Royal College of Psychiatrists

Consultation Response

DATE: 31 March 2011

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS and RETHINK

RESPONSE TO: *Healthy Lives, Healthy People* consultation on Transparency in Outcomes: Proposals for a Public Health Outcomes Framework

- The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

- Rethink works to help everyone affected by severe mental illness recover a better quality of life. We are a campaigning organisation and the largest voluntary provider of mental health services. We help over 52,000 people every year through our face-to-face services, and our advice and helpline services receive over 40,000 calls. We endorse the recommendations made by the Royal College of Psychiatrists for the Public Health Outcomes Framework.

We are pleased to respond to this consultation. This consultation was prepared by Dr Kam Bhui, Dr Jonathan Campion, Rethink and Richard Meier from the Policy Unit at the College.

This consultation was approved by: Dr Laurence Mynors-Wallis, Registrar

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Consultation response to *Healthy Lives, Healthy People* consultation on Transparency in Outcomes: Proposals for a Public Health Outcomes Framework

Summary

The Royal College of Psychiatrists welcomes the Public Health Outcomes Framework and believes that it will work most effectively if it is simple, concise and is truly focused on outcomes rather than processes. However, at a time of such significant financial pressures, the College is concerned that there may not be sufficient resources to fund these good intentions. The College recognised that this represents a major change and upheaval for public health and recommends that a reasonable period of time is allowed to see whether these changes have been effective before any further restructuring is carried out.

A general criticism the College has of the draft framework however is that it makes far too little mention of mental health. This, we believe, is a major oversight given that the mental state, psychological wellbeing and inherited psychological makeup transmitted from parents through experience of parenting are all important in preventing future ill-health. Key public mental health outcomes that the College would like to see are:

- Reductions in the rate of mortality rate of people with mental illness
- More people with mental illness in employment
- Reduced prevalence of maternal smoking
- Reduction in smoking rate of people with serious mental illness
- Improved health-related quality of life for older people
- Reduction in the suicide rate
- Increased levels of resilience in children and young people
- Reduction in alcohol-related problems and other addictions
- Reduced levels of stigma related to mental illness

We therefore feel that the absence of sufficient attention to mental illness and mental health in the outcome framework renders the current public health strategy as a whole less effective, since it fails to address an important determinant of human behaviour and one of their most important that links behavioural change with better health outcomes. We feel that, were these concerns to be adequately addressed then the framework and overall strategy could be effective.

Response to questions

Q1. 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?

One option would be for the outcomes framework to be used as a menu which health and wellbeing boards can choose from (i.e. choose those outcomes which directly reflect the local needs). This can be communicated to the centre which can then help in directing and reviewing progress made on these outcomes.

Q2. Do you feel these are the right criteria to use in determining indicators for public health?

The Colleges welcomes the criteria by which outcome indicators are to be assessed; however, criteria 2 and 3 depend on the level of evidence available and also whose priorities and values dominate in the discussion about what is important. Where there is a lack of evidence, or where the evidence is contested, there should be some capacity to include proxy outcomes for areas of performance that are important. Research is essential in this area and pilots should be set up rather than expensive intervention programmes and implementation programmes which are unlikely to yield benefit.

The general issue of levelling up across all health is important but there has to be some recognition that this might lead to sustained or widened inequalities; it is not clear what the document aims to achieve: levelling up of all health outcomes, reducing the inequalities in which case specific attention needs to be put on this, or is it about preventing widening of inequalities.

As far as frequency goes (i.e. penultimate bullet point on page 11), it is worth remembering that the most burdensome disorders to the society are long-term conditions (including mental disorders) and therefore any reporting of outcome data on a quarterly basis will not indicate significant improvement within such a short time span.

Q3. 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?

Although the Marmot review is referred to, there seems not to be sufficient attention to the social determinants of ill-health within the Outcomes Framework, for example, work, finances and housing. Thus, while the College welcomes the focus on major causes, the impacts of health inequality disease and premature mortality, the draft framework lacks sufficient attention to mental health and wellbeing, to mental capital and mental illness specifically. These all interact and are central to healthy lifestyles and behavioural changes, in prevention and intervention. As yet the document is poor at outlining how these issues will be addressed in the Outcomes Framework.

Public health directors will need to identify and explore factors contributing to health inequality in a local authority catchment area. This intelligence will then inform the prioritisation of local projects, and the outcomes framework will have to take in to account the goals set by such projects. This means that there will have to be a bidirectional movement in terms of outcomes with the

local authorities being offered outcomes on health issues on a national basis, whilst local authorities through health and wellbeing boards informing the centre about the locally agreed outcomes.

In spite of the proposal to introduce a health premium, the College remains concerned that those areas which are poorest and with the greatest need will continue to lag and, therefore, that the whole strategy might compound inequalities unless those in the poorest areas or the poorest performing areas are given specific targeted interventions and have adequate resources.

The College feels that a system of measurement needs to be put in place to allow for review of performance against the outcomes put forward in the framework. There will need to be a mechanism for identifying oversights, for example inequalities being compounded. The College would like to see a specific set of outcomes for inequalities by age, gender and ethnicity.

Q4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

It is clear that NHS, social care and public health have to align their outcomes and programmed activity to achieve a reduction in health inequalities, and the College welcomes the ambitious but sensible explanation contained in the consultation which recognises the overlap between areas of endeavour.

Given this overlap, health and wellbeing boards will have a huge responsibility to interact with public health commissioners and GP consortia to ensure that outcomes are achieved through buying in pathways for each disorder across preventive to tertiary care (including social care) rather than focusing on individual components of care.

However, the comparative diagram of different outcome frameworks is partial; education for children, children's wellbeing and parenting are omitted, for

example, and for social care within the NHS housing, environment, heating, noise and social support are all omitted. The focus taken in the document is narrowly health-related and risks failure as it will not address the wider social determinants.

Q5. Do you agree with the overall framework and domains?

Mental illness and health need specific mention as the most significant causes of disability associated with high levels of co-morbidity and mortality.

The College supports the overall framework. However, it believes that if the desired improvements to public health are to be realised then health and wellbeing boards will need to be able to derive and deliver their sets of outcomes based on their local inequalities, rather than be required to conform to the national framework.

The health protection and safety elements appear to be overstated in comparison to resilience which seems to be silent throughout the document. More attention needs to be put on resilience, perhaps with a separate domain – resilience, mental capital and wellbeing as the domain between domains 1 and 2. Domains 4 & 5 largely appear to be very similar and could be merged.

Q6. Have we missed out any indicators that you think we should include?

None of the proposed indicators for Domain 1 - 'Health Protection and Resilience' - relate to mental health and it seems therefore that the resilience to which the domain refers to does not include emotional resilience (see previous point in answer to question 5). The College believes that this is a major oversight and recommends that an indicator(s) of child, adolescent or adult resilience be added.

Mental health also is a key determinant of health risk behaviours and healthy lifestyles and, therefore, should be mentioned separately in domain 2. In domain 3, is there sufficient evidence to suggest healthy weight at the age 4 and 5 is important, rather than 10 or 11? Similarly, in adults, should we not be looking at specific critical points, for example 18, 40 and say 55, knowing that unless weight is managed prior to retirement it is unlikely to settle after retirement?

We believe that Domain 3 might also include work stress, unexplained medical complaints and additional indicator of prescribed medication (and the type so that costs can be allocated).

Under domain 4, suicide attempts should be included as well as the rate of hospital admissions as a result of self harm. Unexplained medical complaints should also be included. Under item 49 (bottom of page 23) the elderly are again omitted; it is important that the strategy does not compound inequalities by age.

Finally, the College believes that a measure of the uptake of public health interventions should be developed and included.

Q7: 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?

As the Royal College of Psychiatrists, we would rank all the following indicators as the most important (with those we feel are most crucial in bold):

Domain 2: Proportion of people with mental illness and or disability in employment
Domain 4: Maternal smoking prevalence (including during pregnancy)
Domain 4: Smoking rate of people with serious mental illness

Domain 4: Health-related quality of life for older people
Domain 5: Suicide rate
Domain 5: Mortality rate of people with mental illness by different health conditions
Domain 2: Proportion of people with mental illness and or disability in settled accommodation
Domain 2: Social connectedness
Domain 3: Self-reported well-being
Domain 4: Rate of hospital admissions as a result of self-harm
Domain 4: Breastfeeding initiation and prevalence at 6-8 weeks after birth
Domain 4: Child development at 2-2.5 years

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

No comment.

Q9: How can we improve indicators we have proposed here?

The College believes that, if adequately validated, measures of social connectedness should be used for all age groups (and that this would be more appropriate / effective than *Perceived community safety* suggested in Domain 2).

The College believes that the proposed indicators for Domain 3 - *Number leaving drug treatment free of drug(s) dependence* – should be changed to one(s) which relate to the employment/benefit use and/or housing status of people treated for drug-dependence as this will provide a much better measure of the effectiveness of these services in enabling patients to lead more constructive and productive lives.

Regarding the proposal for an indicator on *Self-reported wellbeing*, the College feels that it cannot recommend either the Warwick-Edinburgh Scale or the EQ-

5D at this stage. These instruments measure different things, and we suggest that, instead, a specific project or scoping exercise, or evidence synthesis, be undertaken to identify an appropriate instrument. Possible instruments which we feel this process might explore include the Manchester Short Assessment of **Quality of Life** and the Lancashire Quality of Life Profile.

Regarding the proposed indicator, *Rate of hospital admissions as a result of self-harm,* the College believes that presentations at A&E would be a better indicator. Most people who go to hospital for self-harm are likely to go through A&E; if, therefore, the indicator is trying to capture the number of people self-harming as a measure of the level of seriousness of mental distress, presentations at A&E would be a better indicators since relatively few who go to A&E are then admitted to a hospital bed.

However, an even better indicator would be the number of people attending hospital (general hospital and A&E) who receive a psychosocial assessment (as required by the NICE guideline) because research shows that the prognosis is better when this takes place and that there are fewer repeat episodes from people who have had a psychosocial assessment.

While the College welcomes the general thinking behind the proposal for an indicator on *Child development at 2-2.5 years*, it believes that using a tool to measure child development and emerging social-emotional problems at an earlier age would be more effective in terms of potential early intervention work with children and families where concerns are identified. To this end the College believes that an evidence-based review should be undertaken to identify a suitable tool (and would be interested in hosting such a process).
The College welcomes the proposal to include the indicator: *Smoking rate of people with SMI using the Adult Psychiatric Morbidity Survey*. However, this survey is only conducted every seven years, and we therefore recommend that it is carried out more frequently, or that an alternative (and more frequent)

method of capturing this data is identified (e.g. Mental Health Minimum Data Set or National Morbidity Survey) or developed.

Regarding the proposed indicator, *Emergency readmissions to hospitals within 28 days of discharge*, the College has concerns that bed pressures may make this indicator unrealistic given detention rates are going up despite better community services.

The College welcomes the proposal to include the indicator *Health-related quality of life for older people*. However, it believes that similar measures for children and young people, and adults should also be included. Attention to the elderly is somewhat missing, indeed, even the imposition of an age range of 75 for some of the indicators I think would suggest that despite growing life expectancy, many people going into old age, into their 80s and 90s, are not included.

Suicide rates should be shown by age, gender, ethnicity and income levels.

Q10. Which indicators do you think we should incentivise? (Consultation on this will be through the accompanying consultation on public health finance and systems)

Given that different areas will face different challenges, any incentivisation of indicators should be particular and appropriate to an individual area/locality, rather than a top-down, blanket approach from the Department of Health

Q11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

No comment.

Q12: How well do the indicators promote a life-course approach to public health?

No comment

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