AGENDA ITEM: 5

Department of Health

Improving outcomes and supporting transparency

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

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Description	This update sets out a new Public Health Outcomes Framework. In three parts, Part 1 - this document - introduces the overarching vision for public health, the outcomes we want to achieve and the indicators that will help us understand how well we are improving and protecting health. Part 2 specifies all the technical details we can currently supply for each public health indicator and indicates where we will conduct further work to fully specify all indicators, and Part 3 consists of the Impact Assessment and Equalities Impact Assessment.
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Contact Details	Jazz Bhogal and Simon Dowlman PHDU G20 Wellington House 135-155 Waterloo Road SE1 8UG
For Recipient's Use	

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Executive summary

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

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

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

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

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

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

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

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

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

1. Increased healthy life expectancy.

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

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

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

These indicators are grouped into four domains:

> improving the wider determinants of health

> health improvement

> health protection

> healthcare public health and preventing premature mortality.

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

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

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

The new public health system

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

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

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

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

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

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

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

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

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

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

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

2. A new framework for public health outcomes

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

Overarching outcomes, domains and indicators

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

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

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

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

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

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

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

Public Health Outcomes Framework

OUTCOMES

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

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

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

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

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

DOMAINS

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

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

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

The domains

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

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

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

2 Health improvement

Objective

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

Indicators

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

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

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

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

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

4 Healthcare public health and preventing premature mortality

Objective

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

Indicators

- Infant mortality
- Tooth decay in children aged 5
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- *Mortality from communicable diseases (Placeholder)*
- *Excess under 75 mortality in adults with serious mental illness (Placeholder)*
- Suicide
- *Emergency readmissions within 30 days of discharge from hospital (Placeholder)*
- Preventable sight loss
- *Health-related quality of life for older people (Placeholder)*
- Hip fractures in over 65s
- Excess winter deaths
- *Dementia and its impacts (Placeholder)*

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

3. Developing the public health indicator set

Design principles

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Technical development

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

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

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

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

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

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

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

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

4. Transparency and accountability

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

Local government

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

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

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

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

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

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

The NHS

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

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

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

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

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

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

Public Health England

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

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

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

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

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

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

4.17 While the Public Health Outcomes Framework establishes determinants to tackle the range of public health issues in England, a number of the wider determinants covered in the framework will be relevant to improvements in public health across the UK. We will work closely with the devolved administrations on areas of shared interest including on UK-wide issues in health protection.

5. Next steps and future development

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

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

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

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

Managing the transition

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

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

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

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

Appendix A: Overview of outcomes and indicators

Vision

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

1 Improving the wider determinants of health

Objective

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

Indicators

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

2 Health improvement

Objective

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

Indicators

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

3 Health protection

Objective

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

Indicators

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

4 Healthcare public health and preventing premature mortality

Objective

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

Indicators

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

Appendix B: Indicator criteria assessment

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

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

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

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

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

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

*The fit for purpose criteria were:

1. Does it measure what it is intended to measure?

2. Will the measure allow change over time to be detected, ie is it possible to measure year-to-year progress?

3. Will data be available (by April 2013) at least annually to monitor the measure?

4. The measure is not vulnerable to perverse incentives that might lead to the wrong public health behaviours

The selection process

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

> HM Treasury Transparency Framework criteria

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

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

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

> Use indicators that are meaningful to people and communities

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

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

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

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

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

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

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

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

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

> aligns with the government s direction for public health

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

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

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

> is linked to helping reduce inequalities in health

> is linked to helping improve healthy life expectancy

> is statistically appropriate and fit for purpose

> is at least feasible at national level

> is at least feasible at local authority level.

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

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

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

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

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

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

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

Equalities

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

> socioeconomic group

> area deprivation (or postcode)

> age

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

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

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

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

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

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

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

Please note:

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

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

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

Availability of breakdowns for Public Health Outcomes Framework indicators

Key

Y Currently collected and published

N Not currently collected

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

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

n/a Not applicable to this indicator

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

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

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

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

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

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

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

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

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

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

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

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

Appendix D: Readiness of indicators

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

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

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

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

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

Indicator-by-indicator assessment of readiness

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

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

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

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