Draft Response to Consultation – Public Health Outcomes Framework

Q1: How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

The council supports moves to recognise the wider determinants of health as represented by the proposed measures. The measures present a more holistic view of public health and seeks to show the important role decent, safe homes and neighbourhoods play in a persons' well-being.

Better housing can contribute significantly to improved public health outcomes and be cost effective. Every £1 spent on providing housing support to vulnerable people can save around £2 in reduced health service costs, tenancy failure, crime and residential care. Spending between £2,00 and £20,000 on adaptations that enable and elderly person to remain in their home can save £6,00 per year in care costs.[1]

We envisage the recognition of wider determinants to play a useful role in encouraging more joint planning and working towards shared outcomes.

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

As a set of criteria these seem appropriate. The challenge will be in interpreting them when setting specific indicators.

Experience of setting outcome indicators suggests that there are a number of risks which need to be considered:

- Apparent improvements (or deteriorations) can in fact be fluctuations in relatively small numbers which are not statistically significant. There may be a knock on cost as sample sizes need to be increased to allow data to be collected at the right spacial level and frequency.
- Systems for data collection need to robust across partnerships
- Time lag can be a significant problem for setting and measuring targets.

Q3: 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?

Some fields of activity will impact on individual behaviour over different time frames. Government should be mindful to assess the impact of some indicators over a not too short a period to get a truer picture of the longer term impact on health inequality.

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

[1] University of Brighton 2000.

The key issue will always be where boundaries are drawn between budgets and this is especially significant as between the three Government Departments whose budgets are involved.

It is also important to recognise other outcomes framework such as that for DfES or DCMS, for example when considering physical acitivity.

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

We broadly agree with the suggested framework and domains. The areas covered and overlaps between the domains should mean that all important Housing and Public Protection (i.e. environmental health) contributions can be properly included and recognised. Similarly we recognise our physical activity role across domains 3 and 4.

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

We are mindful of the government's intention to minimise the number of indicators required, so with this in mind we suggest there are perhaps too many indicators focused at the healthcare end of the public health scale.

On the other hand, the health protection and health improvement pillars might well be supported by more, appropriate, indicators. We suggest you might consider the following:

Housing Services:

- Domain 2 - Hazards within the home – i.e. Category 1 hazards as measured through the Housing Health and Safety Rating System (HHSRS).

- Domain 2 - Housing Decency.

Public protection / environmental health:

- Domain 2 - Life years lost from air pollution as measured by nitrogen dioxide. Evidence presented to a recent House of Commons Environmental Audit Committee said that the number of premature deaths per annum could be as high as 50,000, and that for some particularly sensitive individuals exposed to the poorest air quality the reduction in life expectancy could be as high as 9 years. This means that in York up to 158 premature deaths per year may be attributable to air pollution. (House of Commons, Environmental Audit Committee - Air Quality, Fifth report of session 2009-10 Volume 1).

- Perhaps disappointingly, there is nothing about contaminated land. Estimates of historic industrial land use indicate that approximately 2% of land across England and Wales could be contaminated. This is equivalent to 540 hectares within the City of York Council area. A

review of historic maps and records has revealed 3,668 potentially contaminated sites in York. The council has a legal duty to assess all of these sites for contaminated land under Part 2A of the Environmental Protection Act 1990.

- Nor is there anything on clean drinking water. Private water supplies are likely to be more of an issue in rural areas.

- We think there should include a focus on climate change / carbon reduction within the Domain 1, Resilience and protection from harm - given the significant health threats presented by extreme weather events (flooding etc).

Q7: We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?

CYC would support those Quality of Life indicators which are readily understood by residents.

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

We support the move to a wider range of indicators recognising the wider determinants of public health. It would be a pity to lose this holistic vision.

Q9: How can we improve indicators we have proposed here?
We suggest the method for measuring overcrowding (Ref D2.3) should use the HHSRS not the Bedroom Standard.

We welcome the falls measure for older people in Domain 4 (Ref. 4.15), and wonder if this could be adapted to record falls arising from 1. poor property standards and 2. personal needs of the customer.

The rationale/description for measuring particulate matter (reference D1.3) seems totally impractical and too long term. How will anthropogenic and naturally occurring PM 2.5 be measured? Will this just be a matter of statistics or will local authorities be expected to monitor this pollutant? Few local authorities will have the ability, but we do at our air quality monitoring station at Fishergate, York.

The percentage of the population affected by noise (reference D2.16) maybe more difficult to assess as what is the definition of affected by noise? We are all affected by noise. The question is whether it has a significant adverse impact in terms of amenity, quality of life and most importantly, health. n.b WHO guidelines. Could this be collected via the number of complaints to local authorities (not all are substantiated)? This should be monitored annually, in line with other returns and statistics.

Work sickness absence rate (reference D4.6) - The suggested outcome indicator is the 'work sickness absence rate', collected by the Department of Work and Pensions. Another indicator that could be considered is the data sitting behind notifications made under the Reporting of Injuries, Diseases and

Dangerous Occurrences Regulations 1995. Data is collected centrally for this regulation and is an indicator of the health and safety of the working population.

We are pleased to see 5 x 30 minutes of physical activity for adults included but are concerned that there is no indicator for active young people.

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

We would like to see the falls prevention work, especially within the home, incentivised through the health premium and work around people with mental health and complex needs.

At the very least progress towards meeting health based air quality objectives should be incentivised, possibly via the "health premium".

We would be interested in ensuring that the mortality indicators in domain 5 are tackled by incentivising work in domain 3 (health improvement).

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

We support it.

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

Subject to our comments above we think the indicators do promote a life-course approach to public health.