and on the whole support a shift away from short term inputs, or rather seek a more effective overall balance of prevention, intervention and treatment in the local health economy. Audit and evaluation tools need to be developed to support this approach. The approach needs to be based on an understanding of pathways and of the efficacy of alternative strategies – in other words, 'what works'.

The statement in paragraph 27 that the Framework is 'not a performance management tool' is surprising. Further clarification of its purpose would be helpful, if the framework is not to be used to support performance management.

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

The question reflects a fundamental failure to achieve a step change in the role and nature of public health interventions and the true nature of the social determinants of health. The diagram encompasses a pathology of care – linking patients and clients. The fundamental purpose of public health is to prevent people becoming patients or clients. As such the model needs to encompass a wider range of pathways, services and activities. Transport, spatial planning, environment management, environmental health and education are examples. The model reinforces the long term medicalisation of public health that needs to be reversed in order to be effective.

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

The overall framework does reflect the points already made in this response concerning the relative importance of prevention. It must be reiterated that the indicators that are being suggested do not, as it stands, fully reflect this conceptual approach.

It is crucial that the indicators link in some realistic way to the power or ability of the local regime to influence outcomes. Local partnerships can have an impact, but only when higher factors are in place. These include global issues and the fiscal context. Whilst the Government may wish to delegate power, influence and resources under the localism agenda this fact will remain. Unless a balance is struck partnerships will be set up to fail and will become disillusioned and frustrated.

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

We suggest that the Vision should include overarching indicators such as:

- The index of multiple deprivation
- The percentage of people reporting that their health is good in the last 12 months
- When developed, the proposed index of National Wellbeing
- Income should form an indicator in addition or in place of the proxies that are already included

Domain 2 "Tackling the wider determinants of health" should include:

- The percentage of people satisfied with their local neighbourhood
- Some measure of the quality of housing e.g. Decent homes (public and private), Building for Life
- Access to fresh food
- A walking indicator

Domain 3 “Health improvement” should include:
- Percentage of people eating five portions of fruit and vegetables a day

Domain 4 “Prevention of ill-health” should include:
- Percentage registered with and accessible to a GP
- Percentage registered with a dentist
- Percentage satisfied with their local health services

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?

Those indicators that are truly outcome based and which make a strong link with the social determinants of health and inequality. Income and lack of employment have been shown to be the most significant in predicting inequality in health. Those indicators are therefore most important alongside the tracking (i.e. life expectancy) indicators.

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

Indicators should relate to true outcomes and avoid both output and process indicators, which inevitably result in tick box approach, with an emphasis on inputs.

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

The framework could be greatly strengthened if it were based on a convincing conceptual model of outcomes and if the indicators were generated in a transparent way from first principles (the vision and the domains, for instance). It is not possible to see readily how the indicators link to the social determinants of health, and it would help greatly if they were contextualised by some measure of their efficacy in tackling inequalities.

A holistic framework would include:
- Lifestyle (diet, physical activity)
- Community (social capital, networks)
- Local economy
- Activities (active travel, play, learning, shopping)
- Built environment (housing, streets and public realm, parks and open space)
- Natural environment (air, water and soil quality, natural habitats)
- Global ecosystem (climate stability, resource depletion, biodiversity)

(e.g. Barton H and Grant, M 2006; A Public Health Map)

The set of indicators is some way short of the above scope.

To truly deliver on the vision the set of indicators needs to:
- Reflect the social determinants of health in a balanced way
- Be linked to population outcomes and not outputs or process outcomes
- Give adequate stress to prevention

The set of indicators as they stand do not meet these criteria in all cases. Domain 1 indicators, for example, are largely process and not outcome based.

Steps must be taken to improve the availability of data at the lowest geographical levels. As far possible data should be available at below local authority level (i.e. ward, parish council, neighbourhood) to support neighbourhood planning and to highlight health inequalities. Too many JSNA for instance currently analyse data at a County level. At this scale, and even at District Council level, it is not possible to arrive at meaningful assessments of inequality. It is not clear from the headline indicators or the technical detail in quite a few instances whether this will be practical. Unless this is done local spatial planning, Local Development Frameworks and neighbourhood plans will not have the evidence and the actionable insights with which to effectively address health issues.

Where possible there should be analysis by age, gender, ethnicity and other equalities groups.

Domain 1

A definition of the scope of health protection would have been helpful and would have underpinned the indicators. Climate change should be considered as a health protection issue but is not addressed. Food quality and safety may also be an issue, which has national and local dimensions and is a factor in inequality.

There needs to be a clear boundary between national action and local intervention. Locally generated indicators such as air quality should be mapped and inequalities between areas measured.

It is not clear that life years lost through a measure of particulate matter is robust. Many conditions such as coronary heart disease and asthma are exacerbated by poor air quality. Those events may not therefore be captured by this measure.

It is not clear what a ‘sustainable development management plan’ is or how it relates to this domain.

Domain 2

This indicator set suffers from a failure to adopt a conceptual model to generate indicators from the social determinants of health. The result is that it is not clear why these indicators have been suggested. Further advice is given above as to an alternative high level set based on the ‘health map’.

It is arguable whether killed and seriously injured casualties on England’s roads (KSI) is a social determinant or is more properly listed under Domain 1. KSI demonstrates a high level of inequality and yet typically this dimension is not captured by highway authorities.

Domain 3

This set would benefit from a clear definition of health improvement and its scope.
Physical activity, mental health, access to fresh and good quality food are not fully reflected in the proposed indicators.

Domain 4

This domain suffers from a lack of a conceptual model. There is significant overlap with domain 3. Obesity and, for instance, rates of bariatric surgery or weight-related medication might be considered as an indicator in this set, just as healthy weight is included in domain 3.

Domain 5

There needs to be read across to the Vision in that life expectancy is an important indicator relating to domain 5. The dimension of inequality as expressed in this set is not strong or even obvious, as in others. The technical detail does not reassure. KSI for under 15s or 21s would be a possible indicator given that it is the leading cause of death in some younger age groups.

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)

Incentivisation should take account of:

- The degree of influence – it is counterproductive to allocate resources where the degree of influence over an indicator is insignificant
- The balance between short term and the long term
- Broadly speaking, high level but realistic indicators that demonstrate wellbeing as distinct from symptomatic impacts.

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?

The whole framework should be designed so that there is a high degree of integration between different spheres. GPs and clinicians should be making full use of public health interventions to ameliorate and prevent ill health.

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

The coverage of each aspect of the life course is adequate, however unless the life course is embedded in the system as a specific mode of analysis the impact will be reduced, as the life course ‘effects’ would not overtly be monitored. It may therefore be desirable to require a ‘life course impact evaluation’ as part of some annual review.