Healthy Lives, Healthy People: Transparency in Outcomes

Proposals for a Public Health Outcomes Framework

A Consultation Document

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For Recipient's Use	

Healthy Lives, Healthy People:
Transparency in Outcomes

Proposals for a Public Health Outcomes Framework

Prepared by the Public Health Development Unit, DH

Contents

How to Respond

The questions for consultation are listed in Annex A of this document, which also provides further detail about the consultation process. This consultation will close on 31 March 2011. You can contribute to the consultation by providing written comments to:

By email: publichealthengland@dh.gsi.gov.uk

Online: http://consultations.dh.gov.uk/healthy-people/funding-and-commissioning

By post: Public Health Consultation
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Foreword

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

In our White Paper *Healthy Lives, Healthy People*, we set our ambition for the future of public health. Core features are the establishment of a new body, Public Health England, as part of the Department of Health, and the return to local government of public health leadership and responsibility.

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, crime and pollution. The NHS, social care, the voluntary sector and communities will all work together to make this happen.

We propose a new Outcomes Framework for public health at national and local levels. It will be evidence-driven, taking into account the different needs of different communities.

Public health is everyone's business. So the Outcomes Framework will set out how we will measure success in public health both nationally and locally.

One of the aims of the Public Health Outcomes Framework will be to promote joint working where local organisations share common goals. It will therefore be crucial to make the Framework work from day one, to break down barriers to delivery. This consultation document seeks views on the proposed approach and asks how we can improve to make it.

We propose a broad structure for this Outcomes Framework. There are five domains: health protection and resilience, tackling the wider determinants of ill health, promoting healthy choices and healthy lifestyles, preventing ill health, and focusing on premature mortality and the health of the most vulnerable.

We want your help in shaping this framework further and in particular, we want to work with you to refine and clarify the indicators. We are required to consult on the proposals set out in this paper. However, we want to do more than that. We want to co-produce this Outcomes Framework with you, and see the consultation period as a continuation of the engagement and involvement we have already begun.

Anne Milton, Parliamentary Under Secretary Public Health

Introduction

1. Society, government and individuals share the collective responsibility to improve and protect the health of the population. In our White Paper *Healthy Lives, Healthy People*, we set our overarching ambition for public health for the future. A core element of this will be the establishment of Public Health England as part of the Department of Health, and the return of local public health leadership and responsibility to local government.

2. In recent years there have been far too many central initiatives and targets, often well meaning, but without a hope of success when dictated to local areas. It is time to free-up local government and local communities to decide how best to improve the health and wellbeing of their citizens, deciding what actions to take locally with the NHS and other key partners, without interference from the centre. It is time also to restate the national responsibilities of Government, of business and industry; and it is time to reassert the voluntary sector's critical role in connecting with communities.

3. Public health challenges are not static, and our system will have to respond actively to evolving challenges. The new public health system will effectively protect and improve the health of the nation through a dynamic new system approach that involves integration, localism, partnership and collaboration.

4. At the local level, an integrated approach through Health and Wellbeing Boards and Health and Wellbeing Strategies will enable an efficient and effective focus and response to local health needs. We will focus on enabling and incentivising local government with the wider public health sector, the NHS, the voluntary sector and local communities, through local partnerships to do this, but will not prescribe how it should be done.

5. At the same time, the national level has its responsibilities too. Within Public Health England and across Government, we will focus on those functions that are best performed at the national level either because they are irreducibly Government's responsibility or where economies of scale can be achieved. The role of Government should be strong leadership to support local delivery and to add value – not hinder it with top-down performance management.

6. Ultimately we want to achieve the same goal whether we work at a national or a local level; whether we work in local government or in the NHS or in the voluntary sector – we want to improve and protect the health and wellbeing of all people and especially those with the poorest health in our society. This means that we need a system where everyone at all levels understands the contribution they can and should make to this goal.

7. We propose to put in place a new strategic outcomes framework for public health at national and local levels, based on the evidence of where the biggest challenges are for health and wellbeing, and the wider factors that drive it. This will be different to old style top down frameworks used to drive targets and performance management – rather it will set out the outcomes for public health across public services and at all levels of responsibility – national to local.

8. We make these proposals for a new *Public Health Outcomes Framework* in light of the recent consultations on the *NHS Outcomes Framework* and the ongoing consultation on *Transparency in Outcomes: A Framework in Adult Social Care* Together these three

aligned frameworks will set out the outcomes that local government, the health and care sectors are responsible for achieving. It is essential that outcomes and indicators are aligned across the frameworks to enable joined up working and where it matters most to people, hold organisations to account for delivering integrated services.

The purpose of this consultation

9. In this consultation, we make detailed proposals for a Public Health Outcomes Framework in parallel with the Public Health White Paper, so that local government, the wider public health sector and local communities can take the lead in designing it.

10. In particular, we are seeking views on the overall structure and scope of the framework and the range of outcomes and measures within it, including views on those measures that should be incentivised.

Co-production

11. Based on what councils and voluntary organisations and communities themselves tell us, we believe that a co-produced and nationally applicable Outcomes Framework is the best vehicle for combining requirements in one place. Government should not dictate what is contained in the data set, but can support its production and maintenance.

12. We have worked closely with the public health community and consulted the Local Government Association informally on the current set of outcomes and indicators that we think may be included within the framework. The co-operation and direct involvement of Directors of Public Health (DsPH) from across the country and specialist representative bodies including the Faculty of Public Health, the Royal Society of Public Health, the UK Public Health Association and the Association of Directors of Public Health has been critical to the development of the proposals in this framework document. The LGA, represented on the Chief Medical Officer's Stakeholder Group, has also contributed to the development of proposals for the Public Health Outcomes Framework.

13. We do not want to stop there with our plans for engagement. We need to consult on the Outcomes Framework and we will continue to work closely with public health and local government colleagues to do so. However, we want to go further and co-produce the final set of outcomes with our partners in the public health sector and local government, to ensure that we arrive at a robust set of indicators. Later in this document, we will set out how you and your organisations can contribute to the development of this framework through the consultation process. We would very much appreciate your responses to a set of core questions relating to aspects of our proposals within this consultation at Annex A.

14. Getting the leadership right will be important, and there will be a need to build new partnerships to co-produce the Outcomes Framework. This will not just be about central government inviting public health and local government to join in the consultation process, but about a real shared endeavour, which reflects localism.

Q1 Consultation question: 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?

How have we developed these proposals?

15. There are huge opportunities to go further and faster in tackling today's causes of premature death and illness. People in the poorest areas can expect to live up to seven years less and live up to 17 years less without disability than richer areas, have higher rates of mental illness, harm from alcohol, drugs and smoking, and child emotional and behavioural problems. Although infectious diseases now account for only 1 in 50 deaths, rates of tuberculosis and sexually transmitted infections are rising and pandemic flu is still a threat. Responding and acting upon these challenges is the prime function of the proposed Public Health Outcomes Framework.

Principles for development

16. Public health is everyone's business. The Outcomes Framework will have to reflect the collective responsibility of communities, local authorities and their partners and the role of Government in improving and protecting health. To do this, we have been guided by the following principles to develop the Outcomes Framework. It will:

- use indicators which are meaningful to people and communities;
- focus on major causes and impacts of health inequality, disease, and premature mortality;
- take account of our legal duties in particular under equalities legislation and regulations[1].
- take a life course approach, and
- as far as possible, use data collated and analysed nationally to reduce the burden on local authorities.

17. Specifically, we have used the following detailed criteria to guide the selection of indicators for consultation (accepting that indicators may not meet all of the listed criteria).These are set out in the draft Impact Assessment at Annex B and as part of the consultation on this Outcomes Framework.

1) Are there evidence-based interventions to support this indicator?
2) Does this indicator reflect a major cause of premature mortality or avoidable ill health?
3) By improving on this indicator, can you help to reduce inequalities in health?
4) Will this indicator be meaningful to the broader public health workforce and to the wider public?

[1] The **Equalities Act 2010 legislation imposes a duty on public bodies (the protected characteristics are** race, disability, gender, age, sexual orientation, religion or belief, pregnancy and maternity and gender reassignment.) **to have due regard to the need to:**
(a) eliminate unlawful discrimination, harassment, and victimisation;,
(b) to advance equality of opportunity ; and.
(c) foster good relations between people who share a relevant protected characteristic and those people who do not.

5) Is this indicator likely to have a negative / adverse impact on defined groups (groups sharing a characteristic protected by equalities legislation)? (If yes, can this be mitigated against?)

6) Is it possible to set measures, SMART[2] objectives against the indicator to monitor progress in both the short and medium term?

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

- Is it available at the appropriate spatial level (e.g. Local Authority)?
- Is the time lag for data short, preferably less than one year
- Can data be reported quarterly in order to report progress?

Q2 Consultation question: Do you think these are the right criteria to use in determining indicators for public health?

[2] Specific, Measurable, Attainable, Realistic, Timely

The Purpose of the Outcomes Framework

18. Having set out the challenge above, we believe that this Outcomes Framework should have three purposes:

    - to set out the Government's goals for improving and protecting the nation's health, and for narrowing health inequalities through improving the health of the poorest, fastest;

    - to provide a mechanism for transparency and accountability across the public health system at the national and local level for health improvement and protection and inequality reduction; and

    - to provide the mechanism to incentivise local health improvement and inequality reduction against specific public health outcomes through the 'health premium'.

19. As set out above and within the White Paper itself, we know that public health is everyone's responsibility. Therefore, the Outcomes Framework needs to reflect the breadth of contributions all partners should make at the national and local level and across public services.

20. The Government is radically shifting power to local communities, enabling them to improve health across people's lives, reduce inequalities and focus on the needs of the local population. The Outcomes Famework will include measures that allow us to assess health improvement across all years of life, and enable a focus on those key life changes where there can be good opportunities to influence health outcomes.

21. Further, it is clear from the work of Sir Michael Marmot's independent review[3] that health is not experienced equally across our society. In the poorest places, people die 7 years earlier and spend 17 years in poorer health than the wealthiest. Health inequalities are systematic; they are not caused by chance. This Outcomes Framework, in its breadth and focus and the health premium we will implement (see paragraph 23) alongside our other reforms, are explicitly designed to tackle these inequalities.

22. Frank Field has published an independent review of Poverty and Life Chances. We will look closely at the Review's findings and, where appropriate reflect them within the Public Health Outcomes Framework.

Q3 Consultation question: 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?

23. The Local Authority Public Health allocation and the health premium are the subject of a separate consultation document *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health*.

[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/

24. The Public Health Outcomes Framework will provide a context for public health activity across the whole of the public health system. The current plan is that it will include a set of indicators based on nationally collated and analysed data relating to public health (thereby minimising the burden on local authorities). We have deliberately proposed a much larger number of indicators for consultation than we expect will form the final framework. We have committed to reducing the burden of data collection and reporting on local authorities, so our approach intends to demonstrate the scope of issues and priorities identified through our engagement with the public health and local government sectors, with a view that through the consultation process we will be able to refine these indicators to a core set.

Transparency of outcomes

25. The backbone of our proposed approach is to make publicly available a set of data and information relating to the public's health at national and where possible at local authority levels. To ensure transparency and to reduce data burdens, we propose specific data are published in one place by Public Health England. Public health data come from a number of sources, and people have told us that the best way to support analyses is to publish this in one place, and in a common format. At the national level, this information will allow our partners and us across government and beyond, to understand the key priorities for health and aid in our efforts to prioritise action. At the local level, this will allow people to interrogate the information as they want, and minimise costs of reproduction on councils. This will also make it easy for local areas to compare themselves with others across the country, and where possible how performance is changing within areas, and lever improvements. So that we drive equality in public health outcomes, it is vital that we are able to disaggregate public health data by key equality characteristics and neighbourhoods where possible. We will work with the Association of Public Health Observatories during the consultation process.

26. In addition, information about health and care services will need to be made available in order to support Public Health England and local government to assess the impact of public health interventions and action. In terms of information about health and care services more generally, as set out in the consultation *Liberating the NHS: An Information Revolution,* this Government is committed to moving away from a culture in which information has been held close and recorded in forms that are difficult to compare, to one characterised by openness, transparency and comparability.

27. The Public Health Outcomes Framework is not a performance management tool, and it must not replicate the approach of the previous National Indicator Set. It should be a consistent means of presenting the most relevant, available data on public health for national and local use. Our current thinking is that a small number of the indicators would focus on health improvement relating to the causes of the greatest burden on disease and death (eg indicators relating to obesity, smoking, alcohol and level of physical activity). The rest of the indicators would cover other domains of public health, including health protection and preventative services, and reflect the wider determinants of health, to link in the different local services that play a part in delivering health and wellbeing and to hold national Government to account.

28. For a subset of those indicators, which we will agree with our public health and local government partners, we would attached a 'health premium' which aims to incentivise councils to make progress on health improvement priorities and reduce health inequalities.

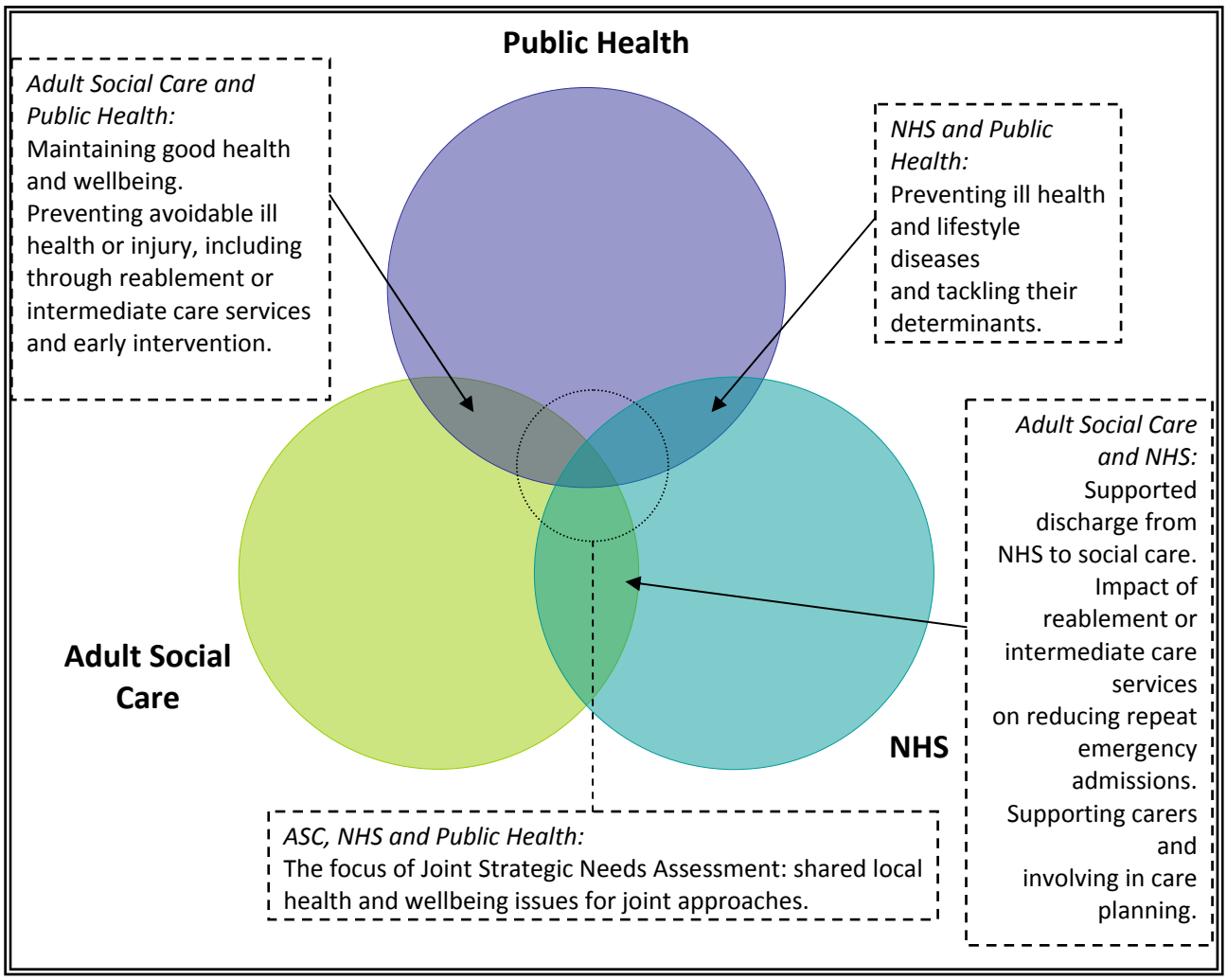
Relationship with other outcome frameworks

29. As noted above, one of the most important aims of the Public Health Outcomes Framework will be to support local partners to work together where they share common outcome goals. To do so, it will be critical that alignment is built in with the partner frameworks for the NHS, adult social care and others from the outset, and to avoid creating barriers, which might act against delivery.

30. Figure 1 below shows how we might envisage the relationship between public health, the NHS and adult social care in terms of shared outcomes.

31. This diagram shows some key areas of overlap, where local services share an interest and where a whole-systems approach could support better outcomes. By sharing the same or complementary measures between sectors, there is a stronger incentive for local services to work together and measure their progress on the same basis. This approach assumes that the three Outcomes Frameworks act as whole rather than three separate entities.

Figure 1



32. Our aim has been that all three Outcomes Frameworks align well and tell the 'story' of health from a whole systems approach. A core function of public health is tackling the wider determinants of health and wellbeing, whereas the NHS and adult social care

frameworks cover those outcomes for people who are in need of health and social care services.

33. There are other local services crucial to achieving outcomes, and which public health will work with in partnership – children's services, employment services, leisure, transport and housing, for instance. Whilst this diagram does not yet include all the relevant areas of overlap and focus for all partners, we are clear that the contribution to public health from these services is vital.

34. It is also critical we understand that many of these services 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.

35. Later in this document, we make specific proposals to go further than alignment across these frameworks. Responses to the consultation of the NHS Outcomes Framework were clear. There is a strong case for explicitly recognising the shared responsibility of public health and the NHS to reduce rates of premature mortality. The NHS has a clear role in premature mortality amenable to healthcare, whilst public health's role is to reduce premature mortality through preventative approaches. We set out detailed proposals later in this paper on shared outcomes to reduce premature mortality.

36. The Government has also announced a new Transparency Framework[4] as part of the Spending Review. Under the new framework, each Department has published its Business Plan, including the reforms it will make and the key indicators on inputs (costs and activity) and impact (results achieved) by which the public can form their own judgment at the national level. Public health will play a part in that framework, with a clear relationship between the outcome measures proposed in this document and the indicators in the Transparency Framework to reinforce a common view of the most important areas shared nationally and locally.

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

[4] The Transparency Framework was announced as part of the Spending Review 2010. See the full document at http://cdn.hm-treasury.gov.uk/sr2010_completereport.pdf

Our Proposed Approach

37. The Outcomes Framework we propose will therefore be based on:

- A high-level vision for public health,

"To improve and protect the nation's health and to improve the health of the poorest, fastest"

- Supported by 5 key domains for public health outcomes that reflect national, local and community level actions;

Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
Health Protection and Resilience: protect the population's health from major emergencies and remain resilient to harm	**Tackling the wider determinants of health:** tackling factors which affect health and wellbeing and health inequalities	**Health Improvement:** Helping people to live healthy lifestyles, make healthy choices and reduce health inequalities	**Prevention of ill health:** reducing the number of people living with preventable ill health and reduce health inequalities	**Healthy life expectancy and preventable mortality:** preventing people from dying prematurely and reduce health inequalities

- Delivered through actions that are evidenced based, can be measured, and which can be used by the public to hold local services to account for improvements in health. This is shown in diagrammatic form (figure 2).

38. The five domains for public health represent those high-level goals that we want to achieve through the Public Health England to deliver our overarching vision for public health. Domains are sequenced to reflect the spectrum of public health ranging from influencing the wider determinants of health, to opportunities to improve and protect health, through to preventing ill health (morbidity) and avoiding premature death (mortality). Overarching this spectrum is Domain 1, a central focus for Public Health England and supported by local delivery mechanisms.

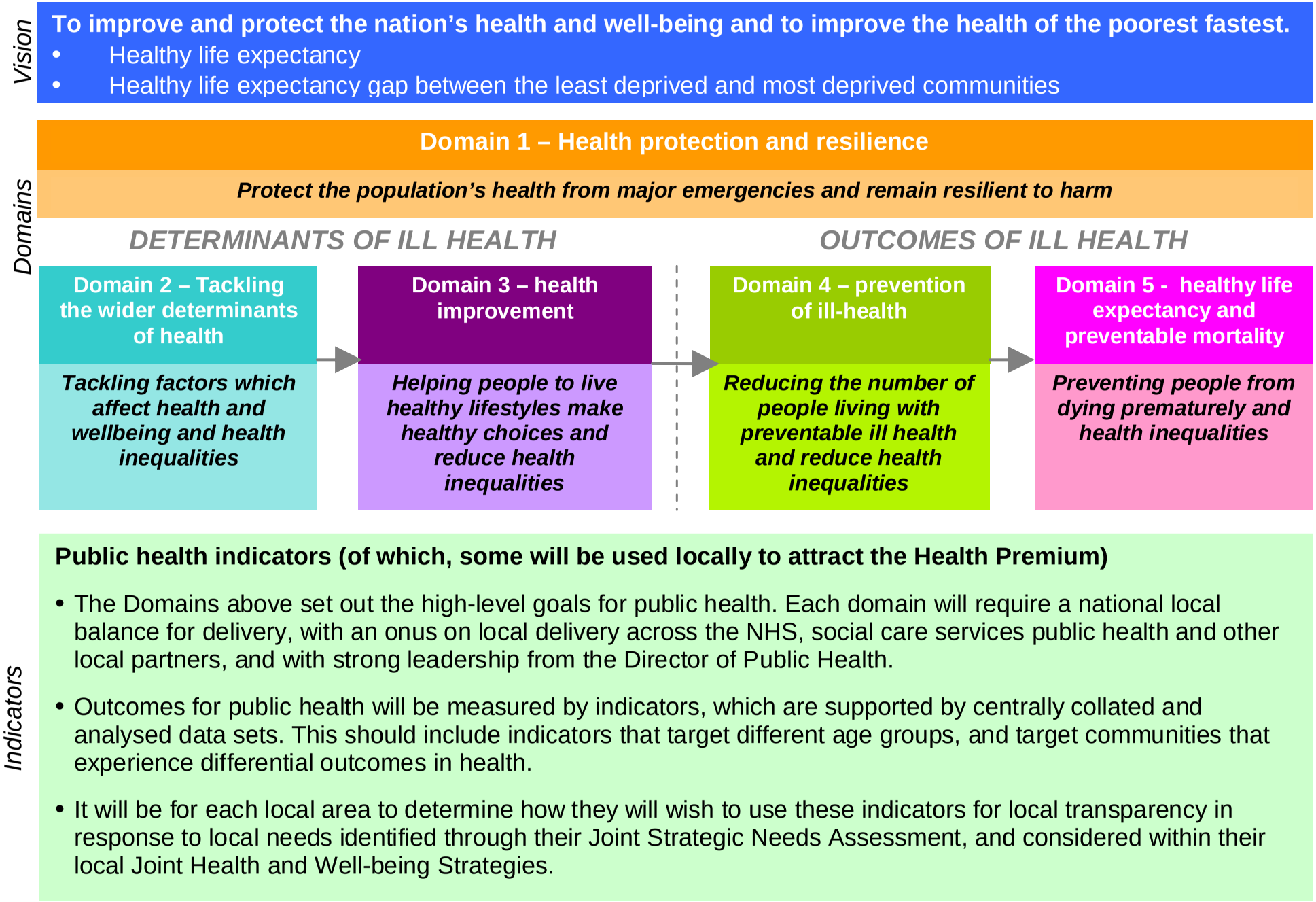
39. The overarching aim of this Outcomes Framework is *to improve and protect the nation's health, and to improve the health of the poorest, fastest*. In focusing on how to improve the public's health in its broadest sense, local authorities and their partners must also seek to advance equalities, eliminate the impact of discrimination and narrow inequalities in health behaviours between communities. This will be a core element of each domain through the disaggregation of all indicators by the different equality characteristics and down to neighbourhood level, where feasible.

40. We know that safeguarding is a very important issue on which local health and wellbeing partnerships across public health, the NHS, social care and other children's services will need to work together. Professor Eileen Munro is currently conducting a review of Child Protection and is due to report finally in April 2011. We will look at the findings of the Review to see whether there are outcomes relating to safeguarding and child protection that should be included in the Public Health Outcomes Framework.

41. We are also keen to hear any thoughts or proposals during the consultation period on how we might appropriately reflect safeguarding and child protection outcomes in the Public Health Outcomes Framework.

Q5 Consultation question: Do you agree with the overall framework and the domains?

Figure 2 – A frame work for public health outcomes



The Indicators

42. We have worked closely with public health professionals in the development of these proposed indicators. Expert input has been essential to the development of these and we want to get your views on how we can develop these further.

43. We remain committed to reducing data burdens on local government and across the health and care sectors. We will seek to collate and analyse data centrally where possible and to use information already routinely collected by Local Authorities, the NHS and from wider local government – we will avoid as far as possible the creation of new data burdens. Therefore across all three aligned Outcomes Frameworks (for the NHS, public health and adult social care), we want to reduce the overall number of indicators. However, whilst we expect the number of health improvement and protection indicators will reduce from previous indicator sets, stakeholders have been keen to see a broader approach to public health, requiring a breadth of measures across the five domains set out above. We want to work with you to achieve these aims.

How can we measure improvement in public health?

44. Below we have set out measures that help define and deliver the above Domains, and then describe the broad contributions to these that can be made at the local and national levels. More detail on the rationale for these indicators and other details can be seen at Annex C. Proposed developmental indicators are shown in italics. These are indicators that are not yet routinely collected and where further development is required to ensure appropriate and high quality data at local as well as national levels can be provided. Some developmental indicators will require significant work to progress, whereas others may already be work in progress. We will work with you during the consultation period to develop these further whist reviewing any other suggestions for developmental indicators.

45. Each domain includes indicators that to a varying degree will be reliant on national or local delivery. Whilst local government will have an important and leading role in public health, this Outcomes Framework proposes indicators that will require the joint efforts of the NHS and other public services as well as local government. This Outcomes Framework will be for all partners and at all levels to deliver.

VISION **To improve and protect the nation's health and wellbeing and to improve the health of the poorest, fastest.**
These are over-arching indicators that can be used nationally and locally to give a good snapshot of health inequalities and general health status. They cut across the proposed domains as do health inequalities and are intended to be available for use at a local as well as a national level.
Proposed Indicators
- Healthy life expectancy - Differences in life expectancy and healthy life expectancy between communities.

Domain 1:

Health Protection and Resilience: Protect the population's health from major emergencies and remain resilient to harm

The activities to deliver this domain can most appropriately be co-ordinated nationally by Public Health England, which will have oversight of population health protection and resilience across the country.

Local authorities will want to contribute to these outcomes particularly in their role in leading local resilience arrangements, and in providing surveillance information.

Proposed Indicators

- Comprehensive, agreed, inter-agency plans for a proportionate response to public health incidents are in place and assured to an agreed standard. These are audited and assured and are tested regularly to ensure effectiveness on a regular cycle. Systems failures identified through testing or through response to real incidents are identified and improvements implemented.
- Systems in place to ensure effective and adequate surveillance of health protection risks and hazards.
- Life years lost from air pollution as measured by fine particulate matter
- Population vaccination coverage (for each of the national vaccination programmes[5] across the life course)
- Treatment completion rates for TB
- Public sector organisations with a board approved sustainable development management plan.

46. Health protection measures will be critically important at all levels of delivery and as stated above will require the collective efforts of Public Health England, Local Authorities and the NHS to deliver. We anticipate the actions required to improve outcomes in this domain are essential and will not be subject to the same local determinations as for the other domains. Hence, we have presented this domain as having a prominent place within Figure 2 above. We will also need to consider through the consultation period, the impact of these proposed measures on the Devolved Administrations where there are shared health protection functions.

[5] Including for example, the childhood, adolescent, cervical cancer and seasonal flu immunisation programmes.

Domain 2:

Tackling the wider determinants of ill health: tackling factors which affect health and wellbeing

Locally, Health and Wellbeing Boards will take a broad approach to health improvement requiring the full participation by all partners to focus on improving the wider determinants of health that drive poor health outcomes especially in the most disadvantaged.

The very nature of the indicators we've proposed require the combined efforts of all public services to focus on the factors that drive health problems amongst the poorest and most disadvantaged in our communities.

Proposed Indicators

- Children in poverty
- School readiness: foundation stage profile attainment for children starting Key Stage 1
- Housing overcrowding rates
- Rates of adolescents not in education, employment or training at 16 and 18 years of age
- Truancy rate
- First time entrants to the youth justice system
- Proportion of people with mental illness *and or disability*[6] in settled accommodation**
- Proportion of people with mental illness *and or disability*[6] in employment *, **
- Proportion of people in long-term unemployment
- Employment of people with long-term conditions
- Incidents of domestic abuse**
- Statutory homeless households
- Fuel poverty
- Access and utilisation of green space
- Killed and seriously injured casualties on England's roads
- The percentage of the population affected by environmental, neighbour, and neighbourhood noise
- Older people's perception of community safety**
- Rates of violent crime, including sexual violence
- Reduction in proven reoffending
- *Social connectedness*
- *Cycling participation*

**Shared responsibility with the NHS*

*** Shared responsibility with Adult Social Care*

[6] Further work is required to define disability in the context of these indicators and to identify appropriate data sources

47. We will need to continue working across Government at national and local levels to refine and agree the full range of measures that best reflect the wider determinants of health and where we have good evidence that actions relating to these measures have demonstrable and positive impacts on health and health inequality reduction.

Domain 3:

Health Improvement: Helping people to live healthy lifestyles and make healthy choices

Nationally, there is a clear role for Government in contributing to delivering these indicators, for example through legislation or regulation, and through partnerships with business and industry. Some functions such as some national campaigns, will need to be led at a national level where it is possible to maximise economies of scale and value for money.

However much of the delivery of these indicators will take place at the local level. Here, health improvement will be the responsibility of local government led by DsPH in partnership with proposed Health and Wellbeing Boards. DsPH will be responsible for investing in health improvement using the ring-fenced public health budget.

Proposed Indicators

- Prevalence of healthy weight in 4-5 and 10-11 year olds
- *Prevalence of healthy weight in adults*
- Smoking prevalence in adults (over 18)
- Rate of hospital admissions per 100,000 for alcohol related harm
- Percentage of adults meeting the recommended guidelines on physical activity (5 x 30 minutes per week)
- Hospital admissions caused by unintentional and deliberate injuries to 5-18 year olds
- Number leaving drug treatment free of drug(s) of dependence
- Under 18 conception rate
- Rate of dental caries in children aged 5 years (decayed, missing or filled teeth)
- *Self reported wellbeing*

48. The proposed indicators for this domain will help us track the impact of national and local actions to tackle health improvement and reduce the burden of disease related to lifestyle choices.

Domain 4:

Prevention of ill health: Reducing the number of people living with preventable ill health

Nationally the role of Government with its partners in business and industry and beyond will be critical.

Across local health and wellbeing partnerships, public health would share responsibility with the NHS, adult social care and children's services to improve outcomes in this domain.

Proposed Indicators

- Hospital admissions caused by unintentional and deliberate injuries to under 5 year olds.
- Rate of hospital admissions as a result of self-harm
- Incidence of low-birth weight of term babies
- Breastfeeding initiation and prevalence at 6-8 weeks after birth
- Prevalence of recorded diabetes
- Work sickness absence rate
- Screening uptake (of national screening programmes)
- Chlamydia diagnosis rates per 100,000 young adults aged 15-24
- Proportion of persons presenting with HIV at a late stage of infection
- *Child development at 2 - 2.5 years*
- Maternal smoking prevalence (including during pregnancy)
- Smoking rate of people with serious mental illness
- Emergency readmissions to hospitals within 28 days of discharge*, **
- Health-related quality of life for older people**
- Acute admissions as a result of falls or fall injuries for over 65s**
- *Take up of the NHS Health Check programme by those eligible*
- *Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed*

**Shared responsibility with the NHS*

*** Shared responsibility with Adult Social Care*

49. A number of proposed indicators within this Domain require a shared contribution across public health and children and adult social care services. The proposed outcomes and transparency framework for adult social care includes a number of shared indicators included within this domain.

Domain 5:

Healthy life expectancy and preventable mortality: *Preventing people from dying prematurely*

At the local level, improvements in these indicators will be driven by local health and wellbeing partnerships with shared responsibility across the NHS, public health and care services.

Healthy life expectancy is considered as an over-arching outcome under vision and not repeated in this domain. Therefore, the indicators below focus on the causes of premature mortality.

Some delivery will be for other local partners to prevent seasonal mortality for example, or Public Health England locally (currently Health Protection Units) on communicable disease.

National contribution across Government, the NHS Commissioning Board and other national bodies in setting policy or to avoid mortality as a result of major emergencies for example.

Proposed Indicators

- Infant mortality rate*
- Suicide rate
- Mortality rate from communicable diseases
- Mortality rate from all cardiovascular disease (including heart disease and stroke) in persons less than 75 years of age*
- Mortality rate from cancer in persons less than 75 years of age*
- Mortality rate from Chronic Liver Disease in persons less than 75 years of age*
- Mortality rate from chronic respiratory diseases in persons less than 75 years of age*
- Mortality rate of people with mental illness*
- Excess seasonal mortality

**Shared responsibility with the NHS*

50. In this domain, a set of shared mortality improvement areas where both the NHS and Public Health England can have an impact in improving outcomes will be included in the NHS Outcomes Framework. We propose that this approach is taken in the Public Health Outcomes Framework too. These shared outcomes reflect the fact that it is very difficult to disentangle the relative contributions of Public Health England and the NHS in delivering against them.

51. The outcome of **‘reducing premature death in people with mental illness’** is included as a shared mortality improvement area in both frameworks as many of the risk factors to which people with serious mental illness are particularly vulnerable are related to lifestyle as well as healthcare and service access.

52. In using mortality to determine improvement areas, there is a risk that factors impacting on children are not sufficiently reflected, as the numbers of child deaths is so small. Therefore, it is proposed that ‘Infant mortality’, which captures outcomes for children up to the age of 1, is included as a shared improvement area in both frameworks as it is influenced by both NHS and public health interventions.

Consultation questions

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

Q7. Consultation question: 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?

Q8. Consultation question: Are there indicators here that you think we should not include?

Q9. Consultation question: How can we improve indicators we have proposed here?

Q10. Consultation question: Which indicators do you think we should incentivise through the health premium? (Consultation on how the health premium will work will be through an accompanying consultation on public health finance and systems).

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

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

A New Approach to Partnership and Accountability

53. The proposals set out above aim to engender closer working across organisational cultures and boundaries – driving improved partnership working where there is room for improvement, keeping in step where close and productive partnerships are already strong, and making a difference. The shared responsibility of Government, business and industry is vital to the national contribution to these proposed outcomes. At the local level, partnerships across the local authority, the NHS and other public services will be essential to health improvement and protection and reducing inequalities. However, in the final analysis local communities and neighbourhoods will lead improvement themselves, through holding their local services to account.

Local transparency and accountability

54. Based on the principles of transparency and localism, data will be published in one place by Public Health England enabling national and local democratic accountability for performance against those outcomes. This will make it easy for local areas to compare themselves with others across the country and incentivise improvements. So that we drive equality in public health outcomes, it is vital that we are able to disaggregate public health data by key equality characteristics, and where feasible communities should be able to see how outcomes differ at local neighbourhood level.

55. Health and Wellbeing Boards will be core to the assessment and agreement of local priorities. The Outcomes Framework will be used alongside the Joint Strategic Needs Assessment to determine local priorities. Through this process, it will be for Health and Wellbeing Boards to determine local priorities and to set out strategies for which they will be held locally accountable to deliver.

56. We propose that a new health premium will pay local government retrospectively for progress against public health indicators, through a simple formula that incentivises action to improve local health and reduce health inequalities.

57. Our current thinking is that payments would be weighted to their level of health inequalities and the progress made. We are seeking your views on how the health premium is designed as part of the consultation on public health finance, which is taking place alongside this consultation on the Outcomes Framework.

Next Steps

58. We are required to consult on the proposals set out in this paper. However, we want to do more than that. We want to co-produce this Outcomes Framework with you, and see the consultation period as a continuation of the engagement and involvement we have already begun. We want your help in shaping this framework further and in particular, we want to work with you to refine and clarify the indicator set.

59. We intend to run a consultation period for the next 14 weeks ending on 31st March 2011, where we want to hear your views and have your input to the questions we have posed throughout this document. Following this consultation period, we will pull together responses and publish the Outcomes Framework in summer 2011.

60. The new framework will be in operation from April 2012. During 2011/12, we will continue our work with the NHS and local government in preparing for and implementing transition arrangements.

How you can be involved

61. We will take forward a programme of engagement and involvement in developing our proposals further. We have provided a template at Annex A with all the questions from each chapter within this consultation document, which we hope you will find helpful in shaping your response. Please see guidance on how to respond to this consultation below.

The Consultation Process

Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultation's process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:

Link to consultation Code of Practice

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

Contact Consultations Co-ordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE

E-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's **Information Charter.**

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must

comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation response

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at
http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

How to respond to this consultation

This consultation closes on the **31 March 2011**. You can contribute to the consultation by providing written comments to:

By e-mail: publichealthengland@dh.gsi.gov.uk

Online: http://consultations.dh.gov.uk/healthy-people/funding-and-commissioning

By post: Public Health Outcomes Consultation
Department of Health, Room G16, Wellington House
133-155 Waterloo Road,
London SE1 8UG

We will also be arranging a number of consultation events around England. Details will be posted on the DH website as well as through stakeholder networks.

Annex A: Questions for consultation

Question 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?
Question 2.	Do you feel these are the right criteria to use in determining indicators for public health?
Question 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?
Question 4.	Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?
Question 5.	Do you agree with the overall framework and domains?
Question 6.	Have we missed out any indicators that you think we should include?

Question 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?
Question 8. Are there indicators here that you think we should not include?
Question 9. How can we improve indicators we have proposed here?
Question 10. Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)
Question 11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?
Question 12. How well do the indicators promote a life-course approach to public health?

Annex B: Impact Assessment

Title: Public Health Outcomes Framework **Lead department or agency:** **Department of Health** **Other departments or agencies:**	IMPACT ASSESSMENT (IA) **IA NO:** 3027 **DATE: 27/10/10** **STAGE:** CONSULTATION **SOURCE OF INTERVENTION:** Domestic **TYPE OF MEASURE:** OTHER

What is the problem under consideration? Why is government intervention necessary?

The current Government, elected in May 2010, abolished the Public Service Agreement (PSA) system, and the system of Local Area Agreements. Whilst the proposed NHS Outcomes Framework will be able to monitor and drive forward improvements in NHS services, there are no equivalent arrangements in place for the delivery and monitoring of improvements in public health yet. This impact assessment is concerned with the potential costs and benefits of the proposed Public Health Outcomes Framework, though no actual costs and benefits can yet be estimated.

What are the policy objectives and the intended effects?

The Outcomes Framework reinforces the vision for the future of public health, and is a mechanism by which this vision can be achieved. This vision is 'to improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest.'. As part of the consultations on the Public Health White Paper there will be a consultation document on the Outcomes Framework that will propose indicators and invite suggestions as to which indicators will finally be included in the Outcomes Framework. The consultation will also invite suggestions on the structure of the framework itself. Public Health delivery partners will then be encouraged to demonstrate improvement against these indicators, this will then have a direct effect on protecting and improving the nation's health.

What policy options have been considered? Please justify preferred option (further details in Evidence Base)

1. Do nothing
2. Develop a Public Health Outcomes Framework

WHEN WILL THE POLICY BE REVIEWED TO ESTABLISH ITS IMPACT AND THE EXTENT TO WHICH THE POLICY OBJECTIVES HAVE BEEN ACHIEVED?	**SEE ANNEX**
ARE THERE ARRANGEMENTS IN PLACE THAT WILL ALLOW A SYSTEMATIC COLLECTION OF MONITORING INFORMATION FOR FUTURE POLICY REVIEW?	**YES**

Ministerial Sign-off For consultation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:..... Date: .....

Description: Option 2 - Develop a Public Health Outcomes Framework

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low:	High:	Best Estimate:

COSTS (£M)	TOTAL TRANSITION (CONSTANT PRICE) YEARS		AVERAGE ANNUAL (EXCL. TRANSITION)	TOTAL COST (PRESENT VALUE)
LOW	OPTIONAL		OPTIONAL	OPTIONAL
HIGH	OPTIONAL		OPTIONAL	OPTIONAL
BEST				

DESCRIPTION AND SCALE OF KEY MONETISED COSTS BY 'MAIN AFFECTED GROUPS'

AS THE DEVELOPMENT OF THE NEW OUTCOMES FRAMEWORK IS STILL IN ITS EARLY STAGES AND THE FINAL APPROACH TAKEN, AS WELL AS THE INDIVIDUAL OUTCOME INDICATORS SELECTED, WILL BE DETERMINED POST-CONSULTATION, COSTS CANNOT BE ESTIMATED AT THIS STAGE.

OTHER KEY NON-MONETISED COSTS BY 'MAIN AFFECTED GROUPS'

.

BENEFITS (£M)	TOTAL TRANSITION (CONSTANT PRICE) YEARS		AVERAGE ANNUAL (EXCL. TRANSITION)	TOTAL BENEFIT (PRESENT VALUE)
LOW	OPTIONAL		OPTIONAL	OPTIONAL
HIGH	OPTIONAL		OPTIONAL	OPTIONAL
BEST				

DESCRIPTION AND SCALE OF KEY MONETISED BENEFITS BY 'MAIN AFFECTED GROUPS'

OTHER KEY NON-MONETISED BENEFITS BY 'MAIN AFFECTED GROUPS'

THERE SHOULD BE REFOCUSING AND STRENGTHENING OF PUBLIC HEALTH OUTCOMES AND THEIR
DELIVERY AT LOCAL AND NATIONAL LEVELS. OUTCOME MEASURES MAY INCENTIVISE COST-EFFECTIVE INTERVENTIONS RESOURCES SHOULD BE SAVED FROM REDUCING THE BURDEN OF CURRENT TOP-DOWN PERFORMANCE MANAGEMENT STRUCTURES AND STREAMLINING AS A RESULT
OF SYNERGY ACROSS THE ADULTS SOCIAL CARE AND NHS OUTCOMES FRAMEWORK.

KEY ASSUMPTIONS/SENSITIVITIES/RISKS

Impact on admin burden (AB) (£m):			Impact on policy cost	In
New AB:	AB savings:	Net:	Policy cost savings:	Yes/No

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			01/04/2012		
Which organisation(s) will enforce the policy?					
What is the annual change in enforcement cost (£m)?					
Does enforcement comply with Hampton principles?			N/A		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			Traded:	Non-traded:	
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			Costs:	Benefits:	
Annual cost (£m) per organisation (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	N/A	N/A	N/A	N/A	N/A

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on…?	Impact	Page ref within IA
Statutory equality duties[7] Statutory Equality Duties Impact Test guidance	Yes	Appendix I
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment	No	

3.1 [7] Race, disability and gender Impact assessments are statutory requirements for relevant policies. Equality statutory requirements will be expanded 2011, once the Equality Bill comes into force. Statutory equality duties part of the Equality Bill apply to GB only. The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Wider environmental issues Wider Environmental Issues Impact Test guidance	**No**	
Social impacts		
Health and wellbeing Health and Well-being Impact Test guidance	**Yes**	
Human rights Human Rights Impact Test guidance	**No**	
Justice system Justice Impact Test guidance	**No**	
Rural proofing Rural Proofing Impact Test guidance	**No**	
Sustainable development Sustainable Development Impact Test guidance	**No**	

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

References

Include the links to relevant legislation and publications, such as public impact assessment of earlier Stages (E.G. Consultation, Final, Enactment).

NO.	LEGISLATION OR PUBLICATION
1	**OUTCOMES NOT TARGETS, CONSERVATIVE PARTY (2008).** **HTTP://WWW.CONSERVATIVES.COM/~/MEDIA/FILES/GREEN%20PAPERS/HEALTH_POLICY_PAPER.ASHX?DL=TRUE**
2	***EQUITY AND EXCELLENCE: LIBERATING THE NHS***
3	**Healthy Lives, Healthy People: Our strategy for public health in England**
4	

+ Add another row

Evidence Base

Ensure that the information in this section provides clear evidence of the information provided in the summary pages of this form (recommended maximum of 30 pages). Complete the **Annual profile of monetised costs and benefits** (transition and recurring) below over the life of the preferred policy (use the spreadsheet attached if the period is longer than 10 years).

The spreadsheet also contains an emission changes table that you will need to fill in if your measure has an impact on greenhouse gas emissions.

Annual profile of monetised costs and benefits* - (£m) constant prices

	Y_0	Y_1	Y_2	Y_3	Y_4	Y_5	Y_6	Y_7	Y_8	Y_9
Transition costs										
Annual recurring cost										
Total annual costs										
Transition benefits										
Annual recurring										
Total annual benefits										

* For non-monetised benefits please see summary pages and main evidence base section

Public Health Outcomes Framework: Impact Assessment

A1. This Impact Assessment is part of a suite of impact assessments that accompany the public health White Paper. Other impact assessments in this suite are:

- Structure of the public health service;
- Commissioning in the public health service;
- Ring-fenced funding of public health;
- Information and intelligence for public health;
- Social marketing; and
- Health visitors

A2. This Impact Assessment considers what framework and indicators could be used to monitor and drive public health improvements. It directly impacts the public sector only.

A3. The Outcomes Framework provides a vision for the future of public health, and demonstrates a mechanism by which this vision can be achieved. This vision is 'To improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest.' As part of the consultations on the Public Health White Paper there will be a consultation document on the Outcomes Framework that will propose indicators and invite suggestions as to which indicators will finally be included in the Outcomes Framework as well as suggestions on the structure of the framework itself. Public Health delivery partners will then be encouraged to demonstrate improvement against these indicators, this will then have a direct effect on protecting and improving the nation's health.

A4. The current Government, elected in May 2010, abolished the Public Service Agreement (PSA) system, and the system of Local Area Agreements. Whilst the NHS Outcomes Framework will be able to monitor and drive forward improvements in NHS services, there

are no equivalent arrangements in place for the delivery and monitoring of improvements in public health yet. This impact assessment is concerned with the potential costs and benefits of the proposed Public Health Outcomes Framework, though no actual costs and benefits can yet be estimated.

What policy options have been considered?

A5. We have assessed the impact of two options:

1. Do nothing.

2. Develop a Public Health Outcomes Framework.

Option 1 – do nothing

A6. As mentioned above currently there is no single system in place that specifically measures public health outcomes. The Health Bill, building on *Equity and Excellence: liberating the NHS,* published in July 2010 has put forward proposals to abolish the Vital Signs and the National Indicator Set which currently report on selected public health indicators.

A7. Current inefficiencies include:

- There is a top-down bureaucratic focus on processes rather than outcomes.
- Vital Signs tiers do not allow local decisions to be made about priorities for health improvement.
- There is duplication of performance management processes.
- There is a lack of prioritisation of public health and wellbeing outcomes at the expense of NHS process and treatment focused delivery.

A8. Without the introduction of an Outcomes Framework, there would be no robust system in place that is able to monitor the extent of health protection or emergency preparedness measures. Addressing this issue is of vital importance if we are to consider resilience or preparation for emergency events.

A9. In addition to a lack of monitoring of public health outcomes, there is an implicit lack of accountability at the local and national level that would drive forward improvements in health protection, health improvement and wellbeing.

A10. Without a performance framework that addresses delivery and impact on different groups, it will not be possible to continue to assess the impact of services on core public health outcomes for these groups. Doing nothing does not further develop our approach to tackle the gender, age, geographical, or socioeconomic health inequalities that currently exist.

Preferred: option 2 – develop a Public Health Outcomes Framework

A11. In line with the approach taken by the NHS Outcomes Framework and the Social Care Outcomes Framework, the current proposal for the Public Health Outcomes Framework

includes selected indicators in five domains. These domains currently include (subject to change):

A12.

- Domain 1: Health protection and resilience
- Domain 2: Tackling the wider determinants of health
- Domain 3: Health improvement
- Domain 4: Prevention of ill health
- Domain 5: Healthy life expectancy and preventable mortality

A13. The indicators in this Outcomes Framework will be selected because they provide the most robust mechanism by which progress towards the overarching public health outcomes can be monitored

A14. In addition, this framework will provide a mechanism by which improvement by delivery partners can be monitored, incentivised, and held to account.

A15. Regarding the development of candidate indicators pre-consultation, the following criteria were used to inform the selection:

a. HM Treasury Transparency Framework criteria

b. Are there evidence-based interventions to support this indicator?

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

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

e. Use indicators which are meaningful to people and communities

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

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

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

i. Is it available at the appropriate spatial level (e.g. Local Authority)?

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

k. Can data be reported quarterly in order to report progress?

A16. Post consultation on the candidate indicators, additional criteria will be applied prior to final publication incorporating the following three principles/analytical tasks:

- Risk-adjustment. Underlying characteristics (e.g. socio-economic profile) could impact on achievement at a local level. This will pose challenges for comparing indicators between areas and negotiating local contributions to national ambitions. It is anticipated that a process of risk adjustment will be developed and applied where feasible and based on data broken down by agreed characteristics. This process might be applied differently to differentiate between those health improvement indicators where a financial incentive might be applied and those indicators used for monitoring purposes.

- Calibration. Where feasible, the analytical, research and development functions of the PHS will review the incremental contribution of indicators in terms of their relative importance to contributing to the over-arching public health outcomes of 1) improving healthy life expectancy and 2) reducing the healthy life expectancy gap between the least deprived and most deprived communities. This will enable Health and Wellbeing Boards to formulate their priorities. It is important to note that for indicators, which focus on the broader determinants of health, requiring cross-cabinet collaboration, the analytical and Research & Development support might sit outside of the Public Health Service.

- Comprehensiveness: A broad set of candidate indicators will be circulated as part of the consultation process including those that focus on the broader determinants that impact on the public's health. The consultation should expose any gaps and ensure that the list remains comprehensive, reflecting the areas of public health activity most likely to impact on the aforementioned over-arching outcomes. Comprehensiveness will be considered prior to publication of the final indicator set alongside the need for representativeness and balance.

A17. It is important to note that these principles will pose significant challenges with regards to their translation into practice, (e.g. data availability) which will be fully considered post the initial consultation period.

A18. Achievement of public health outcomes requires a cross-government approach and this must be supported by the alignment of the outcome framework across the NHS, public health and adult social care, taking a life-course approach. The Secretary of State for health has made clear the value of evaluation and we will continue to build proposals and options based on strong evidence where it is available.

A19. Consultation will include:

- Departmental stakeholder events;

- Engagement with public health community (Directors of Public Health Advisory Group), BME communities;

- Engagement across Government, and wider public health workforce, including regional teams (Public Health Observatories, Regional Public Health Groups); and

- Formal 12 week consultation

A20. Secretary of State has made clear his intention that an Outcomes Framework, which will drive forward improvements in public health, will be fully implemented by 2012/13. He has also made clear his intention that the Public Health Outcomes Framework will have strong links with the Outcomes Frameworks for both the NHS and Adult Social Care.

Impacts, Costs and Benefits of preferred option

Costs and benefits

A21. Identifying impacts as a result of achieving different outcomes would be the subject of a further Impact Assessment after the consultation period. Local level contribution to the outcome indicators will be driven by local need, dependent on the outcomes chosen and any associated level of ambition agreed regarding outcome indicators.

A22. Regarding the Outcomes Framework under development, anticipated positive impacts are:

- An overall reduction in the performance monitoring burden at a local level;
- Refocusing and strengthening of public health outcomes and their delivery at local and national levels;
- Alignment between the NHS Outcomes Framework/ Adult Social Care Framework and Public Health Outcomes Framework; and
- Prioritisation of health indicators with the greatest potential to impact on the public's health (and health inequalities), supported by an evidence base of intervention to improve health outcomes.

A23. Regarding the Outcomes Framework under development, possible negative impacts are:

- Current proposal for the Public Health Outcomes Framework may be seen by Local Authorities, and others as regressive because of its top-down nature;
- Continuity may be difficult to achieve between existing frameworks (e.g. Vital Signs / National Indicator Set) and the new Outcomes Framework;
- The prioritisation process to develop top-level indicators could result in unintended consequences e.g. they become the focus for local action over and above local need / priorities; and
- There may be limitations in the evidence base underpinning the interventions required to improve selected outcome indicators.

A24. The Outcomes Framework is under development and the final approach taken as well as the individual outcome indicators selected will be determined post-consultation. Therefore, it is not possible to estimate costs at this stage.

Anticipated costs

- If new data collections are needed to monitor outcomes, then these will have cost implications for the public health service. In most cases, data underpinning outcome indicators may already be collected. However, the frequency and timeliness of existing indicators may have to be improved in order to be suitable for accountability purposes.

- In other cases, based on the final indicator set, new data collection systems may need to be established incurring additional costs including as appropriate, the setting up and evaluation of pilots.

- To be determined at local level, additional costs may be as a result of diverting public health expenditure to meet locally agreed ambitions resulting in opportunity costs.

Anticipated benefits

- Outcome measures may incentivise cost-effective interventions. It is not possible to quantify these at this stage.

- Resources saved from reducing the burden of current top-down performance management structures and streamlining as a result of synergy across the Adults Social Care and NHS Outcomes Framework.

- Until the framework is fully developed and indicator set agreed following consultation, it will not be possible to quantify or evaluate the net benefit of this approach.

A25. Wherever possible, we will use existing data sources, and will report on progress at the national level. We anticipate the National Child Measurement Survey as being the only area where responsibility will transfer from the NHS to Local Government.

Summary and weighing of options

A26. Option 2, representing the setting up of an Outcomes Framework, is the preferred option.

A27. Provided the outcome indicators and levels of ambition selected are appropriate, and fulfil the conditions explained above and in the Consultation document, we would expect benefits to outweigh costs .

A28. However, the full costs and benefits of establishing an Outcomes Framework cannot be estimated at this stage, with considerable uncertainties about the likely shape and content of the framework

Annex C – Proposed Public Health Indicators: Technical Detail

NB – indicators in *italics* are included as potential developmental indicators
TBC – to be confirmed

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

Reference	Outcome Indicator	Rationale/Description	Data Source	Spatial Level Available	Can be disaggregated by equality characteristic[8] (Y- Yes, N- No, P- Partial)	Frequency of Collection
V1	Healthy life expectancy	Life expectancy is increasing and it is desirable for increased years of life to be spent in good health. The measure uses a self-reported health assessment, applied to life expectancy data. In part, this is a subjective measure but is an indicator of whether efforts are being appropriately targeted at conditions or behaviours that improve people's lives.	ONS (based on death registrations, population estimates, and general health questions in modules of the Integrated Household Survey)	National (currently). Local Authority data should become available in late 2011 (subject to ONS development work)	P	Annual
V2	Differences in life expectancy and healthy life expectancy between communities.	These 2 measures would work as a package covering both morbidity and mortality, and addressing within-area differences and between-area differences.	ONS for Life Expectancy (LE) and Healthy Life Expectancy (HLE) or Disability Free	(1) Within-LA measure: at LA level with a national summary measure.	P overall. Y for gender and area deprivation. N for ethnicity. Age would be possible but essentially we are	Annual

[8]The majority of outcome indicators (where applicable) can be disaggregated by some equality domains (e.g. age and gender) but not all (e.g. sexual orientation). However, following consultation, further work will be undertaken to review the final indicators selected, identifying and addressing gaps in existing data collection where it is possible to do so.

	This uses 2 underpinning measures: (1) The slope index of inequality in life expectancy within every Local Authority (LA) area and (2) the gradient of inequality in healthy life expectancy between LAs	They support action to improve health in small pockets of deprivation everywhere as well as larger areas of deprivation, which are below the national average at LA level but may have small within-area gaps.	Life Expectancy (DFLE)	(2) Between-LAs; National-level. The underpinning data is available at national, LA and super output area (SOA) for Life Expectancy and at National levels for HLE/DFLE. (LA level is under development)	proposing measures which capture all-ages. It would be possible to breakdown into certain age categories.	

Domain 1: Health Protection and Resilience

Reference	Outcome Indicator	Rationale/Description	Data Source	Spatial Level Available	Can be disaggregated by equalities (Y-Yes, N- No, P-Partial)	Frequency of Collection
D1.1	Comprehensive, agreed, inter-agency plans for responding to public health incidents in place, audited and assured to an agreed standard and tested to ensure effectiveness on a regular cycle.	Rationale is based on a principle of most incidents should be manageable at a local level. Reference to Civil Contingencies Act 2004, National Risk Assessment (Cabinet Office)	No data collected on compliance or performance re; health emergency preparedness & response by DH. National Capability Survey (NCS) held by Cabinet Office every 2 years	NCS National but aggregated up from local and regional organisations	N/A	NCS every 2 years
D1.2	Systems in place to ensure effective and adequate surveillance of health protection risks and hazards.	(Technical detail under discussion).	TBC	TBC	TBC	TBC
D1.3	Life years lost from air pollution as measured by fine particulate matter	Comparing a 2008 birth cohort exposed over their lifetimes to 2008 levels of anthropogenic fine particulate matter (PM2.5) with a birth cohort not exposed	UK National Air Quality Archive and Health Protection Agency	National (UK)	N/A	Annual

		to anthropogenic PM2.5 at all over their lifetime (which represents the hypothetical removal of anthropogenic PM2.5) shows a loss in life expectancy of about 6 months per person. (see http://www.defra.gov.uk/environment/quality/air/airquality/panels/igcb/documents/100303-aq-valuing-impacts.pdf Adding similar calculations for other cohorts suggests a cumulative overall impact of between 18.2 and 32.4 million life-years lost for the current UK population.				
D1.4	Population vaccination coverage (for each of the national vaccination programmes across the life course)	Immunisation is a central public health intervention that continues to evolve as more diseases become amenable to cost effective immunisation programmes. The purpose of this outcome measure is to ensure that successful immunisation programmes are in place and that the protection provided by existing and newly introduced programmes can continue to be improved.	Various reporting mechanisms are used including COVER, KC50 and ImmForm with significant input by the HPA. This will require central coordination by Public Health England	National, Local Authority and Output Area	P	Annual/Quarterly (subject to vaccination programme and reporting mechanism)
D1.5	Treatment completion rates for TB	Tuberculosis has been on the increase in England, reaching 8423 cases in 2009 (an increase of 5.3% from the previous year).	Enhanced Surveillance TB System (currently coordinated by HPA)	National, Local Authority	P	Annual

		Properly completed treatment can prevent development of drug resistance and reduce treatment costs by at least 80% and treatment time by at least a year and a half per case.				
D1.6	Public sector organisations with board approved sustainable development management plan.	(Technical detail under discussion)	TBC	TBC	TBC	TBC

Domain 2: Tackling the Wider Determinants of Health

Reference	Outcome Indicator	Rationale/Description	Data Source	Spatial Level Available	Can be disaggregated by equalities/ inequalities (Y-Yes, N-No, P-Partial)	Frequency of Collection
D2.1	Children in Poverty	Growing up in poverty damages children's health and wellbeing adversely affecting their future health and life chances as adults. This is currently measured as % of children living in families receiving means tested benefits.	Based on data provided by Department for Work and Pensions	National / Local Authority / Output Area	P	TBC
2.2	School readiness: foundation stage profile attainment for starting Key Stage 1	(Technical detail under discussion)	TBC	TBC	TBC	TBC
D2.3	Housing overcrowding rates	DCLG can provide data on overcrowding rates (based on bedroom standard) for households and individuals by tenure.	Department for Communities and Local Government (DCLG) English Housing Survey	National and regional. LA level may be possible and is currently being investigated.	P	TBC
D2.4	Rates of adolescents not in education, employment or	Non-participation in education, employment or training between the ages of 16 and 18 is a predictor of later unemployment, low income, depression,	Client case-load information system (CCIS) currently maintained by	National / Local Authority	TBC	Annual

	training at 16 and 18 years of age	involvement in crime and poor mental health.	Local Authorities (collection post 2011 to be confirmed)			
D2.5	Truancy rate	Research has shown that children who are not in school are most vulnerable and are easily drawn into crime. Those children who play truant are more likely to offend than those who do not. Secondary school persistent absence rate has been used to measure truancy.	NB Department for Education (DFE) have not included this in their impact indicators. Previously managed by DFE predecessor and based on Termly School Census	National / Local Authority	TBC	Annual
D2.6	First time entrants to the youth justice system	(Technical detail under discussion)	TBC	TBC	TBC	TBC
D2.7	Proportion of people with mental illness *and or disability* in settled accommodation	(Technical detail under discussion) Further work is required to define disability in the context of these indicators and to identify appropriate data sources	TBC	TBC	TBC	TBC
D2.8	Proportion of people with mental illness *and or disability* in employment.	Costs of working age ill health in the UK is £100 billion per year. There were 9.8 million working days lost in 2009/2010 due to work-related stress, depression or anxiety. It is expected there will be a rise of 60% over the next 10 years in people with 3 or more long-term conditions. Further work is required to define disability in the context of these indicators and to identify appropriate data sources	TBC	TBC	TBC	TBC
D2.9	Proportion of	There is a strong evidence to suggest that	Department for	TBC	TBC	TBC

	people in long-term unemployment	work is generally good for physical and mental health and wellbeing, taking into account the nature and quality of work and its social context, and that worklessness is associated with poorer physical and mental health.	Work and Pensions			
D2.10	Employment of people with long-term conditions	The data source exists to measure this outcome, however the method by which the employment rate of people with long-term conditions will be mapped to the employment rate of the general population needs to be developed.	Labour Force Survey	Not currently available but possible to construct	P	Not currently published but data is available quarterly
D2.11	Incidents of domestic abuse	Domestic abuse victims have the highest level of repeat victimisation, often with the severity of incidents escalating over time. In addition, alcohol use is indicated in a high proportion of incidents.	APACS (Assessments of Policing and Community Safety)	National / Local Authority	TBC	Quarterly
D2.12	Statutory Homeless households	Homelessness is a social determinant of health and an indicator of extreme poverty. Statutorily homeless households contain some of the most vulnerable members of society.	DCLG via P1E-Local Authority returns	National/Local Authority	P	Quarterly
D2.13	Fuel Poverty	Low income, poorly insulated housing and expensive and inadequate heating systems may contribute to fuel poverty, which itself contributes to excess winter mortality.	TBC	TBC	TBC	TBC
D2.14	Access and utilisation of green space	There is strong evidence to suggest that there is a positive relationship between green space and the general health of the population. Studies indicate that better health is linked to green space provision, regardless of the socio-economic status of the people who use it. There is strong	Monitor of Engagement with the Natural Environment (MENE) survey	TBC	TBC	TBC

		evidence to suggest that green spaces have a beneficial impact on mental wellbeing and cognitive function through both physical access and usage. This indicator measures the number of people using green spaces for personal health and exercise.				
D2.15	Killed and seriously injured casualties on England's roads	Road user safety is a public health issue as incidents and collisions on the roads are a significant cause of death and injuries; disproportionately so among young age groups and in disadvantaged areas. They have a large affect on the resources of health and rescue services and there are strong synergies between active travel, road safety and health. Road safety is also one of the key factors affecting how pleasant an area is to live in. This indicator will monitor progress in this area by showing the changes in the number of people killed and seriously injured on English roads.	Stats 19 reports / Department for Transport	National / Local Authority	P	Annual
D2.16	The percentage of the population affected by environmental, neighbour, and neighbourhood noise.	The first aim of the **Noise Policy Statement for England** is to avoid significant adverse impacts on health and quality of life from environmental, neighbour and neighbourhood noise. This outcome would assist in achieving this aim.	National Noise Attitude Survey (NAS).	England	P	Every 2 years
D2.17	Older people's perception of community safety	(Technical detail under discussion)	TBC	TBC	TBC	TBC
D2.18	Rates of violent crime, including sexual violence	(Technical detail under discussion)	TBC	TBC	TBC	TBC
D2.19	*Reduction in*	*(Technical detail under discussion)*	*TBC*	*TBC*	*TBC*	*TBC*

	proven reoffending					
D2.20	*Social connectedness*	*This is a strong candidate indicator for measures of social capital that have a bearing on health. Evidence suggests that where individuals have an opportunity to discuss health issues in social groups they are less likely to make poor decisions about their own health. In a UK setting, this effect is likely to be measured best by using survey measures to assess social connectedness rather than, for example, membership of groups.*	*Existing questions in DCLG 'citizenship survey' adapted locally for measures at LA level.*	*TBC*	*TBC*	*TBC*
D2.21	*Cycling participation*	*Measures the percentage of the population cycling by frequency (no. of days) during previous 4 weeks.* *Evidence suggests that cycling may be a good proxy for physical activity participation.* *Nearly all frequent (once a week or more) cyclists meet recommended physical activity levels.*	*Sport England's Active People Survey.* *Rolling national phone survey. Data collection started Oct 2010.* *(Note this is a new additional question tracking any cycle journey).*	*National / Local Authority*	*P* *The data (at a national and LA level) could be further analysed by gender, age range, ethnic profile, educational level, household type, car ownership, disability, working status and job type, and income.*	*Quarterly*

Domain 3: Health Improvement

Reference	Outcome Indicator	Rationale/Description	Data Source	Spatial Level Available	Can be disaggregated by equalities (Y-Yes, N- No, P-Partial)	Frequency of Collection
D3.1	Prevalence of healthy weight in 4-5 and 10-11 year olds	Obese/overweight individuals cost the NHS approximately £4.2bn per annum. By 2015, it is estimated that 53,000 deaths each year will be due to excess weight.	National Child Measurement Programme	National, Local Authority & Output Area	P	Annual
D3.2	*Prevalence of healthy weight in adults*	*Obese/overweigh individuals cost the NHS approximately £4.2bn per annum. By 2015, it is estimated that 53,000 deaths each year will be due to excess weight. The potential inclusion of this proposed indicator is subject to further work to develop an accurate and cost-effective means of measurement at local authority level.*	*Health Survey for England*	*National / Regional*	*P*	*Annual*
D3.3	Smoking prevalence in adults (over 18)	Causes approximately 80,000 deaths in England each year and costs the NHS between £2.5 - £5bn per annum.	Integrated Household Survey	National, Regional & Local Authority	P	Quarterly
D3.4	Rate of hospital admissions per 100,000 for alcohol related harm	There are substantial differences in the health consequences of alcohol use between affluent and deprived communities. Deprived areas suffer higher levels of alcohol related mortality, hospital admission, crime, absence from work, school exclusions, teenage pregnancy and road traffic accidents linked to greater levels of alcohol consumption. Much of this harm is preventable - one in eight of	Hospital Episode Statistics	National, Local Authority & Output Area	P	Quarterly

		those drinking at higher-risk levels will reduce their drinking if they receive brief advice - reaping economic and health benefits for individuals and communities. Alcohol-related admissions are considered to be sensitive to the impact of prevention interventions - i.e. when prevention interventions are improved, hospital admission for specific chronic and acute conditions should slow in the short, medium and long term. This indicator will therefore measure the impact of prevention interventions for alcohol, without creating an additional burden for local healthcare organisations Estimates of alcohol-related deaths between 9,000 and 30,000 each year and costs to the NHS of approximately £2.7bn per annum.				
D3.5	Percentage of adults meeting the recommended guidelines on physical activity (5 x 30 minutes per week)	Physical inactivity costs the NHS approximately £1.8bn per annum and WHO report that it is one of the 10 leading causes of death in developed countries.	Sport England's Active People Survey - derived	TBC	TBC	TBC
D3.6	Hospital admissions caused by unintentional and deliberate injuries to 5-18s	Injuries are the leading cause of death in children and disproportionately affect children from lower socioeconomic groups. This indicator concerns finished in-year emergency admissions for patients aged between 5 and 18 years of age with an external cause of morbidity. Focusing on this age group addresses strong evidence on the incidence of self-harm and serious accidents.	Hospital Episode Statistics	National, Local Authority & Output Area	P	Annual

D3.7	Number leaving drug treatment free of drug(s) of dependence	Illicit drug misuse can cause significant harm to individuals, their families and communities. Illicit drug misuse costs the NHS between £0.85 - £1.05 billion per annum. The indicator is defined as the number of drug users that left drug treatment successfully as recorded in the National Drug Treatment Monitoring System (NDTMS), who do not then re-present to treatment again within 12 months.	National Drug Treatment Monitoring System	National, Local Authority	P	Monthly
D3.8	Under 18 conception rate	Evidence shows that teenage parenthood leads to poorer health outcomes for both teenage parents and their children - babies born to teenage parents have a 60% higher risk of infant mortality and teenage mothers and three times more likely to suffer from post-natal depression.	ONS	National, Local Authority	P	Quarterly - 14 month time lag
D3.9	Rate of dental caries in children aged 5 years (decayed missing or filled teeth)	Dental disease is more common in deprived, compared with affluent, communities. The indicator is good direct measure of dental health and an indirect, proxy measures for child health and diet. (See Health Profile Indicator Guide (APHO): http://apho.org.uk/resource/view.aspx?RID=50204	Currently the Dental Observatory	National, Local Authority (but not where the sample size is <30)	P	Every 2 years
D3.10	*Self reported wellbeing*	*TBC –* *Promoting wellbeing can improve health outcomes, life expectancy as well as educational, social and economic outcomes. We can explore the potential to use the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) tool incorporated into the Health Survey for England. Alternatively, EQ5D data may be captured via the GP survey.*	*TBC - Potential to use Health Survey for England and or / National GP Survey*	*TBC*	*TBC*	*TBC*

Domain 4: Prevention of Ill Health

Reference	Outcome Indicator	Rationale/Description	Data Source	Spatial Level Available	Can be disaggregated by equalities (Y-Yes, N-No, P-Partial)	Frequency of Collection
D4.1	Hospital admissions caused by unintentional and deliberate injuries (1-5 years)	Injuries are a leading cause of death in children and disproportionately affect children from lower socioeconomic groups. This indicator concerns finished in-year emergency admissions for patients between 1 and 5 years of age with an external cause of morbidity. In addition a focus on this age group links to early years child protection activities led by local government.	Hospital Episode Statistics	National, Local Authority & Output Area	P	Annual
D4.2	Rate of hospital admissions as a result of self-harm	(Technical detail under discussion)	TBC	TBC	TBC	TBC
D4.3	Incidence of low-birth weight of term babies	Low birth weight is a known risk factor for infant mortality. This indicator measures live and stillborn infants with low birthweights as a percent of all live and stillborn infants with a stated birthweight.	ONS	National / Local Authority	TBC	Quarterly
D4.4	Breastfeeding initiation and prevalence at 6-8 weeks after birth	There is evidence that breastfeeding has positive health benefits for both mother and baby in the short and longer term (beyond the period of breastfeeding). See http://www.nhs.uk/Planners/breastfeeding/Pages/breastfeeding.aspx	Currently PCT coordinated Child Health Information Records.	Currently at PCT level	P	Reported to DH at quarterly intervals

D4.5	Prevalence of recorded diabetes	There were an estimated 3 million people with diabetes in England in 2009; estimates suggest that the number of people with diabetes could rise to 4.6 million by 2030. Based on the indicator currently used in the Local Health Profiles (APHO), this proposed indicator will measure prevalence of QOF-recorded diabetes (in adults aged 17+) in the population.	Quality Management Analysis System	National, Local Authority & GP Practice	P	Annual
D4.6	Work sickness absence rate	The costs of working age ill health in the UK is estimated at £100 billion per year, greater than the annual budget for the NHS. Around 172 million working days were lost to sickness absence in 2007, at a cost to the economy of over £13 billion.	Department of Work and Pensions	TBC	TBC	TBC
D4.7	Screening uptake	This indicator will measure screening uptake. Discussion is underway regarding which of the national screening programmes will be included.	TBC	TBC	TBC	TBC
D4.8	Chlamydia diagnosis rates per 100,000 young adults aged 15-24	29.9% of the population aged 15-24 were tested for chlamydia in 2009/10 and 142,200 (7.2%) tested positive. This indicates a high burden of infection in young people. Annual testing and testing at partner change in this age group is expected to reduce the transmission rate, leading to a fall in prevalence and a secondary reduction in the incidence of new infections. Early diagnosis and treatment will reduce the severe effects of chlamydia in women, such as pelvic inflammatory disease and infertility.	Currently Health Protection Agency	National / Local Authority / Output Area	TBC	Annual
D4.9	Proportion of persons presenting with HIV at a late stage of infection	Late diagnosis is the single most important factor associated with HIV-related morbidity and mortality in the UK. Late diagnosis is defined as a CD4 count of less than 350 mm^3 within three months of diagnosis. The sooner a person with HIV is diagnosed the sooner they can benefit from effective treatment when	Currently Health Protection Agency	National / Local Authority/ Output Area (subject to numbers)	P	Annual

		indicated and make any behavioural changes to prevent further HIV transmission.				
D4.10	*Child development at 2 - 2.5 years*	*We will explore the development of an outcome indicator of young children's health and well-being at age 2-3 that can be used locally and nationally as a basis for monitoring and accountability. This will reflect the importance of parenting and neurological development during pregnancy and the early years of life and children's development at age 5 and beyond. It will assess the feasibility of providing a common outcome measure that supports the HCP, health visiting, Family Nurse Partnership and Sure Start Children's Centres.* *Work to develop and test the measure will take place over the next 12 to 18 months using indicators based on existing measures of children's development, as there are a number of established validated tools.*	*TBC*	*TBC*	*TBC*	*TBC*
D4.11	Maternal Smoking Prevalence	Smoking during pregnancy contributes to 6% of all infant deaths and accounts for about a third of the difference in infant deaths between the most and least deprived groups in the population. The proportion of mothers who smoked throughout their pregnancy is much higher in mothers under 20 years of age.	DH (Health Improvement Analytical Team)	National / currently commissioning Primary Care Trusts	P	Quarterly
D4.12	Smoking rate of people with serious mental illness	People with mental ill health are much more likely to smoke and die younger. Almost half of total tobacco consumption and smoking-related deaths occur in people with a mental disorder. People with schizophrenia have an average 25-year lower life expectancy than the general population, which is primarily due to smoking.	Adult Psychiatric Morbidity Survey	National and Regional	P	Currently every seven years
D4.13	Emergency readmissions to hospital within 28	This indicator demonstrates the success of secondary prevention measures in delaying dependency and supporting effective reablement and rehabilitation. It provides a link between public health and the NHS and	Hospital Episode Statistics	National, Local Authority & Output Area	P	Quarterly

	days of discharge	adult social care outcome frameworks.				
D4.14	*Health-related quality of life for older people (placeholder)*	*This candidate indicator is intended to reflect the role of public health and social care prevention activity in promoting active ageing, and improving quality of life for older people. This indicator is likely to be available from the GP Survey, and more analysis is needed.*	*GP Patient Survey*	*National, Local Authority*	*TBC*	*Annual*
D4.15	Acute admissions as a result of falls or fall injuries for over 65s	Falls account for the majority of hospital admissions for unintentional injury in older people, and falls prevention is one of the key public health priorities. This indicator reflects the success of prevention in reducing admissions resulting from falls, and provides a strong link to the NHS and adult social care.	Hospital Episode Statistics	National, Local Authority & Output Area	P	Quarterly
D4.16	*Take up of the NHS Health Check programme by those eligible*	*This indicator intends to measure take up of the NHS Health Check programme, a clinically and cost effective preventative programme which aims to reduce the number of people with heart disease, stroke, diabetes and chronic kidney disease. Everyone receiving a NHS Health Check will have a personal risk assessment and be given individually tailored advice and support to help them stay well for longer*	*National data collection*	*National and Local Authority Level*	*P*	*Quarterly*
D4.17	*Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed*	*(Technical detail under discussion)*	*TBC*	*TBC*	*TBC*	*TBC*

Domain 5: Healthy Life Expectancy and Preventable Mortality						
Reference	**Outcome Indicator**	**Rationale/Description**	**Data Source**	**Spatial Level Available**	**Can be disaggregated by equalities (Y-Yes, N- No, P-Partial)**	**Frequency of Collection**
D5.1	Infant Mortality	Infant mortality is a widely used indicator of the overall health of a population. It reflects a broad range of determinants including upstream determinants such as economic development, general living conditions and social and environmental factors.	ONS Mortality Extract	National, Local Authority	P	Annual
D5.2	Suicide rate	This indicator intends to measure the age standardised mortality rate from suicide and injury of undetermined intent. (3-year rolling average) Suicide is related to a number of socio-economic factors including social exclusion and inequalities in access to relevant service provision.	ONS Mortality Extract	National / Local Authority (subject to numbers)	P	Annual
D5.3	Mortality rate for communicable diseases	There are evidence-based prevention, detection and treatment interventions for most communicable diseases yet the incidence of certain diseases continues to increase (e.g. Mycobacterium Tuberculosis). This indicator intends to reflect the effectiveness of primary and secondary prevention activity to reduce mortality from communicable diseases. This indicator includes mortality as a result of health care acquired infections (HCAIs). Incidence of HCAIs is a separate indicator proposed in the NHS Outcomes Framework.	ONS Mortality Extract	National / Local Authority	P	Annual
D5.4	Mortality rate	Circulatory diseases are the biggest cause of	ONS	National/	P	Annual

	from all cardiovascular disease (including heart disease and stroke) persons less than 75 years of age	preventable death in England and a major cause of health inequality. In 2008, approximately 40,000 persons under 75 years died from circulatory diseases in England (NHS Information Centre)	Mortality Extract	Local Authority/ Output Area		
D5.5	Mortality rate from cancer in persons less than 75 years of age	Cancer is one of the three leading causes of death in people of all ages. Inequalities exist in cancer mortality rates between the most deprived areas and the most affluent. Approximately 62,000 persons under 75 years of age died of cancers in England 2008. (NHS Information Centre).	ONS Mortality Extract	National/ Local Authority/ Output Area	P	Annual
D5.6	Mortality rate from Chronic Liver Disease in persons under 75 years of age	Liver disease mortality is rising by 10% per annum and has increased 2 fold in the past two decades. There has been a 3-fold increase in cirrhosis during that time and a 5-fold increase in the 35-55 year age group in the last 10 years in contrast to our neighbours in France, Italy & Spain all of which have decreased during that time. The average age of death from liver disease is currently 59 years and continues to fall. The main cause appears to be alcohol but there are increased trends from fatty liver (obesity) and hepatitis B&C viruses.	ONS Mortality Extract	National/ Local Authority	P	Annual
D5.7	Mortality rate from chronic respiratory diseases in persons less than 75 years of age	(Technical detail under discussion)	ONS Mortality Extract	National/ Local Authority	P	Annual
D5.8	Mortality rate of	(Technical detail under discussion)	TBC	TBC	TBC	TBC

	people with mental illness					
D5.9	Excess seasonal mortality	(Technical detail under discussion)	TBC	TBC	TBC	TBC

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