March 2011 **Paper 2**

Cheshire East Council Response to Consultation

Healthy lives, Healthy people: Transparency in Outcomes

Summary

This consultation document sets out proposals to put in place a new strategic outcomes framework for public health at national and local levels.

The consultation is 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.

The proposed Outcomes Framework is guided by a set of principles. The Framework 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 (Equalities Act 2010)
- Take a life course approach
- As far as possible, use data collated and analysed nationally to reduce the burden on local authorities

The 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'.

The Public Health Outcomes Framework should be a consistent means of presenting the most relevant, available data on public health for national and local use.

The Public Health Outcomes Framework is linked with the NHS and Adult Social Care Outcomes Frameworks, which are explored in this consultation document.

The proposed Outcomes Framework will be based on a high level vision for public health, which will be supported by 5 key domains for public health outcomes that reflect national, local and community level actions. There are also a set of indicators that sit under the vision and each domain.

Vision

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

Proposed indicators for the overall vision:

- Healthy life expectancy
- Differences in life expectancy and healthy life expectancy between communities

It will be supported by 5 key domains for public health outcomes that reflect national, local and community level actions. There is also a set of indicators that sit under the vision and each domain.

These domains will need to be delivered through actions that are evidence based, can be measured, and which can be used by the public to hold local services to account for improvements in health.

Domain 1: Health protection and resilience

Protect the population's health from major emergencies and to remain resilient to harm.

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 across the life course)
- Treatment completion rates for TB
- Public sector organisations with a board approved sustainable development management plan

Domain 2: Tackling the wider determinants of health

Tackling factors which affect health and wellbeing and health inequalities.

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 in settled accommodation
- Proportion of people with mental illness and or disability6 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

Domain 3: Health improvement

Helping people to live healthy lifestyles, make healthy choices and reduce health inequalities.

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

Domain 4: Prevention of ill health

Reducing the number of people living with preventable ill health and reduce health inequalities.

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

Domain 5: Healthy life expectancy and preventable mortality

Preventing people from dying prematurely and reduce health inequalities.

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

Consultation questions and responses

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?

Good partnership working across different partner organisations, communities and individuals will be key to delivering public health outcomes. It is therefore important to make sure that barriers to collaborative working are minimised. An equitable reward system is needed, that ensures all agencies are recognised for their contribution. Commissioning and contracting arrangements should recognise the contributions of all agencies involved in achieving positive outcomes.

Clear lines of accountability will be required. The outcomes need to be specific, measured, relevant, timely, targeted and achievable. They will need to be reviewed and refined.

The single outcomes framework for all partners will encourage collaborative working.

There are a number of indicators which are not easily measured in the short term. Others have no technical definition or are not properly defined. This could create perverse incentives for some organisations.

Further work is required - it would be helpful to make data available at a more local level e.g. Lower Super Output Area, Middle Super Output Area, so that the outcomes can be judged by citizens and communities who may (or may not) recognise the outcomes reported.

2. Do you feel these are the right criteria to use in determining indicators for public health?

These appear to be the right criteria to use in determining indicators for public health. It is important however to revisit the indicators periodically and to refine the system in light of experience. Ongoing refinement in light of practical experience is to be welcomed, but we should avoid radical overhauls on a regular basis.

The outcomes are likely to be long term – application of the health premium should bear this in mind when assessing progress.

Outcomes should also bear in mind that it is sometimes difficult to measure interventions, but this does not necessarily mean that they are ineffective. Innovative means may need to be used to provide evidence of effectiveness.

It is important to use indicators which are meaningful to partners and the public.

Standardisation across the country is important to allow for comparisons.

3. 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?

It is difficult to design a system that ensures that all actions contribute fully to health inequality reduction. Reduction in inequalities in health and wellbeing is a corner stone of the government's health reforms and as such all systems and processes should be structured to reward progress in delivering the expected improvements. In so doing it is likely that some areas will make more progress than others and this is unavoidable.

The focus should be to continue to reward delivery of outcomes where possible, rather than rewarding activity. This will allow for innovation in the means of achieving those outcomes.

The Outcomes Framework should require a clear audit path, with clear accountability to clarify that a commissioned activity has been targeted toward desired outcome.

Local Authorities will become mainly responsible for achieving health outcomes, but influence in this area does not lie solely with the public health service or partners within the Health & Well-being Board. Key determinants may rest with industry, government and the public themselves. Accountability of the outcomes will be a challenge to achieve between these different sectors.

4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health Frameworks?

We believe that it is. The alignment of the three frameworks ensures that public health is an integral component of commissioning for all commissioning organisations. This also promotes an area based approach, with the outcomes frameworks aligned so that associated agencies are all working towards shared outcomes.

5. Do you agree with the overall framework and the domains?

Structuring the Framework around the five domains is a useful way of designing the outcomes framework, but it is essential that the Framework is robust as a stand-alone public health outcomes framework.

Although there is some overlap between the domains, there is the capacity to work across the domains.

The use of an outcomes framework would provide a logical and comprehensive approach to realising outcomes within a 2-5 year timeframe. There is also the capacity to work towards intermediate objectives.

6. Have we missed out any indicators that you think we should include?

We welcome the inclusion of a wide variety of indicators within the outcomes framework. Some gaps exist, but development of indicators within the framework should not be rushed, and different agencies might contribute to this over time.

Development of local Health and Wellbeing strategies, Local Inequalities Plans and local JSNAs will all be able to contribute to identification of additional indicators to enrich the Framework - this opportunity should not be missed.

Some important aspects of public health are hard to measure. It may be better to use themes, with some further work undertaken to devise more robust indicators.

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?

The framework should provide a breadth of indicators to cover all the domains comprehensively, which this framework aims to do. Healthy life expectancy for men and women is a fundamental deficit measure and we see this as an important outcome measure.

While it is useful to have this level of detail in the structure of the framework, it is not necessary to expect all agencies to measure all or many of these indicators. Agencies should be able to choose a basked of indicators that reflect their local public health priority and collect, monitor and report only the relevant indicators on a regular basis. The selection of the indicator would reflect its significance to achieving the desired outcome.

A number of key dimensions, for example asset and deficit indicators, performance and vigilance indicators need to be considered when designing measures to support this approach. Consideration to all-age indicators and breakdown is needed.

Examples of asset indicators:

- % reporting coping on current income/confident in ability to receive financial help in a crisis
- % Redundant in past year who found a new job or entered education or training or took up regular volunteering work
- % reporting recommended levels of recreational exercise
- % reporting participation in local groups and/or frequency of meeting people outside own household

- % reporting positive mental wellbeing (WEMWBS or equivalent measure of life satisfaction for all age)
- % reporting positive evaluation of functioning in local area (i.e. ability to influence local decisions, sense of belonging in local area, feeling safe at home at night)

8. Are there indicators here that you think we should not include?

It is more important to understand how the indicators included will be measured before considering if they will be included. The indicator needs to be appropriate and easily measured.

9. How can we improve indicators we have proposed here?

Indicators can be improved by being specific and ensuring the indicator is measurable and appropriate. For example: life years lost from air pollution as measured by fine particulate matter (Domain 1). Many authorities will not have the necessary equipment in place to measure particulate matter; it is also difficult to quantify life years lost from air pollution, as this is subjective.

A more appropriate indicator would be 'To reduce the number of Air Quality Management Areas' over a specific time frame. This work will already be measurable and this would then ensure that all partners would contribute to reaching this outcome.

10. 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).

The framework should use composite indicators to set the baseline, based on an index of multiple determinants. Incentives should reward progress against that baseline using both composite and individual indicators. This system would allow the flexibility locally to address the multiple causes of inequality in local communities.

This system would also allow a focus on the key areas which affect health e.g. smoking, cancer, obesity, alcohol, etc. Timescales for these indicators are important but need to be realistic and SMART.

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

As suggested earlier, it is important to align the three Public Health, NHS and Social Care Frameworks. We can see benefit in sharing domains to assess successful integration of activities to achieve outcomes that span more than 1 domain.

While we approve of the sharing of this domain, we will require a more joined-up approach between local authority and GP consortium commissioning, for example by giving key responsibility to GPs to improve quality and public health responsibilities.

Public health outcomes are needed within the NHS Outcomes Framework as well as within the Public Health Service.

12. How well do the indicators promote a life-course approach to public health?

This will become more apparent as we all begin to use the framework and integrate it within our plans and activities to address the complex public health issues.

The indicators should be presented as a life course 'model'.

A composite indicator based on an index of multiple determinants would also be a useful measure.