SHADOW HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

27th February 2012

at 9.30 a.m.

in One Life Centre,
Park Road, Hartlepool

MEMBERS: SHADOW HEALTH AND WELLBEING BOARD

Voting Members (statutory members)

Directly Elected Mayor, Executive Members of the Local Authority, Chief Executive of Local Authority, Representative of Clinical Commissioning Group, Chief Executive/Director of the PCT (transitional arrangements until 2013), Director of Public Health, Director of Child and Adult Social Services, HealthWatch Board Member, Representative of the NHS Commissioning Board, Patient Representative.

Non-Voting Members (non-statutory members)

Director of Regeneration and Neighbourhoods, North Tees and Hartlepool NHS Foundation Trust, Tees Esk and Wear Valley NHS Trust, Voluntary Sector Representative(s), North East Ambulance NHS Trust, Cleveland Fire Authority.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST**

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 16th January 2012 *(attached)*

4. **MATTERS ARISING FROM MINUTES**

   4.1 Health Watch – Verbal Update, Assistant Director, Adult Social Care

5. **ITEM FOR INFORMATION**

5.1 Feedback from Children's Services Portfolio Holder on attendance at Leadership Academy – Verbal Update
5.2 Feedback from Acting Chief Executive on Regional Health and Wellbeing Board Event – 31 January – Verbal Update
5.3 Joint Strategic Needs Assessment progress – Verbal Update, Assistant Director, Health Improvement
5.4 Public Health Transition Plan for Hartlepool – Assistant Director, Health Improvement (*attached)*
5.5 Public Health Improving Outcomes and Supporting Transparency – Policy Document – Assistant Director, Health Improvement (*attached)*
5.6 North East Health and Wellbeing Board Transition Workstream – Local Authority Level of Preparedness - Hartlepool's position – Assistant Director, Health Improvement (*attached)*
5.7 Immunisation Strategy – Verbal Update, Assistant Director, Health Improvement

6. **ITEMS REQUIRING DECISION**

6.1 Draft Work Programme – Assistant Director, Health Improvement (*attached)*
6.2 Consultation on Plain Packaging for Cigarettes – Verbal Update, Head of Health Improvement

7. ITEM FOR DISCUSSION

7.1 Presentations by Assistant Director, Adult Social Care and Head of Service on the following:-
(i) Reablement
(ii) Extra Care Housing Strategy (*attached)*

8. FUTURE AGENDA ITEMS

9. ANY OTHER BUSINESS

SHADOW HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

16th January 2012

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

The Mayor, Stuart Drummond - In the Chair

Statutory Members

Councillors: Jonathan Brash (Housing and Transition Portfolio Holder)
Gerard Hall (Adult and Public Health Services Portfolio Holder).
Cath Hill (Culture, Leisure and Tourism Portfolio Holder),
Robbie Payne (Deputy Mayor) (Finance and Procurement Portfolio Holder),
Chris Simmons (Children's Services Portfolio Holder),
Hilary Thompson (Performance Portfolio Holder),

Nicola Bailey, Acting Chief Executive
Jill Harrison, Assistant Director, Adult Social Care
Caroline O'Neill, Assistant Director, Performance and Achievement
Louise Wallace, Assistant Director, Health Improvement

Dr Paul Pagni, representing Clinical Commissioning Group
Margaret Wrenn, Hartlepool LINK Chair

Non Statutory Members: -

Christopher Akers-Belcher, Hartlepool LINK Co-ordinator
Carole Langrick, Deputy Chief Exec, North Tees and Hartlepool NHS Foundation Trust
Keith Bayley, HVDA
Dave Stubbs, Director of Regeneration and Neighbourhoods

In attendance as substitutes:-

Les Morgan as substitute for Martin Barkley, Tees, Esk and Wear Valleys NHS Foundation Trust

Present representing Cleveland Fire Authority:-

Les Jones, Head of Community Safety

Dave Turton, District Manager, Hartlepool

Also Present:-

Councillor Brenda Loynes, Hartlepool Borough Council/LINK

Officers:-

Sarah Bowman, Speciality Registrar Public Health, NHS Tees
Catherine Frank, Partnerships Manager, Hartlepool Borough Council
Peter Kelly, Executive Director of Public Health, NHS Tees
Alison Wilson, Director of Health Systems Development, NHS Hartlepool
Amanda Whitaker, Democratic Services Team Manager

23. Apologies for Absence

Councillor Pam Hargreaves (Transport and Neighbourhoods Portfolio Holder), Councillor Peter Jackson (Regeneration and Economic Development and Skills Portfolio Holder), John Bentley, Hartlepool PCT, Martin Barkley, Chief Exec, Tees and Esk Valley NHS Trust

24. Declarations of interest by Members

Councillor Brash declared a personal interest relating to his employment in a local General Practice and relating to his father's profession and role in Clinical Commissioning Group.

25. Minutes

The minutes of the meeting held on 21st November 2011 were confirmed.

26. Matters Arising from Minutes

(i) Development of Immunisation Strategy – The Assistant Director, Health Improvement, referred to discussions at the previous meeting and the positive media coverage arising from those discussions. The Shadow Board had agreed at that meeting that an Immunisation Strategy should be drafted. It was noted that the draft Strategy would be submitted to the next meeting of the Board. Arising from the update, discussion took place on parental responsibility and the support which could be given to parents. The Board reiterated comments made at the last meeting regarding the potential role of schools and the use of school data. A possible link to the school admissions process was also suggested. The Assistant Director undertook to ensure the issues which had been raised by Board Members were included in the draft Strategy to be submitted to the next meeting of the Board.

(ii) Health and Wellbeing Strategy – The Speciality Registrar Public Health advised the Shadow Board that the Strategy framework was continuing to be developed and that relevant partners would be involved in discussions. The Speciality Registrar Public Health was due to attend Accelerated Learning set and Board Members were asked if there were any issues that they wanted to be raised. The Assistant Director, Health Improvement ,updated the Board on the timescale for production of the Strategy. It was noted that the Outcome Framework and budget details had not yet been received.

27. Public Health Update

The Assistant Director, Health Improvement gave a verbal update on progress of the Public Health Transition Plan which was to be considered by the Council's Cabinet on 23rd January. A report would be submitted also to the next meeting of the Shadow Board. It was highlighted that the Plan had wide ranging impact and was critical in terms of the transition of public health responsibilities. The Director of Public Health provided the Board with information on timescales for receipt of budget information. . He highlighted also that Public Health England had not yet appointed the Chief Operation Officer and key policy documents had yet to be received.

It was noted that the Transition Plan was important to both the Council and to NHS Hartlepool. It was confirmed that details of the areas which would be transferred and become the responsibility of the Local Authority would be detailed in the Plan. It was not expected that there would be any changes to the areas which had been identified but that there would be additional responsibilities transferred to the Council in the longer term.

During the discussion which followed the update, concerns were expressed regarding the implications of potential reductions in budgets and the implications of changes in priorities if budgets were reduced. It was considered that it would be necessary to lobby for optimum resources available and to make best use of those resources.

Decision

The update was noted.

28. Healthworks: Annual Health and Wellbeing Report – November 2011 (*North Tees Foundation Trust*)

The Deputy Chief Executive/Director of Strategic Development presented the background to the production of the first Healthworks report which provided a summary of the activities of the Foundation Trust in the past year. Tribute was paid to the contribution which the Council's Assistant Director, Health Improvement, had made to the report. Three levels of intervention had been identified and the areas identified were currently

being translated into the Plans of the Trust. The report was commended to the Shadow Board.

Councillor Brash, Chair of Alcohol Strategy Group, referred to statistics included in the report relating to alcohol misuse. It was highlighted that 7,500 admissions to Hartlepool and North Tees hospitals in 2009/10 had been attributable to alcohol. Considerable discussion followed during which Board Members highlighted a number of areas to be considered including the input of Board Members to the Joint Alcohol Strategy, the work of the Clinical Commissioners Group including identification as priority area, investment in mental health services and lobbying Government in relation to the introduction of minimum pricing of alcohol. Discussion also related to the link between alcohol and domestic violence, the need for cultural and licensing changes, child protection issues, under age drinking, the role of parents and the work which could be carried out in schools to educate children and young people on issues associated with misuse of alcohol. The role of the Safer Hartlepool Partnership, in addressing issues which had been raised, was highlighted.

Decision

That the alcohol strategy be included in the Work Programme of this Shadow Board.

29. Letter from David Behan, Director General for Social Care, Local Government and Care Partnerships, Department of Health

A letter had been circulated which updated the Board on the announcement made by Secretary of State for Health, Andrew Lansley, which covered a new start date for Local Healthwatch (April 2013), details of funding made available for the Healthwatch pathfinders and new funding of £3.2m for start up costs for Local Healthwatch.

The Assistant Director, Adult Social Care responded to a request for clarification regarding funding including potential transition arrangements. It was noted that LINK funding would continue until a Local Healthwatch was in place. However, there was some lack of clarity nationally and it was hoped that further guidance would be received.

Decision

The letter was noted.

30. Presentation on

(i) Clinical Commissioning Group – Proposed Configuration

(ii) Clinical Commissioning Group – Good Health – Everybody's Business; A Clear and Credible Plan for Commissioning Health Services for the Populations of Hartlepool and Stockton-on-Tees

A paper had been circulated which set out details of the proposed final configuration of the Clinical Commissioning Group (CCG) that would serve Hartlepool and which sought the Board's consideration of the assurances it would require to ensure successful delivery of its future priorities and objectives. A final draft report which had been prepared by the Clinical Commissioning Group entitled 'Good Health – Everybody's Business' had also been circulated. The 'Clear and Credible Plan' set out the Group's objectives over the next five years giving specific focus on the next three years.

The Director of Health Systems and Development gave a presentation covering both documents focussing on Policy Ambitions, the role of the Clinical Commissioning Groups, the Clear and Credible Plan Structure, the Clinical Commissioning Group Configuration and its priorities.

Following the presentation, the Board discussed the rationale for a single Commissioning Group covering Hartlepool and the area north of the Tees and the relationship with the Hartlepool CCG. It was recognised that alternative options would not have been viable. Discussion took place also in relation to representation on the CCG Board and its Locality Board. It was recommended that Local Authority representation should be included on both Boards. Discussion followed on governance and transparency issues and the role of this Shadow Board was highlighted together with the role of Patient Participation Groups and the communication message included in the Clear and Credible Plan. It was noted also that this Board was represented on the Clinical Commissioning Group. The Mayor highlighted that a joint letter which he had sent with the Chair of the Clinical Commissioning Group, to the Secretary of State for Health seeking a decision on the new hospital development, was an example of joint working. The Mayor undertook to forward a copy of the letter to Shadow Board Members.

Decision

(i) The Director of Health Systems and Development undertook to refer the issue of Local Authority representation on the CCG Board and the Locality Board to the Primary Care Trust.

31. Excess Seasonal Deaths and Winter Warmth – Presentation, Assistant Director, Health Improvement and Cleveland Fire Authority Representatives

The Board received a presentation by the Assistant Director, Health Improvement, on Winter Warmth. An explanation was provided of what was defined as 'Fuel Poverty' and the impact on Children and Young People. It was highlighted that excess winter deaths were usually from circulatory disease and respiratory disease exacerbated by exposure to indoor and outdoor cold and that those deaths could be avoided. The Board was updated on the scale of the problem and action taken to address the issue. It was noted that one off grant funding of £20,000 had been received which was to be spent by March 2012 and the funding was expected to be utilised for this winter 2011/12. The key aim of the funding was to raise awareness about the risks of cold weather and to provide advice and support on keeping warm to people across the Borough. A breakdown of how the funding was intended to be spent was provided to the Board.

Representatives of Cleveland Fire Authority advised the Board of the 'Stay Safe and Warm 2011/12' initiative and the key partners involved. The initiative addressed both fire and health related issues. It provided a signposting service for longer term support and demonstrated joined up service delivery. The initiative worked through referrals to the Fire Brigade and involved rapid provision of emergency equipment and advice to keep people warm within their own homes. The Board was updated on key findings in respect of a breakdown of referrals received in 2010/11 and the areas of the town which had been covered in 2011/12. A number of case studies were also presented which demonstrated the scope of referrals received.

A Board Member referred to previous discussions in relation to representation on this Board and proposed that a representative of Cleveland Fire Authority be invited to attend meetings of this Board as a non voting member.

Members of the Board paid tribute to the fantastic service provided by the Fire Authority. It was considered timely to consider the relationship between health and housing and 'pooling' funding if appropriate to address problems arising from fuel poverty in the town. The Assistant Director, Health Improvement acknowledged the sentiments which had been expressed and agreed to include the issue in the Board's future Work Programme.

Decision

The presentations were noted.

32. Future Agenda Items

It was noted that the next meeting of the Board was scheduled for 27th February. It was suggested that the time of commencement of the meeting be changed from 1.00 p.m. to 9.30 a.m. and that the meeting be held at the One Life Centre, Park Road. Items for the agenda for that meeting included Reablement, the Immunisation Strategy for approval and it was suggested that the alcohol issues discussed earlier in the meeting could also be included on the agenda. In addition, in response to concerns expressed regarding establishing a relationship between this Board and other Partnerships, it was agreed to submit a report on this issue to the next meeting in light of the Local Strategic Partnership Review.

33. Any Other Business

(i) 'Mind the Hunger Gap' – The Mayor advised that he had signed up for this initiative and agreed to circulate details to the Board.

(ii) North East Leadership Academy – It was noted that the Association of North East Councils, in partnership with Public Health North East were running a free Leadership Academy for Leaders/Elected Mayors and senior elected members – scrutiny chairs and portfolio holders - who have a leadership role in preparing for the transition of public health functions to Local Authorities, developing Health and Wellbeing Boards and ensuring better outcomes in health and wellbeing at a local level. Councillor Simmons, Children's Services Portfolio Holder, had agreed to attend the Leadership Academy.

(iii) The following items were identified for inclusion on future Board agendas:-

- Transport
- Teenager Risky Behaviours – Safeguarding Partnership report
- Mental Health – prevention issues

Decision

The meeting concluded at 12.10 p.m.

CHAIR

Public Health Transition Plan For Hartlepool

2011-2013

Louise Wallace – November 2011

1. Introduction

1.1 The publication of 'Healthy People, Healthy Lives: Our Vision for Public Health in England 2010' (Department of Health) proposed radical reform of the future delivery of public health in England. This white paper proposed new responsibilities for Local Government for improving health and resources to enable this to happen. It also proposed responsibilities for the NHS Commissioning Board for public health interventions including screening and immunisations. The paper signalled the creation of a new Executive Agency 'Public Health England' with public health responsibilities in including health protection and public health intelligence and knowledge.

1.2 This new system for public health is aimed at being integrated across all of the various parts but with a strong focus on localism, with Local Government playing a leading role, with public health teams led by a Director of Public Health.

1.3 Implementing the new system is a complex process and one that must be completed by April 2013. Therefore, it is essential to have a local transition plan that describes the key issues and actions that must be undertaken to ensure a smooth transition from the old system to the new system.

1.4 This transition plan is jointly owned between NHS Hartlepool as the statutory body currently responsible for public health and Hartlepool Borough Council who by 2013 will be responsible for public health. Joint ownership of this plan is essential, as it is imperative that there is robust governance, due diligence and accountability arrangements in place throughout the transition year 2012/13. This plan identifies what needs to be done; by when and who is responsible for ensuring progress is made and actions delivered.

1.5 This transition plan must be agreed with NHS Hartlepool and Hartlepool Borough Council Executive in draft form by the end of January 2012. This agreement must be in place as by this date a draft plan must be submitted to the Regional Director of Public Health (RDPH). The RDPH has responsibility for assuring the transition across the Strategic Health Authority clusters and approving each areas public health transition plans.

1.6 The creation of the Health and Well Being Board by 2013 was also a key feature of the public health white paper. This Board will also want to ensure the public health transition plan reflects the work of the Board and the Joint Strategic Needs assessment for Hartlepool.

Hartlepool
Public Health Transition Plan

Key Theme – Policy and Strategy

Key Issue	Actions	Timescale	Lead Officer	Progress
Publication of Healthy People Healthy Lives White Public Health Paper - Consultation 30th November – 31st March Publication of public health outcomes framework for consultation Publication of funding and commissioning of public health	Brief Corporate Management Team	December 2010	Assistant Director of Health Improvement	Complete
	Brief Cabinet	January 2011	Assistant Director of Health Improvement	Complete
	Establish cross departmental Assistant Director Transition Steering Group	January 2011	Assistant Director of Health Improvement	Complete
	Respond to White paper before 31st March	31st March 2011	Assistant Director of Health Improvement And Portfolio Holder for Public Health	Complete

Key Issue	Actions	Timescale	Lead Officer	Progress
Cross reference proposed public health outcomes framework	Consider framework alongside corporate outcomes framework (s)	End of February 2011	Policy Officer and Assistant Director of Health Improvement	Complete
Contribute to Regional Public Health Transition Group and Regional Health and Well Being Board Workstream	Ensure Hartlepool is represented regionally on transitions steering group	Ongoing	Assistant Director of Health Improvement	Underway and Hartlepool regularly feeds issues into group via Peter Kelly
Health and Well Being Partnership functioning in shadow form	Expression of interest submitted to be a pathfinder.	April 2011	Assistant Director of Health Improvement and assistant Director of Adult Social Care	Pathfinder status confimed
Establish shadow Health and Well Being Board		March 2012	Assistant Director of Health Improvement	Agreement secured through Cabinet to establish Board and 1st meeting took place n 10th October 2011 with elected Mayor to Chair

Key Issue	Actions	Timescale	Lead Officer	Progress
Ensure Public Health representation in GP Consortia for Hartlepool	Secure a place on the emerging GP Consortia Board	April 2011 / 12	Assistant Director of Health Improvement	Assistant Director of Health for Health Improvement is a voting member of Hartlepool Clinical Commissioning Group (CCG) for Hartlepool. Key public health issues such as immunisations, cancer and alcohol issues have already been debated by the CCG. There is representation from the CCG on shadow Health and Well Being Board.
Joint Strategic Needs Assessment and Public Health Intelligence	Refresh JSNA for 2011 and then for 2012 and 2013 when it becomes the responsibility of the Local Authority	October 2011 October 2012 October 2013	Assistant Director of Health Improvement	Underway and is a key task of shadow Health and Well Being Board.

Key Issue	Actions	Timescale	Lead Officer	Progress
Develop a draft Health and Well Being Strategy through Health and Well Being Board	Identify a team and process for writing strategy on behalf of board	April 2012	Assistant Director of Health Improvement	Underway

Human Resources

Key Issue	Actions	Timescale	Lead Officer	Progress
Publication of the Public Health Human Resources Concordat	Consider the Human resources Concordat in NHS Hartlepool and Hartlepool Borough Council (HBC) and identify issues for staff.	January 2012	Chief Customer and workforce Officer (HBC) and Director of Corporate Affairs (NHS Hartlepool)	HR Concordat published and work ongoing
Cabinet to consider options for appointing a Director of Public Health	Cabinet paper with options to be discussed and agreed by Cabinet.	5th December 2011	Acting Chief Executive	Complete
Recruitment of Director of Public Health	Job description to be developed and submitted to Faculty of Public Health for approval. Job advertised through NHS Hartlepool.	December 2011	Acting Chief Executive	Job description completed and submitted to faculty of Public Health

Key Issue	Actions	Timescale	Lead Officer	Progress
	Panel to be appointed. Interview candidates.	March 2012	Acting Chief Executive	Job to be advertised and panel appointed
Existing Public Health Staff	Transfer public health staff working base to Civic Centre	February 2011	Assistant Director of Health Improvement	Complete
	Undertake 1-1 interviews with all staff and assign them into groups as required by NHS HR	February 2011	Assistant Director of Health Improvement	Complete
	Consider implications of HR guidance for staff in relation to TUPE, terms and conditions, consultation and discussions with staff side and unions.	April 2012	Assistant Director of Health Improvement with Chief Customer and workforce Officer (HBC) and Director of Corporate Affairs (NHS Hartlepool)	This is dependent on national HR framework for public health / NHS staff and affordability.

Ring Fenced Budget

Key Issue	Actions	Timescale	Lead Officer	Progress
Publication of shadow public health ring fenced allocations to local authorities	Ensure investment programme for this resource is consistent with overall financial strategy of the Local Authority.	January 2012	Acting Chief Executive, Chief Finance Officer	HBC has contributed to the mapping exercise of actual 2010 / 11 spend as part of a national exercise to assist the DOH in identifying formulae and budget for each area. Shadow budget expected 2012/13
	Develop plans to invest this resource through the Health and Well Being Board to deliver the Health and Well Being Strategy	April 2012	Assistant Director of Health Improvement	Key task of shadow health and well being board is to develop Health and Well Being Strategy including plans for investment in services.

Contracting and Procurement

Key Issue	Actions	Timescale	Lead Officer	Progress
Identify contracting and procurement issues associated with services transferring to Local Authority responsibility in appendix 1.	Undertake a stocktake of all contracts, service level agreements and memorandum of understanding in place for all public health services as outlined in appendix 1 for 2011/12.	December 2011	PCT Public Health Contracts Manager Deputy Director of Procurement PCT	Underway and being led by PCT.
	Identify key leads for each of the contracts, service level agreements and memorandum of understanding from HBC and PCT during 2012 transitional year and beyond.	March 2012	Assistant Director of Health improvement / Assistant Director of Procurement	

Key Issue	Actions	Timescale	Lead Officer	Progress
	Prepare a legacy document of all programmes, schemes, services and activities commissioned with public health resources for 2011/12. This document will outline the services or activity, levels of investment and outcomes delivered to inform Local Authority of the legacy relating to this investment.	October 2012	Assistant Director of Health improvement	

Public Health Delivery

Key Issue	Actions	Timescale	Lead Officer	Progress
Identify services that can be shared with neighbouring authorities to maximise economies of scale for public health.	Participate in the prepare of a paper for the Tees Valley Chief Executives regarding in principle sharing arrangements of public health functions across Tees.	November 2011	Acting Chief Executive / Assistant Director of Adult Social Care	Complete
	Present to cabinet wider public health functions that could be shared across Tees of Tees Valley. List is appendix 2.	5th December 2011	Acting Chief Executive	Complete
	Present to cabinet wider public health functions that could be shared across Tees of Tees Valley. List is appendix 2.	5th December 2011	Acting Chief Executive	Complete

Key Issue	Actions	Timescale	Lead Officer	Progress
	Identify a lead Local Authority to host these functions.	February 2012	Acting chief Executive supported by assistant Director of Health Improvement	
	Agree a service specification and costings model and service level agreement for these functions.	October 2012	Acting Chief Executive supported by assistant Director of Health Improvement	
	If Hartlepool is not the lead authority hosting these functions, ensure the lead Authority considers and acts on all human resource issues relating to staff.	October 2012	Acting Chief Executive supported by assistant Director of Health Improvement / Director of Corporate Affairs (PCT)	
Integrate Public Health into the management structure of the Local Authority.	Identify the span of control and management functions and arrangements of	March 2012		

Key Issue	Actions	Timescale	Lead Officer	Progress
	public heath as a Corporate function within the Local Authority.	March 2013	Acting Chief Executive	
Core Public Health Offer to Clinical Commissioning groups	Identify and agree the core public health offer to clinical commissioning groups including the local public health team in Hartlepool and shared functions across Tees / Tees Valley	October 2012	Tees Executive Director of Public Health / Assistant Director of Health Improvement / Chair of Clinical Commissioning Group	

Risk, Resilience and Emergency Planning Through Transition

Key Issue	Actions	Timescale	Lead Officer	Progress
Public Health representation on Local Resilience Forum (LRF)	Assistant Director of Health improvement (Hartlepool) to represent NHS Tees on LRF during 2012/13 for all emergency planning health issues.	Until April 2013	Assistant Director of Health Improvement (Hartlepool)	Ongoing
	Participate in the creation of Local Health Resilience Forum sub group of the LRF.	April 2013	Assistant Director of Health Improvement (Hartlepool)	Ongoing
Maintain NHS Emergency planning arrangements and business continuity	NHS Hartlepool will continue to host the emergency planning manager and prepare	April 2013	Assistant Director of Health Improvement (Hartlepool)	Ongoing

Key Issue	Actions	Timescale	Lead Officer	Progress
	plans to comply with the Civil Contingency Act 2004 until national guidance is produced indicating how this duty is to be discharged post PCT.	April 2013	Assistant Director of Health Improvement (Hartlepool)	Ongoing

Health Protection Through Transition

Key Issue	Actions	Timescale	Lead Officer	Progress
Maintain strong relationships with the Health protection Agency as their functions migrate to Public Health England	Ensure regular dialogue with the Unit Director of the HPA with HBC.	Ongoing	Assistant director of Heath Improvement and Unit Director of HPA	
	Ensure the Local Authority Cabinet and Health and Well Being Board are briefed on the importance of health protection and identify it as a key strategic	December 2011	Assistant Director of Health Improvement	HPA presentation to Health and well Being Board regarding transition and importance of health protection. Agreement has been secured to make immunisation uptake a key public health priority to address in 2012.

Key Issue	Actions	Timescale	Lead Officer	Progress
	priority for public health and the Health and well Being Strategy.	April 2013	Assistant Director of Health Improvement	

Governance Through Transition

Key Issue	Actions	Timescale	Lead Officer	Progress
Agree a governance process to ensure due diligence for all aspects of public health transferring to the local authority (contracts, staff indemnity, incident reporting, risk sharing agreements scheme of delegation, clinical governance etc.)	Scope issues with the Chief solicitor and the Director of Corporate Affairs for the PCT and agree a process and plan to mitigate risks.	March 2012	Chief Solicitor / PCT Director of Corporate Affairs	
	Identify any information governance issues as public health transfers to the Local Authority. This might be paper based or electronic information (Caldicott Guardian and information controller issues).	July 2012	Chief Solicitor / PCT Director of Corporate Affairs	

Infrastructure

Key Issue	Actions	Timescale	Lead Officer	Progress
Access to HBC IT for Public Health staff	Ensure all public health staff have access to HBC IT and email accounts	February 2011	Assistant Director of Health Improvement	Complete
Asset register and transfer of assets	Identify all PCT assets currently used by public health staff and identify how these assets will be returned or utilised in future.	March 2012	Head of IT PCT	

Communication and Engagement Plan through Transition

Key Issue	Actions	Timescale	Lead Officer	Progress
Develop a joint communication plan regarding public health transition with HBC and NHS Hartlepool	Ensure the plan meets needs of staff through transition	Ongoing until April 2013	Head of communications HBC and Head of Communications PCT	
	Ensure the plan communicates a range of partners on a frequent basis e.g.: with Health and Well Being Board, community and voluntary sector providers, LINX or emerging health Watch, Clinical Commissioning Group	Ongoing until April 2013	Head of communications HBC and Head of Communications PCT	

NHS Commissioning Board – Public Health Transition (Local Level)

Key Issue	Actions	Timescale	Lead Officer	Progress
Clarity regarding critical public health functions including immunisation screening and infection control through transition.	Work with the Regional Public Health team to identify and agree a transition plan for those public health services transferring to the responsibility of the NHS commissioning board.	October 2012	Assistant Director of Health Improvement	Regional work on screening is underway.

Appendix 1

Public Health Functions Transferring from Primary Care Trusts to Local Authorities

1. Introduction

1.1 The publication of 'Healthy People, Healthy Lives: Our Vision for Public Health in England 2010' (Department of Health) described mandated functions that will transfer to the responsibility of the Local Authority.

'The Health and Social Care Bill allows the Secretary of State to prescribe that certain services should be commissioned or provided by local authorities, and certain steps taken. *Healthy Lives, Healthy People: update and way forward* set out why and how the Government intends to use these powers. We said:

"Wherever possible, we wish to transfer responsibility and power to the local level, allowing local services to be shaped to meet local needs. But there are some circumstances where a greater degree of uniformity is required. With this in mind, the Health and Social Care Bill allows the Secretary of State to prescribe that certain services should be commissioned or provided by local authorities, and certain steps taken. We consulted on which services should be prescribed in this way. Our decisions have been guided by the following principles. We will require local authorities to deliver or commission particular services where:

- *services need to be provided in a universal fashion if they are to be provided at all (this is particularly relevant to health protection, because if certain health protection services are not provided in a universal fashion, or not provided at all, there may be risks to population health and wellbeing);*
- *the Secretary of State is already under a legal duty to provide a certain service, but in practice intends to delegate this function to local authorities. Mandation will ensure that these obligations are met;*
- *certain steps that are critical to the effective running of the new public health system.*

"Reflecting on the consultation responses and following the above principles, we plan to prescribe that local authorities deliver the following services or steps:

- *appropriate access to sexual health services;*
- *steps to be taken to protect the health of the population, in particular, giving the Director of Public Health a duty to ensure there are plans in place to protect the health of the population;*
- *ensuring NHS commissioners receive the public health advice they need;*
- *the National Child Measurement Programme;*
- *NHS Health Check assessment;*
- *elements of the Healthy Child Programme."* [paragraphs 2.19-2.20]

It can be seen from the extract above that mandation is not intended to identify some services as more important than others. We expect all local authorities to tackle the key local health improvement issues, but their strategies will be determined by local needs rather than central diktat. Rather the issue is that in some areas greater uniformity is required. Below we provide more detail on each of the above areas. We plan to lay draft regulations in [mid 2012] before making final regulations later that year.

Public health topic	Proposed activity to be funded from Public Health budget
Sexual health	Testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, all outreach and preventative work
Immunisation against infectious disease	School immunisation programmes, such as HPV.
Seasonal mortality	Local initiatives to reduce hospital admissions and seasonal excess deaths
Accidental injury prevention	Local initiatives such as falls prevention and reducing childhood injuries
Public mental health	Mental health promotion, mental illness prevention and suicide prevention

Nutrition	Locally led initiatives
Physical activity	Local programmes to reduce inactivity; influencing town planning such as the design of built environment and physical activities role in the management / prevention of long tram conditions
Obesity programmes	Local programmes to prevent and treat obesity, e.g. delivering the National Child Measurement programme; commissioning of weight management services
Drug misuse	Drug misuse services, prevention and treatment
Alcohol misuse	Alcohol misuse services, prevention and treatment
Tobacco control	Tobacco control local activity, including stop smoking services, prevention activity, enforcement and awareness campaigns
NHS Health check	Assessment and lifestyle interventions
Health at work	Local initiatives on workplace health and responsibility deal
Prevention and early presentation	Behavioural/ lifestyle campaigns/ services to prevent cancer, long term conditions, campaigns to prompt early diagnosis
Children's public health 5-19	The Healthy Child Programme for school age children, school nurses, health promotion and prevention interventions by the multi professional team
Community safety and violence prevention and response	Specialist domestic violence services that provide counselling and support services for victims of violence including sexual violence
Social exclusion	Support for families with multiple problems, such as intensive family based interventions
Dental Public Health	Targeting oral health promotion strategies to those in greatest need.

Appendix 2 – Extract from Cabinet Paper 5th December 2011 Public Health – Future Options.

1. What is already shared across Tees for Public Health and what could be shared across Local Authorities in future?

Public Health is currently hosted within the NHS through the Primary Care Trust (PCTs). The 4 PCTs across Tees work on a shared management arrangement. The following public health functions are provided to support the 4 locality public health teams:

- Public health intelligence
- Infection control
- Emergency planning (including flu pandemic)
- Screening
- Immunisations
- Seasonal flu
- Dental public health
- Research
- Health equity audit
- Health needs assessments
- Oral health needs assessment
- Health impact assessment
- Cancer –early detection and awareness
- Cardiovascular disease
- Sexual health
- Commissioning obesity services
- Respiratory disease
- Long term conditions
- Public health input into funding

2 What Can be Done on a Supra Local Authority Basis (Beyond Tees Valley?)

2.1 There are also public health services that are currently commissioned or resources to participate in are committed to on a much wider scale than just the Tees Local Authorities. This includes the following:

FRESH – regional Tobacco Office
BALANCE – regional alcohol office
Regional Maternity Service Office
Public Health North East Intelligence North East (PHINE)
Better Health Fairer Health Strategy – Regional Action Groups
School of Public Health
Academic Public Health – FUSE

5.5

Department of Health

Improving outcomes and supporting transparency

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

DH INFORMATION READER

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning / Clinical	Finance
	Social Care / Partnership Working

Document Purpose	Policy
Gateway Reference	16891
Title	Healthy Lives, Healthy People: Improving outcomes and supporting transparency
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Target Audience	PCT CEs, Directors of PH, Local Authority CEs, Directors of Adult SSs, GPs, Communications Leads, Directors of Children's SSs, Public Health Professionals
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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.
Cross Ref	Healthy Lives, Healthy People: Our Strategy for Public Health in England, Healthy Lives, Healthy People: Update and way forward
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
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For Recipient's Use	

Contents

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 (such as those around child poverty, fuel poverty, alcohol, justice and road safety) 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)*

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)*

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

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

January 2012
Produced by the Department of Health

www.dh.gov.uk/publications

North East Health and Wellbeing Board Transition Workstream **5.6**
Local Authority Level of Preparedness
February 2012

Please find below the second quarterly return for completion.

The Health and Well Being board workstream was established as part of the NHS Transition Programme. Its purpose is to support local authorities in their responsibility to establish Health and Well Being Boards by April 2013

Key to this workstream is providing assurance to the NHS transition Programme Board and Regional Local Authority Chief Executives that sufficient progress is being made across the region in establishing Health and Well Being boards and where needed appropriate support is given either across the region or to individual local authorities

The level of preparedness, set out below, attempts to define the various stages, which each local authority will need to go through in order to effectively:

- Establish a shadow health and well being board;
- Undertake the Joint Strategic Needs Assessment
- Develop a Joint Health and Well Being Strategy
- Establish Healthwatch structures

It is intended that the level of preparedness acts as a checklist which individual local authorities can assess their progress. It is not intended to be prescriptive - as its up to individual local authorities how they discharge their responsibilities – it is merely intended as a mechanism to track progress and not increase the burden on local authorities.

The outcome of which will be used to provide assurance to the NHS Transition Programme Board and Regional Local Authority Chief Executive's that progress is being made across the region. The information will also be used to identify where additional support may be needed. Mechanisms have also been established to ensure that the Health and Well Being Board Workstream aligns with other NHS Transformation Programme workstreams – in particular the Clinical Commissioning and Public Health workstreams.

It is requested that the officer within the local authority who is leading on establishing the Health and Well Being Board answers each of the statements within the assessment, there is also a comments box after each section to include a brief explanation for your assessment.

The chair of the Health and Wellbeing Board Transition Workstream will assess progress on a quarterly basis. It is intended that this monitoring process will take place up until April 2014.

North East Health and Wellbeing Board Transition Workstream
Local Authority Level of Preparedness
February 2012

The outcome of the January assessment will be collated and discussed at the next regional Health and Well Being Board meeting scheduled for 7th March 2011.

If you have any queries regarding this level of preparedness please contact Kathryn Warnock, Middlesbrough Council Kathryn_Warnock@middlesbrough.gov.uk

Please Return Your Completed Survey to Michael Lydon, Department of Health, by no later than Friday 17th February 2012 - Michael.lydon@northeast.nhs.uk

Thank you for supporting this process

Ian Parker - Chief Executive, Middlesbrough Council
Chair of Health and Well Being Board Transition Workstream

North East Health and Wellbeing Board Transition Workstream
Local Authority Level of Preparedness
February 2012

Local Authority **Hartlepool**	**Completed By** **Louise Wallace, Assistant Director Health Improvement**

Level 1		Level 2		Level 3		Level 4		Level 5	
PLANNING	**Y/N**	**EARLY IMPLEMENTATION**	**Y/N**	**DEVELOPMENT**	**Y/N**	**REVIEWING AND REVISING**	**Y/N**	**OPERATIONAL**	**Y/N**
Shadow Health and Wellbeing Board									
There is agreement to establish shadow Health and Wellbeing Board	Y	A Shadow Health and Wellbeing Board has been established	Y	The Shadow Health and Wellbeing Board is meeting regularly	Y	The governance structure and membership for the Health and Well Being Board Governance has been reviewed and agreed.	Y	Short to medium term outcomes achieved.	N
There is levels of awareness of H&WBB across the organization ▪ Elected members ▪ Overview and Scrutiny ▪ Officers	Y	There are Terms of Reference for the Shadow Board agreed.	Y	The Board development needs have been identified and a development plan in place	N	The Shadow board development plan has been implemented	N	A performance management framework for the Health and Well Being Board is in place	N

North East Health and Wellbeing Board Transition Workstream
Local Authority Level of Preparedness
February 2012

Level 1		Level 2		Level 3		Level 4		Level 5	
PLANNING	**Y/N**	**EARLY IMPLEMENTATION**	**Y/N**	**DEVELOPMENT**	**Y/N**	**REVIEWING AND REVISING**	**Y/N**	**OPERATIONAL**	**Y/N**
Discussions have taken place about the establishment of H&WBBs held with: ▪ Clinical commissioning group(s) ▪ NHS providers ▪ LINk/Healthwatch pathfinder ▪ Voluntary sector ▪ Other parts of council	Y	Draft agreement in place on governance issues(subject to review) with: ▪ Children`s Trust, ▪ LSP, ▪ Safeguarding Boards, ▪ Crime and Disorder Partnership ▪ Council/Cabinet	N	A Stakeholder Communication and Engagement Plan has been developed	N	Medium and long term outcomes have been identified and agreed	N	The H&WB Board is a formal committee within Council (2013)	N
Membership of the Shadow Health and Well Being Board has been agreed (recognizing it may change) and consideration given to the involvement of: ▪ LINk or HealthWatch pathfinder ▪ Voluntary sector ▪ Providers	Y			There is a means of engaging whole council in H&WB agenda determined.	N				
				Short term outcomes identified and agreed – linked to JSNA	N	There is alignment and agreement across the range of commissioning plans.	N		

North East Health and Wellbeing Board Transition Workstream
Local Authority Level of Preparedness
February 2012

Level 1		Level 2		Level 3		Level 4		Level 5	
PLANNING	**Y/N**	**EARLY IMPLEMENTATION**	**Y/N**	**DEVELOPMENT**	**Y/N**	**REVIEWING AND REVISING**	**Y/N**	**OPERATIONAL**	**Y/N**
Comments: The shadow Health and Well Being Board was established in October 2011. The Board meets every six weeks and is chaired by the elected Mayor of Hartlepool, Stuart Drummond. The vice chair is Dr Paul Pagni who is a member of the Hartlepool Clinical Commissioning Group. All cabinet executive elected members are members of the Health and Well Being Board. The Board has providers of services as non voting members, including North Tees and Hartlepool NHS Foundation Trust, Tees Esk and Wear Valley NHS Trust and Cleveland Fire Brigade. The shadow Board has discussed issues including health protection and immunization, excess winter deaths and reablement as part of the initial work programme. This resulted in some excellent media coverage and stronger partnership working.									
Joint Strategic Needs Assessment (NB already a statutory document so levels may follow different path in different councils)									
There is a process and timetable for reviewing JSNA has been agreed	Y	Scope, depth and mandate for JSNA agreed	Y	Data gathered	Y	Refreshed JSNA produced and agreed by all parties	N	Integrated commissioning plans developed	N
There are mechanisms established to engage with: ▪ VCS ▪ GP ▪ Community ▪ Wider partners	Y	Gaps in data identified	Y	Short and long term needs of population identified and agreed	Y				
Comments: The refresh of the JSNA is well underway, building on three previous years of a very comprehensive JSNA process. The existing JSNA is being used to inform NHS commissioning intentions through the pathfinder Clinical Commissioning Group. JSNA has been discussed at Local Authority Cabinet and the Clinical Commissioning Group.									

North East Health and Wellbeing Board Transition Workstream
Local Authority Level of Preparedness
February 2012

Level 1		Level 2		Level 3		Level 4		Level 5	
PLANNING	**Y/N**	**EARLY IMPLEMENTATION**	**Y/N**	**DEVELOPMENT**	**Y/N**	**REVIEWING AND REVISING**	**Y/N**	**OPERATIONAL**	**Y/N**
Joint Health and Well Being Strategy									
There is a process and timetable for developing JHWBS agreed	Y	Short and medium terms outcomes agreed – linked to JSNA	Y	A draft joint Health and Wellbeing strategy is produced	N	JH&WBB Strategy agreed by H&WBB	N	Short and medium-term outcomes achieved.	N
								Medium and long-term outcomes identified and agreed.	N
Comments: The Joint Health and Well Being Strategy will be completed in draft by April 2012. In the meantime there is an existing public health strategy informed by JSNA that will inform the 11/12 commissioning intentions of both the NHS and the Local Authority. The timetable for producing the strategy will be agreed at first meeting of the shadow board at the end of September.									
Development of HealthWatch and patient and public engagement (NB Process needs to reflect existing LINk or Healthwatch pathfinder structure, whether there is a HealthWatch pathfinder in place and therefore there may be different starting points and pathway for each council).									
There is engagement with local LINk/Healthwatch pathfinder and wider stakeholders on developing a local HealthWatch	Y	The scope and model for a local HealthWatch is agreed	N	The commissioning process for the new arrangements has commenced	N	There is agreement on wider public and patient agreement	N	Health Watch Representative(s) selected for H&WBB	N
A plan and process for developing a local HealthWatch is established.	Y	A draft specification for the local HealthWatch is in place.	N			The Health Watch contract has been awarded	N	There is a process in place to monitor and review its effectiveness	N
Comments: Hartlepool LINk is a HealthWatch Pathfinder focused on building on existing partnership work and exploring relationships with the Clinical Commissioning Group and Health & Wellbeing Board, developing links between HealthWatch and the public health role and understanding the role of HealthWatch in promoting access to information and exercise of choice. Options for the provision and commissioning of HealthWatch have been developed following a Working Together for Change workshop in October 2011 and will be considered by Cabinet later in 2012. The current LInK contract has been extended to March 2013 following the national announcement regarding the delayed start date for HealthWatch.									

Health and Wellbeing Board, 27th February 2012

Dear all,

Please find attached the 2012 Housing, Care, and Support Strategy and the 2012/13 Action Plan

This strategy replaces the Older Person's Housing, Care, and Support Strategy (2008) which was written by Peter Fletcher Associates.

The new strategy has been widened to include six vulnerable groups which include:
Mental Health,
Learning Disabilities,
Physical Disabilities,
Young People
Substance Misuse
Older People

The new 2012 strategy aims to be a more holistic strategy that looks at housing, care, and support needs across all these vulnerable groups. In particular the strategy aims to ensure that all people have access to suitable housing and the appropriate support to enable them to live as independently as possible, where they choose.

Housing, along with other key components, plays an important role in ensuring an individual's health and wellbeing. As such the Housing, Care, and Support Strategy is being brought to the Health and Wellbeing Board. The strategy links to other key areas and strategies and as a result we are currently taking the strategy to all relevant groups and partnerships to ask for any comments or feedback.

An annual 2012/13 Action Plan has been drafted together and has also been sent around to all relevant groups for comments. This will be a working document that will drive the work of the Housing, Care, and Support Steering Group.

The final strategy will be taken to Cabinet in March 2012, due to the tight timescales we would ask that any comments of feedback for the strategy and action plan are provided at the next Health and Wellbeing Board on the 27th February.

A full presentation on the Housing, Care, and Support Strategy will be provided at the Health and Wellbeing Board and any comments or feedback can either be discussed at the meeting or can be sent beforehand to **Hannah Gill, Modernisation Lead- Housing, Care, and Support**. **Email: Hannah.gill@hartlepool.gov.uk, Telephone: 01429 284300**