CABINET MEMBER FOR HEALTH AND WELLBEING

Venue: **Town Hall, Moorgate Street, Rotherham S60 2TH**

Date: **Monday, 13th February, 2012**

Time: **11.30 a.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested, in accordance with the Local Government Act 1972 (as amended March 2006).

2. To determine any item which the Chairman is of the opinion should be considered later in the agenda as a matter of urgency.

3. Minutes of meeting (Pages 1 - 4)

4. Health and Wellbeing Board
   - verbal report on any issues arising from the last Board meeting

5. Public Health Outcomes Framework for England 2013-2016 (Pages 5 - 59)

6. Smoking Cessation Service Annual Report (Pages 60 - 74)
   - Simon Lidster to report, Rotherham NHS Stop Smoking Service

7. Conferences
   - Deaths, Funerals and Coroners – Past, Present and Future
   6th March, 2012
   London

(The Chairman authorised consideration of the following item to enable Members to be fully informed)

8. Keeping Warm in Yorkshire and Humber: Briefing Document (Pages 75 - 76)

CABINET MEMBER FOR HEALTH AND WELLBEING
Monday, 16th January, 2012

Present:- Councillor Wyatt (in the Chair); Councillors Buckley, Jack, Pitchley and Steele.

An apology for absence was received from Councillor Burton.

K38. MINUTES OF PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 5th December, 2011, be approved as a correct record.

Arising from Minute No. 35 (British Heart Foundation Heart Town), it was noted that the community pledge was to be signed on 18th January, 2012.

K39. HEALTH AND WELLBEING BOARD

It was noted that the next Board meeting was to be held on 18th January, 2012, the agenda for which included:-

Cold Weather Plan
CYPS Programme
NHS Operating Framework and the new Outcomes Framework
Work Programme for the Board

Councillor Jack raised the issue of PIP breast implants and the confusion and conflicting messages in the media. Jo Abbott, Consultant in Public Health, reported that the national position was that if an implement had been carried out on the NHS it would be removed by the NHS if found to be causing problems; if the procedure had been carried out by a private provider then it was for that provider to correct. The Cluster Medical Director was currently looking at issuing a statement setting out Rotherham's position.

The current policy for Rotherham NHS was that they would be removed but not reinserted. Obviously this was not the case for those who had had a Mastecomy.

Resolved:- That the issue be raised at the Health and Wellbeing Board.

(Councillor Jack declared a personal interest in the above item)

K40. NHS HEALTH CHECK/MAKING EVERY CONTACT COUNT

Sally Jenks, Public Health Specialist, Department of Public Health, gave the following powerpoint presentation:-

What is the NHS Health Check?

– 'The purpose of the NHS Health Check is to identify an individual's risk of cardiovascular disease, for this risk to be communicated in a way that the individual understands and for that risk to be managed by appropriate lifestyle advice, referral and clinical follow-up'

The annual performance for the NHS Health Check Programme is:-

- 20% of the eligible population annually invited for screening
- 18% coverage rte per annum (commencing April 2012)
- A total of 90% of the eligible population screened at 5 years (by march 2017)

In Rotherham

- 25,283 screens plus an explanation of risk recorded had been carried out (38% of the eligible population)
- Practices received a payment of £10 for every patient with a risk score and explanation of risk recorded, rising to £24.20 for every patient above 45% of the eligible practice population
- 13 Rotherham practices had exceeded the 45% threshold for NHS Health Check

What the NHS Health Check is telling us

- 16% of screened patients have a CVD risk of >20%
- Of the patients with a >20% risk
  70% were overweight or obese
  35% were moderately inactive or inactive
  31% were current smokers
- 47% of patients with a >20% risk of CVD had been prescribed statins

The Future

- Commissioning arrangements from April, 2013 which were expected to reflect the following 2 components
  - Public Health would be responsible for commissioning and contract managing the identification of the population and screen element
  - The management of the risk would be the responsibility of the GP commissioning process
- Quality assurance
- NHS Health Check organised as a screening programme commencing April, 2012 – 5 year call and recall (2016/17)
- Making Every Contact Count – staff competence

Making Every Contact Count – What is it all about?

- Industrialising behaviour change
- Supporting clients to make healthier lifestyle choices/change behaviour
- Competence Framework
- The Self-Assessment Tool

Person Centred

- One of the main principles of MECC was to work with individuals and communities from their perspective
- This meant being responsive and offering advice tailored to individual circumstances
- Not only was this likely to be more effective, it would make advice and support services more accessible and meaningful for the individual

Better for Less

- The approach used the every day contact people already had with services

to offer brief advice and guidance
- Training and preparing staff to Make Every Contact Count would 'build in' the ability of more and more staff to offer brief advice and interventions to help people

Discussion ensued on the presentation with the following suggestions made:-

- Involve the British Heart Foundation Heart Town
- Contact all Parish Councils for inclusion in their Parish Newsletters

Resolved:- That the presentation be noted.

K41. THE ROTHERHAM OLYMPICS 2012

Sally Jenks, Public Health Specialist, Department of Public Health, gave the following powerpoint presentation:-

The Rotherham Olympics 2012
There had never been a better time to harness the opportunity
- Physical activity participation
- Green spaces
- Play spaces
- The cultural Olympiad

Exciting Opportunities
- Using our local resource to increase participation rates
- Innovation and re-invigoration
- Collaborative working

Potential areas identified
- Events and activities
- Volunteering
- Tickets
- Schools
- Community cohesion
- Torch relay
- Health improvement

Their Friends in the North
- Collaboration with Barking % Dagenham
- Networking schools
- Virtual competitions
- Reciprocal visits
- Sharing best practice
- Linking up the Public Health Team

Discussion ensued on the presentation. The Chairman reported that there was to be a major announcement shortly with regard to the funding available throughout the country through Sport England. The South Yorkshire Sports Partnership, of which Rotherham was a member, had already been allocated substantial funding.

Schools had already commenced their Olympic themes which funding had been received for.

Resolved:- That the presentation be noted.

K42. UPDATE ON SEASONAL VACCINATION PROGRAMME

Jo Abbott, Public Health Consultant, presented an update on the seasonal vaccination programme as at 1st January, 2012.

In 2010/11 the vaccination programme had been extended to include pregnant women (regardless of underlying health problems) as part of the routine cohort. The groups included were:-

- People over the age of 65 years
- People 6 months to 65 years with chronic or long term conditions
- People living in long stay care facilities e.g. care homes
- Carers
- Pregnant women (any stage of pregnancy)
- Frontline health and social care staff.

Whilst the programme was delivered primarily through GPs, alternative providers had been commissioned. Rotherham Foundation Trust had identified 2 Midwives who would administer a vaccination programme in Greenoaks from the beginning of January and District Nurses would continue to vaccinate patients (and their partners if present) on their caseload.

Whilst Community and Primary Care Indicators and influenza like illness consultations remained relatively low at the present time, within seasonally expected levels, an increase could not be ruled out. It was, therefore, essential that as many vulnerable people as possible were vaccinated before significant levels of flu were circulating.

It was noted that Council staff classed as front line social care were eligible for the flue vaccination, information on which was included on Team Briefings.

Resolved:- That the report be noted.

K43. CONFERENCE

Resolved:- (1) That the Chairman (or substitute) be authorised to attend the LGA Public Health Annual Conference 2012 – Political and Managerial Leadership in Public Health – to be held on 28th February, 2012, in London.

(2) That the conference costs be met externally.

Department of Health

The Public Health Outcomes Framework for England, 2013-2016

The responsibility to improve and protect our health lies with us all – government, local communities and with ourselves as individuals.

There are many factors that influence public health over the course of a lifetime. They all need to be understood and acted upon. Integrating public health into local government will allow that to happen – services will be planned and delivered in the context of the broader social determinants of health, like poverty, education, housing, employment, crime and pollution. The NHS, social care, the voluntary sector and communities will all work together to make this happen.

The new framework

The new Public Health Outcomes Framework that has been published is in three parts. Part 1 introduces the overarching vision for public health, the outcomes we want to achieve and the indicators that will help us understand how well we are improving and protecting health. Part 2 specifies all the technical details we can currently supply for each public health indicator and indicates where we will conduct further work to fully specify all indicators. Part 3 consists of the impact assessment and equalities impact assessment.

Informed by consultation

We received many responses to our consultation on outcomes. There was widespread welcome for our approach, including the focus on the wider determinants of health combined with many constructive proposals for improving it. In this framework, we also bring further clarity to the alignment across the NHS, Public Health and Adult Social Care Outcome Frameworks, while recognising the different governance and funding issues that relate to these.

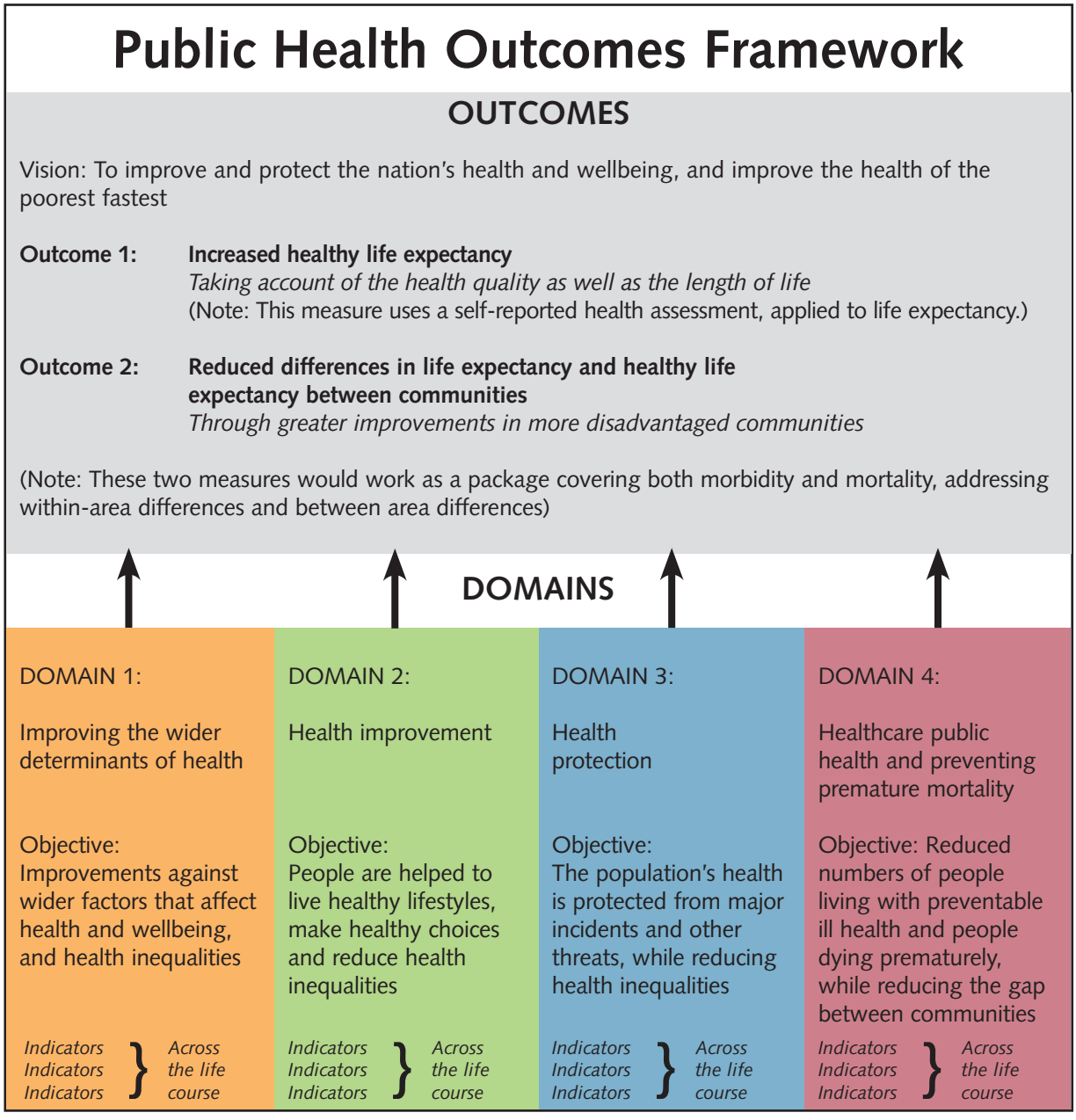
In *Healthy Lives, Healthy People: Update and way forward* the Government promised to produce a number of policy updates setting out more detail on the new public health system. The Public Health Outcomes Framework is part of this series of updates that set out what we would want to achieve in a new and reformed public health system.

The framework follows on from two preceding web-based updates in the series on the roles and function for local government and the Director of Public Health, and how Public Health England will support all parts of the new system to improve and protect the public's health.

The whole system will be refocused around achieving positive health outcomes for the population and reducing inequalities in health, rather than focused on process targets, and will not be used to performance manage local areas.

The Public Health Outcomes Framework sets the context for the system, from local to national level. The framework will set out the broad range of opportunities to improve and protect health across the life course and to reduce inequalities in health that still persist (see graphic below).

Much of the proposed new public health system that is described in the document depends on the provisions of the Health and Social Care Bill, which has yet to be passed by Parliament.



High-level outcomes

The framework focuses on the two high-level outcomes we want to achieve across the public health system and beyond.

These two outcomes are:
- increased healthy life expectancy
- reduced differences in life expectancy and healthy life expectancy between communities.

These outcomes reflect the focus we wish to take, not only on how long we live – our life expectancy, but on how well we live – our healthy life expectancy, at all stages of the life course.

Our second outcome focuses attention on reducing health inequalities between people, communities and areas in our society. We are using both a measure of life expectancy and healthy life expectancy so that we are able to use the most reliable information available to understand the nature of health inequalities both within areas and between areas.

Produced: January 2012
Gateway reference: 16891

While we will be able to provide information on the performance against both these outcomes, the nature of public health is such that the improvements in these outcomes will take years – sometimes even decades – to see marked change.

So we have developed a set of supporting public health indicators that help focus our understanding of how well we are doing year by year nationally and locally on those things that matter most to public health, which we know will help improve the outcomes stated above.

These indicators are grouped into four domains:
- improving the wider determinants of health
- health improvement
- health protection
- healthcare public health and preventing premature mortality.

Indicators have been included that cover the full spectrum of what we understand public health to be, and what we can realistically measure at the moment.

We intend to improve this range of information over the coming year and we have set out in this document how we intend to do that, with the continued engagement and involvement of our partners at the local and national levels.

This framework focuses on the respective role of local government, the NHS and Public Health England, and their delivery of improved health and wellbeing outcomes for the people and communities they serve.

Department of Health

Improving outcomes and supporting transparency

Part 1: A public health outcomes framework for England, 2013-2016

DH INFORMATION READER	
Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning / Clinical	Finance
	Social Care / Partnership Working

Document Purpose	Policy
Gateway Reference	16891
Title	Healthy Lives, Healthy People: Improving outcomes and supporting transparency
Author	DH/HIPD/PHDU
Publication Date	January 2012
Target Audience	PCT CEs, Directors of PH, Local Authority CEs, Directors of Adult SSs, GPs, Communications Leads, Directors of Children's SSs, Public Health Professionals
Circulation List	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs, Public Health Professionals
Description	This update sets out a new Public Health Outcomes Framework. In three parts, Part 1 - this document - introduces the overarching vision for public health, the outcomes we want to achieve and the indicators that will help us understand how well we are improving and protecting health. Part 2 specifies all the technical details we can currently supply for each public health indicator and indicates where we will conduct further work to fully specify all indicators, and Part 3 consists of the Impact Assessment and Equalities Impact Assessment.
Cross Ref	Healthy Lives, Healthy People: Our Strategy for Public Health in England, Healthy Lives, Healthy People: Update and way forward
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
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For Recipient's Use	

Contents

Executive summary

The responsibility to improve and protect our health lies with us all – government, local communities and with ourselves as individuals.

There are many factors that influence public health over the course of a lifetime. They all need to be understood and acted upon. Integrating public health into local government will allow that to happen – services will be planned and delivered in the context of the broader social determinants of health, like poverty, education, housing, employment, crime and pollution. The NHS, social care, the voluntary sector and communities will all work together to make this happen.

The new Public Health Outcomes Framework is in three parts. Part 1 – this document – introduces the overarching vision for public health, the outcomes we want to achieve and the indicators that will help us understand how well we are improving and protecting health. Part 2 specifies all the technical details we can currently supply for each public health indicator and indicates where we will conduct further work to fully specify all indicators. Part 3 consists of the impact assessment and equalities impact assessment.

We received many responses to our consultation on outcomes. There was widespread welcome for our approach, including the focus on the wider determinants of health combined with many constructive proposals for improving it. In this framework, we also bring further clarity to the alignment across the NHS, Public Health and Adult Social Care Outcome Frameworks, while recognising the different governance and funding issues that relate to these.

In *Healthy Lives, Healthy People: Update and way forward* the Government promised to produce a number of policy updates setting out more detail on the new public health system. The Public Health Outcomes Framework is part of this series of updates that set out what we would want to achieve in a new and reformed public health system. The framework follows on from two preceding web-based updates in the series on the roles and function for local government and the Director of Public Health, and how Public Health England will support all parts of the new system to improve and protect the public's health.

The whole system will be refocused around achieving positive health outcomes for the population and reducing inequalities in health, rather than focused on process targets, and will not be used to performance manage local areas. This Public Health Outcomes Framework sets the context for the system, from local to national level. The framework will set out the broad range of opportunities to improve and protect health across the life course and to reduce inequalities in health that still persist.

Much of the proposed new public health system which is described in this document

depends on the provisions of the Health and Social Care Bill, which has yet to be passed by Parliament.

The framework will be focused on the two high-level outcomes we want to achieve across the public health system and beyond. These two outcomes are:

1. Increased healthy life expectancy.

2. Reduced differences in life expectancy and healthy life expectancy between communities.

These outcomes reflect the focus we wish to take, not only on how long we live – our life expectancy, but on how well we live – our healthy life expectancy, at all stages of the life course. Our second outcome focuses attention on reducing health inequalities between people, communities and areas in our society. We are using both a measure of life expectancy and healthy life expectancy so that we are able to use the most reliable information available to understand the nature of health inequalities both within areas and between areas.

While we will be able to provide information on the performance against both these outcomes, the nature of public health is such that the improvements in these outcomes will take years – sometimes even decades – to see marked change. So we have developed a set of supporting public health indicators that help focus our understanding of how well we are doing year by year nationally and locally on those things that matter most to public health, which we know will help improve the outcomes stated above.

These indicators are grouped into four domains:

> improving the wider determinants of health

> health improvement

> health protection

> healthcare public health and preventing premature mortality.

Indicators have been included that cover the full spectrum of what we understand public health to be, and what we can realistically measure at the moment. We do intend to improve this range of information over the coming year and we have set out in this document how we intend to do that, with the continued engagement and involvement of our partners at the local and national levels.

Attending to these outcomes will require the collective efforts of all parts of the public health system, and across public services and wider society. This framework focuses on the respective role of local government, the NHS and Public Health England, and their delivery of improved health and wellbeing outcomes for the people and communities they serve.

1. Introduction: improving outcomes across a locally-led system

The new public health system

1.1 The Government is creating a new, integrated and professional public health system designed to be more effective and to give clear accountability for the improvement and protection of the public's health. The new system will embody localism, with new responsibilities and resources for local government, within a broad policy framework set by the Government, to improve the health and wellbeing of their populations. It will also give central government the key responsibility of protecting the health of the population, reflecting the core accountability of government to safeguard its people against all manner of threats.

1.2 Public Health England will be the new national delivery organisation of the public health system. It is being set up to work with partners across the public health system and in wider society to:

> deliver support and enable improvements in health and wellbeing in the areas set out in this outcomes framework

> design and maintain systems to protect the population against existing and future threats to health.

1.3 The NHS will remain critical to protecting and improving the population's health. It will be charged with delivering some public health services, and with promoting health through all its clinical activity, striving to use the millions of patient contacts that take place each day as opportunities to promote healthier living – "making every contact count"[1].

1.4 The NHS clinical contribution is therefore central. But outside the clinical arena the key responsibility for improving the health of local populations, including reducing health inequalities, will rest with democratically accountable upper tier and unitary local authorities. The Health and Social Care Bill will, subject to Parliament, give each unitary and upper tier local authority the duty to "take such steps as it considers appropriate for improving the health of the people in its area". Elected Members in local authorities will take on leadership for

1 The NHS Future Forum will report in January on the best way for the NHS to contribute to improving the public's health.

public health at the local level. Local authorities will set up statutory health and wellbeing boards to drive local commissioning and integration of all health services, based upon local needs, giving new opportunities to improve the health and wellbeing of local communities right across the life course.

1.5 Local authorities will commission public health services on their populations' behalf, resourced by a ring-fenced grant, and put health and wellbeing at the heart of all their activity. They will also take on key roles in supporting the public health system as a whole: thus they will be responsible for ensuring that there are robust plans in place to protect the health of their populations, and will support the NHS with public health advice on clinical commissioning, ensuring that the needs of the whole population are driving local clinical commissioning. Directors of Public Health will be appointed to be the key health adviser for local authorities and to exercise these new functions on their behalf; they will also be statutory members of health and wellbeing boards. Last but not least, Public Health England will support and advise Directors of Public Health and local authorities across the range of their responsibilities to help ensure consistency and excellence across the public health system, for example through a single authoritative web portal on public health information and evidence.

1.6 In this new system, the Secretary of State for Health sets the strategic direction, through this, the first-ever Public Health Outcomes Framework, and through leading for health across government. The Cabinet Sub-Committee on Public Health, which the Secretary of State chairs, brings together key departments to consider how to promote public health, including tackling health inequalities. The Secretary of State will incentivise delivery of some outcomes through a health premium, and will also allocate ring-fenced public health budgets to local authorities. Public Health England will support the Secretary of State in considering how the Government can best achieve its strategic objectives across the system, working in partnership with local government and the NHS.

1.7 The development of this framework has depended on the committed input from colleagues working across the public health system. We are thankful for the support and contributions of Chris Bull, chief executive of Herefordshire County Council and Herefordshire NHS, and the Public Health Engagement Group for their assistance in developing the framework and across the series of policy updates.

2. A new framework for public health outcomes

2.1 In this section, we provide further details on our vision for a new Public Health Outcomes Framework, one that supports the whole public health system, reflecting the responses received during the public health consultation exercise and the Listening Exercise. In July, we published a summary of the responses received to our consultation document *Healthy Lives, Healthy People: Transparency in Outcomes* as part of the overall consultation response. The outcomes framework set out in this document has been shaped by these responses.

Overarching outcomes, domains and indicators

2.2 The Public Health Outcomes Framework consists of two overarching outcomes that set the vision for the whole public health system of what we all want to achieve for the public's health. The outcomes are:

> increased healthy life expectancy, ie taking account of the health quality as well as the length of life

> reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)[2].

2.3 This framework is not just about extending life: it also covers the factors that contribute to healthy life expectancy, including, importantly, what happens at the start of life and how well we live across the life course. The two outcomes together will underpin our overall vision to improve and protect the nation's health while improving the health of the poorest fastest.

2.4 Therefore, these outcomes will be delivered through improvements across a broad range of public health indicators grouped into four domains relating to the three pillars of public health: health protection, health improvement, and healthcare public health (and preventing premature mortality); and improving the wider determinants of health.

2.5 The diagram overleaf sets out a model for understanding the Public Health Outcomes Framework.

2 Healthy life expectancy is used as the key headline measure to reflect our focus on morbidity as well as mortality. Life expectancy is also included in the second outcome to enable us to measure within-area inequalities as well as between-area inequalities in health (it is not feasible to collect data on within-area differences in healthy life expectancy).

Public Health Outcomes Framework

OUTCOMES

Vision: To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest

Outcome 1: **Increased healthy life expectancy**
Taking account of the health quality as well as the length of life

(Note: This measure uses a self-reported health assessment, applied to life expectancy.)

Outcome 2: **Reduced differences in life expectancy and healthy life expectancy between communities**
Through greater improvements in more disadvantaged communities

(Note: These two measures would work as a package covering both morbidity and mortality, addressing within-area differences and between area differences)

DOMAINS

DOMAIN 1:	DOMAIN 2:	DOMAIN 3:	DOMAIN 4:
Improving the wider determinants of health	Health improvement	Health protection	Healthcare public health and preventing premature mortality
Objective: Improvements against wider factors that affect health and wellbeing, and health inequalities	Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities	Objective: The population's health is protected from major incidents and other threats, while reducing health inequalities	Objective: Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities
Indicators Indicators Indicators } *Across the life course*	*Indicators Indicators Indicators* } *Across the life course*	*Indicators Indicators Indicators* } *Across the life course*	*Indicators Indicators Indicators* } *Across the life course*

2.6 Over the next few pages, we set out the full range of indicators for public health. Part 2 of this document, *The Public Health Indicator Set: Technical specification* (published separately) sets out in detail the technical specifications as far as we have developed them so far – they provide the rationale and technical information that support each indicator. In some cases further development is required over the next 10-12 months. Indicators where major development work is required are included in this initial framework as "placeholders" and denoted below in italics.

2.7 The public health indicators have been allocated into the four domains to which they most relate and arranged in order of their likely impact across the life course. An "at a glance" summary of all public health indicators is provided at Annex A.

The domains

1 Improving the wider determinants of health
Objective Improvements against wider factors that affect health and wellbeing and health inequalities
Indicators • Children in poverty • *School readiness (Placeholder)* • Pupil absence • First-time entrants to the youth justice system • 16-18 year olds not in education, employment or training • People with mental illness or disability in settled accommodation • *People in prison who have a mental illness or significant mental illness (Placeholder)* • Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness • Sickness absence rate • Killed or seriously injured casualties on England's roads • *Domestic abuse (Placeholder)* • *Violent crime (including sexual violence) (Placeholder)* • Re-offending • *The percentage of the population affected by noise (Placeholder)* • Statutory homelessness • Utilisation of green space for exercise/health reasons • Fuel poverty • *Social contentedness (Placeholder)* • *Older people's perception of community safety (Placeholder)*

2.8 In improving the wider determinants of health, we have included a range of indicators that reflect factors that can have a significant impact on our health and wellbeing. These indicators are in line with those recommended by Sir Michael Marmot in his report *Fair Society, Healthy Lives* in 2010, and focus on the "causes of the causes" of health inequalities. Wherever possible, the indicators will follow the formulation published by the Marmot Review team and the London Health Observatory.

2.9 Local authorities with their partners, including the police and criminal justice system, schools, employers, and the business and voluntary sectors, will all have a significant role to play in improving performance against these indicators.

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- *Child development at 2-2.5 years (Placeholder)*
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- *Emotional wellbeing of looked-after children (Placeholder)*
- Smoking prevalence – 15 year olds
- Hospital admissions as a result of self-harm
- *Diet (Placeholder)*
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- *Cancer diagnosed at stage 1 and 2 (Placeholder)*
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible
- Self-reported wellbeing
- Falls and injuries in the over 65s

2.10 Domain 2 focuses on actions to help people make healthy choices and lead healthy lifestyles. Improvements in these indicators will, in the main, be led locally through health improvement programmes commissioned by local authorities. However, for some, the core role for the delivery of related services might lie with the NHS. For example, we have already confirmed that the NHS will have responsibility for the delivery of screening services according to specifications set by Public Health England. More on the way in which the NHS will be held to account for their part in improving public health outcomes follows later in Chapter 4.

2.11 Indicators are ordered in this and all domains where possible in order of their impact through the life course.

3 Health protection
Objective The population's health is protected from major incidents and other threats, while reducing health inequalities
Indicators • Air pollution • Chlamydia diagnoses (15-24 year olds) • Population vaccination coverage • People presenting with HIV at a late stage of infection • Treatment completion for tuberculosis • Public sector organisations with board-approved sustainable development management plan • *Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)*

2.12 Domain 3 includes a critical range of indicators focusing on those essential actions to be taken to protect the public's health. While Public Health England will have a core role to play in delivering improvements in these indicators, this will be in support of the NHS's and local authorities' responsibility in health protection locally.

4 Healthcare public health and preventing premature mortality
Objective Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.
Indicators • Infant mortality • Tooth decay in children aged 5 • Mortality from causes considered preventable • Mortality from all cardiovascular diseases (including heart disease and stroke) • Mortality from cancer • Mortality from liver disease • Mortality from respiratory diseases • *Mortality from communicable diseases (Placeholder)* • *Excess under 75 mortality in adults with serious mental illness (Placeholder)* • Suicide • *Emergency readmissions within 30 days of discharge from hospital (Placeholder)* • Preventable sight loss • *Health-related quality of life for older people (Placeholder)* • Hip fractures in over 65s • Excess winter deaths • *Dementia and its impacts (Placeholder)*

2.13 Improvements in indicators in this domain will be delivered by the whole public health system. Under 75 mortality indicators will be shared with the NHS Outcomes Framework, where contributions will focus on avoiding early deaths through healthcare interventions. Public health contributions would be made locally led by local authorities, supported by Public Health England, to preventing early death as a result of health improvement actions – such as those reflected in indicators in preceding domains.

3. Developing the public health indicator set

Design principles

3.1 The development of the Public Health Outcomes Framework has been firmly based on a set of principles that were developed through consultation with stakeholders (and with our partners).

The Public Health Outcomes Framework will cover the three pillars of public health

3.2 In addition to the inclusion of a domain focused on the wider determinants of health, one of the overwhelming responses to the consultation was that the use of domains was a helpful and powerful means to group public health priorities.

3.3 However, the existing and already acknowledged spectrum of public health known as the "three pillars" of public health, were thought to be a better way of describing the breadth of public health. We have therefore included domains that reflect these three pillars while including an additional domain on the wider determinants of health.

Alignment across the Public Health, Adult Social Care and NHS Outcomes Frameworks will be clear and meaningful

3.4 The proposals we made on alignment between the three outcomes frameworks were well received by respondents who acknowledged the need for three separate frameworks, recognising the different governance and accountability arrangements for Public Health England, local authorities and the NHS. Responses during the consultation encouraged us to develop our plans for alignment across the three frameworks based on a series of shared or complementary indicators. More recently, the NHS Future Forum's interim letter (ahead of its full report in December) to the Secretary of State for Health made specific recommendations to ensure that where relevant, indicators or outcomes measures were twinned across the NHS and Public Health Outcome Frameworks, focusing on shared goals and common priorities.

3.5 Therefore, we intend to create alignment with the NHS Outcomes Framework through a shared set of indicators that straddle domain 4 of the Public Health Outcomes Framework (Healthcare Public Health and Preventing Premature Mortality) and domain 1 of the NHS Outcomes Framework (Preventing People from Dying Prematurely).

3.6 We will share a set of indicators focused on premature mortality from specific disease areas. These will be formed of measures that are shared with the NHS on mortality rates from cancer, cardiovascular disease, respiratory disease and liver disease, and on excess premature mortality amongst people who suffer from serious mental illness and on infant mortality. In the case of the Public Health Outcomes Framework, we also include preventable mortality for cancer, cardiovascular disease, respiratory disease and liver disease. The NHS Outcomes Framework will consider how best to measure the NHS's role in reducing mortality for cardiovascular disease, respiratory disease and liver disease, in the same way that survival rates can be used to measure the NHS's role in reducing mortality from cancer.

3.7 In addition, a range of indicators will be complementary across the NHS, Public Health and Adult Social Care Outcomes Frameworks, for example where we wish to focus on improving outcomes for specific client groups. These might include those with mental illness, learning disabilities or long-term conditions. Other more specific areas where we intend to align across the NHS, Public Health and Adult Social Care Outcomes Frameworks include a focus on quality of life for older people, and hospital readmissions.

3.8 The NHS Outcomes Framework was published in December 2010 and the Adult Social Care Outcomes Framework was published in March 2011. The NHS Outcomes Framework will, like the Public Health Outcomes Framework, undergo an annual refresh. The first refresh of the NHS Outcomes Framework has been and should be read alongside this framework, including a complementary description of alignment.

3.9 However, we have not restricted the concept of alignment to the three Department of Health sponsored outcomes frameworks. Indicators focused on the wider determinants of health offer an opportunity to align this framework with any that may emerge from other Government departments or indeed at local level across a range of related public services. We will also be considering how the frameworks work together to improve outcomes in specific areas. The development of an outcomes strategy for children and young people's health and wellbeing (see paragraph 3.12) will be the first example of such a coordinated approach.

3.10 The Government's response to Professor Eileen Munro's recent review of child protection in England referred to the further development of a suite of performance information for safeguarding children, which will include health information, building on the work undertaken in the review. This same response recognises the significance and potential for alignment with the Public Health Outcomes Framework. In addition, the children's services sector has, through the Children's Improvement Board (membership of which includes the Association for Directors of Children's Services, the Society of Local Authority Chief Executives and the Local Government Association), commissioned work to develop children's services data profiles to provide a means for local benchmarking to support local authority sector-led improvement.

The Public Health Outcomes Framework will support health improvement and protection at all stages and across the life course, and especially in the early years

3.11 In presenting this approach and confirming the detail of the framework, we are clear that this is not just about extending life – it needs to cover all the factors that contribute to healthy life expectancy including, importantly, what happens at the start of life and how well we live across the life course. The two outcomes together will ensure our overall vision to improve and protect the nation's health while improving the health of the poorest fastest.

3.12 Addressing and improving health and wellbeing across the life course will be essential particularly in the early years where we are more likely to make the greatest impact on achieving healthy life expectancy across the social gradient as advised by Sir Michael Marmot. This was a strong theme in *Healthy Lives, Healthy People*, and the outcomes framework consultation showed strong support in particular for specific coverage of children and young people. The framework includes a large number of indicators on children and young people's health and with the NHS Outcomes Framework sets a clear direction for children's health. We will develop an outcomes strategy for children and young people's health and wellbeing to ensure the outcomes measured are the ones that matter most to children, young people and their families, and the professionals that support them, and set out how different parts of the system will contribute to delivery of these outcomes. The strategy development will be led by a Children and Young People's Forum, who will advise on outcomes and approaches to delivery.

3.13 The life course approach is an integral part of each domain, reflecting the extent to which action at different ages can contribute to the top level outcomes, and enabling a robust analysis of how outcomes are improving at all ages.

The Public Health Outcomes Framework will focus attention on reducing health inequalities to promote equality

3.14 It is clear from the work of Sir Michael Marmot's independent review[3] that health is not experienced equally across our society. For example, data from 2008-2010 shows that, in England, the gap between local authorities with the highest and lowest life expectancy is around 11 years for both males and females.

3.15 The high-level outcome of reduced differences in life expectancy and healthy life expectancy between communities will be the key element in addressing health inequalities within this framework.

3.16 The indicators included in domain 1 – improving the wider determinants of health – present an important opportunity to get to grips with the most detrimental factors on health inequalities. However, the majority of indicators in this framework have potential to impact on inequalities and we aspire to make it possible for all indicators to be disaggregated by equalities characteristics and by socioeconomic analysis wherever possible in order to support work locally to reduce in-area health inequalities where these persist. Annex C describes the extent to which each indicator can be disaggregated in this way.

Technical development

3.17 We selected indicators using a set of criteria we consulted on in 2011, which were subsequently improved and refined with expert input to ensure they provided a comprehensive means of assessing the suitability of each candidate indicator. The final sift criteria and more detailed information setting out the process for selection of indicators is set out in full in Annex B.

3.18 Our starting point was to focus on the 62 indicators that were included in the original Public Health Outcomes Framework consultation document, plus a further 25 indicators that were proposed by stakeholders in response to the consultation – either suggested as improvements to existing indicators or as brand new indicators.

3.19 Based on this rigorous criteria assessment, a number of indicators were deemed not suitable for inclusion within the final framework. These are included at Annex B.

3 The Marmot Review Team (2010) *Fair Society, Healthy Lives: The Marmot Review. Strategic Review of Health Inequalities post-2010*. Available at www.marmotreview.org

3.20 In addition to assessing each measure against the criteria, we have also assessed whether indicators could be disaggregated by any or all of the inequalities and equalities dimensions. Further information on this is included at Annex C.

3.21 As part of this selection process, we worked with our partners across Whitehall in a series of workshops and bilateral discussions over the summer of 2011. These were complemented by a series of workshops and discussions with wider stakeholders, including those representing public health professionals, local government, the NHS and the voluntary and community sector.

3.22 The life course approach is an integral part of the design of each domain, reflecting the extent to which action at different ages can contribute to the top level outcomes, and enabling a robust analysis of how outcomes are improving at all ages. Within each domain, the indicators at Annex A are listed in order of their potential to have impact across the life course for communities and the population.

3.23 In particular, the NHS Outcomes Framework sets out our intention to ensure alignment with the Public Health Outcomes Framework through the inclusion of shared or complementary indicators relating to under 75 mortality. These related indicators will automatically therefore be included within domain 4, Healthcare Public Health and Preventing Premature Mortality, to satisfy this commitment.

4. Transparency and accountability

4.1 A main purpose of the outcomes framework is to provide a framework for transparency and accountability across the public health system. As governance and accountability for Public Health England, local government and for the NHS differ from each other, so will their relationship to demonstrating performance towards improving public health outcomes.

Local government

4.2 Guiding the relationship between national and local government is the principle of localism. It will be for local authorities, in partnership with health and wellbeing boards, to demonstrate improvements in public health outcomes through achieving progress against those indicators that best reflect local health need (as set out in the Joint Strategic Needs Assessment, and reflected in the Joint Heath and Wellbeing Strategy). It is therefore envisaged that specific progress against the measures in the framework will be being built into the Joint Strategic Needs Assessment and Joint Heath and Wellbeing Strategy as appropriate.

4.3 It is also critical for us to understand that many of the services that will affect progress against indicator measures operate at a range of levels. In areas in the country with a two-tier local government system, many of these services operate at a lower local authority tier. Given our aim is that public health leadership, in the form of the Director of Public Health, sits at the upper tier it is imperative that district and city councils are able to play their part in driving health improvements through close collaboration.

4.4 The use of the data within the outcomes framework for benchmarking makes the Public Health Outcomes Framework an essential tool alongside the NHS, Adult Social Care and other sectors' frameworks for driving local sector led improvement. There is widespread support from within the sector for the principle of using the framework to drive improvement and this will need to be developed further. This would be led by local authorities themselves, much as they have done for other areas such as for adult and children social care services.

4.5 In addition, some indicators will reflect those services we will require all local authorities to commission under powers set out in the Health and Social Care Bill. We will set out in more detail those services we will require all local authorities to commission in further updates later in the year.

4.6 There will be a strong link between the Public Health Outcomes Framework and the health premium. Building on the breadth of the outcomes framework, the health premium will highlight, and incentivise action on, a small number of indicators that reflect national or local strategic priorities. We will set out further details on our plans for a health premium as part of a finance update shortly.

4.7 Clause 28 of the Health and Social Care Bill, which has yet to be passed by parliament, inserted the new section 73B(1) into the NHS Act 2006. Under this new section, a local authority exercising the new public health function under the Bill must have regard to any document published by the Secretary of State for Health for the purposes of Section 73B(1). We intend that the Public Health Outcomes Framework will be published for the purposes of section 73B(1). Consequently, subject to the passage of the Bill through parliament, local authorities will have a statutory duty to have regard to this document.

The NHS

4.8 The NHS will continue to play a major role in public health, both in terms of delivering specific health programmes such as on immunisations or screening, as well as in maximising opportunities to make every patient contact count through providing health improvement advice. The Government's mandate to the NHS Commissioning Board will set expectations of the NHS, including ambitions for reducing preventable mortality.

4.9 An agreement between the Secretary of State for Health and the NHS Commissioning Board[4] will enable the NHS to deliver services funded from the ring-fenced public health budget, such as national screening and immunisation programmes. The NHS Commissioning Board will be accountable for the NHS contribution to improvements against specific indicators for these services. For example, the NHS will aim to deliver improvements against cancer screening coverage in domain 2.

4.10 At the local level, Clinical Commissioning Groups will, subject to legislation, be full statutory members of local Health and Wellbeing Boards and subject to local

4 The agreement would be made under the new section 7A of the NHS Act 2006, as proposed in the Health and Social Care Bill, which would provide for arrangements for the delegation of the Secretary of State's public health responsibilities.

accountability and scrutiny by HealthWatch and local authority health scrutiny committees. Clinical Commissioning Groups will work alongside local partners on Health and Wellbeing Boards, including Directors of Public Health, to agree the Joint Health and Wellbeing Strategies and to reflect those strategies in their local commissioning plans.

4.11 We intend to share a small number of indicators across the public health and NHS outcomes frameworks where there is a strong argument for a shared approach. These will be mostly concentrated in domain 4 of the Public Health Outcomes Framework, Healthcare Public Health and Preventing Premature Mortality, but not exclusively. To illustrate, we envisage both the NHS and public health frameworks including an indicator on infant mortality, however the NHS will be responsible for the delivery of healthcare services that preserve and improve the health of babies in their first year of life through antenatal and neonatal services and offer treatment to mothers who have mental health problems[5]. Wider circumstances such as the mother's socioeconomic background and health behaviour will have a significant impact on the health of an infant, and will be best influenced by public health interventions led by local authorities.

Public Health England

4.12 As well as having a central role on behalf of the wider public health system in publishing national and local data on progress against the outcomes, Public Health England will have a primary role in delivering a number of the outcomes. Last year we published an operating model for Public Health England, which sets out the responsibilities for Public Health England in relation to the Public Health Outcomes Framework.

4.13 Public Health England will be accountable to Government as an executive agency, through an agreed business plan setting out the objectives we expect Public Health England to achieve each year. The role of Public Health England in supporting the improvement of outcomes will be central to setting objectives.

5 A phrase used in this strategy as an umbrella term to denote the full range of diagnosable mental illnesses and disorders, including personality disorder. Mental health problems may be more or less common and acute or longer lasting, and may vary in severity. They manifest themselves in different ways at different ages and may present as behavioural problems (for example, in children and young people). Some people object to the use of terms such as "mental health problem" on the ground that they medicalise ways of thinking and feeling and do not acknowledge the many factors that can prevent people from reaching their potential. We recognise these concerns and the stigma attached to mental ill health, however there is no universally acceptable terminology that we can use as an alternative.

4.14 Public Health England, in partnership with agencies such as the National Institute for Health and Clinical Excellence, will ensure provision of expertise and knowledge of the latest developments and best practice in public health to the rest of the public health delivery system, including the NHS and local government, in order to support their contribution to improving public health outcomes.

4.15 Public Health England will regularly publish data on the indicator measures, including the disaggregation of data to local authority level, and by key equality and inequality characteristics – where available. Public Health England will also publish tools that support benchmarking of outcomes between and within local areas to provide insights into performance. We expect this information will assist local leaders in developing and implementing their strategies to improve health and wellbeing, and the wider public as they seek to understand how well their local services are supporting them.

4.16 Under its transparency agenda, Public Health England will measure and report on the Public Health Outcomes Framework and support the Department of Health in the development of public health indicators for the Public Health Outcomes Framework.

4.17 While the Public Health Outcomes Framework establishes determinants to tackle the range of public health issues in England, a number of the wider determinants covered in the framework (such as those around child poverty, fuel poverty, alcohol, justice and road safety) will be relevant to improvements in public health across the UK. We will work closely with the devolved administrations on areas of shared interest including on UK-wide issues in health protection.

5. Next steps and future development

5.1 The Public Health Outcomes Framework is a multi-year framework, with a built-in expectation that it should be refreshed each year as data quality improves, technical capability across the public health system develops, and importantly as we maintain an aligned approach across the NHS, local authorities and Public Health England.

5.2 Further development of indicators set out here will be essential in order to arrive at a full set of baselines to support local service planning by the autumn of 2012. Public health observatories will play a key role, in partnership with local authorities and the NHS, with the Department of Health leading the next technical stages to develop final technical specifications for each indicator over 2012-13.

5.3 The London Health Observatory will carry out this work on behalf of the network of public health observatories in the short term. In the longer term it is expected that Public Health England will carry out this work.

5.4 As mentioned in the previous chapter, we intend that the Public Health Outcomes Framework will be published for the purposes of section 73B(1) of the NHS Act 2006. Section 73B(1) is a new section of the 2006 Act that was inserted by clause 28 of the Health and Social Care Bill. When the Bill is passed, and the new section 73B(1) is brought into force, we will need to re-publish this document formally in order for it to have the desired legal effect.

Managing the transition

5.4 2012/13 will be crucial year in which further development of the outcomes framework will be a key feature of ongoing work. However, while we focus on development of this new framework, it is vital that we do not neglect the day job – improving and protecting the health of the population now – not just in the future.

5.5 As primary care trust clusters and strategic health authority clusters focus on managing the transition to the new systems, their prime responsibilities remain the commissioning and performance management of health and healthcare services. We have ensured the NHS Operating Framework for 2012/13

provides the means for a smooth transition to the new Public Health Outcomes Framework, by including headline performance measures that will reflect both the services we expect the NHS to commission in the future as well as those services that the NHS will hand over to local authorities. This transitional work is subject to the passage of the Health and Social Care Bill.

5.6 To support the roll-out of the new framework, we will work with and through Public Health England with local authorities and the NHS Commissioning Board alongside public health professionals over the coming year. Building on the extensive engagement we have already enjoyed, we wish to see any future development of the Public Health Outcomes Framework as a joint effort – as a result of strong partnerships between national and local government, between the NHS and local government, and most importantly with the citizens and communities whose health we need to improve and protect.

Appendix A: Overview of outcomes and indicators

Vision

To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.
Outcome measures
Outcome 1: Increased healthy life expectancy, ie taking account of the health quality as well as the length of life.
Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

1 Improving the wider determinants of health

Objective

Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators

- Children in poverty
- *School readiness (Placeholder)*
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness or disability in settled accommodation
- *People in prison who have a mental illness or significant mental illness (Placeholder)*
- Employment for those with a long-term health condition including those with a learning difficulty/ disability or mental illness
- Sickness absence rate
- Killed or seriously injured casualties on England's roads
- *Domestic abuse (Placeholder)*
- *Violent crime (including sexual violence) (Placeholder)*
- Re-offending
- *The percentage of the population affected by noise (Placeholder)*
- Statutory homelessness
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- *Social connectedness (Placeholder)*
- *Older people's perception of community safety (Placeholder)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- *Child development at 2-2.5 years (Placeholder)*
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- *Emotional wellbeing of looked-after children (Placeholder)*
- *Smoking prevalence – 15 year olds (Placeholder)*
- Hospital admissions as a result of self-harm
- *Diet (Placeholder)*
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- *Cancer diagnosed at stage 1 and 2 (Placeholder)*
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible
- Self-reported wellbeing
- Falls and injuries in the over 65s

3 Health protection

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development management plans
- *Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)*

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

Indicators

- Infant mortality
- Tooth decay in children aged five
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- *Mortality from communicable diseases (Placeholder)*
- *Excess under 75 mortality in adults with serious mental illness (Placeholder)*
- Suicide
- *Emergency readmissions within 30 days of discharge from hospital (Placeholder)*
- Preventable sight loss
- *Health-related quality of life for older people (Placeholder)*
- Hip fractures in over 65s
- Excess winter deaths
- *Dementia and its impacts (Placeholder)*

Appendix B: Indicator criteria assessment

We selected indicators using a set of criteria we consulted on in 2011, which were subsequently improved and refined with expert input to ensure they provided a comprehensive means of assessing the suitability of each candidate indicator. The final sift criteria are set out below.

Sift criteria	Y	P	N	?
	Criterion fully or largely met	**Criterion partly met**	**Criterion not met**	**Information not available**
Measure of health outcome or factor closely correlated to a health outcome	Mostly or completely a measure of health outcome, ie one that measures a change in the length and/ or quality of life, or a factor closely correlated to a health outcome	Partly an outcome measure and partly a process measure	Completely a measure of health process and not closely correlated to a health outcome	Information is not sufficient to make a current judgement about this criterion
Aligns with the government's direction for public health	In line with the government's direction for public health and is one of the government's commitments (eg is a public health national ambition)	In line with the direction for public health but not one of the Government's commitments	Not in line with the direction for public health	Information is not sufficient to make a current judgement about this criterion

Sift criteria	Y	P	N	?
	Criterion fully or largely met	**Criterion partly met**	**Criterion not met**	**Information not available**
Aligns with OGD priorities/ strategies	Completely in line with OGD priorities/ strategies	Partially in line with OGD priorities/ strategies	Not in line with OGD priorities/ strategies	Information is not sufficient to make a current judgement about this criterion or this criterion is not applicable
Evidence-based interventions to support the measure	Substantial evidence to suggest that interventions exist that would have a positive impact on this measure	Some evidence to suggest that interventions exist that would have a positive impact on this measure	Evidence that interventions have a negative impact on this measure	No/insufficient evidence that interventions have a positive impact on this measure
Amenable to public health intervention, eg by public health professionals, local authorities, Public Health England, NHS	Public health interventions are the most important way to make progress on this measure	Public health interventions are one of two or more factors that have a positive impact on progress against this measure	Public health interventions have minimal or no impact on progress against this measure	Information is not sufficient to make a current judgement about this criterion
Major cause of premature mortality or avoidable ill health	Recognised as a major cause of premature mortality or avoidable ill health	Not a major cause but recognised as a contributing factor to premature mortality or avoidable ill health	Not a cause of, or contributing factor to, premature mortality or avoidable ill health	Information is not sufficient to make a current judgement about this criterion

Sift criteria	Y	P	N	?
	Criterion fully or largely met	**Criterion partly met**	**Criterion not met**	**Information not available**
Improvements in this measure will improve health-related quality of life (including mental health)	Evidence that improvements in this measure would improve health-related quality of life	Some evidence to suggest that improvements in this measure may improve health-related quality of life	Evidence that improvements in this measure do not improve health-related quality of life	No/insufficient evidence that improvements in this measure improve health-related quality of life
Improvement in this measure will help reduce inequalities in health	Evidence that improvement in this measure could help reduce health inequalities at population level significantly, eg where there is a strong social gradient and large numbers of people affected by the inequality or where it has high impact on length or quality of life	Evidence that improvement in this measure could help reduce health inequalities for moderate or low numbers of people or in few areas and/or with low impact on length and/or quality of life	Evidence that improvements in this measure do not reduce health inequalities	No/insufficient evidence that improvements in this measure reduce health inequalities
Improvement in this measure will help improve healthy life expectancy	Substantial evidence to suggest that improvement in this measure would improve healthy life expectancy	Some evidence to suggest that improvement in this measure may improve healthy life expectancy	Evidence that improvements in this measure do not improve healthy life expectancy	No/insufficient evidence that improvements in this measure would improve healthy life expectancy

Sift criteria	Y	P	N	?
	Criterion fully or largely met	**Criterion partly met**	**Criterion not met**	**Information not available**
Meaningful to, and likely to be perceived as important by, the public	The public understand the principle of the measure, the intended direction of travel and perceive the measure as important	The public only partly understand the principle of the measure or there is some uncertainty regarding the importance of the measure to the public	The principle of the measure is not understood by the public or they do not think it is important	Information is not sufficient to make a current judgement about this criterion
Meaningful to, and likely to be perceived as important by, local authorities	Local authorities understand the principle of the measure, the intended direction of travel and perceive the measure as important	Local authorities only partly understand the principle of the measure or there is some uncertainty regarding the importance of the measure to local authorities	The principle of the measure is not understood by local authorities or they do not think it is important	Information is not sufficient to make a current judgement about this criterion
Existing system to collect data required to monitor the measure	Existing system in place to collect at least national and local authority data and there are no plans to cease collection	Existing system in place to collect national but not local authority data and there are no plans to cease collection	No system currently in place to collect required data or system currently in place but there are plans to cease collection	Information is not sufficient to make a current judgement about this criterion

Sift criteria	Y	P	N	?
	Criterion fully or largely met	**Criterion partly met**	**Criterion not met**	**Information not available**
Statistically appropriate, fit for purpose*	The measure satisfies all four of the "fit for purpose" criteria	The measure satisfies two or three of the "fit for purpose" criteria	The measure satisfies only one or none of the "fit for purpose" criteria	Information is not sufficient to make a current judgement about this criterion

*The fit for purpose criteria were:

1. Does it measure what it is intended to measure?
2. Will the measure allow change over time to be detected, ie is it possible to measure year-to-year progress?
3. Will data be available (by April 2013) at least annually to monitor the measure?
4. The measure is not vulnerable to perverse incentives that might lead to the wrong public health behaviours

The selection process

The initial list of candidate indicators was developed using the following criteria:

> HM Treasury Transparency Framework criteria

> Are there evidence-based interventions to support this indicator?

> Does this indicator reflect a major cause of premature mortality or avoidable ill health?

> By improving on this indicator, can you help to reduce inequalities in health?

> Use indicators that are meaningful to people and communities

> Is this indicator likely to have a negative/adverse impact on any particular groups? (If yes, can this be mitigated?)

> Is it possible to set measures, SMART objectives and targets against the indicator to monitor progress in both the short and medium term?

> Are there existing systems to collect the data required to monitor this indicator and;

– Is it available at the appropriate spatial level (eg local authority)?

– Is the time lag for data short, preferably less than one year?

– Can data be reported quarterly in order to report progress?

The Department of Health held a formal 12-week publication consultation on the proposal to introduce a Public Health Outcomes Framework, in which respondents were invited to comment on the proposed structure and composition of the framework.

Post-consultation the list of criteria was refined in consultation with leads for Public Health Outcomes Framework indicators. These policy and analytical leads (in the Department of Health and other Government departments) were then asked to conduct an assessment against the set of criteria – this was done for all 62 indicators included in the original consultation and the 25 that were subsequently suggested in consultation responses. This criteria assessment was quality assured by analysts in the Department of Health.

To conduct a first sift of the indicators we identified a number of key criteria (from the full list of criteria), namely whether a candidate indicator:

> aligns with the government's direction for public health

> is amenable to public health intervention, eg by public health professionals, local authorities, Public Health England and the NHS

> represents a major causes of premature mortality or avoidable ill health (note: if indicators in the improving the wider determinants of health domain did not meet this criterion then they were not sifted out)

> is linked to improvements in health-related quality of life (including mental health)

> is linked to helping reduce inequalities in health

> is linked to helping improve healthy life expectancy

> is statistically appropriate and fit for purpose

> is at least feasible at national level

> is at least feasible at local authority level.

Indicators were sifted out if they had been assessed as "criterion not met" on any of the key criteria as part of the criteria assessment exercise.

Those indicators that were deemed suitable for consideration for the final list of public health indicators after this process were then allocated to domains on the basis of their likely impact meeting the objectives of each domain. We then worked

with key public health colleagues in the Department of Health, other Government departments and the public health system to develop the final set of indicators via a series of stakeholder engagement workshops.

Once a draft final set of indicators was decided upon we carried out some additional pieces of analysis – these are included in the full impact assessment that accompanies this framework.

Calibration: One of the key criteria considers if improvements in an indicator will improve healthy life expectancy (one of the overarching outcomes of the framework). To try to quantify this criterion an assessment was made, where possible, of incremental contribution of indicators to improving life expectancy (which is a component of healthy life expectancy). In addition to aiding the selection of indicators, presenting this analysis will provide a means by which local authorities, with knowledge of the costs of interventions, can apportion cost to benefits at a later stage and make an informed decision on which indicators they might want to prioritise in their local area. Further details of how this assessment was carried out can be found in Annex 5 of the impact assessment.

Assessment of comprehensiveness: It is important that the set of indicators is comprehensive and constitutes a life course approach to public health. Therefore comprehensiveness was considered in terms of assessing the number of indicators that covered each of the different life stages. Further details of the comprehensiveness assessment can be found in Annex 3 of the impact assessment.

Risk-adjustment: Underlying characteristics (eg socioeconomic profile) could impact on achievement at a local level against indicators. This will pose challenges for comparing indicators between areas. For a number of illustrative examples (see Annex 2 of the impact assessment) we considered for what factors it may be appropriate to risk adjust. Work on risk adjustment will need to be taken forward in the future when considering how the indicators will be monitored.

Equalities

For each breakdown policy leads were asked to indicate whether data is available now/will be available by 2013/feasible in future/not feasible/unsure. The breakdown areas were:

> socioeconomic group

> area deprivation (or postcode)

> age

- disability
- ethnicity
- gender
- religion
- sexual orientation.

In order to conduct this assessment exercise, policy leads from the Department of Health and other Government departments consulted with voluntary and independent sector organisations (experts in the field of each indicator) to ascertain the appropriateness of the data sources that support each indicator – as well as the equalities impact of having each measure, and the existing evidence on the appropriateness of each measure.

Engagement on equalities issues has been built into the development of the outcomes framework from the project's inception. Indeed the consultation document contained the following specific question in regards to equality: "How can we ensure that the outcomes framework, along with the local authority public health allocation, and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?"

Full details of the equalities issues that have been considered in the development of the framework can be found in the Equalities Impact Assessment that has been published alongside this document. A table detailing the data breakdowns (including those for equalities strands) that are currently available for each indicator is found in Annex C.

Appendix C: Breakdown of indicators: local disaggregation, inequalities and equalities characteristics

An initial assessment has been made of whether national and upper tier local authority level breakdowns are currently available for each of the indicators included in the Public Health Outcomes Framework. We will extend this work in the future to consider the availability of data at lower geographical levels, eg lower tier local authorities and clinical commissioning groups, and to consider the feasibility of producing particular geographical breakdowns for indicators where they are not already available.

The Department of Health has made tackling health inequalities a priority. It is also under a legal obligation to promote equality across the equality strands protected in the Equality Act 2010. There is therefore both a legal requirement and a principle in designing the Public Health Outcomes Framework that its introduction will not cause any group to be disadvantaged. We have used the equalities and inequalities breakdowns to assess data availability in order to monitor this commitment. Data collection is more complete for some of the strands than others, for example there is generally better coverage for age and gender than for religion or sexual orientation.

Please note:

1. The assessment presented in this annex is likely to change as further information becomes available as we develop the Public Health Outcomes Framework indicators.

2. In this annex, we outline data that is currently available (as at November 2011). For many of the indicators there may already be work in progress to extend data collections to produce additional geographical/equalities breakdowns but this information is not captured in this table.

3. The information presented in the table relating to equalities and inequalities breakdowns is related to national level data only. This work will be extended in the future to consider the availability of this data at local authority level.

Availability of breakdowns for Public Health Outcomes Framework indicators

Key

Y Currently collected and published

N Not currently collected

P The breakdown itself is not currently published but is collected (or can be constructed from data that is already collected)

tbc Further work is required to determine if the breakdown is available

n/a Not applicable to this indicator

* A star next to one of the above ratings (eg Y*) indicates that although a breakdown is available, it should be treated with caution, eg there may be issues with the reliability of the data or the statistical validity of a particular breakdown

	Geographical		**Equalities strands (national level)**						**Inequalities (national level)**	
	National	Upper tier local authority	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
Indicators corresponding to the overarching outcomes										
0.1 Healthy life expectancy	Y	P	P	tbc	N	Y	N	N	tbc	P
0.2 Differences in life expectancy and health expectancy between communities	P	tbc	P*	tbc	N	P	N	N	tbc	P

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier local authority	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
Domain 1: Improving the wider determinants of health										
1.1: Children in poverty	Y	Y	P	Y	Y	N	N	n/a	n/a	n/a
1.2: School readiness (Placeholder)	P	P	Y	P	P	P	N	n/a	P	P
1.3: Pupil absence	Y	Y	P	P	Y	Y	N	n/a	N	N
1.4: First time entrants to the youth justice system	Y	Y	Y	Y	Y	Y	tbc	n/a	P	P
1.5: 16-18 year olds not in education, employment or training	Y	Y	P	P	P	P	N	N	N	P
1.6i: People with learning disabilities in settled accommodation	P	P	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc
1.6ii People receiving secondary mental health services in settled accommodation	Y	P*	P	N	N	P	N	N	N	P
1.7: People in prison who have a mental illness or significant mental illness	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier local authority	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
Domain 1: Improving the wider determinants of health										
1.8: Employment for those with a long-term health condition including those with a learning difficulty/ disability or mental illness	P	P	P*	P*	P*	P*	P*	P*	P*	P*
1.9i/19ii: Sickness absence rate: Percentage of employees who had at least one day off sick in the previous week/Number of working days lost due to sickness absence	Y	P	Y	N	N	Y	N	N	N	N
1.9iii: Sickness absence rate: Rate of fit notes issued per quarter (tbc)	N	N	N	N	N	N	N	N	N	N
1.10: Killed and seriously injured casualties on England's roads	Y	Y	P	N	N	P	N	N	N	P
1.11: Domestic abuse (Placeholder)	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc
1.12: Violent crime (including sexual violence) (Placeholder)	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc
1.13: Re-offending	Y	Y	Y	N	Y	Y	N	N	N	P
1.14: Percentage of population affected by noise	P	P*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier local authority	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
Domain 1: Improving the wider determinants of health										
1.15i: Statutory homelessness: Homelessness acceptances	Y	P	P	P*	Y	P	N	N	N	N
1.15ii: Statutory homelessness: Households in temporary accommodation	Y	P	N	N	P*	P	N	N	N	N
1.16: Utilisation of green space for exercise/health reasons	Y	P	P	P	P	P	N	N	P	P
1.17: Fuel poverty	Y	Y	Y	Y	Y	P	N	N	N	N
1.18: Social connectedness (Placeholder)	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc
1.19: Older people's perception of community safety (Placeholder)	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier local authority	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
Domain 2: Health improvement										
2.1: Low birth weight of term babies	Y	P	P	N	P	P	N	n/a	P	P
2.2: Breastfeeding	Y	N	N	N	N	Y	N	n/a	N	N
2.3: Smoking status at time of delivery	Y	N	N	N	N	Y	N	N	N	N
2.4: Under 18 conceptions	Y	Y	P	N	N	Y	N	N	N	tbc
2.5: Child development at 2-2.5 years (Placeholder)	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc
2.6: Excess weight in 4-5 and 10-11 year olds	Y	P	Y	N	P	Y	N	n/a	P	P
2.7: Hospital admissions caused by unintentional and deliberate injuries in under 18s	Y	Y	P	N	P*	P	N	N	N	P
2.8: Emotional wellbeing of looked-after children (Placeholder)	Y	P*	P	N	P	P	N	N	N	P
2.9: Smoking prevalence – 15 year olds	Y	N	n/a	N	P	Y	N	N	N	N
2.10: Hospital admissions as a result of self-harm	Y	Y	P	N	P*	P	N	N	N	P

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier local authority	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
Domain 2: Health improvement										
2.11: Diet (Placeholder)	Y	N	Y	P	P	Y	N	N	Y	P
2.12: Excess weight in adults	Y	N	Y	P	Y	Y	N	N	P	P
2.13: Proportion of physically active and inactive adults	Y	Y	Y	Y	Y	Y	N	N	Y	N
2.14: Smoking prevalence – adults (over 18s)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.15: Successful completion of drug treatment	Y	Y	P	N	P	P	N	N	N	P
2.16: People entering prison with a substance dependence issue who are previously not known to community treatment	N	N	N	N	N	N	N	N	N	N
2.17: Recorded diabetes	Y	Y	P	N	P	P	N	N	N	P
2.18: Alcohol-related admissions to hospital	Y	Y	Y	N	P*	Y	N	N	N	Y
2.19: Cancer diagnosed at stage 1 and 2 (Placeholder)	N	N	N	N	N	N	N	N	N	N

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier local authority	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
Domain 2: Health improvement										
2.20: Cancer screening coverage	Y	P	Y	N	tbc	Y	N	N	tbc	P
2.21i and ii: Access to non-cancer screening programmes: Infectious disease testing in pregnancy – HIV, syphilis, hepatitis B and susceptibility to rubella	Y	N	P	N	P	n/a	N	N	N	N
2.21iii: Access to non-cancer screening programmes: Antenatal sickle cell and thalassaemia screening	P	N	P	N	P	n/a	N	N	N	N
2.21iv: Access to non-cancer screening programmes: Newborn blood spot screening	Y	P	P	N	P	P	N	N	P	P
2.21v: Access to non-cancer screening programmes: Newborn hearing screening	Y	Y	P	N	P	P	N	N	P	P

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier local authority	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
Domain 2: Health improvement										
2.21vi: Access to non-cancer screening programmes: Newborn physical examination	P	P	P	N	P	P	N	N	P	P
2.21vii: Access to non-cancer screening programmes: Diabetic retinopathy	P	P	P	tbc	P	P	N	N	P	P
2.22: Take up of the NHS Health Check programme – by those eligible	Y	N	P	N	N	N	N	N	N	N
2.23: Self-reported wellbeing (based on current measure of seven-item Warwick-Edinburgh Mental Wellbeing Scale)	Y	P	P	P	P	P	P	P	P	P
2.24: Falls and fall injuries in the over 65s	P	P	P	N	P*	P	N	N	N	P

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier local authority	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
Domain 3: Health protection										
3.1: Air pollution	Y	P*	n/a	n/a	n/a	n/a	n/a	n/a	N	P*
3.2: Chlamydia diagnoses (15-24 year olds)	Y	Y	P	N	P	P	N	N	N	P
3.3: Population vaccination coverage	Y	N	Y	tbc	N	N	N	N	N	N
3.4: People presenting with HIV at a late stage of infection	Y	P	P	N	P	P	N	P	N	P
3.5: Treatment completion for tuberculosis	Y	P	Y	N	Y	Y	N	N	N	P
3.6: Public sector organisations with board-approved sustainable development management plan	Y	P	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
3.7: Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)	tbc	tbc	n/a	n/a	n/a	n/a	n/a	n/a	tbc	tbc

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier local authority	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
Domain 4: Healthcare public health and preventing premature mortality										
4.1: Infant mortality	Y	Y	P	N	Y	Y	N	n/a	Y	P
4.2: Tooth decay in children aged five years	Y	Y	Y	N	P	N	N	n/a	P	P
4.3 Mortality from causes considered preventable and sub-indicators 4.4ii, 4.5ii, 4.6ii and 4.7ii on preventable mortality	N	N	N	N	N	N	N	N	N	N
4.4i: Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)	Y	Y	P	N	N	Y	N	N	N	P
4.5i: Under 75 mortality rate from all cancers	Y	Y	P	N	N	P	N	N	N	P
4.6i: Under 75 mortality rate from liver disease	P	P	P	N	N	P	N	N	N	P
4.7i: Under 75 mortality rate from respiratory diseases	P	P	P	N	N	P	N	N	N	P
4.8: Mortality from communicable diseases (Placeholder)	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier local authority	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
Domain 4: Healthcare public health and preventing premature mortality										
4.9: Excess under 75 mortality in adults with serious mental illness (Placeholder)	P	P*	P	N	N	P	N	N	N	P
4.10: Suicide	Y	Y	P	N	N	P	N	N	N	P*
4.11: Emergency readmissions within 30 days of discharge from hospital (Placeholder)	Y	Y	Y	N	P*	Y	N	N	N	Y
4.12: Preventable sight loss	P	P	P	P	P	P	N	N	P	P
4.13 Health-related quality of life for older people (Placeholder)	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc
4.14: Hip fractures in over 65s	Y	Y	P	N	P*	P	N	N	N	P
4.15: Excess winter deaths	Y	Y	P	N	N	P	N	N	N	P
4.16: Dementia and its impacts (Placeholder)	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc

Appendix D: Readiness of indicators

We have rated all indicators in the Public Health Outcomes Framework in terms of their readiness for use. This assessment considers the readiness of both the indicator definition and the data source.

We allocated ratings as outlined in the table below. This summarises where the 66 indicators (and two indicators relating to the overarching outcomes) are in terms of the nine possible categories based on the combined readiness of definitions and data sources.

Based on our assessment we can see that 29 indicators fall into the category of having both a definition and data source that are already ready. This means that approximately half of the Public Health Outcomes Framework indicators are ready for the framework now without any further development work being necessary.

			Data source		
			A	B	C
			Ready	Needs further development	New data source required
Definition	1	Ready	29	7	0
	2	Needs further development	16	10	2
	3	New data source required	0	4	0

To show how we arrived at this summary table, we present a full indicator-by-indicator assessment of readiness for definitions and data sources on the next page.

Indicator-by-indicator assessment of readiness

	Readiness of definition	Readiness of data source
Indicators corresponding to overarching outcomes		
0.1 Healthy life expectancy	2	A
0.2 Differences in life expectancy and health expectancy between communities	2	A
Domain 1: Improving the wider determinants of health		
1.1: Children in poverty	1	A
1.2: School readiness (Placeholder)	2	B
1.3: Pupil absence	1	A
1.4: First-time entrants to the youth justice system	1	B
1.5: 16-18 year olds not in education, employment or training	1	A
1.6: People with mental illness and/or disability in settled accommodation	1	A
1.7: People in prison who have a mental illness or significant mental illness (Placeholder)	2	B
1.8: Employment for those with a long-term health condition, including those with a learning difficulty/disability or mental illness	2	A
1.9: Sickness absence rate	2	B
1.10: Killed and seriously injured casualties on England's roads	1	A
1.11: Domestic abuse	2	B
1.12: Violent crime (including sexual violence) (Placeholder)	2	B
1.13: Re-offending	1	A
1.14: The percentage of the population affected by noise (Placeholder)	2	A
1.15: Statutory homelessness	1	A
1.16: Utilisation of green space for exercise/health reasons	1	A
1.17: Fuel poverty	1	A
1.18: Social connectedness (Placeholder)	3	B
1.19: Older people's perception of community safety (Placeholder)	2	B

	Readiness of definition	Readiness of data source
Domain 2: Health improvement		
2.1: Low birth weight of term babies	1	A
2.2: Breastfeeding	1	B
2.3: Smoking status at time of delivery	1	B
2.4: Under 18 conceptions	1	A
2.5: Child development at 2-2.5 years (Placeholder)	3	B
2.6: Excess weight in 4-5 and 10-11 year olds	1	A
2.7: Hospital admissions caused by unintentional and deliberate injuries in under 18s	1	A
2.8 Emotional wellbeing of looked after children (Placeholder)	2	A
2.9: Smoking prevalence – 15 year olds	1	B
2.10: Hospital admissions as a result of self-harm	1	A
2.11: Diet (Placeholder)	2	B
2.12: Excess weight in adults	1	B
2.13: Proportion of physically active and inactive adults	1	A
2.14: Smoking prevalence – adults (over 18s)	1	A
2.15: Successful completion of drug treatment	1	A
2.16: People entering prison with substance dependence issues who are previously not known to community treatment	2	B
2.17: Recorded diabetes	2	A
2.18: Alcohol-related admissions to hospital	2	A
2.19: Cancer diagnosed at stage 1 and 2 (Placeholder)	2	C
2.20: Cancer screening coverage	1	A
2.21: Access to non-cancer screening programmes	1	B
2.22: Take up of the NHS Health Check programme – by those eligible	1	A
2.23: Self-reported wellbeing	1	A
2.24: Falls and fall injuries in the over 65s	2	A

	Readiness of definition	Readiness of data source
Domain 3: Health protection		
3.1: Air pollution	1	A
3.2: Chlamydia diagnoses (15-24 year olds)	1	A
3.3: Population vaccination coverage	1	A
3.4: People presenting with HIV at a late stage of infection	1	A
3.5: Treatment completion for tuberculosis	1	A
3.6: Public sector organisations with board-approved sustainable development management plan	2	B
3.7: Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)	2	C
Domain 4: Healthcare public health and preventing premature mortality		
4.1: Infant mortality	1	A
4.2: Tooth decay in children aged five years	1	B
4.3 Mortality from causes considered preventable	2	A
4.4 Mortality from cardiovascular diseases (including heart disease and stroke)	2	A
4.5 Mortality from cancer	2	A
4.6 Mortality from liver disease	2	A
4.7 Mortality from respiratory diseases	2	A
4.8: Mortality from communicable diseases (Placeholder)	2	A
4.9: Excess under 75 mortality in adults with serious mental illness (Placeholder)	2	B
4.10: Suicide	1	A
4.11: Emergency readmissions within 30 days of discharge from hospital (Placeholder)	2	A
4.12: Preventable sight loss	2	A
4.13: Health-related quality of life for older people (Placeholder)	3	B
4.14: Hip fractures in over 65s	1	A
4.15: Excess winter deaths	1	A
4.16: Dementia and its impacts (Placeholder)	3	B

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Rotherham NHS Stop Smoking Service

Annual Report 2010-11

Simon Lister

Service Manager

Contents **Page**

Rotherham NHS Stop Smoking Service Mission Statement
To provide high quality and value for money stop smoking services to people who live or work in Rotherham.

Introduction
Smoking remains the largest cause of preventable illness and premature death in the UK, in Rotherham smoking results in about 500 premature deaths per year. Stop smoking interventions are proven to be both effective and cost effective ways of reducing illness and preventing premature deaths.

Aim of report
The aim of the report is to highlight the achievements of Rotherham NHS Stop Smoking Service (RSSS) over the last year and to consider the challenges currently facing the service.

RSSS is specialist service that provides support for anyone who lives or works in Rotherham. The service provides one to one, drop-in, group and telephone support. Sessions are delivered in a number of venues across Rotherham (including the Quit Stop in the town centre) during the day, evenings and Saturday mornings. The service also provides:

- A dedicated service for pregnant women and their partners
- A dedicated service within secondary care which includes the Stop Smoking Centre in the Rotherham Hospital foyer
- Training and support for a large network of intermediate advisors working predominantly in primary care.
- Brief intervention and very brief intervention training for staff across the health community
- Promotional work
- Data management for all specialist and Locally Enhanced Service providers

Service Objectives
Rotherham NHS Stop Smoking service is commissioned by NHS Rotherham. The service specification contains a number of very challenging objectives including:

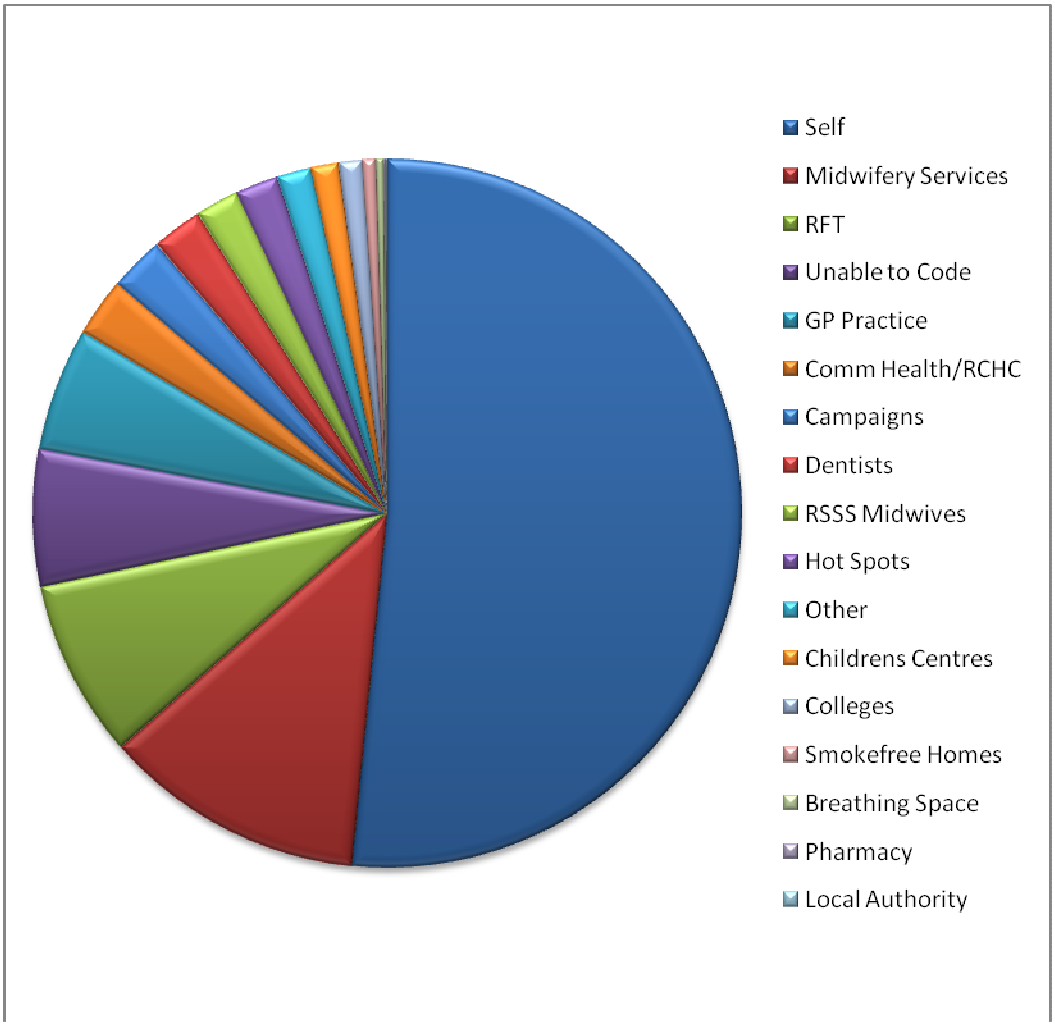
- Meet the specific 4-week quitter target (1,850/annum)
- Meet the specific pregnant women 4-week quitter target (160/annum)
- Achieve an average of 50% conversion rate
- Achieve 85% CO verification rate of clients who quit
- Support the achievement of the LES target (1,000/annum)
- Contribute to the reduction of health inequalities by targeting specific groups e.g. routine and manual groups, pregnant smokers, young people, Black Ethnic and Minority groups (BME), patients suffering with mental health and deprived communities.

The service specification for 2010-11 contained significant financial penalties should the service not meet the 4-week quitter, pregnant women 4-week quitter and conversion rate targets. These penalties have subsequently been removed.

Performance Data

Referral source (N= 6,572 RSSS only)

The single largest referral source by far is 'self' followed by the midwifery service and the Rotherham NHS Foundation Trust (TRFT). The midwifery service has an opt-out referral system whereby all smoking pregnant women are referred unless the specifically ask not to be. Although GP practices account for the fourth largest source of referrals, previous audits have demonstrated a very large variance in referral rates between practices. Referrals from pharmacies and RCHS remain disappointing



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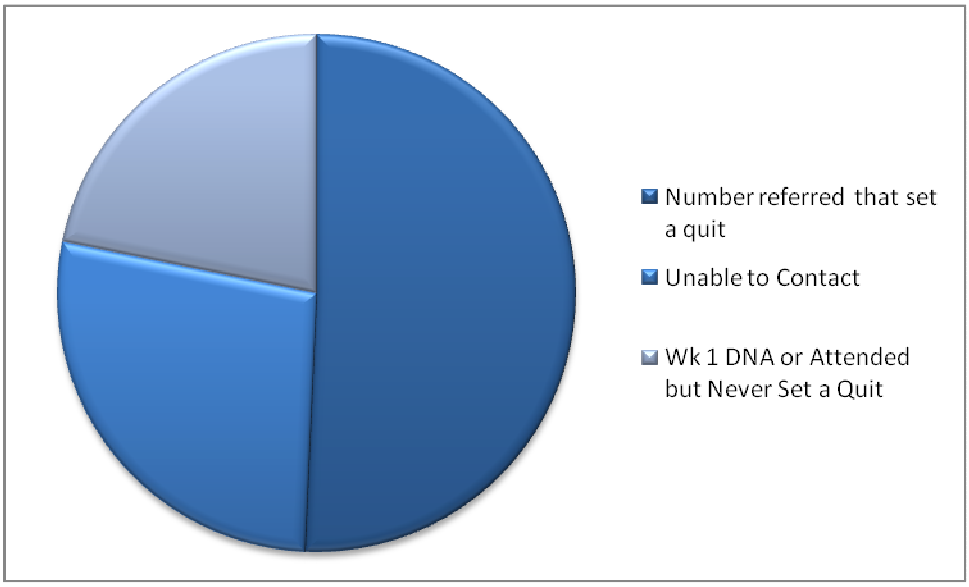
Ratio of referrals to quitters

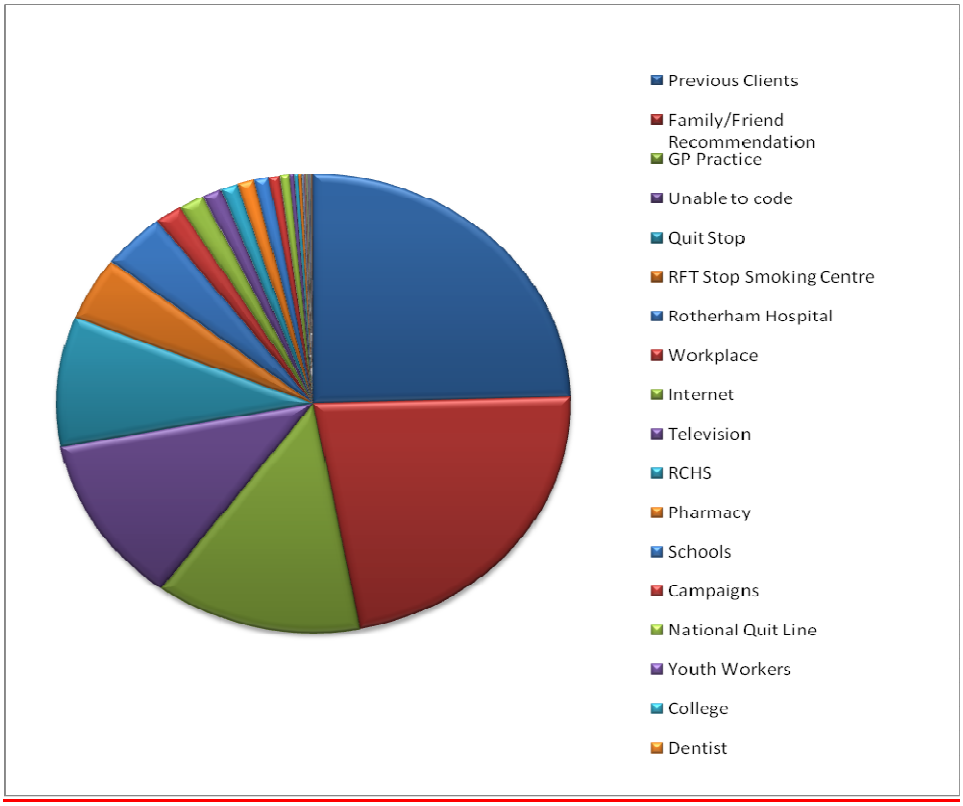
Of the 6,572 referrals received by RSSS, only about half (3,333) attended and set a quit date. RSSS was unable to contact 1,807 and a further 1,432 were contacted but did not attend or attended but did not set a quit date. RSSS needs to develop interventions to increase the ratio of quitters to referrals.

Since last year much progress has been made with this issue. RSSS has introduced digital pen technology and trained 28 out of 44 LES advisors to input data directly onto quitmanager (the services database). This has released some administration time (previously data was collected on paper forms and manually inputted onto the database) to facilitate the implementation of an improved referral management system. RSSS has also been working with the provider of quitmanager to develop a sophisticated referral management system and has developed a number of resources (letters and leaflets) to mail out to clients. It is intended that clients will also receive text message appointment reminders and it is anticipated that the system will be implemented early in the New Year.

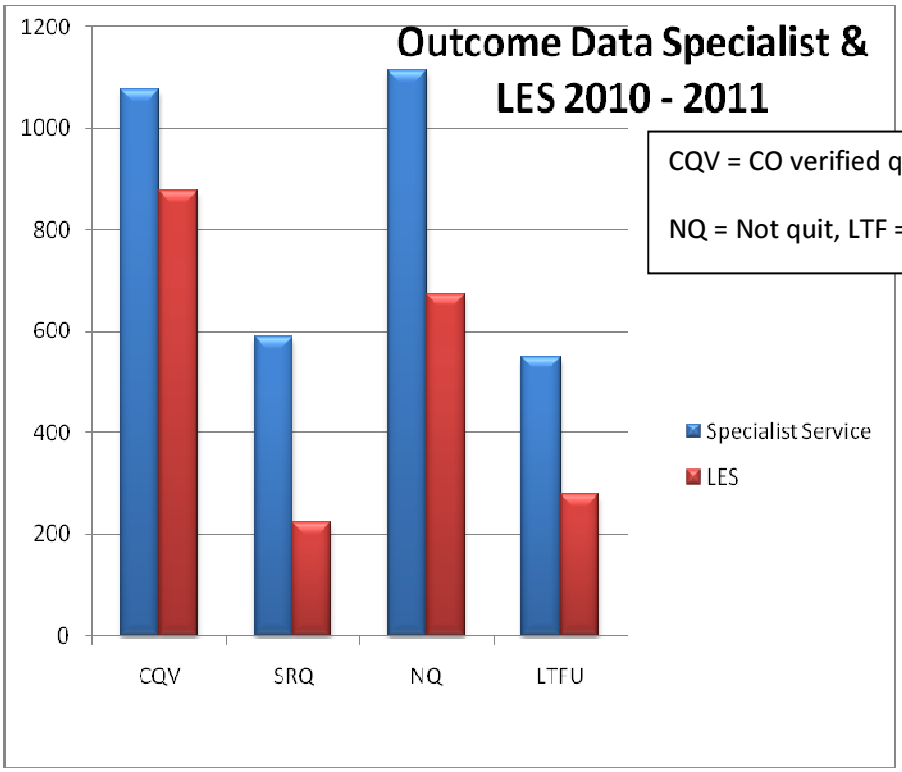


Self referral awareness source (RSSS only)

The main awareness source for self referrals are previous clients and friend and family, which accounted for nearly half of all awareness source. RSSS has recently introduced a ‘member get member’ scheme to maximise the number of referrals from this route. Clients finding the service simply by walking past the Quit Stop and the Stop Smoking Centre in the RFT make a significant contribution to the total number of self referrals, the two ‘shops’ therefore represent an important part of service marketing. GP’s make up the bulk of awareness source for the remainder of self referrals with some from RSSS internet and direct marketing campaigns.



Outcome data (all outcomes by specialist and LES)

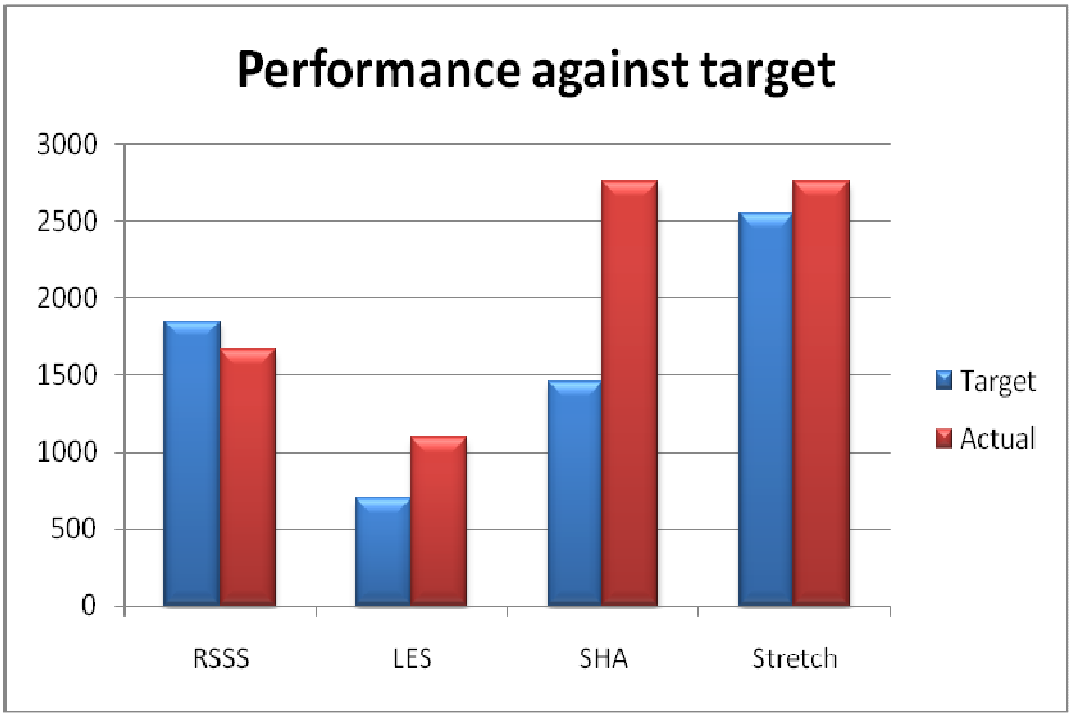


CQV = CO verified quitter, SRQ = Self report quitter,

NQ = Not quit, LTF = lost to F/U

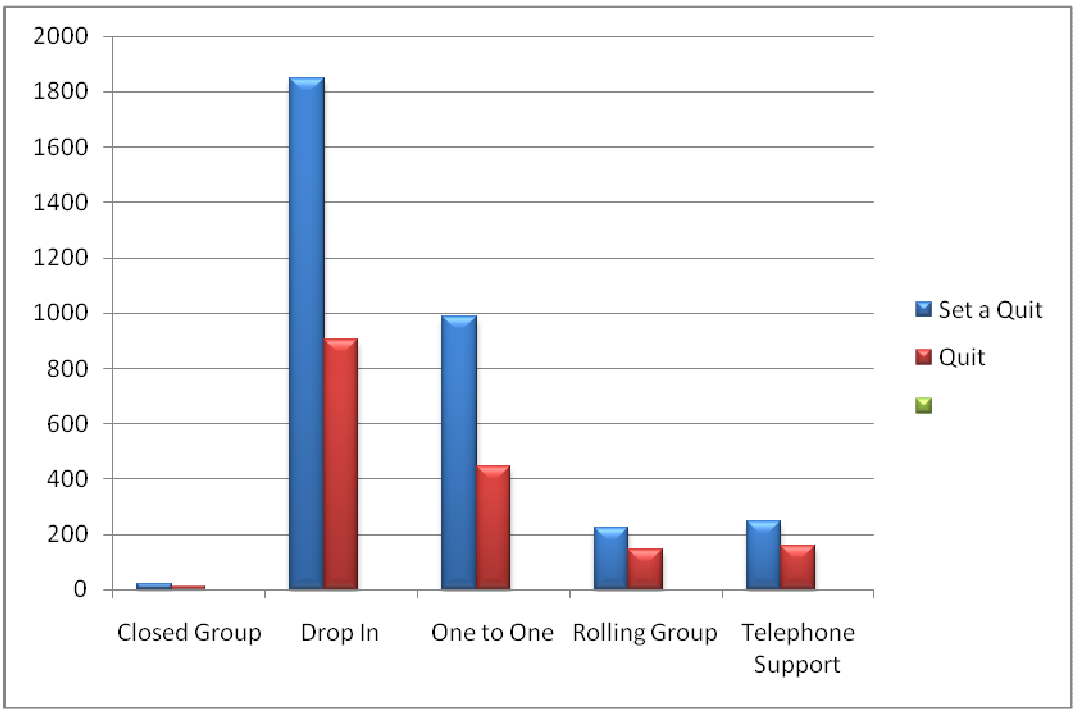
Overall quit rates in 2010-11 for RSSS and the LES were 50% and 53.4% respectively. RSSS quit rate has improved from 46.6 % in the previous year, the LES quit rate had decreased slightly from 57.7% in the previous year.
RSSS has a higher ratio of self report quitters than the LES 35% and 20% respectively. The probable explanation for this is that RSSS provides a dedicated telephone service whereas the LES provides face to face support only.
In 2009-10 RSSS had significantly higher 'Lost to Follow-up' rates (22% against 7%) than the LES. To address this RSSS introduced an initiative whereby follow-up was conducted by the out of hour's telephone service. In 2010-11RSSS reduced it's lost to follow-up rates to 16.5% whereas the LES lost to follow-up rate increased to 13.3%.

Performance against target
RSSS failed to meet the local 4 week quitter target in 2010-11(1662 actual, against 1850 target). However RSSS was in dispute with NHSR for much of the year regarding this target. During 2010-11 RSSS advisor staff establishment reduced by nearly one third due to temporary contracts coming to an end and staff not being replaced. At the same time NHSR expected RSSS to deliver the outturn of the previous year when all the additional staff were in post. The LES exceeded its target delivering 1089 quitters against a target of 700. Taken together the Specialist service and LES exceeded both the Strategic Health Authority and local stretch 4 week quitter targets.



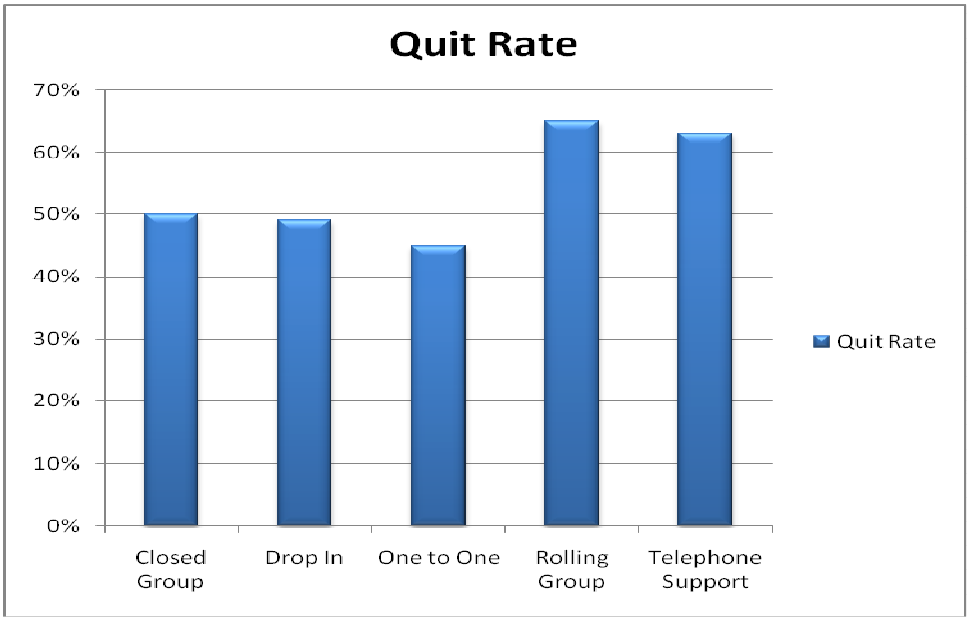
Quitters by Intervention Type (RSSS only)

The greatest number of quitters attended either drop-in or one to one sessions



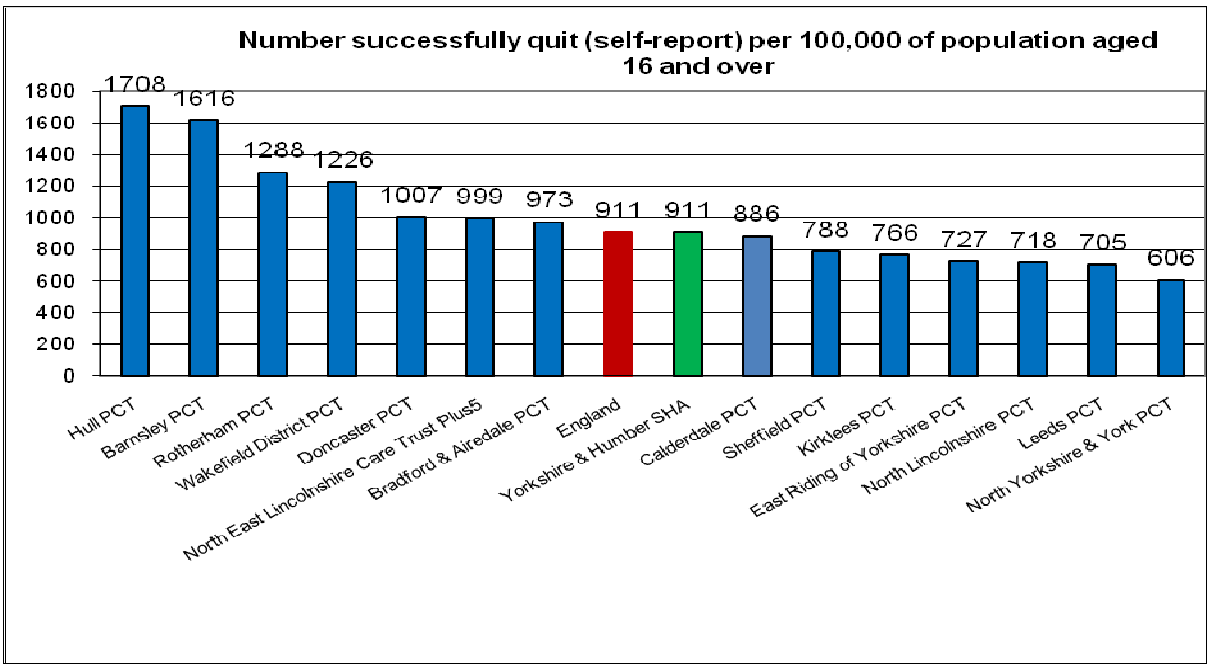
Quit rate by intervention type (RSSS only)

The greatest quit rate was achieved from rolling groups or telephone support, the lowest from one to one sessions.



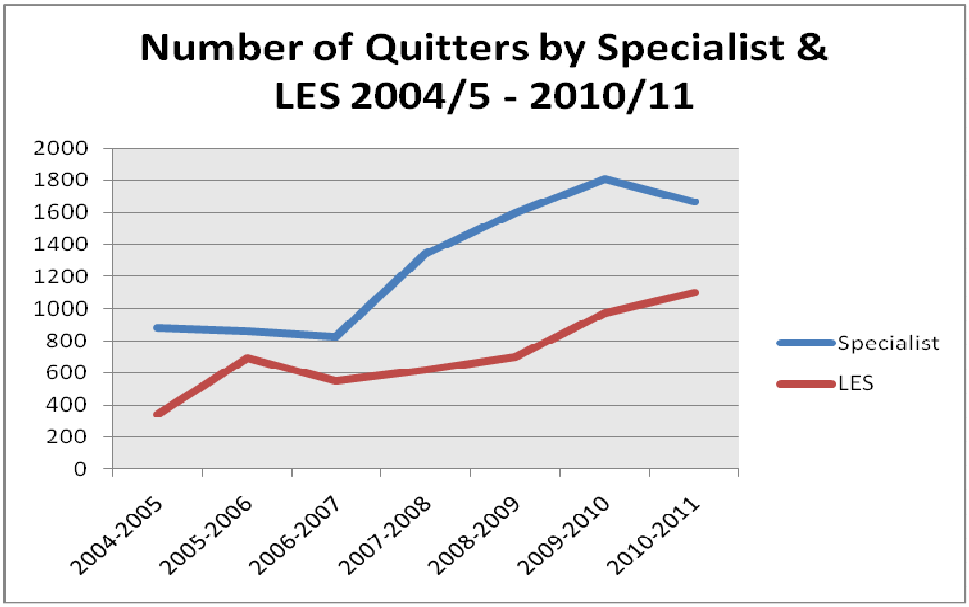
Number successfully quit (self-report) per 100,000 of population aged 16 and over, by PCT 2010-11

The chart below shows comparative quitter data by PCT across the region for 2010-11 (includes both RSSS and LES activity). Rotherham compares very favourably with other PCT's in the region in terms of quitters per 100,000 of population, delivering well over the England and regional averages.

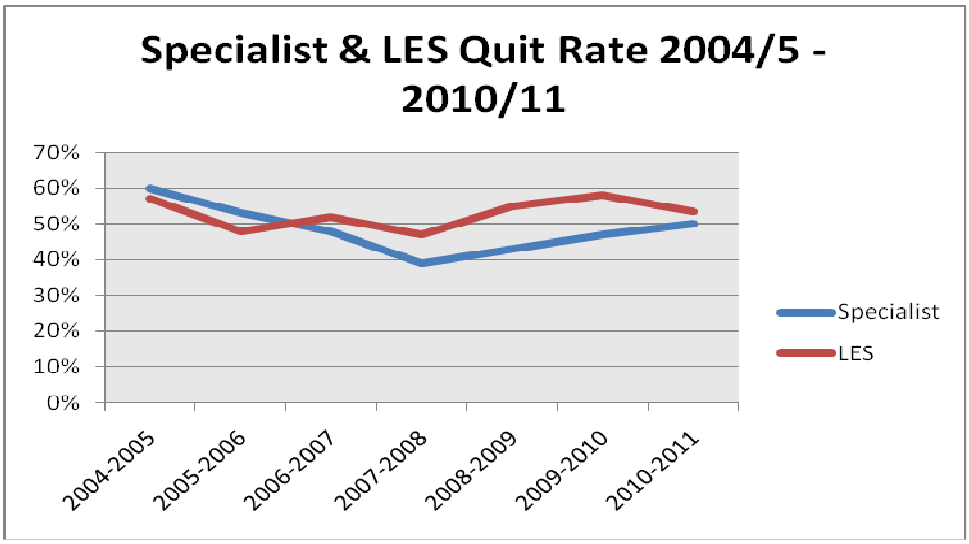


Number of Quitters Over Time by Specialist and LES

Between 2005-10 the number of RSSS quitters per year more than doubled but activity has dipped in the last year, at the same time LES quitter activity per year has nearly trebled.



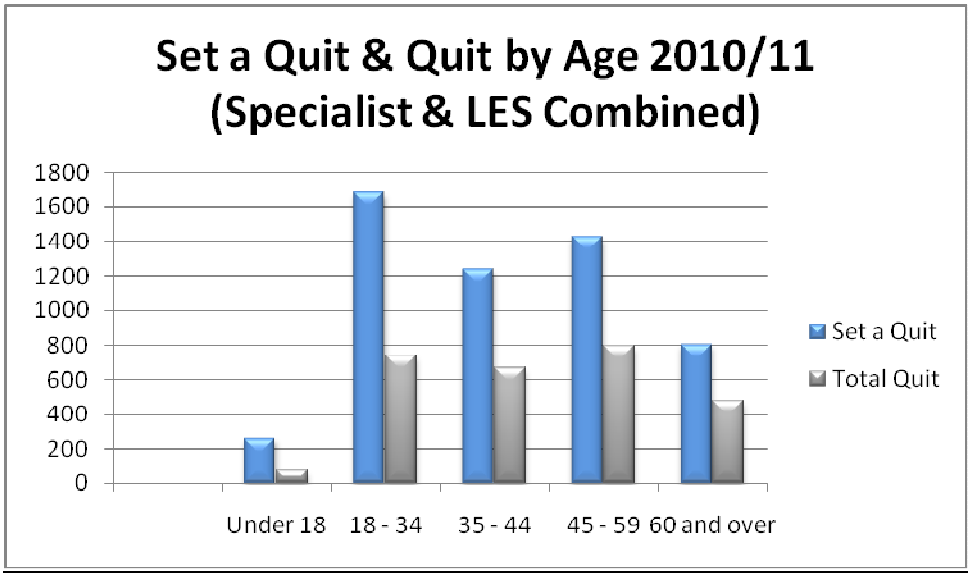
Specialist and LES Quit Rate Over Time by Specialist and LES



In 2010-11 the quit rate for the specialist service was slightly lower than that of the LES (50% compared to 53%). This represents an improvement for RSSS of nearly 4% on the previous year, the LES quit rate reduced slightly over the same period. The specialist service previously had quit rates of 60% but this has declined over recent years, however the quit rate has improved since its low point in 2007-8. It is noteworthy that the reduction in quit rate has occurred at the same time as the dramatic increase in the absolute number of quitters delivered by the Specialist Service. This has been associated with interventions aimed at increasing access to meet increasing quitter targets.

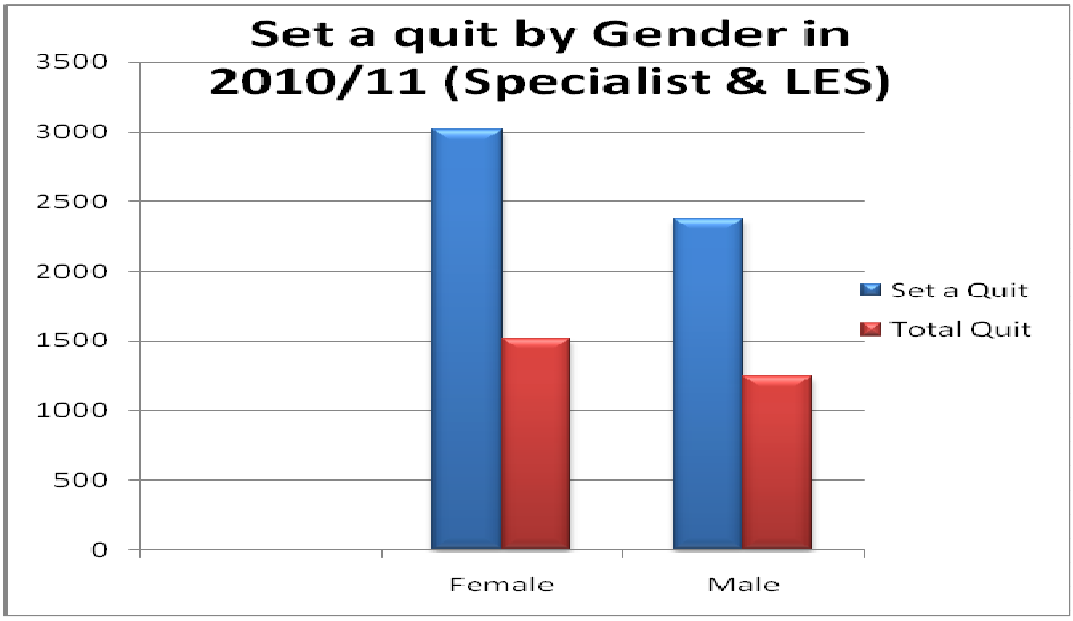
Set a quit and quit by Age in 2009/10 (Specialist and LES combined

A similar number of clients quit across age groups 18-59, however quit rates were lower in the 18-34 age group. Not surprisingly few clients aged under 18 quit and the quit rate in this group was very low (see graph below).



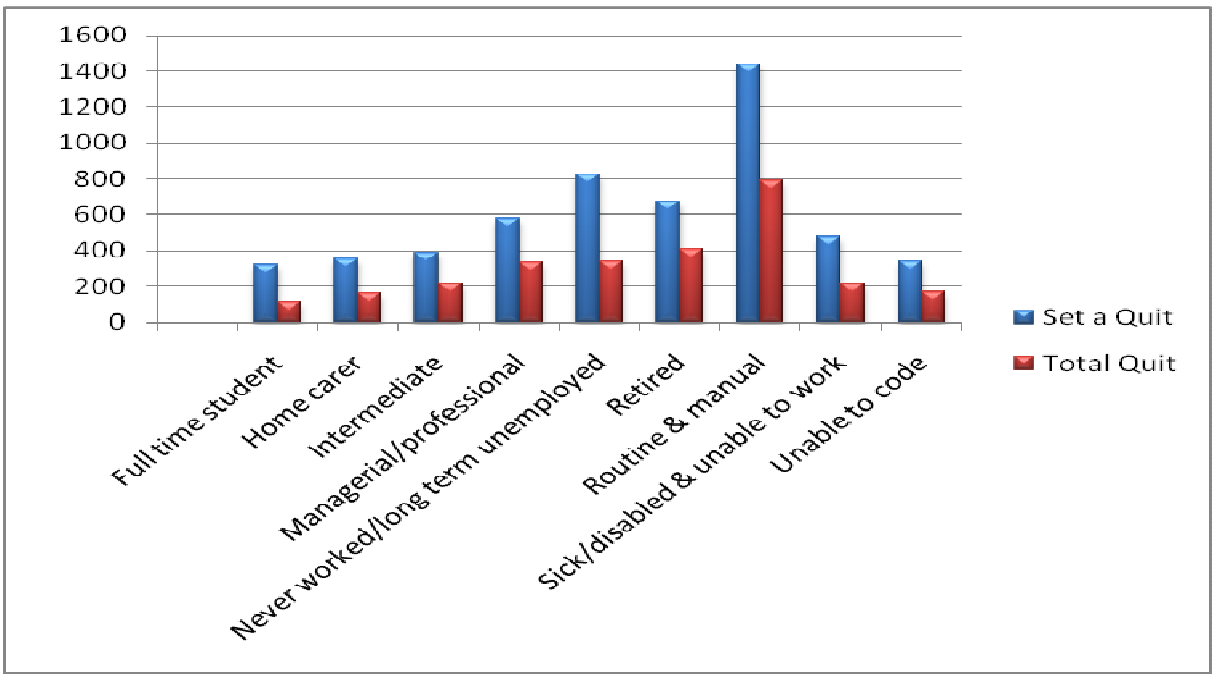
Set a quit and quit by Gender in 2009/10 (Specialist and LES)

Significantly more women attend stop smoking services and quit compared to men but men have a slightly higher quit rate. The differences in attendance and quit rates due to gender remain unchanged from last year. The targeting of pregnant women with 3 WTE staff could at least partially explain why there are more women quitters.



Set a Quit and Quit by Occupation

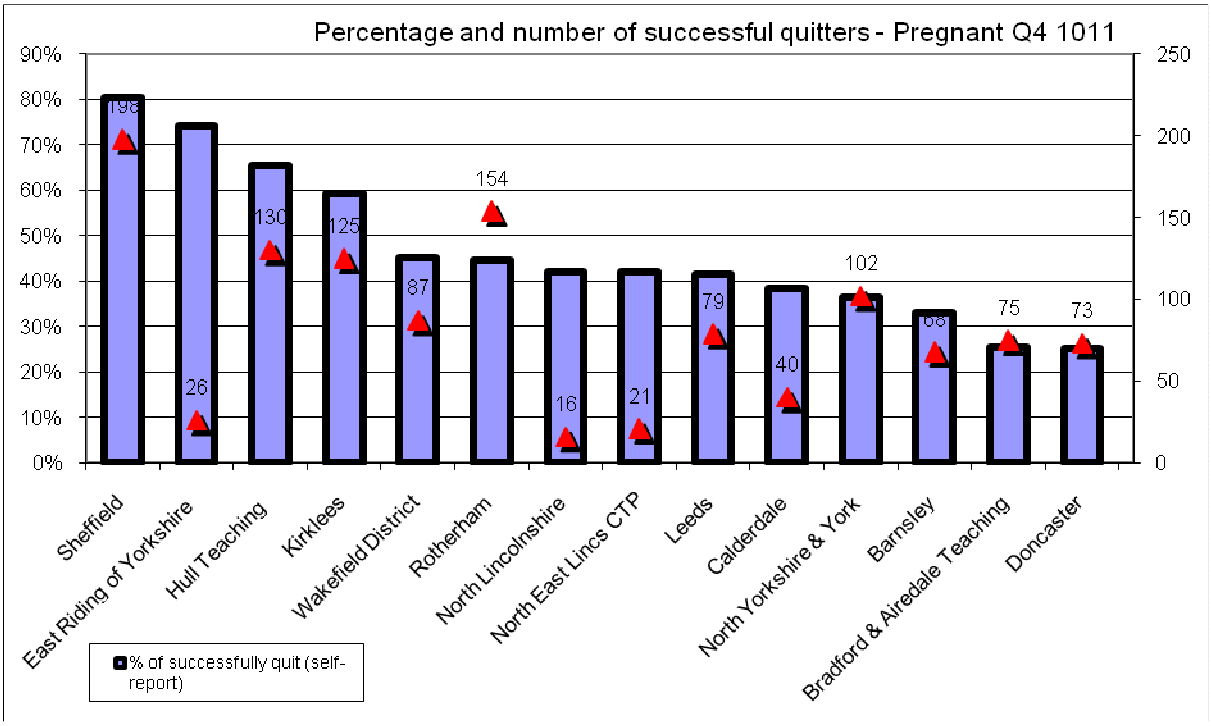
Routine and manual workers (R&M) are a key target group for stop smoking services. The above graph would suggest that R&M smokers are being effectively targeted within Rotherham.



Pregnant Women

In 2010-11 RSSS delivered 161 pregnant women quitters against a target of 160, increasing from 143 quitters in the previous year. It is worth noting that RSSS delivered the second highest number of pregnancy quitters in the region (Sheffield recorded the highest), a significant achievement for a service covering an area the size of Rotherham (the discrepancy in graph below and total number of pregnant women quitters was due to delays in reporting).

RSSS has continued to work closely with NHS Rotherham and TRFT maternity services to deliver the Rotherham smoking in pregnancy pathway. The pathway is the first in the country to integrate RSSS within maternity services such that all pregnant smokers are seen by the RSSS specialist midwife whilst attending their maternity outpatient appointment.



Primary Care and the Locally Enhanced Service

RSSS provides support for staff in primary care (mainly GP practices and pharmacies) to deliver stop smoking interventions including the Locally Enhanced Service (LES).

The LES delivered 1089/2751 (40%) of the total quitters in 2010-11, compared to 975/2783 (35%) in the previous year.

In 2010-11 there were 34 GP practices, 32 pharmacies and 5 dental surgeries delivering the LES. However there was a large variance in performance between providers, providers did not always have a service level agreement with NHSR and access to stop smoking services was not equal across the borough. Therefore RSSS has worked closely with NHSR to improve the co-ordination of RSSS and LES

delivery and to improve the performance management of the LES, this work is ongoing.

Quit-Stop
The Quit-Stop is located at 16 Bridgegate in Rotherham town centre. The Quit-Stop is open Monday to Saturday, one to one appointments and drop-in sessions are available. It delivered 715/1662 (43%) of all Rotherham NHS Stop Smoking service's quitters and therefore represents a very important part of the service. The quit rate was 47%.

Community Sessions
During 2010-11 RSSS delivered between 8-12 daytime and 5-8 evening sessions per week. The sessions were typically delivered in health centres and GP practices but some were delivered in pharmacies and even public houses. Over the course of the year most of these sessions were delivered as groups. Taken together the community sessions supported 810 clients to set a quit and 445 to quit, giving a quit rate of 55%.

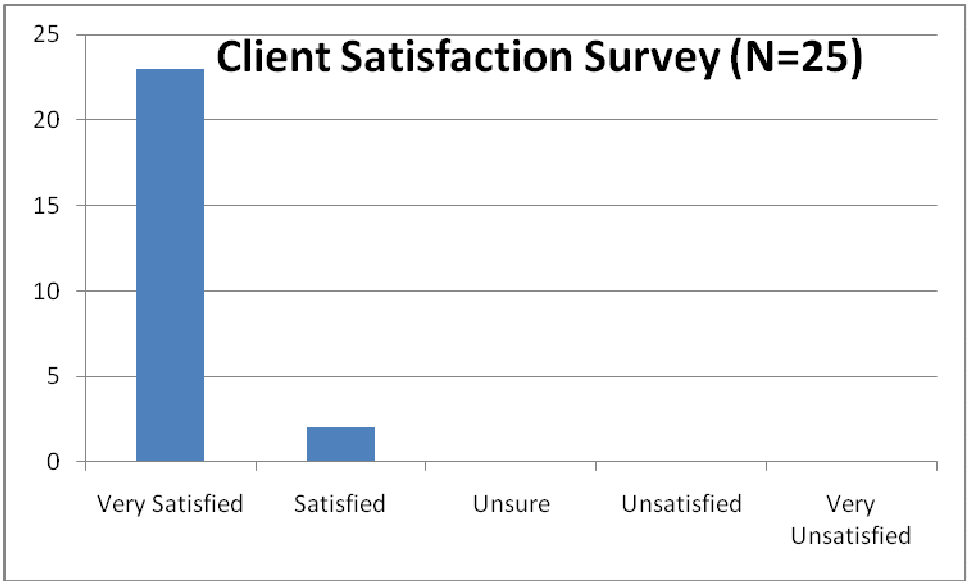
Rotherham Hospital
RSSS provides support for patients, visitors and staff via the Stop Smoking Centre, located in the Health Information area within the recently redeveloped main concourse of Rotherham Hospital. The facilities in the health Information area are much improved from the previous unit and include a private consultation room. The centre opening times are coterminous with the outpatient department opening times. In 2010-11 the centre in the hospital supported 315 clients to set a quit date, 134 quit giving a quit rate of 43%.

Telephone Service
RSSS introduced an out of hours, pro-active telephone support service in January 2010, operating Monday to Thursday 5-8pm. The service is the first and only of its kind in the region and has proven very successful. In 2010-11, it supported 269 clients to set a quit date, of these 169 quit, giving a quit rate of 63%. The CO validation rate for the telephone service is 24%, hence some work is needed to increase the number of clients attending at the 4 week quit point and blowing into a CO monitor.

Patient and Public Engagement
Stop Smoking Services, unlike all other NHS services are constantly under pressure to recruit clients in order to meet very challenging quitter targets. RSSS developed a comprehensive marketing plan which included a combination of stakeholder activation and various forms of direct marketing, including internet, face to face and the Quit-stop window campaigns. RSSS also contributed significantly to the

development of the NHSR website and since the reorganisation of service structures in 2011 RSSS has developed content within the TRFT internet and intranet sites.

Levels of client satisfaction with RSSS are consistently very high with 100% of clients within a survey reporting they are very satisfied or satisfied with the service they received.



Staff Training and Development

RSSS strongly believes in staff development. In addition to the corporate Personal Development Review process RSSS has adopted the regional Tobacco Control Office continuing professional development pack for all specialist and advisor staff. In the last year all RSSS advisor and specialist staff also completed Stage 1 training with the NHS Centre for Smoking Cessation Training and RSSS was compliant with local mandatory training standards.

Challenges and Aspirations

2010-11 was a very challenging year for RSSS. During the year the service lost nearly a third of its advisor and half of its administration establishment due to temporary contracts coming to an end and staff not being replaced. At the same time the 4 week quitter target was increased from 1550 to 1850. These changes led to a review of the service structure with consequent changes to roles and responsibilities and a review of service provision.

Looking ahead 2011-12 will be another very challenging year for RSSS, the main challenge again for the service will be to meet the performance and quality targets

set out in the service specification but with a reduced establishment. This will mean the service will need to find ways of significantly increasing productivity.

Aspirations

1. Meet all performance and quality targets.
2. Maximise the functionality of the ‘quitmanager’ database and mobile technology.
3. Improve referral management and follow-up systems.
4. Continue to review options for service delivery linked to target achievement (this will include increasing the ratio of group sessions to one to one and drop-in).
5. Maintain the improvement in the co-ordination and performance management of the LES.
6. Continue to support staff learning and development.
7. Work with the GP pathway lead to include referral to stop smoking services in all chronic disease pathways.

Keeping Warm in Yorkshire and Humber: briefing document

Purpose: Information and clarification

Background

A number of organisations came together to secure funding from the Department of Health 'Warm Homes, Healthy People Fund for 2012 for a project to help staff to plan and prepare more effectively, in line with the Cold Weather Plan for England. The project funding is hosted by Rotherham MBC and NHS Rotherham, on behalf of all the partners.

What is the problem and why are we doing this work?

Last year across Yorkshire and the Humber 2754[1] people are estimated to have died from illness due to being too cold in their own homes (see below for local breakdowns). These were preventable deaths and by encouraging people to take simple actions and invest in future warmth, we believe we can reduce the impact of cold weather and improve the lives of some of our most vulnerable citizens.

Under the Cold Weather Plan[2] local organisations and individuals are expected to take certain actions at each of four levels:-
1 - long term planning and winter preparedness
2 - alert and readiness
3 - severe weather action
4 – Major incident & emergency response.

What are we trying to achieve?

To make sure that vulnerable older people receive correct, clear, consistent, useful and actionable advice and information from the local organisations they come into contact with, in line with the 'four stages of preparedness' in the cold weather plan.

Why 'older' people?

Many different groups within society can be considered 'vulnerable' to the adverse affects of cold weather. However, for this project we are targeting the people who we consider to be most at risk of serious illness or even death.

The person may be;	They may have health problems including;	Their circumstances may include;
• Over 75 years old • Elderly and living alone	• Frail • Pre-existing cardiovascular or respiratory illnesses and other chronic medical conditions	• Living in deprived circumstances • Living in a home with mould • Being fuel poor (needing to

[1] Three year average per Local Authority area. Source: Yorkshire and Humber Public Health Observatory 2011

[2] Cold Weather Plan for England: Protecting health and reducing harm from severe cold weather – The Department of Health November 2011

	• Severe mental illness or Dementia	spend 10% or more of household income on heating the home)

How will we achieve this?

Working collaboratively to produce a package of tools and resources to help staff to plan, prepare and communicate with older people, their families and carers, about keeping warm in winter.

We will build on the latest insights from research into what older people believe and do and the most effective ways to help them. Developing and using a common set of tools should increase the impact and effectiveness of communication and help to build greater understanding within local organisations about how to work together on this aspect of their winter plans. It should also reduce duplicated effort, freeing up staff time and resources.

Who is involved?

The following organisations are involved;

- The NHS
- Local Authority
- Department for Work and Pensions
- AGE UK
- Sheffield Hallam University
- National Energy Action
- Department of Health
- The Yorkshire and Humber Public Health Observatory

Spread the word

Please pass this briefing on to anyone within your network who may benefit from the information within it.

Local breakdowns

Area	Excess Winter Deaths	Area	Excess Winter Deaths
Selby	59	East Riding	192
Craven	50	Hambleton	44
Rotherham	188	North East Lincs	93
Doncaster	215	Leeds	350
Richmondshire	27	Barnsley	122
Ryedale	34	Wakefield	163
York	101	Scarborough	66
Kingston upon Hull	144	Bradford	217
Sheffield	284	Kirklees	171
North Lincs	93	Calderdale	82
		Harrogate	61

Three year average 2006/07 to 2008/09 – Source Yorkshire and Humber Public Health Observatory 2011

Contact details

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END