ROTHERHAM BOROUGH COUNCIL –
REPORT to HEALTH AND WELLBEING BOARD

1.	**Meeting**	**Health and Wellbeing Board**
2.	**Date**	**02/06/2014**
3.	**Title**	**Public Health Outcome Framework**
4.	**Directorate**	**NAS**

5. Summary

For adults there are three outcomes frameworks, one each for public health, NHS and adult social care.
The frameworks set out high level domain areas for improvement, alongside supporting indicators, to track progress without overshadowing our locally agreed priorities. They help highlight common challenges at the local level across the health and care system, inform local priorities and joint action, whilst reflecting the different accountability mechanisms in place. They are therefore critical to informing the joint strategic needs assessments and the Health & Wellbeing strategy.
The purpose of the Public Health outcomes framework is to provide transparency and accountability across the health and care system, setting out opportunities for local partnerships to improve and protect health and improve services.

This is focussed on two high level outcomes:

1. Increased healthy life expectancy (takes account of quality and length of life).
2. Reduced inequalities in life expectancy and healthy life expectancy between communities (through greater improvement in the more disadvantaged).

There are 66 public health indicators across the 4 domains:

1. Improving the wider determinants of health
2. Health improvement
3. Health protection
4. Healthcare public health and preventing premature mortality

The Public Health Indicators contain shared indicators with the NHS and Social Care Outcome frameworks. They include outcome indicators for children. This overlap is illustrated in the diagram at the end of this report.

6.Recommendations

The Board note progress against comparable areas.

That the Board support the work to improve performance against the Outcome Framework and the operation of performance clinics.

That the key priority areas identified are tackled as multiagency performance clinics.

7. Proposals and details

Overarching Indicators

For avoidable mortality Rotherham is currently ranked as the best (ranked 1st out of 15) of comparable local authority areas. It is ranked 94th out of 150 local authorities nationally and is ranked as poorly performing.

1. **Improving the wider determinants of health**

Child poverty, school readiness and pupil absence are all rated red. Young people not in education or training is rated red. Sickness absence rates are high and there appears to be an excess of admissions to hospital from violent crime.
There is a high level of noise complaints and poor utilisation of outdoor space.

2. **Health Improvement**

Breast feeding rates are poor and smoking at delivery is high. This is reflected in low birth weight of term babies – a marker of poor maternal health.
Adults are inactive and smoke too much. The drug service is not withdrawing as many people from opiate dependency as comparators.
Diabetic retinopathy screening is not meeting national targets.

3. **Health Protection**

No outlying Indicators

4. **Healthcare public health and preventing premature mortality.**

About one third of the excess avoidable mortality seen in Rotherham is caused by the 3 main causes of death, cardiovascular disease (heart attack and stroke), cancer (mainly lung cancer) and respiratory disease (pneumonia and chronic lung diseases). Mortality rates appear high for communicable disease, this formed part of the analysis in the Director of Public Health annual report which identified pneumonia as contributing to both this indicator and the indicator for respiratory disease.
A detailed analysis of the mortality indicators is included in this years DPH Annual Report and this forms the basis for action planning to reduce mortality.
A separate report Reducing Potential years of Life Lost accompanies this report.

8. Finance

Not applicable

9. Risks and uncertainties

Differences in health outcomes reflect, and are caused by, social and economic inequalities in society.
Unhealthy behaviour and access to healthcare are not the only factors that cause health inequalities. Genetics, environmental influences, infectious disease play a significant part.
People in poorer areas die earlier but spend more of their shorter lives with a disability. The response needs to be across the life course and reflect need at the life stage.

Key Priority Areas

- Emergency Readmissions
- Maternal health
- Physical activity related to health
- Healthcare plans should specifically address disease causes of inequalities
- Obesity management of the metabolic consequences
- Workplace Health

10. Policy and Performance Agenda Implications
Performance Clinics
2 multi agency performance clinics have been held and one further on Breastfeeding.

Key Actions Agreed from the two performance clinics April 2014

- Obesity
  - Better management information needed to track improvement
  - Development of wider council policies to prevent obesity
  - Better information to all services
  - Developing Single Point of Access to weight management services
  - Targeting children in reception years
  - Increase in prevention/lower level interventions
  - Common Assessment Framework for children identified as needing support
  - Active partnership with Green Spaces

- Drug Treatment
  - Work with GP's to increase support
  - Deliver the new recovery hub
  - Targeted action at GP's with high volumes of users and new entrants – top 5 priority areas
  - Improve housing advice.
  - Need only 20 more successful treatments to be national average

11. Background Papers and Consultation

http://longerlives.phe.org.uk/area-details#are/E08000018/par/E92000001

http://www.phoutcomes.info/

12. Keywords: [Keywords]

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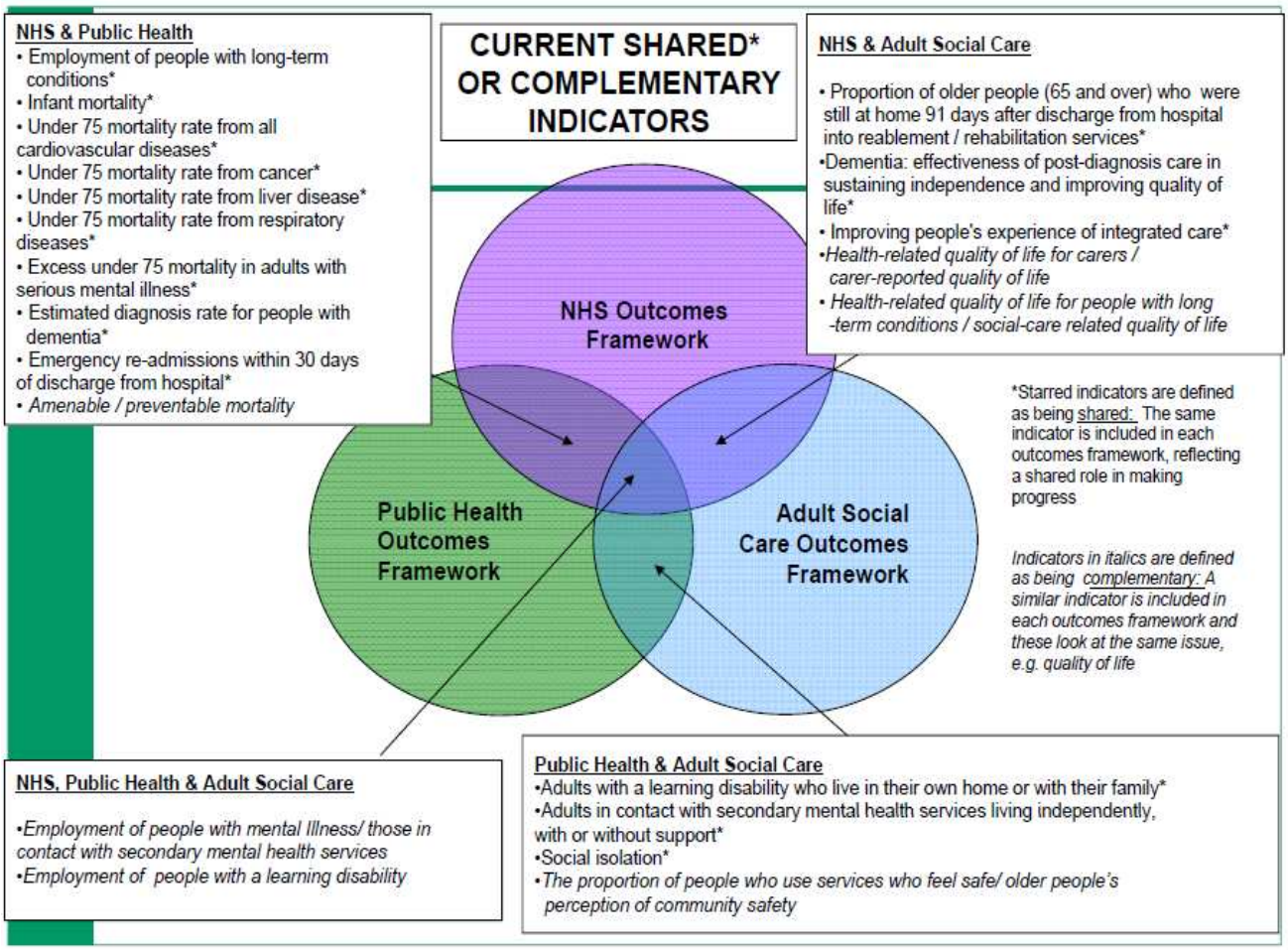
CURRENT SHARED* OR COMPLEMENTARY INDICATORS
NHS & Public Health
• Employment of people with long-term conditions*
• Infant mortality*
• Under 75 mortality rate from all cardiovascular diseases*
• Under 75 mortality rate from cancer*
• Under 75 mortality rate from liver disease*
• Under 75 mortality rate from respiratory diseases*
• Excess under 75 mortality in adults with serious mental illness*
• Estimated diagnosis rate for people with dementia*
• Emergency re-admissions within 30 days of discharge from hospital*
• Amenable / preventable mortality
NHS & Adult Social Care
• Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services*
•Dementia: effectiveness of post-diagnosis care in sustaining independence and improving quality of life*
• Improving people's experience of integrated care*
•Health-related quality of life for carers / carer-reported quality of life
• Health-related quality of life for people with long -term conditions / social-care related quality of life
NHS Outcomes Framework
Public Health Outcomes Framework
Adult Social Care Outcomes Framework
*Starred indicators are defined as being shared: The same indicator is included in each outcomes framework, reflecting a shared role in making progress
Indicators in italics are defined as being complementary: A similar indicator is included in each outcomes framework and these look at the same issue, e.g. quality of life
NHS, Public Health & Adult Social Care
•Employment of people with mental Illness/ those in contact with secondary mental health services
•Employment of people with a learning disability
Public Health & Adult Social Care
•Adults with a learning disability who live in their own home or with their family*
•Adults in contact with secondary mental health services living independently, with or without support*
•Social isolation*
• The proportion of people who use services who feel safe/ older people's perception of community safety