FPH response to the NHS consultation on Performance Assessment

This response is submitted on behalf of the UK Faculty of Public Health (FPH, the Faculty), as developed by the Health Services Committee. The FPH, as part of the medical Royal College arrangements, is the standard-setting body for public health in the UK and professional home for over 5,000 members of the public health workforce. We advocate on key public health issues and have a strong mandate and responsibility to ensure that the essential functions, standards and resources of a robust public health system are maintained. Our role is to improve the health and wellbeing of local communities and national populations. We do this by supporting the training and development of the public health workforce and improving public health policy and practice in partnership with local and national governments in the UK and globally.

1. **To what extent do you agree or disagree that the proposed approach set out in the draft NPAF offers an objective and consistent approach to assessment?**

Somewhat agree.

The Faculty supports a drive for consistency as important to underpin fairness, transparency and equity in allocation, delivery and population outcomes from health services. The emphasis of that consistency is equally important in achieving the best health outcomes. The emphasis in this framework is pointing towards financial balance as the prime consideration of high achievement. Whereas patient and public functional outcomes and quality and safety of care are in the Faculty's view, of equal importance.

2. **To what extent do you agree that NHS England's assessment of ICB and provider capability should be used to inform how we support organisations to improve but that it should not influence segmentation?**

Somewhat disagree.

As above, if financial considerations over-ride others, the impact of ICBs on the ICS success, or the equitable allocation of health care to their populations, or better than expected health outcomes, will take a less important role and the contribution of these dimensions (important in the Model ICB) will be under-rated.

3. **To what extent do you agree that ICB segmentation should continue to consider system performance?**

Strongly agree.

Population health outcomes and equitable distribution of healthcare as measures of performance should be key to ICB segmentation. However, as we discuss in question 7, we have concerns about the proposed content of system performance.

4. To what extent do you agree that segments 1 and 2 should be limited to organisations achieving financial balance (surplus or breakeven)?

Strongly disagree.

Please see the answer to question 3.

5. To what extent do you agree a shorter list of measures for 2025/26 will simplify the framework and allow a clearer focus on operating priorities consistent with the reset agenda?

Strongly disagree.

The Faculty appreciates the need for a shorter list and a reduction of the burden on organisations. Segmentation is being positioned as a statement of high performance or excellence so the values and inputs that drive those judgements become important. The proposed list is heavily dependent on throughputs and finance. Such 'productivity' does not measure excellence in health care, the complexity of current patient needs, equitable health outcomes, or even the aims of the NHS Constitution. The list is heavily acute focussed (and as number crunching goes, much of it will probably not motivate clinicians there). The narrowness does not reflect the reality of quality or indeed the motivation of staff to improve. Yet the government wants to see more about prevention, shifts to community and smarter use of technology.

ICS's thrive on an integrated approach to care, and the individual items on this performance list focus on the opposite. That said, the Faculty welcomes the inclusion of hypertension measures, infection control in hospitals, neonatal statistics, crisis response in mental health and diabetes control.

We are concerned about the loss of several key health measures:

- Percentage of eligible patients to receive cervical screening
- Percentage of eligible patients to receive breast screening
- Percentage of eligible patients to receive bowel screening
- Percentage of pregnant women supported to quit smoking
- Percentage of inpatients referred to stop smoking services
- Percentage of patients supported by obesity programmes
- Deprivation and ethnicity gap in pre-term births
- Deprivation gap in early cancer diagnosis
- Deprivation gap in myocardial infarction and stroke admissions
- Percentage of patients with serious mental illness to receive an annual healthcheck
- Percentage of patients on GP learning disability registers to receive an annual healthcheck
- Flu vaccination in staff,
- MMR2 uptake at five years of age,
- Antibiotic prescribing in children

This is a significant loss, and it is not clear what policy was pursued in omitting so much – or indeed how the meagre measure that were included were decided upon. In general, the population health measures in primary care are weak in this framework.

We note the absence of any pointer to a greener NHS. Many of the actions to promote a green NHS directly improve patient care and health and wellbeing and are supported by significant numbers of clinicians in the relevant specialties such as respiratory medicine and anaesthetics.

6. **Do you have any comments about the proposal and the impact on advancing equalities and/ or reducing health inequalities?**

Somewhat agree.

As discussed in previous questions, the measures of health are a very thin segment of framework and the segmentation proposed is based on financial considerations. Consequently, how the benefits of health care are distributed equitably will be opaque in this framework. Screening and immunisations are sensitive indicators of inequalities– with mobile and disadvantaged populations at risk of poor coverage and therefore uptake.

Cardiovascular disease and its risk factors are most prevalent in underprivileged groups in the UK. Vaccine hesitancy is particularly stark in certain NHS staff groups – again the dropping of flu vaccine will obscure efforts to overcome this. What is left of the health measures in primary care could provide benefits to populations at highest risk if targeted as such. Universal approaches to community risks do not address inequalities in health adequately. Alongside the changes in remuneration in the QoF in primary care, inequalities unmitigated by needed health care remain a concern of this Faculty.