Table B Outcomes Framework

Question	(Draft) Response
1. How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?	• Consistent approach taken across all three Outcome Frameworks • Flexibility in how outcomes can be achieved • Reduction in bureaucracy • Staff engagement and Partnership Working. • Need clear agreements with partners in health.
2. Do you feel these are the right criteria to use in determining indicators for public health? • Are there evidence-based interventions to support this indicator? • Does this indicator reflect a major cause of premature mortality or avoidable death? • By improving on this indicator, can you help reduce inequalities in health? • Will this indicator be meaningful to the broader public health workforce and wider public? • Is this indicator likely to have a negative/adverse impact on defined groups? • Is it possible to set measures, SMART objectives 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?	Generally yes however some of the indicators are more objective and easy to measure than others. Information regarding the incidence of premature death can be based on defined criteria and can be easily measured and compared to other areas. The main causes of premature death have also been identified. Helping people recover from episodes of ill health can also be measured and judged on the extent to which and the time taken for them to regain independence. Again inequalities in these areas are easily identified and thus it should in theory be possible to identify remedial action. The other three domains are more subjective and harder to measure. Measuring people's satisfaction can be time consuming and may not always pick everything up. Quality of life indicators are also hard to define. At worst the indicator would have no effect on health inequalities and for the area of premature death and recovery, it has the potential to be a positive influence Comments in relation to road safety: • A programme of road safety and transport interventions is already in place with well established evidence bases to support the effectiveness of a range of initiatives. • Yes, road accidents are a major cause of death, especially among the 17 -24 year old age group who are over

	represented in road collision statistics. Lack of physical activity is identified in the white paper as a key reason for premature mortality. • By reducing the number of people killed and seriously injured (KSI) in road accidents, particularly in disadvantaged areas and among vulnerable road user groups, health inequalities can be reduced. An increase in the number of people walking or cycling will reduce mortality rates associated with obesity, stroke and heart disease. Fewer car trips generally will have a positive impact on road safety, health and wellbeing and air quality. • This indicator is easy to understand and meaningful as road safety issues affect most people to a greater or lesser degree. • Reducing the number of people killed and seriously injured should not have a negative/adverse impact on defined groups. • Well established monitoring arrangements are already in place to monitor progress with reducing KSIs (NI47) • Road accident data is supplied by South Yorkshire Police and kept by the council on a software package called 'Accsmap'. Regular counts and other face to face surveys adequately monitor sustainable travel modal split.
3. How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?	The outcome framework focuses on NHS provided services while recognising areas of overlap (particularly with Adult Social Care). However much health inequality is due to social deprivation and unhealthy lifestyles in early life. It is therefore important to ensure locally all strategic aims are aligned to ensure the most potential health gain will be wherever possible from those who experience the most inequality. In terms of road safety, the health premium should be linked to the rate of KSI reduction in disadvantaged areas (there is strong evidence that members of poorer communities are more likely to become road accident casualties than their better-off peers) compared with the borough as a whole. For sustainable and healthy travel the premium should be linked to the numbers of children and adults adopting better travel habits.

4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks? • Diagram on pg 14 showing how 3 frameworks sit together	A good quality JSNA is at the centre of the alignment and this is the right approach. The main weakness with the approach is it does not explicitly link in with wider areas of public policy. To promote prevention and early engagement resources not ring fenced to Social Care or health will need to be released. This is crucial to the prevention and early engagement agendas.
5. Do you agree with the overall framework and domains? • *Health protection and resilience* • *Tackling the wider determinants of health* • *Health improvement* • *Prevention of ill health* • *Healthy life expectancy and preventable mortality*	Agree in principle with these 5 domains. **Domain 2** in particular Addressing issues such as Child poverty fits in with comments earlier regarding fitting in with wider community plans **Domains 3, 4 and 5** Have specific and measurable objectives.
6. Have we missed out any indicators that you think we should include?	None that seem obvious
7. We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?	• D 2.1 Children in Poverty • D 1.4 Population Vaccination • D 1. 6 Public sector organisations with board approved sustainable development management plan. • D 2.9 People in long term unemployment • D2.8 Proportion of people with mental illness *and or disability* in employment • D2.10 Employment of people with long-term conditions • D 2.3 Housing overcrowding rates. • D2.13 Fuel Poverty • D 2.17 Older Peoples perception of community safety • D 2.16 Environmental noise • D 3.8 Under 18 conception rate • D 3.6 and 4.1 Injuries to people aged 5 to 18 and 1 -5 • D 3.3 Smoking Prevalence • D 4.3 and 4.4 Prevalence of Breast feeding and low birth weight

	• D 4.7 Screening uptake • D 4.8 Chlamydia diagnosis rates per 100,000 young adults aged 15-24 • D 4.9 Proportion of persons presenting with HIV at a late stage of • Infection • D 4.11 Maternal smoking prevalence • D 4.13 Emergency readmission rate to hospital • D 4.15 Acute admission due to falls • D 5.1 Infant mortality • D 5.4 Mortality From cardiovascular diseases of people under the age of 75 • D 5.5 Mortality From cancer of people under the age of 75 • D5.9 Excess seasonal mortality
8. Are there indicators here that you think we should not include?	Some for example deaths from communicable diseases and deaths from respiratory diseases could be absorbed into excess seasonal deaths. **Suggested indicators to be taken out:** • D4.14 Health related quality of life for older people (placeholder) could be taken out as it rather subjective • D 4.6 Work sickness absence rate is a wide ranging issue and possibly too big for this agenda • D 4.5 Prevalence of recorded diabetes. Not clear why we need to know this • D 310 Self reported wellbeing is too subjective and gain from info gained probably doesn't justify the effort to obtain the information
9. How can we improve indicators we have proposed here?	Set benchmarks on which success will be judged In terms of the road safety KSI indicator this could be broken down into indicators for the number of people killed and the number seriously injured so that it is in line with indicators likely to be used in the government's new road strategy.

10. Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)	**D2.13** Fuel Poverty (To address this investment is needed in short term. However long term benefits in terms of health and economic wellbeing over a 5 to 10 year period will be significant) **D 2.9** People in long term unemployment (The negative effects of this are immense. It has a negative effect on health, economic regeneration and contributions to savings and pensions. This means higher dependency on means tested services in later life. Investment to encourage employers to create and sustain employment opportunities to see out the current difficult environment will have huge benefits over a 15 to 20 year period. **D 2.3** Housing overcrowding rates. While families are living in overcrowded housing due to affordability issues, many older people are living in larger houses. Incentives to build more suitable accommodation for older people with incentives to move could go a long way to addressing the acute shortage of suitable accommodation for families.
11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?	This seems a sensible proposition. Preventable mortality requires interventions before health problems escalate as well as good quality acute care when crisis point is reached.
12. How well do the indicators promote a life-course approach to public health?	The inclusion of a large number of indicators covering outcomes for children suggests that a whole life approach is being taken