Equality analysis

Title: Healthy Lives, Healthy People: Transparency in Outcomes
Relevant line in Healthy Lives, Healthy People (2:9)**:** We have been working closely with partners, and will shortly consult on detailed proposals for a public health outcomes framework, so that local communities, local government, the NHS and other key partners have an opportunity to shape it. This will sit alongside the proposed NHS outcomes framework and the social care outcomes framework.

What are the intended outcomes of this work?
The Public Health Outcomes Framework reinforces the vision for the future of public health - 'to improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest' - and is a mechanism by which this vision can be achieved.

The Outcomes Framework will be comprised of a number of indicators against which Public Health delivery partners will be encouraged to demonstrate improvement. The introduction of the framework will act as a stimulus to encourage public health delivery partners to make significant improvements in services and share best practice more widely. The intention is that the introduction of benchmarking (through the indicator measures) will have a strong impact on improving public health outcomes – this is consistent with recent evidence that the introduction of indicator measures can have a strong influence on achieving successful Health Outcomes - and will have a direct effect on protecting and improving the nation’s health.

The backbone of our proposed approach is to make publicly available a set of data and information relating to the public’s health at national and where possible at local authority levels. To ensure transparency and to reduce data burdens, we propose that relevant data be published in one place by Public Health England (a new executive agency of the department which is being set up to perform the Secretary of State’s public health functions – as set out in the Health and Social Care Bill) Public health data come from a number of sources, and people have told us that the best way to support analysis is to publish this in one place, and in a common format. At the national level this information will allow us, with our partners across government and beyond, to understand the progress being made across the broad canvas of the public’s health and help to prioritise action. At the local level, this will allow local people to interrogate the information as they want, and will minimise costs of reproduction on councils. This will also make it easy for local areas to compare themselves with others across the country; to see in some causes how performance is changing within areas; and to lever improvements. So that we drive equality in public health outcomes, it is vital that we are able to disaggregate public health data by key equality characteristics at different geographical levels wherever possible. We will work with the Association of Public Health Observatories to further explore further disaggregation of equalities characteristics levels of geographical coverage throughout the life cycle of the Framework.

In contrast with the NHS Outcomes Framework, the PH Outcomes Framework is not intended as a tool for setting out clear levels of accountability between Parliament, SofS (Secretary of State) and LAs. This is because LAs would, subject to the passage of the Health and Social Care Bill, be accountable to their local populations for the delivery of public health services. However, SofS will be accountable to Parliament for the ring fenced budget that would be granted to LAs for public health; and the PH outcomes framework would help to focus LAs on the areas where the ring fenced budget

could be used to make desirable progress.

Ultimately the aim of the Public Health Outcomes Framework is to help the proposed PH system identify and address the causes of health inequalities to make progress against unacceptable variations in public health outcomes and to clarify which parts of the delivery system will be primarily responsible for making improvements in specific areas. The proposed new PH system will, subject to the passage of the Health and Social Care Bill, come into effect from 1st April 2013.

Outcomes Framework and Equality
Initially, one of the most important contribution the framework will make to addressing equality is in creating a robust set of outcome measures that enables services and the local people to whom they are accountable to "drill down" into the underlying data in order to identify areas where different groups do not receive equal access to, experience of and outcomes from, public health services. Public Health already has a strong track record on data for identifying equality; but focus until recently on service activity rather than outcomes has meant that this data has been of less value than we expect it to be under the new outcomes based approach.

We have also endeavoured to identify potential adverse impacts of the outcomes framework on groups with protected equalities characteristics, and have, where possible, adapted the framework to prevent or minimise the effect of these adverse impacts. The delivery of progress against the framework will largely be achieved through specific Public Health interventions by Local Authorities. Consequently, once the framework goes live in April 2013, Local Authorities will need to assess for themselves the impact of specific interventions on groups with protected characteristics.

The data will be published in a transparent manner by Public Health England; used in conjunction with the Outcomes Framework, we expect this will also be a powerful new tool for Public Health Professionals, Local Authorities, third sector organisations and individuals in the drive for equality.

With the except of indicators that are shared between the NHS and PH outcomes framework, Central Government will not be setting levels of ambition against public health outcome measures (although, as part of a separate process, national ambitions will be set for key policy areas such as obesity and Tobacco control). Instead, the Framework and underlying data will support a conversation between commissioners, service providers, people using services and the third sector about local priorities and how to improve quality for everyone. This means that central Government will not be using a "performance management" approach of setting national ambitions to drive equality – instead the framework will support Local Authorities in identifying and addressing equality issues locally.

Selection of indicators for the Framework
In order to select appropriate indicators for the framework, a template was developed to allow evaluation of each measure by key criteria (including there ability to be disaggregated by protected characteristics) and set out evidence to support this evaluation. Templates were then circulated to a variety of stakeholders for an iterative process of comment and revision. Once the process was complete, the templates formed the basis of discussions between the partners – DH, Public Health Professionals and Local Government and OGDs – to agree the measures for inclusion in the final Outcomes Framework. The final templates included the assessment of each measure against the key criteria, as well as an analysis of any risks associated with access, experience and outcomes and any possible alternative measures.

This discussion also sought to determine whether the measures represent the breadth of Public Health issues by balancing measurements across the five domains set out in the Consultation and

other key criteria (in particular whether the selection of measures reflected a “lifecourse” approach). In order to establish whether this was the case, the overall framework was assessed for the balance of indicators for:

- the domains of the Outcome Framework, and
- the five key stages of the lifecourse: Starting Well, Developing Well, Living Well, Working Well and Aging Well

This assessment led to further areas for development being identified to balance the basket of measures – for example in expanding measures on employment to include people with long term conditions, rather than focussing on mental health and learning disabilities only (the *Summary of Analysis* section details how this specific development decision was influenced by consideration of protected characteristics).

Placeholder measures
It is important to note that the current set of outcome measures includes several “placeholders” for areas of work where measures need to be developed – this means that in its first iteration the Outcomes Framework will not provide a complete picture of public health quality and outcomes, although it shall support identification of equality in outcomes for different groups of people in many areas.

Who will be affected?

People using public health services (but also the wider public in general), providers of public health services and their staff and commissioners of services – including local authorities and their Health and Wellbeing Board partners – are all expected to be affected by the proposed changes**.** Groups with protected equalities characteristics will also be affected by the introduction of the framework as, at a national level (with the aspiration of breaking it down at a local level in the future), information for each measure will be available by protected equalities characteristics. Consequently we would expect this data to result in better informed public health interventions by the PH system with regards to groups with these protected characteristics.

To achieve the overarching aim of improving quality and outcomes and reducing variability, we envisage data on public health affecting the above groups through its use in the following ways:

- Local authorities can benchmark their results achieved against other councils to identify areas of improvement and inform strategic commissioning and how to better target interventions;
- Local people can hold their local authorities to account for effectiveness and efficiency so that we all progress towards better public health;
- Where possible, individuals with protected equalities characteristics can view disaggregated data for the measures in the framework which has been grouped by their relevant protected characteristics.
- Local people can use clear definitions of quality to make informed decisions when choosing services, driving quality through competition;
- National Government can use aggregated data to give a picture of quality and outcomes nationally that will inform policy development where relevant and support Ministerial accountability to Parliament; and
- Any other organisation (in particular the third sector) will have access to exactly the same data as national and local Government and can use this for any other purpose such as advocacy or

policy development.

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Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment. For more information, see the current DH Transparency Plan.*

What evidence have you considered?

There is some evidence of public health areas where equality of outcome, access and experience needs attention. There is also evidence of demographic and cultural issues that can lead to a lack of equality if they are not addressed. These data underline the importance of the policy intention of reducing variability in quality and outcomes. The key evidence is set out below:

The approach taken to evidence

The Outcomes Framework has two overarching Outcomes that underpin our vision "To improve and protect the nation's health and wellbeing and for improving the health of the poorest fastest:"

The two outcomes are as follows:

Outcome 1) Increased healthy life-expectancy, i.e. 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)

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 (domain 3), health improvement (domain 2), and health-care public health, including preventing premature mortality (domain 4); and addressing the wider determinants of ill-health (domain 1).

The outcomes framework contains over 60 proposed indicator measures; consequently a detailed consideration of the specific evidence relating to all the measures would not be appropriate. We have therefore focused our analysis on the subject of preventable mortality, as this is a key theme of domain 4.

We have also provided specific examples of evidence for indicators in Domains 1 (Improving the Wider Determinants of Health) and 4 (Health Care Public Health, including preventing premature mortality). Finally, the evidence relating to health inequalities is also covered in order to give an impression of the variances in health outcomes that are experienced across equalities groups.

Preventing Premature Mortality

In order to make progress against reducing differences in life expectancy between communities (outcome 2), it has been necessary to understand why there is such a variance in preventable premature mortality between different groups with protected equalties

characteristics:

Ethnicity

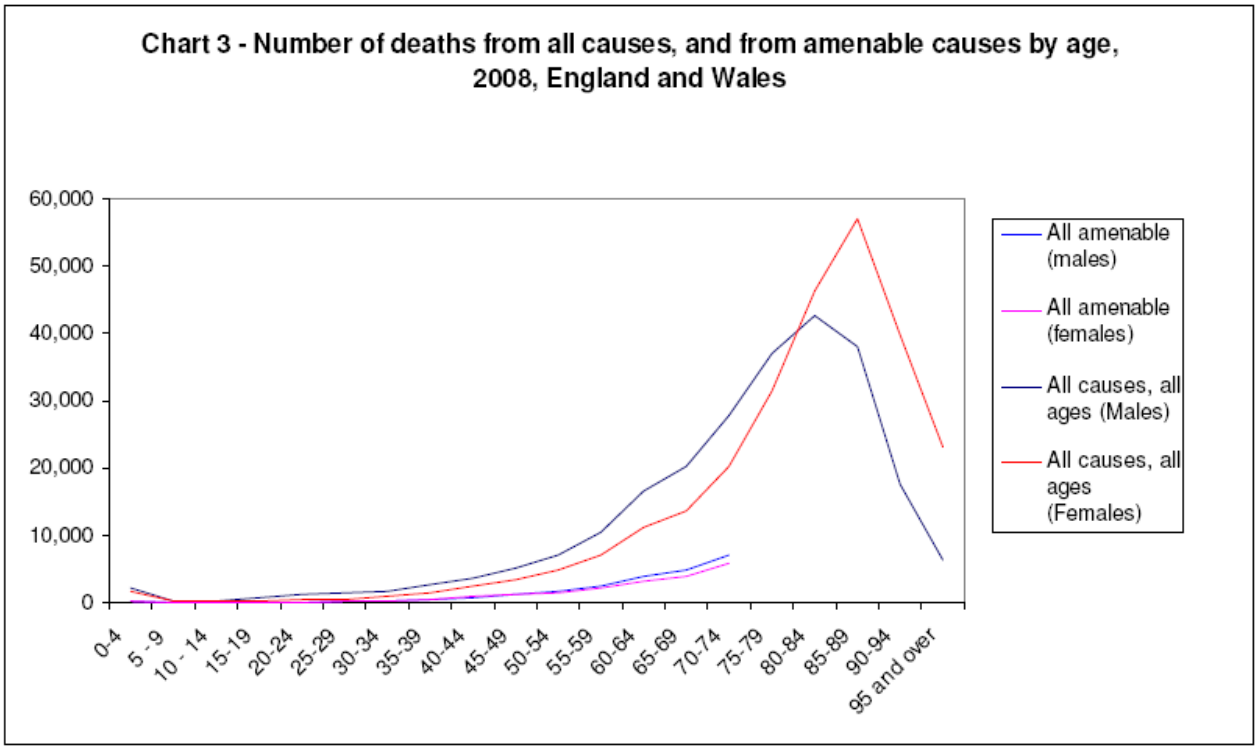
Detailed amenable mortality data for England is not readily available by ethnic group. However there is evidence to show that mortality from some of its constituent causes is higher in certain ethnic groups:

- South Asians, particularly Bangladeshis and Pakistanis, have significantly higher CHD prevalence and mortality than the general population[1]
- Although people of Black and Black British origin have a low prevalence of CHD compared with the white population, they have much higher prevalence of and mortality from hypertension and stroke.[2]
- A study in New Zealand by Martin Tobias et al showed that amenable mortality in 1996-2006 varied across ethnic groups, with Maori amenable mortality rates around three times and Pacific people's rates around two times the corresponding non-Maori or non-Pacific people's rates in both sexes. Asian peoples on the other hand had amenable mortality rates around half those of non-Asian people.[3]
- While people from black and minority ethnic (BME) groups are at a lower risk overall from cancer than the white population, there is an increased risk of certain cancers in the Asian and Black ethnic groups. Asian and black women have lower survival than the white ethnic group for females diagnosed with breast cancer aged under 65 years. The lower number of cancer deaths overall among BME groups may partly be explained by the younger age profile of BME groups.[4]
- The Care Quality Commission (CQC) Maternity Patient Survey in 2007 found that women of Asian and Black origin are less likely to have their first booking appointment with a midwife within 12 weeks of pregnancy and were less likely to have a scan at 20 weeks. These are key risk factors for Infant and Perinatal Mortality and maternal death.[5]
- Infant mortality rates are higher among some ethnic groups than others, with Pakistani and Black and Black British -Caribbean babies being twice as likely to die in their first year compared to White British or Bangladeshi babies.[6]
- A review by the Equality and Human Rights Commission in 2009 found that gypsies and travellers had an infant mortality rate that was three times higher than in the rest of the population.[7] High rates of maternal death during pregnancy and shortly after childbirth have also been reported by Parry et al, 2004.[8]
- The rate of stillbirth in babies born to women with a black ethnicity (African, Caribbean or other) was 2.3 times higher than the rate among babies born to women of white ethnicity. The neonatal death rate was twice as high for babies born to women of black ethnicity compared with babies born to women with white ethnicity. Similarly, the stillbirth rate and neonatal death rate for babies born to women of Asian ethnicity were 2.0 and 1.8 times higher, respectively, compared with those for babies born to women of white ethnicity.[9]

Age

Amenable mortality is by definition capped at age 75. Deaths under 75 are chosen largely because of the difficulty of ascribing cause of death in 75+ age groups where there are often multiple morbidities. For this reason Life Expectancy at 75 is proposed as a companion indicator to amenable mortality.

As the chart below shows, there is also a gender dimension to the age distribution of death. While 42 % of all male deaths in 2008 occurred before the age of 75, only 26% of female deaths did.



Relative survival rates for the major cancers decrease with increasing age at diagnosis, even when the higher mortality from other causes in older people is allowed for:[10]

Five-year relative survival, by site and age at diagnosis, England and Wales, 1996-1999 followed up to the end of 2001

Cancer Type	Sex	Age at diagnosis					
		15-39	40-49	50-59	60-69	70-79	80-99
		%	%	%	%	%	%
Breast	women	76	82	85	82	74	58
Colon	men	61	54	50	50	47	40
	women	58	54	54	52	48	39
Rectum	men	54	55	54	52	47	34
	women	60	61	62	58	49	36
Lung	men	21	9	9	7	5	2
	women	28	13	11	8	4	1

As death rates are so much higher in older age groups child deaths are at risk of being masked by the amenable mortality indicator. This is why two of the improvement area indicators for this domain are concerned with babies and children: infant mortality and perinatal mortality.

In 2009 the infant and perinatal mortality rates were highest in lower socio-economic groups, in babies born to mothers under 20, single mothers and mothers born in Pakistan or the Caribbean.[11]

Disability

Detailed mortality data for England is not readily available by impairment group. However, there is evidence that disability impacts on the length and quality of life, and can adversely affect access to services:

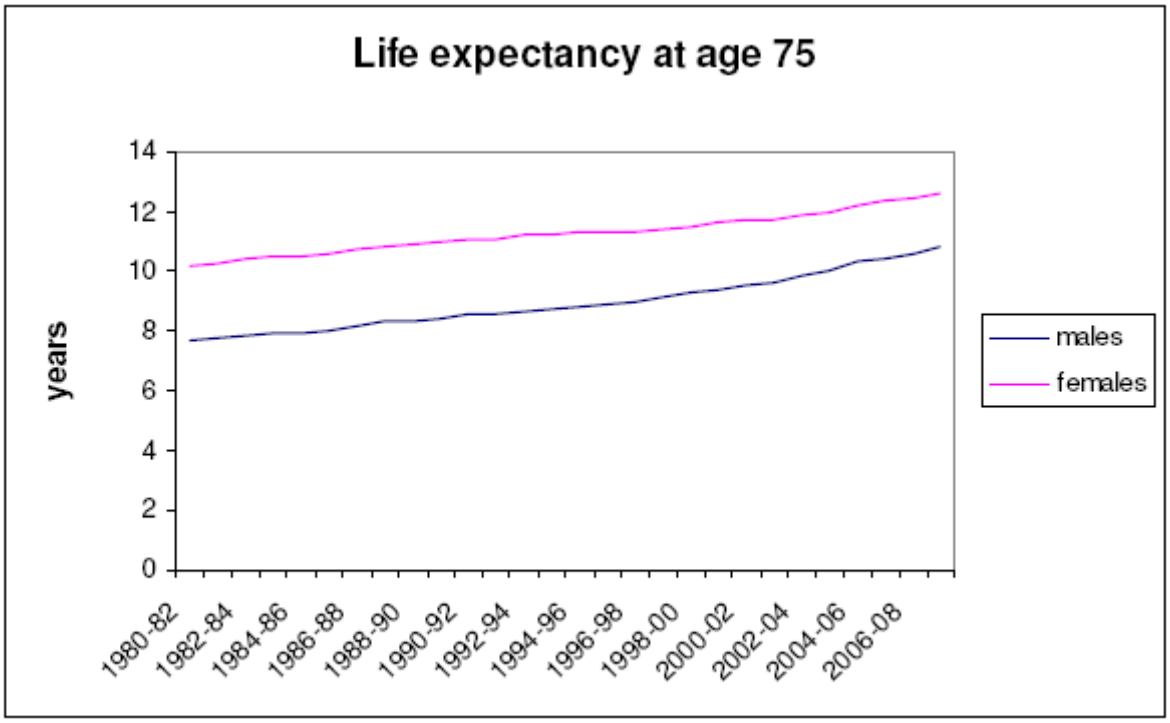
- Access to services can be difficult for people with a physical, cognitive or sensory impairment unless special measures are put in place
- There is low uptake of both breast and cervical cancer screening amongst disabled people:
  - Only 19% of women with a learning disability have cervical smears, compared to 77% in the general population. Access to mobile breast screening units is difficult for women with a physical impairment, but alternative arrangements are in place at static units
- The lack of inclusion of disability in routine recording makes it difficult to measure equity of access and treatment for disabled people, and presence of a disability is not recorded on death certificates so it is not possible to break down ONS mortality data by disability.
- People with learning disabilities:
  - are three times more likely to die from respiratory disease
  - have a higher risk of ischemic heart disease than the general population and this is the second most common cause of death in people with learning disabilities
  - are 58 times more likely to die before the age of 50 than the general population.

- People with a diagnosis of Serious Mental Illness (SMI) are twice as likely to die from coronary heart disease and four times as likely to die from respiratory disease as the general population[12] and people with schizophrenia are more than four times as likely to die from infectious diseases[13]. Rates of diabetes and hypertension are also high.[14] Clients with SMI sometimes find it difficult to engage with primary care services, which results in them not accessing routine health checks. This domain will include an indicator on amenable mortality in people with Serious Mental Illness to address this inequality directly.

Gender

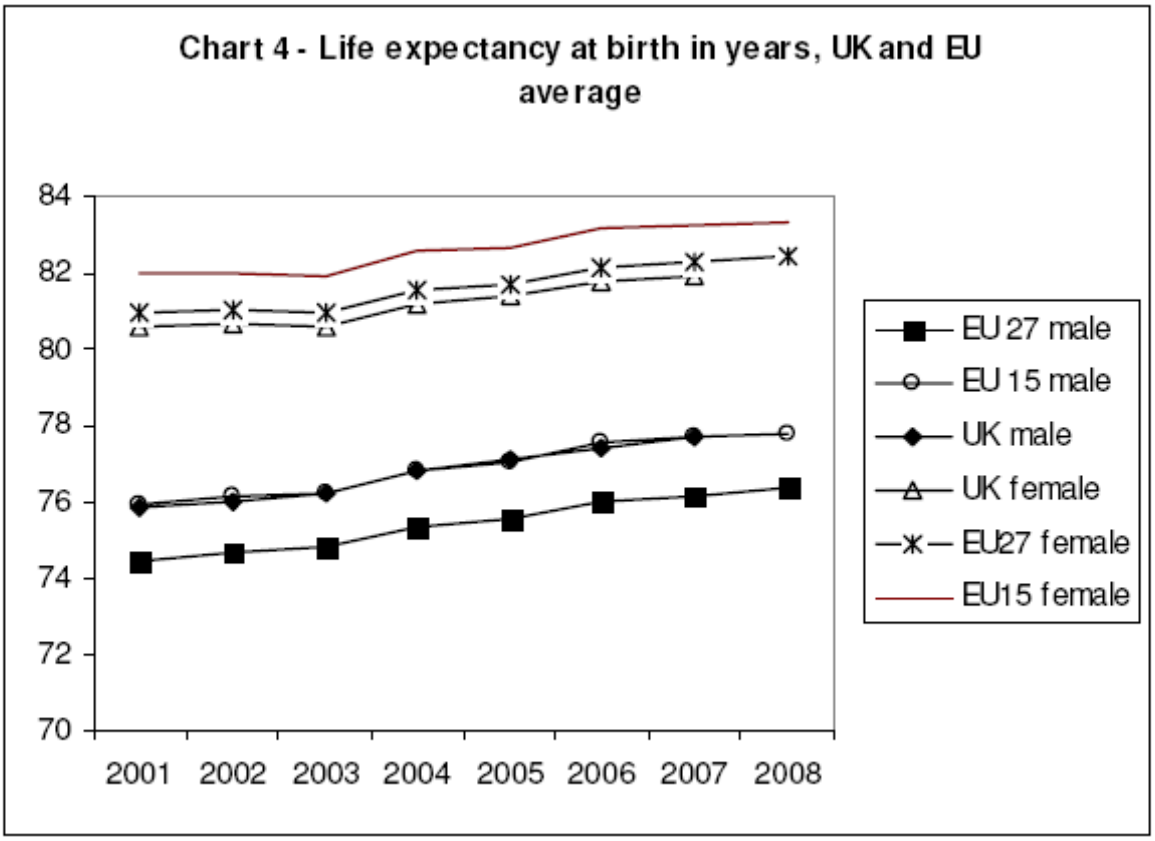
There are particular issues around risk factors and mortality for both men and women:

- Women can expect to live longer than men.
- Although women live longer than men, they also spend more years in sub-optimal health on average, males in England spend 59.1 years in good health and 15.9 years in poor health; for women the corresponding figures are 61.4 years and 18.6 years.
- For both males and females life expectancy at 75 has been increasing in recent decades, but the gap between males and females has decreased slightly over the last fifteen years.

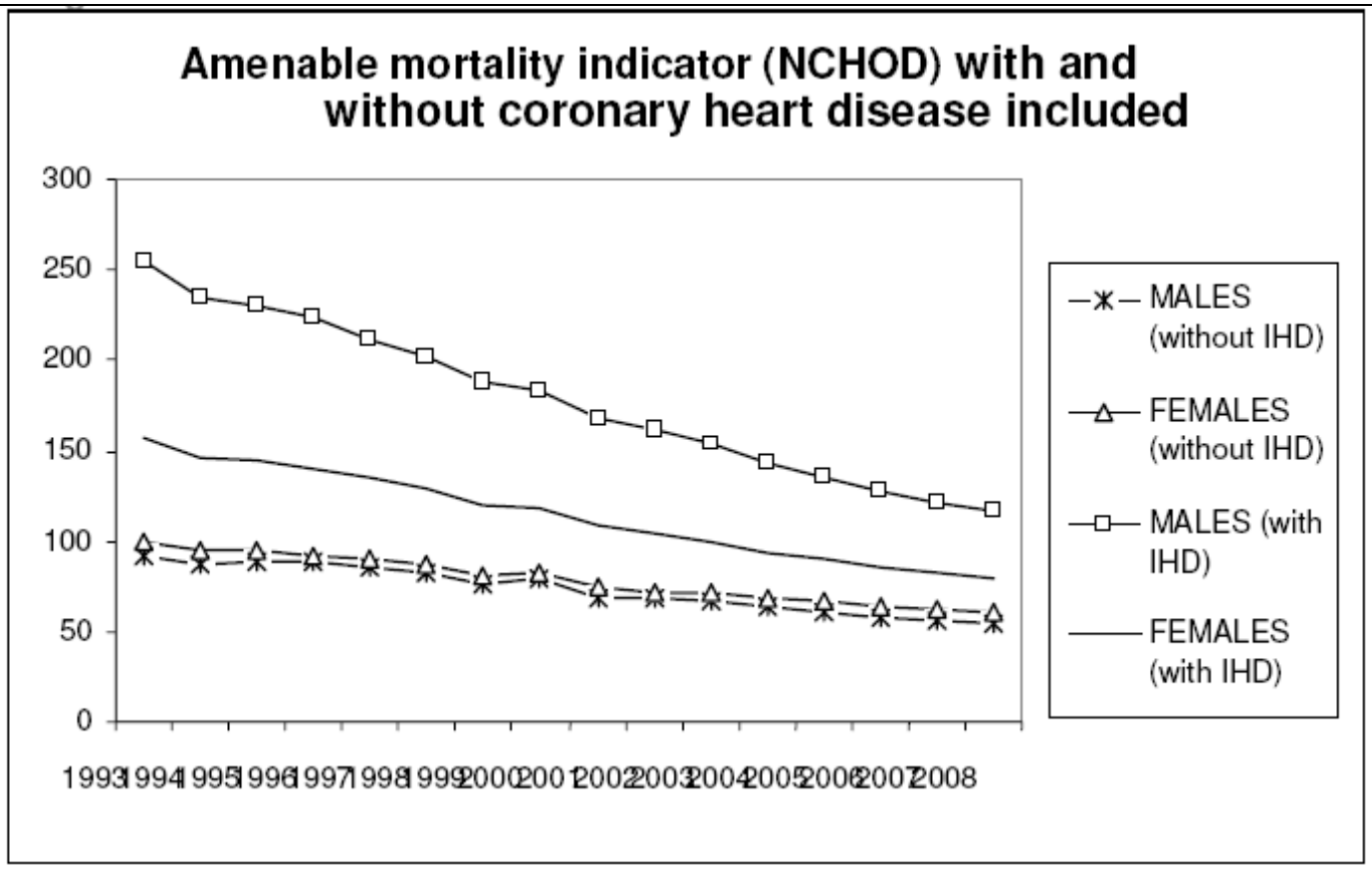


It will be important to make sure that the gender differences noted above do not lead to perverse incentives to focus services more on men for the following reasons:

- There is evidence from international comparisons that women in all countries live on average longer than men, and the difference in life expectancy between men and women is even greater in the EU than in the UK: men's life expectancy in the UK is around the same as the EU15 average, while women's life expectancy in the UK is lower even than the EU27 average which includes the new Eastern European EU members.



- The gender difference in life expectancy is greatest in deprived areas.
- Some cancers are gender specific. For most cancers which affect both men and women, such as lung cancer, age standardised survival rates are somewhat higher in women.[15] However mortality from lung cancer in UK women is higher than the EU15 average, while for men it is lower. This may be related to UK women's relatively higher smoking levels.
- Men are more vulnerable to cardiovascular disease than women, and at a younger age, and are also diagnosed with the majority of cancers.
- Because the death rate from coronary heart disease (CHD) is very different for men and for women, the extent to which this condition is included in any definition of amenable mortality has a large impact on the difference in the amenable mortality rate between men and women. For example, NCHOD[16] publishes data for two versions of an amenable mortality indicator – one includes CHD as a condition amenable to healthcare and the other does not.



When all deaths from CHD are included there are far more male amenable deaths. When CHD is excluded there are slightly more female amenable deaths. The Nolte & McKee definition used in figure 5 includes half of deaths from CHD.

Religion or Belief

In general there is little available evidence on the links between specific religions or beliefs and amenable mortality beyond that relating to race. There are some issues around cancer screening and certain religions:

- Uptake of routine invitations for breast screening is lower amongst Muslim women than among women in the general population possibly due to fear of a male carrying out the mammogram; and
- In the first phase of the bowel screening programme overall population uptake was 62% but only 32% for Muslims.

Sexual orientation

There is currently limited data availability on sexual orientation issues. From the General Household survey, fewer people living in same sex couples had used hospital services in the past year than in the population as a whole, however this is likely to reflect the age profile of those in same sex couples.

A study of mortality among over 8,000 Danish men and women in same-sex marriage concluded that

despite recent marked reduction in mortality among gay men, Danish men and women in same-sex marriages still have mortality rates that exceed those of the general population. However the excess mortality is restricted to the first few years after a marriage, possibly reflecting pre-existing illness at the time of marriage.[17]

Gender-reassignment

There is little evidence available to determine whether the mortality rate from amenable causes in the transgender population is different from the rate in the population as a whole. Available evidence shows:

- 35% of the transgender population report having made at least one suicide attempt. However, the Gender Identity Research and Education Society (GIRES) are not aware of any data that indicate high mortality among severely gender dysphoric people from successful suicide attempts.[18]
- A report of the use of cross–sex hormones in the context of gender reassignment in a hospital in Netherlands from 1995 to 2006 in over 3000 (2236 male-to-female and 876 female-to-male transsexuals) reveals that the mortality rate from cancer and coronary heart disease was not higher than in a comparison group.[19]

Marital status (marriage/civil partnership)

There is evidence to show that single men and to a lesser extent single women have higher mortality rates than married men and women[20] and that single people have a greater risk of dying after surgery[21]. Further study is needed to investigate the reasons for this. It is known that these outcomes are likely to be highly influenced by economic factors, and some studies have shown that stress associated with marital separation affects the body's immune system and its ability to fend off disease.[22]

Infant and perinatal rates are highest among sole registered births and births outside marriage registered jointly by both parents living at different addresses[23].

Missing Information

- ethnic group
- social class
- religion or belief
- sexual orientation
- transgender; and
- marital status

Data in relation to mortality rates for the protected characteristics listed above are not available routinely as it is not recorded on death certificates. Until this information is available an assessment of amenable mortality rates in these groups could be done through detailed investigation of a sample of deaths where the cause was considered ‘amenable’, if there were reliable estimates of numbers in the relevant populations. Mortality data are available by low level geographical area so deprivation of area where the death occurred can be used as a proxy for socio-economic group.

Domain 1: Improving the Wider Determinants of Health

Measure: Gap between the employment rate for those with a limiting long term health condition or learning disability and the overall employment rate:

Employment of people with long-term conditions

The above indicator measures the extent to which people with long-term conditions have the same opportunities in life by looking at their levels of employment. It links in well with other Government department policies. The indicator still needs to be developed. The data, while collected through the Labour Force Survey, are not readily available in the appropriate format as this indicator requires ascertaining the number of people with long-term conditions who are in work and comparing it to employment in the general population.

Ethnicity

A report, *Long-term ill-health, poverty and ethnicity*, by the Joseph Rowntree Foundation, 2007, found that both minority ethnicity and long-term ill health are associated with greatly reduced chances of employment for both men and women.

Respondents with long-term conditions expressed a commitment to paid work and appreciation of its benefits, above and beyond income. However, there was variation in the extent to which paid work was seen as a possibility or priority

The effect of long-term ill health in reducing chances of employment was similar across ethnic groups. However, older Bangladeshis and Pakistanis appeared to be more accepting than white English or Ghanaians of their limited prospects of paid work. Younger people and men often found it harder than older people and women to accept alternatives to paid work. Commitment to employment was positive for some, but for others it conflicted with their health needs or undermined other important roles (such as child-rearing).

Rates of employment were substantially lower for those from three ethnic minority groups studied than among comparable White British men and women.

Risks of unemployment were significantly higher for Pakistani and Black African women compared with their White British counterparts.

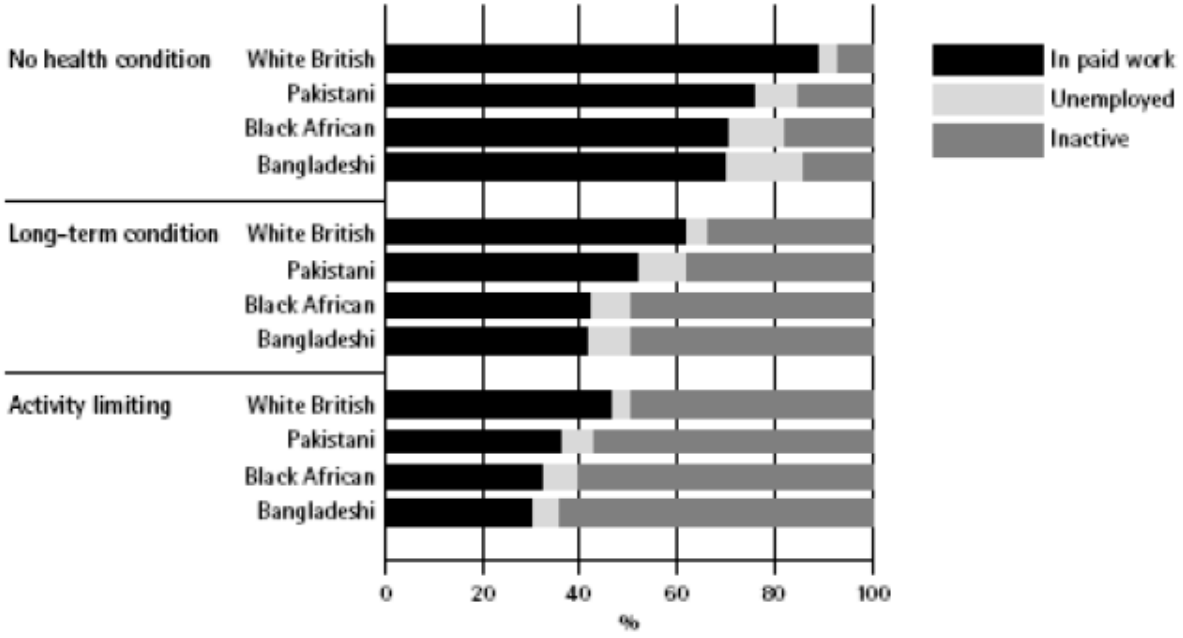
Respondents reported various barriers to employment: their inability following ill health to return to former types of employment (particularly work that was physically demanding); the demands of hospital appointments and the experience of chronic pain; employers' inflexibility; and for those with mental health conditions, stigma and discrimination.

Pay was also affected both by having an activity-limiting health condition and by ethnicity. Pay deficits were particularly large for working Bangladeshi men. Both Bangladeshi men and White British men (and to a lesser extent, White British women) experienced lower pay if they had a long-term health condition.

Penalties due to ethnicity were found for men and for Pakistani women regardless of health status, and Bangladeshi and Black African women without a long-term health condition were also penalised.

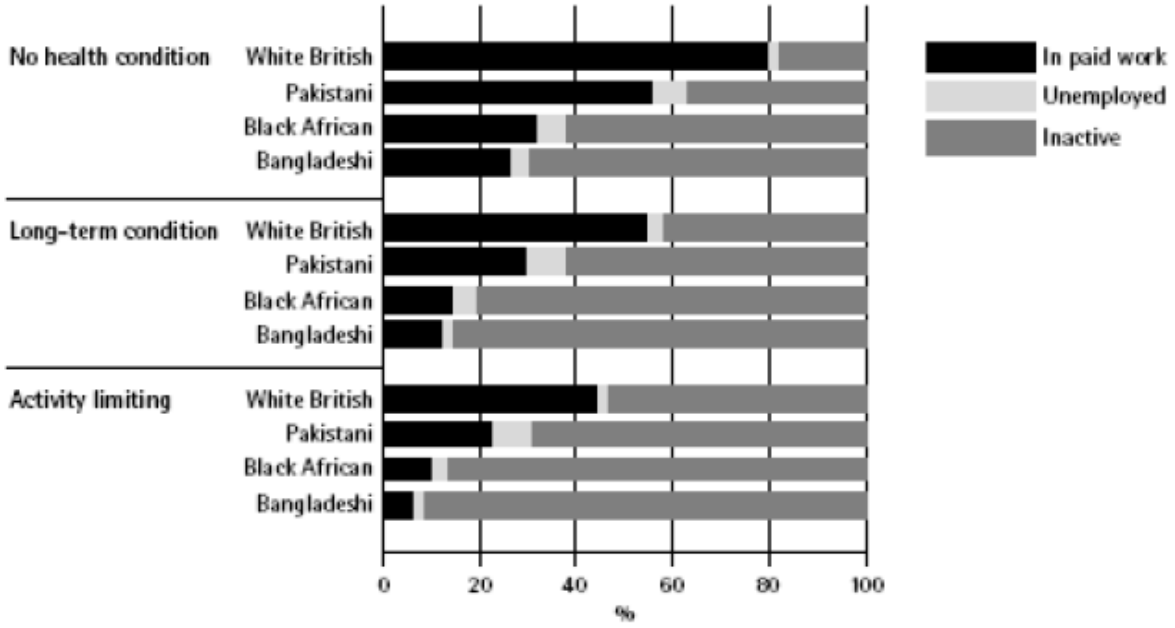
However, the highly selected group of Bangladeshi and Black African working women with an activity-limiting condition were not disadvantaged in pay compared with White British women.

Figure 18: Employment, unemployment and economic inactivity by ethnic group and health status: men



Notes: Proportions are adjusted by person weights.
Source: LFS, pooled quarters, 2002-05

Figure 19: Employment, unemployment and economic inactivity by ethnic group and health status: women



Notes: Proportions are adjusted by person weights.
Source: LFS, pooled quarters, 2002-05

Gender

The *Long-term ill-health, poverty and ethnicity*[24] report also found that the employment rate for women with a long-term condition was slightly lower than for men with a long-term condition.

Another report, *Health, disability, caring and employment, Longitudinal analysis*[25] , found some notable differences in work activity by gender and that were not specifically linked to health. For example, men were more likely than women to have been working across a two-year period (61 per cent compared with 46 per cent) but men who had an limiting health condition across two years were only slightly more likely to remain active than women. Men were no more likely than women to return to work after a period of having a limiting health condition (six per cent).[26]

Age

Older people were more accepting of their limited prospects of paid work. Younger people and men often found it harder than older people and women to accept alternatives to paid work. Commitment to employment was positive for some, but for others it conflicted with their health needs or undermined other important roles (such as child-rearing) (Long-term ill health, poverty and ethnicity, 2007).

Missing information

- Socio-economic status
- Sexual orientation
- Religion

- Disability

Employment of people with mental health problems

Adults with mental health problems[1] are one of the most excluded groups in society. Although many want to work, fewer than a quarter actually do.

Latest data suggest that people in contact with secondary mental health services have an unacceptably low employment rate, which is the lowest amongst any impairment group. Whilst authoritative data is not available, estimates have been made of the employment rate for this group. The NHS Information Centre (IC) estimates that only 3.4% of those on the Care Programme Approach (CPA) are in employment over 16 hours. (The CPA is co-ordinated Health and Social Care provision for mental health service users with complex needs. People on the programme are those considered most at risk or who require a higher level of care co-ordination). However, the figure above is likely to be an underestimate due to data issues. Data from the Labour Force Survey estimates the rate of employment for people with mental health conditions excluding depression (a broader definition than that of the IC) at between 10-16%.

However, estimates suggest that between 86-90% of people with mental health conditions not in employment actually would like to work. Indeed, there is clear evidence that good work is beneficial for a person's well-being and lack of work is detrimental to health and well-being. Re-employment leads to improvement in health and well-being; further unemployment leads to deterioration in health and well-being, (Work, Recovery and Inclusion, Employment support for people in contact with secondary mental health services, HM Government, 2009).

Socio-economic status

There is no evidence looking at socio-economic status and employment rate amongst users of secondary mental health care services. However, a few general points should be noted. A report produced by MIND (2008) states that poverty can be both a determinant and consequence of mental illness:

- People with a mental health problem are more likely to live on lower than average incomes;
- Over 75% are reliant on welfare benefits;
- 1 in 4 people with a mental health problem also report being in debt compared to 1 in 11 of the general population.
- Unemployment rates could be as high as 75%

Deprivation

Deprivation can either influence the prevalence of mental health problems or impact on its severity, including the likelihood of re-occurrence. The follow up study to 'Psychiatric morbidity among adults

[1] 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.

living in private households 2010 also found that people who were of lower socio-economic status were less likely to recover from common mental problems, as were people who were long term sick and disabled and those who were not employed at the time of both interviews, (Mental Health Needs Assessment for Adults of Working Age, (16 to 64 years of age), Hillingdon PCT, NHS, 2008).

Social exclusion and mental health: Current situation and future directions

The relationship between social exclusion and mental ill-health is complex: many of the elements of "exclusion" (poor educational levels, unemployment, low income, poor housing, lack of social networks, neighbourhood deprivation) can be both causal factors and consequences of mental ill-health in different circumstances. In addition there are groups of the population that are often regarded as excluded from society.

An important example is adults aged 16-64 in the general population with common mental health problems. The national surveys of psychiatric morbidity in Britain show that this group, compared with those without mental health problems, were more likely to be, separated or divorced, to have no formal educational qualifications, to be unemployed, and to rent rather than own their accommodation. However, the most significant differences relate to social participation. Adults with neurotic disorders, compared with other people, were more likely to have small primary support groups, express a severe lack of social support, and participate in fewer leisure activities. The situation is even worse for people diagnosed with significant mental health problems; these are among the most 'excluded' in society. At best 15% of people of working age with long-term mental health problems are working, and joblessness is far lower than in any other group of disabled people. Their lack of social networks is often exacerbated by discrimination and profound loss of social status, (Mental Health Needs Assessment for Adults of Working Age, (16 to 64 years of age), Hillingdon PCT, NHS, 2008).

Ethnicity

The following evidence is from the briefing report, Evening the odds, employment support, mental health and Black and minority ethnic communities, Sainsbury Centre for Mental Health, 2010.

Black and ethnic minority mental health patients are less likely to use employment services and less likely to gain employment than their White counterparts.

Currently 63% of Black and ethnic minority people are in employment compared to 72% of all White people, with research showing that since 2005, rates of employment amongst Black and ethnic minority people remains about 10%, lower than the national average.

The employment rate for Bangladeshi people is about 23% lower than for the White population, with men more likely to be employed than women. There is a similar pattern in the Pakistani population but Indians have a higher rate of employment, currently about 6% lower than White people and a greater proportion of Indian women are in employment.

Most people with mental health problems can and would like to work. However, they face barriers getting and keeping jobs and it seems that ethnic minority people have more difficulty overcoming these barriers. Mental health and employment services need to be able to respond positively to this challenge and offer targeted support where it is needed.

The Sainsbury Centre briefing found that almost two thirds of the people from Black and Black British communities had been employed before using mental health services, with 39% educated to graduate and post graduate level. However, no-one amongst those surveyed was employed at the time the study was being carried out, despite evidence of high educational attainment among Black and Black British groups.

The paper points out that former mental health patients from Black and Black British communities have the qualifications and will to get paid employment but barriers which range from low expectations of mental health staff, lack of resources, systemic racism and the stigma of mental illness are hindering this.

Gender

Female mental health service users are more likely to be in paid work than male service users, 26% of women versus 16% of men. (Improving the employment rates of people using secondary mental health services, 2008).

Missing information

- Age.
- Sexual orientation
- Disability
- Religion
- Marital status
- Gender re-assignment

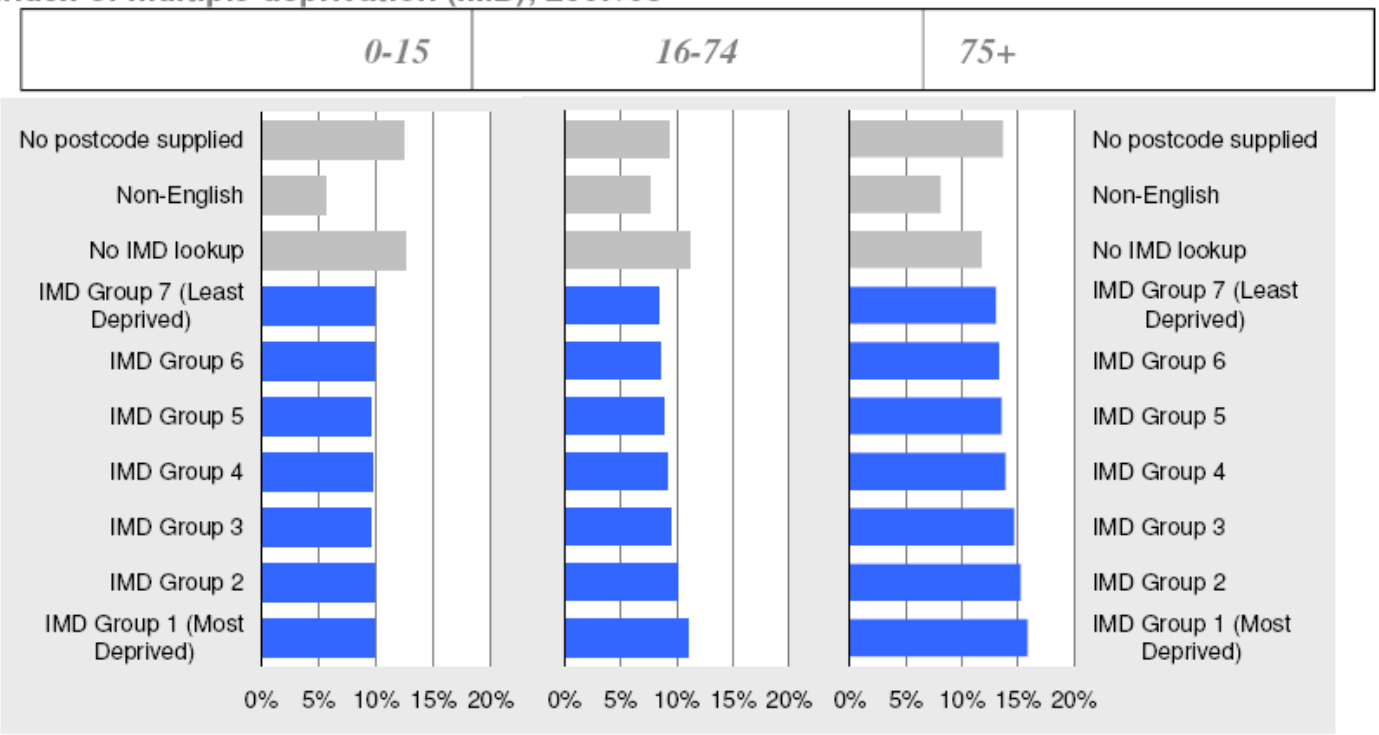
Domain 4: Health Care Public Health:

Measure: Emergency readmissions within 28 days of discharge from hospital:

Socio-economic group

Figure 25 gives a breakdown of this indicator by index of multiple deprivation (IMD). For adults and older people there is a clear pattern: greater deprivation is linked with a higher rate of emergency readmissions. However, as with the difference between males and females, this pattern is not seen in children, where emergency readmission rates are the same for all levels of deprivation.

Figure 25: Emergency readmissions to hospital within 28 days of discharge, by age and index of multiple deprivation (IMD), 2007/08



Age and gender

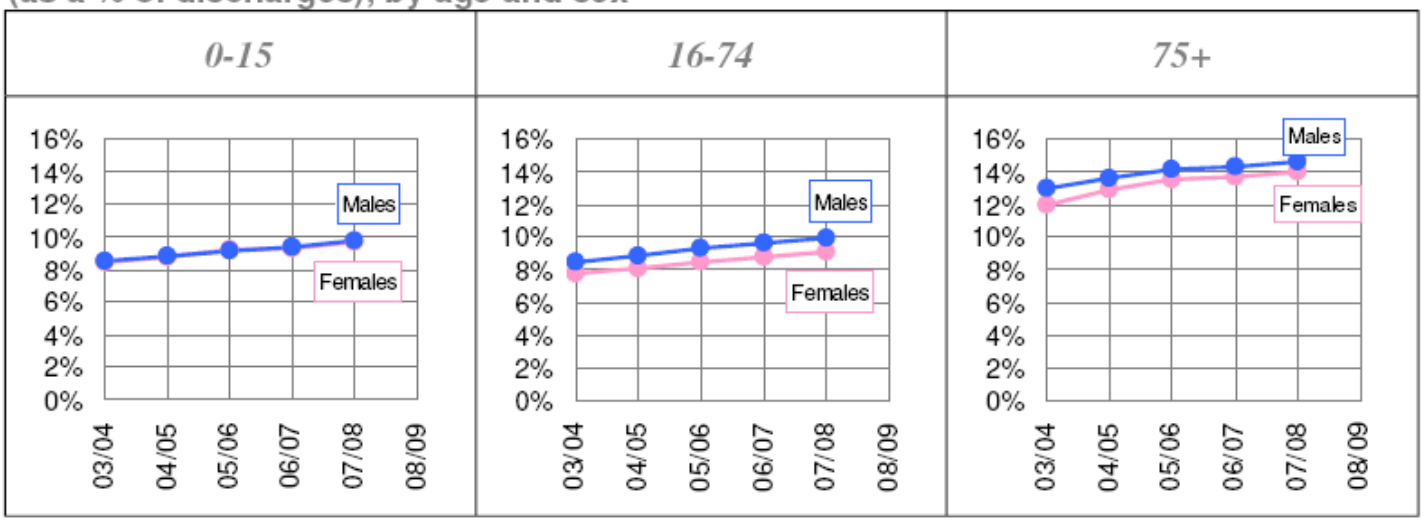
Figure 26 presents the latest five years' data for this indicator, split by sex and age. For all age groups, for males and females, the number of emergency readmissions is rising.

Over 75s are significantly more likely to be readmitted in this way than other age groups. As over 75s are also more likely to be in hospital in the first place, they will account for a large proportion of all readmissions.

In general, males are slightly more likely to be readmitted than females, but there is no difference between the sexes in those aged 0-15.

To improve its score on this indicator the NHS is likely to have to focus on older people. To avoid others, in particular children, being overlooked, it may be helpful to monitor this indicator separately for different age groups.

Figure 26: Emergency readmissions to hospital within 28 days of discharge (as a % of discharges), by age and sex



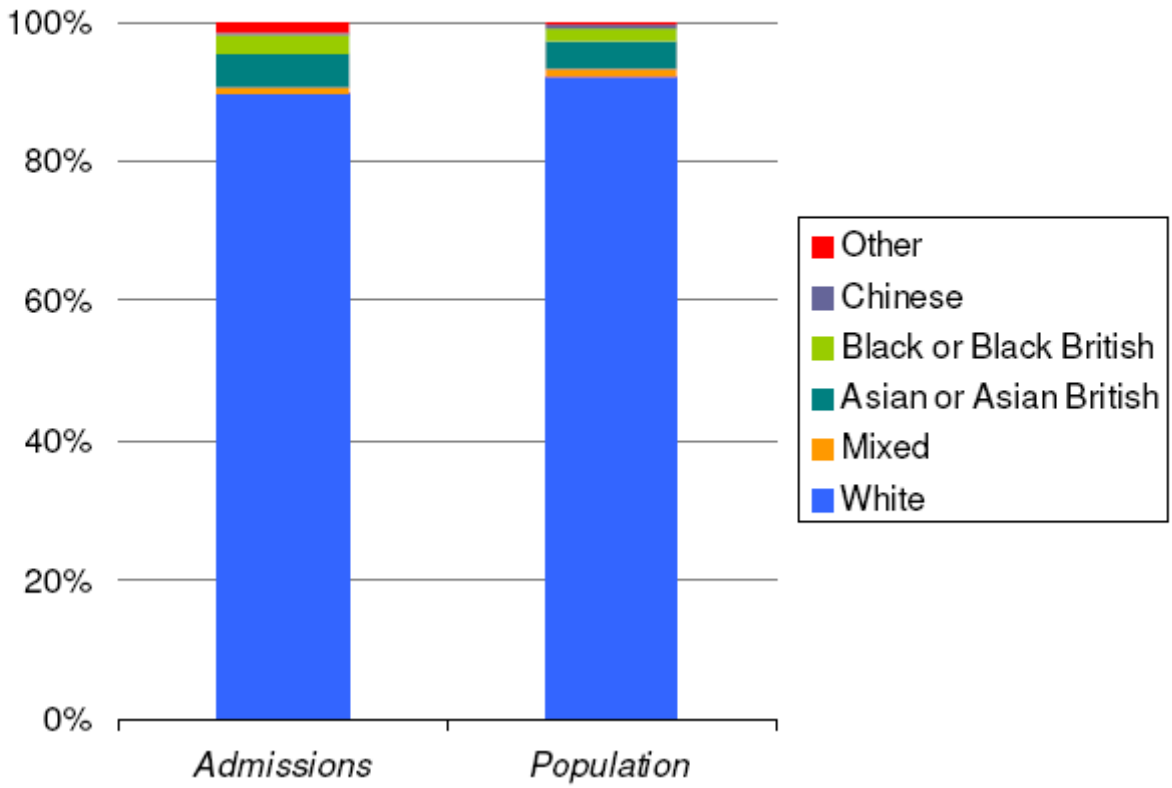
Ethnic group

Figure 27 shows emergency readmission rates for selected ethnic groups, broadly including those with the highest and lowest rates for each age group, as well as the majority group (white British). While there is some variation between ethnic groups, the order is not consistent across different age groups, and no one ethnic group has noticeably high readmission rates for all age groups. This confused picture in part reflects the difficulty in interpreting readmission rates, which has led to the Department deciding to investigate this indicator further before it is used for accountability.

Figure 27: Emergency readmissions to hospital within 28 days of discharge (as a % of discharges), by age and ethnic group

Figure 28 shows the proportion of all hospital admissions attributable to different ethnic groups (this is a complete set of ethnic groups taken at a higher level of aggregation than in previous charts) and compares this with a population breakdown from the 2001 census. It is apparent that minority ethnic groups account for a higher proportion of hospital admissions than they do of the population. An indicator focusing on all hospital admissions (as this one does) will, in broad terms, have a slightly increased focus on minority ethnic groups when compared to a population-level indicator.

Figure 28: proportion of hospital admissions and total population size by et group



Missing Information

There is currently no information on the following areas:

- Religion or Belief
- Sexual orientation
- Gender-reassignment
- Marital status (marriage/civil partnership)

Variance in health outcomes across equalities groups:

Since the baseline period when the Government began to measure progress towards its target to reduce health inequalities (1995–97), the gap between the 'routine and manual' groups and the population as a whole has widened. The gap in men's life expectancy in the period 2005–07 was 4% wider than the baseline period, while for women, this gap was 11% wider[27]. Health inequalities are not only apparent between people of different socio-economic groups—they exist between different genders, different ethnic groups, and older people and people who have mental health problems or learning disabilities also have worse health than the rest of the population. The causes of health inequalities are complex, and include lifestyle factors—smoking, nutrition, exercise to name only a few—and also wider determinants such as poverty, housing and education. Access to healthcare may play a role, but this appears to be less significant than other determinants.

Examples of unacceptable variation in health outcomes are illustrated if we compare a relatively affluent Local Authority, like Westminster, and a relatively deprived Local Authority, such as Newham. For instance, if we look at early deaths from heart disease and strokes from 2007-09, the rate per 100,000 population is 62.05 in Westminster and 116.65 in Newham. Also, if we take life expectancy, the life expectancy in deprivation quintile 3 (2005-2009) for Westminster is 83.59, where as the figure in Newham is 73.93.

Engagement and involvement

Please note this work has been subject to the requirements of the cross-government Code of Practice on Consultation.

How have you engaged stakeholders in gathering evidence or testing the evidence available?

Gathering evidence on equalities issues has been built into the development of the outcomes framework from the project's inception. Public Health Professionals and Independent/volunteer sector organisations were involved in early brainstorming of concepts for the framework (factoring the available evidence) and initial views on the measures to include. They have since been involved in constant engagement events throughout the lifecycle of the framework's development. These

engagement events have often been conducted in the format of workshops and have genuinely influenced the development of the policy.

We will continue to engage with stakeholders in the months and years after the framework has been published.

An example of a key stakeholder engagement event on the use of evidence to support the framework's development was a workshop to gauge feedback on how the department can ensure steps are taken to advance equality in the work of Public Health England. The outcomes framework was one of the areas of focus at this three hour event, which took place on 28th September 2011. The event was attended by the following equalities and third sector organisations:

Afiya Trust
Age UK
Equality 2025
Friends, Families, Travellers
HPA
LGBT
Men's Health Forum
National Equalities Council
NTA
Race Equality Foundation
St. Mungo's
Stonewall
Youth Access
Z2K

The following key pieces of feedback were noted:

- How can you use evidence/data to help raise the status of communities – build in incentives
- The aspiration is worthy - but the data may be poor, with large gaps and/or not in existence. If this is the case, then it is not clear that the ambitions for the framework can be achieved
- There are so many branches of inequalities, and each one needs its own criteria
- The complexity of defining 'quality of life' and 'healthy life'. Need to consult with/ask population sub-groups how they define these terms. How are these measured and according to whose definition? Tendency to be measured in medical terms. Support to access services
- Don't forget the role of (lack of good) housing and debts on health
- The efforts of local government could undermined by the effects of other central government in other areas of policy (eg poverty increased via the measures covered in the Welfare Bill)
- How will LAs provide services to "hidden" communities – if the information is not there to "reveal" them?
- A better measure for pre-mature mortality is needed

Consultation responses

The consultation document for the PH Outcomes Framework contained the following specific question (question 3) on 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?"

Over 2000 responses were received on the joint Healthy Lives, Healthy people consultation and we have attempted to incorporate as much of this feedback as possible.

A sample of specific feedback from equalities groups on question 3 is shown below:

The following response was received from the Lesbian and Gay Foundation:

"The Lesbian and Gay Foundation sees strategic programmes like the National LGB&T Partnership, as well as other LGB&T partnership, as well as other LGB&T groups, playing a pivotal role in contributing to ensure equality and the health needs of LGB&T people being placed robustly within the outcomes Framework".

Age Uk also made the following observations:

"Small groups: There may be a need for Public Health England to develop a range of levers for influencing practice on addressing and meeting needs of relatively small groups of people who experience poor health as small numbers of geographically dispersed people are unlikely to register on the radar of local authorities, for example transgender people."

"We need to ensure that uptake of services or participation in public health activities are corded and monitored, and that data about users and participants include all the equality characteristics. At the moment, only age and gender are routinely recorded well. It may be more difficult to collect data for other equality characteristics such as religion or sexual orientation. While this presents a challenge, it is one that must be met."

The RNIB made the following comment:

"Eye health is an excellent example where the number of people affected and the impact of visual impairment on a person's quality of life clearly justifies increased attention being given to sight loss prevention, especially in areas with a higher than average number of older people or people from ethnic minority origin who are at a higher risk of sight loss. Yet, when asked to identify the major causes of health inequalities and diseases most commissioners will automatically think of obesity, diabetes, heart disease, stroke and dementia."

The following observation was made by Refuge (for women and children Against domestic violence):

"it is important that a systematic approach is undertaken to address gender inequality in health outcomes. For example, consideration of gender-based violence should be undertaken across a number of performance indicators, including those related to: mental health, injuries, chronic physical conditions, unwanted and complicated pregnancy, sexually transmitted infection and substance misuse."

How have you engaged stakeholders in testing the policy or programme proposals?

The following stakeholder groups have been central to the testing of the outcomes framework:

Public Health Professional – In particular we have worked closely with professional public health

representative bodies and through them, their partners (Association of Directors of Public Health and Public Health Engagement Sub-Group).

Local Government – Engagement has been primarily through liaison with the Local Government Group's policy leads, as well as with other bodies such as ADsPH (Association of Directors of Public Health) whose membership is overwhelmingly jointly appointed between the LG and PCTs, or SOLACE (Society Of Local Authority Chief Executives)

Other Government Departments – OGDs have had a vested interest in the outcomes framework given the shared priorities and in particular, a focus on those measures that best reflect the 'causes of the causes' of health and inequalities in health. Bi-lateral discussions with OGD colleagues have taken place where those discussions referred to specific indicator selections alongside the central role of the Cabinet Sub-Committee for Public Health.

Voluntary and Independent sector – The VCS and IS have played an important part during the consultation period in representing the views and needs of specific groups or issues that pertain to public health. We have worked in partnership with some of these organisations to provide tools and advice to the public health systems in improving outcomes for specific group of people, on specific issues. Ongoing dialogue will remain essential once the outcomes framework has been published.

Indicator assessment process

The consultation document on the outcomes framework contained details of a set of 12 criteria that we intended to use in order to access the suitability of the indicator measures in the framework. The consultation document also included the following specific questions on the selection of the indicators:

- "Have we missed out any indicators that you think we should include?"
- "Are there indicators here that you think we should not include?"

We used feedback from stakeholders in the consultation to further develop this list of criteria and then held engagement events with the following stakeholder groups to ascertain whether the criteria were fit for purpose:

- Public Health Professionals
- Local Government
- OGDs
- Voluntary and Independent Sector

Following these events, the criteria were further modified to take on board all the feedback received from stakeholders.

An exercise was then undertaken where policy leads for each indicator were asked to assess their measure against all of the 12 criteria (the template that was used in this exercise can be found in Annex B). In addition to assessing each measure against the criteria, policy leads were also asked to assess which inequalities and equalities dimensions measures could be disaggregated by.

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 as follows:

- Socio-economic group
- Area deprivation (or postcode)
- Age
- Disability
- Ethnicity
- Gender
- Religion or belief
- Sexual Orientation

In order to conduct this assessment exercise, policy leads from DH and OGDs 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.

Public health Professionals, Local Government and voluntary/independent stakeholder organisations were kept informed of the progress of the assessment process through several workshops in July and August. Engagement events for stakeholders were also held in September to communicate the results of the assessment process.

Summary of Analysis *Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.*

Approach to summary of Analysis:

We have used the following mechanism to identify the potential adverse effects of the framework on groups with protected equalities characteristics:

- Through the consultation document, specifically through the following question in the document, “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?”

- Through individual engagement events with equalities groups and third sector organisations (such as the 28th September workshop event on the use of evidence to support the framework’s development).

The following summary details the issues relating to the framework (both in general and with regards to specific measures) and groups with protected equalities characteristics that we have identified, - or been made aware of. The summary also details the actions we have taken to resolve these issues. There may be further issues with regard to specific measures. However, beyond the issues summarised below, no further concerns have been highlighted to us either through the consultation or through specific engagement events with equalities groups/third sector orgs.

Preventing Premature Mortality

- There is a risk that older people (aged 75+) are disadvantaged by the selection of 'mortality amenable to healthcare' as indicators (particularly in the domain "health-care public health, including preventing premature mortality"). This is because mortality amenable to healthcare by definition is capped at age 75, due to multiple morbidities and the consequent difficulties in ascribing cause of death to those aged 75 years and above. Considering all deaths above a particular age as 'not premature' discriminates against older people who still lead healthy and fulfilling lives. To mitigate this risk, 'Life Expectancy at 75' will be used as a companion indicator to amenable mortality. This decision was partly taken in response to feedback from the 28th September engagement event on equalities (see above), at which concerns about pre-mature mortality measures were raised.
- Because deaths from causes considered amenable to healthcare are largely dominated by adults, there is a risk that children will be neglected. To mitigate this risk, outcomes have been selected that specifically relate to periods of childhood where the risk of death is highest: infant mortality and perinatal mortality.

Domain 1: Improving the Wider Determinants of Health

Measure: Gap between the employment rate for those with a limiting long term health condition or learning disability and the overall employment rate:

Research is available on the proportion of adults in contact with secondary mental health services in employment. People in contact with mental health services have an unacceptably low employment rate, which is the lowest among any disability group. Estimates suggest that between 86%-90% of people with mental health conditions not in employment actually would like to be.

The existence of this low employment rate for people with mental health conditions resulted in our decision to specifically incorporate "people with mental health conditions" into this indicator so that the employment rate could be disaggregated for this group. The full measure in the framework is therefore: Employment for those with a long-term health condition including those with a learning difficulty / disability or mental illness

Domain 4: Health Care Public Health:

Measure: Emergency readmissions within 28 days of discharge from hospital:

There is variation between ethnic groups on this proxy outcome measure, but no ethnic groups are noticeably worse off across all age groups. As such we cannot identify obvious inequality on this measure, which in part reflect the difficulty in its interpretation. Hospital admissions per head are higher among minority ethnic groups, so focusing on an admissions-based indicator may lead to increased focus on the health of these groups.

Variance in health outcomes across equalities groups:

As stated in the evidence section, there are unacceptable variances across equalities groups. Health inequalities are not only apparent between people of different socio-economic groups—they exist between different genders, different ethnic groups, and older people and people with mental health problems or learning disabilities also have worse health than the rest of the population. The current variations in quality and outcomes of public health services means that the public health system is

not currently equipped to make improvements against the causes of health inequalities that are not significantly affected by direct healthcare.

Ultimately the aim of the Public Health Outcomes Framework itself is to help the public health system to address the causes of these health inequalities in order to make progress against unacceptable variations in public health outcomes.

Responses to consultation feedback:

The Lesbian and Gay Foundation: The L&GF commented that national third sector partnerships (such as the LGB&T partnership) should play a pivotal role in contributing to progress being made against the indicators for equalities groups. We have therefore emphasised in the final framework publication document that the framework should be used as a tool by the sector (including third sector orgs) to hold LAs and PHE to account for the delivery of progress against indicators.

Age UK: Age Uk made the point that, “a range of levers will need to be developed for influencing practice on addressing and meeting needs of relatively small groups of people who experience poor health as small numbers of geographically dispersed people are unlikely to register on the radar of local authorities, for example transgender people:” Feedback such as this influenced the criteria assessment that we used to determine whether indicators were fit for purpose. We asked indicator leads to confirm whether measures could be disaggregated by the following:

- Socio-economic group
- Area deprivation (or postcode)
- Age
- Disability
- Ethnicity
- Gender
- Religion
- Sexual Orientation

We also asked indicator leads to confirm whether measures could be disaggregated by the following geographical areas:

National level
Local Authority level
Clinical commissioning Group
Middle Super Output
Lower Super Output

The indicators cannot all be disaggregated by these equalities groups and geographical areas. However, we have stated in the final framework publication that we intend to work towards future disaggregation by geographical areas/equalities for every indicator both before the framework goes live in 2013 and during the initial 3 year life cycle of the framework (an annual refresh of the definitions and data sources for the indicators will look at progress on disaggregation and what is possible going forward).

RNIB: Pointed to the fact that most commissioners would automatically think of obesity, diabetes, heart disease, stroke and dementia as being the major causes of health inequalities. However, sight loss prevention can have a disproportionate impact on quality of life in areas with a higher than

average number of older people or people from ethnic minority origin. Because of this disproportion impact on these two equalities groups, we made the decision to include a specific indicator on sight loss in the final framework (despite the fact that it was not in the original list of indicators that were in the consultation document).

Refuge (for women and children Against domestic violence): Refuge stated that “it is important that a systemic approach is undertaken to address gender inequality in health outcome”. Public Health data on gender is more readily available than any other equalities characteristic, and we have attempted to disaggregate all indicators by gender at a national level where possible. Further work will be undertaken before the framework goes live (and in its first lifecycle) to achieve as full a disaggregation as possible for gender both at a national and local level. This principle is true for all equalities characteristics. The final publication includes an Annex on the breakdown of indicators by equalities. This annex indicates the current indicators that can be disaggregated by equalities characteristics at a national level. It also points to our plans for improving the coverage in the future and extending disaggregation to smaller geographic levels It is also attached to this document as annex C.

Action plan

Category	Actions	Target date	Person responsible and their Directorate
Data collection and evidencing	We will continue to develop the data sources for each measure to attempt to disaggregate them by as many equalities dimensions and geographical regions as possible	April 30th 2013 then ongoing	Jazz Bhogal, Health Improvement and Protection
Monitoring, evaluating and reviewing	Annual refresh of Outcomes Framework and data sets to include review of effect on equalities	November 2012	Jazz Bhogal, Health Improvement and Protection
Ongoing accountability to stakeholders	We will ensure ongoing accountability to stakeholders through engagement events (such as a planned reconvening of the group that attended the sited event on 28th September to discuss progress against actions). These events will look at improvements that can be made to the framework, lessons learnt and openly review decisions that are taken as the framework is implemented,	Ongoing	Jazz Bhogal, Health Improvement and Protection

For the record
Name of person who carried out this assessment: Simon Dowlman
Date assessment completed: TBC
Name of responsible Director/Director General: Kathryn Tyson
Date assessment was signed:

Annex A: List of organisations responding to the consultation *Healthy Lives, Healthy People: Our Strategy for Public Health In England*

The consultation on the PH Outcomes Framework was published as part of a group of consultations to support the White Paper “Healthy Lives, Healthy People: Our Strategy for Public Health in England”.

The following organisations submitted written responses to the collective consultation on Healthy Lives, Healthy People. In addition, a number of responses from individuals were also received.

List of organisations who responded to the public consultation on "*Healthy Lives, Healthy People: Our Strategy for public health in England*" and associated documents.

2020 Health	Harrow Council	PHG Foundation
20s Plenty for Manchester	Harrow LINk	Philip Morris Ltd
4Children	Hartlepool Health Sub Group	Physical Activity Alliance
Association of Chartered Physiotherapists in Occupational Health and Ergonomics (ACPOHE)	Harvest Housing Group	Platform 51
Acquired Brain Injury Forum for London	Hazel Ward	Play England
Action for Children	HCV Action	Plymouth Children Trust
Action on smoking and health	Health and Older People Local Strategic Partnership Subgroup, Tunbridge Wells	Plymouth City Council
Active Cumbria - the Sport and Physical Activity Partnership	Health and Well-being Scrutiny Committee	Plymouth Link
Active Devon	Health Empowerment Leverage Project	Plymouth NHS Stop Smoking Service
Active Gloucestershire (The county sport and physical activity partnership for Gloucestershire	Health in Hackney Scrutiny Commission	Plymouth Pride Forum
Association of Directors of Adult Social Services	Health Protection Agency	Plymouth Primary Care Trust
Association of Directors of Childrens Services (ADCS)	Health Scrutinty Sub Committee	POhWER
Adfam - Families, drugs and alcohol	Health Scrutiny Panel	Positive East
AdviceUK	Health Statistics User Group	Positive Health (Lincolnshire)
Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection	Directorate of Public Health NHS Derbyshire County	Positively UK
Advisory Committee on Consumer Engagement	Heart of Birmingham PCT	Prison Reform Trust
Advisory Group for Certifiable Visual Impairment Data & Information Management	Heart of Birmingham Teaching Primary Care Trust	Prostate Cancer Charity
Advisory Group on Contraception	Heart of Mersey	PSBreastfeeding CIC
Race on the Agenda (ROTA)	HEART UK - The Cholesterol Charity	NHS Plymouth, Public Health Development Unit
Afiya Trust	Help the Hospice	NHS Hull and NHS East Riding of Yorkshire, Public Health Directorates
African Health Policy Network	Hereford Primary Care Trust	Public Health Observatories
Age UK	Hertfordshire and Bedfordshire Environmental Health Heads of Service	Public Health Wales NHS Trust
Alcohol Concern	Hertfordshire County Council	NHS Bedfordshire, Public Health
Alder Hey Children's NHS Foundation Trust	Hertforshire Sport and Physical Activity Partnership	Publica Health Consultation
Alliance of Registered Homoeopaths	Herts Aid	Purbeck District Council
All Party Parliamentary Group on Primary Care & Public Health	Herts Sports Partnership	Quit

Allerdale Borough Council	Hillingdon LINk	Raise
Alliance Boots	Hinckley and Bosworth Borough Council	Reading Bowel Cancer Support Group
Alliance for Transforming the Lives of Children	Health Protection Agency - HIV/STI department	Real Baby Milk
Alliance of Registered Homeopaths	Homeless Link	Redbridge LINk
Altogether Better	Hospital Infection Society	Redcar and Cleveland Council
Altogether Better, NHS Yorkshire & the Humber	Housing and Ageing Alliance	Refuge
Alzheimer's Society	HUBB Mental Health User Group	Regional Health, Work and Wellbeing Co-ordinators
Amateur Swimming Association (and on behalf of 8 ASA regions)	Hull City Council	Regional Public Health and Social Care Group
Amber Valley Borough Council	Hull Learning Disability Partnership Board	Regional Voices
All Party Parliamentary Group on HIV and AIDS	Hull Public Health Directorate	Reigate & Banstead Borough Council
Arthritis Care	Herpes Viruses Association (HVA)	Research Department of Epidemiology and Public Health
Arthritis Research UK	NHS North West Immunisation leads	Rethink
Arts Council England	Independent Age	Revolving Doors Agency
Ashfield District Council	Independent Healthcare Advisory Services	Richmond Upon Thames Users and Carers Group
Ashton Leigh and Wigan Community Healthcare NHS Trust	Independent Pharmacy Federation	Right Care, Right Here
Association for Nutrition	Infection Prevention Society (IPS)	Right Property
Association for the Study of Obesity	Information Commissioner	Royal National Institute for the Blind
Association for Young People's Health	Institute of Alcohol Studies	RNIB & Royal College of Opthamologists
Association of Colleges	Institute of Biomedical Science	Royal National Institute for the Deaf
Association of Directors for Public Health	Institute of Health & Society	Roche Products Limited
Association of Greater Manchester Authorities	Institute of Health Promotion and Education	Royal Society for the Prevention of Accidents
Association of Greater Manchester Hepatitis C Strategy	Institute of Home Safety	Ross Training Ltd
Association of Occupational Health Nurse Practitioners	Institute of Occupational Safety and Health	Rossendale Borough Council
Association of the British Pharmaceutical Industry	Institute of Pharmacy Management International	Rotherham Health Network
Assosication of Greater Manchester PCT's Hepatitis C Strategy	Institute of Psychosexual Medicine	Rotherham MBC
Asthma UK	Institute Public Health, University of Cambridge	Rotherham Pharmacy Contractors
Audit Commission	Institution of Occupational Safety and Health	Rowlands Pharmacy
Against Violence and Abuse (AVA)	Involve Yorkshire & Humber	Royal Borough of Kensington and Chelsea
Aylesbury Vale District Council	Isle of Wight NHS Primary Care Trust	Royal College of General Practitioners
Baby Milk Action and the Baby Feeding Law Group	Islington Council	Royal College of Midwives
Badminton England	Islington Primary Care Trust	Royal College of Nursing
Balance	Joint Committee on Vaccination and Immunisation	Royal College of Obstetricians and Gynaecologists
Balance, the North East Alcohol Office	Joint Immunisation Group	Royal College of Paediatrics and Child Health
Barking and Dagenham PCT	Joint Response - NHS Western Cheshire and Cheshire West and Chester partnership	Royal College of Physicians
Barnados Street Level Family Services	Keep Britain Tidy	Royal College of Physicians and Surgeons of Glasgow
Barnsley Metropolitan Borough Council	Kent Local Pharmaceutical Committee	Royal College of Physicians of Edinburgh
British Association of Social Workers (BASW)	Kent Public Health Department	Royal College of Speech and Language Therapists
Bath & North East Somerset Council	Kidney Alliance	Royal Society for Public Health

Bath and North East Somerset Health and Wellbeing Partnership	Kingston upon Thames Interim Health and Well Being Board	Royal Town Planning Institute
Bayer	Kingston Voluntary Action	Royal Town Planning Institute
Be Heard..our advocacy service	Kingston, Richmond and Twickenham Pharmaceutical Committees	Royal Yachting Association
Beat Bullying	Kingtson upon Thames Interim Health and Well Being Board	Rugby Football Union
QIPP Programme- Right Care Workstream	Knowsley Children and Families Board	Runnymede Community Strategy Health & Social Care Task Group, Runnymede Borough Council
Berkshire Local Pharmaceutical Committee	Knowsley Health & Wellbeing Board	Rushmoor Healthy Living
Best Beginnings	La Leche League Great Britain	Safe City Partnership
Bexley Health and Well-being Shadow Board	Lactation Consultants of Great Britain	Safeguarding Children Service, Nottingham City
Bexley, Bromley & Greenwich Local Pharmaceutical Committee	Lambeth LINk	Salvation Army
BHA (Black Health Agency)	Lancashire County Council	Salem Health Project
Birmingham & Solihull Women's Aid	Lancashire Public Health Network	Salford - various third sector organisations
Birmingham Primary Care Shared Services Agency	Lancaster University	Salford Children and Young People's Trust
Birmingham Public Health Transition Board	Leicestershire Aids Support Services (LASS)	Salford City Council
Blackburn with Darwin council and NHS Teaching Care Trust	Lawn Tennis Association	Samaritans
Blackpool Council	London Borough of Greenwich Council	Sanctum Consultants
Body & Soul	London Borough of Merton	Sandwell Metropolitan Borough Council
Bolton Local Pharmaceutical Committee	Local Government Better Regulation Office	Sandwell Primary Care Trust
Bolton PCT	Leeds City Council	Sanofi Pasteur MSD
Bolton, Bury and HMR Breast Screening Group	Leeds Metropolitan University	Scarsdale
Bolton's Children's Trust Board	Leeds Partnerships NHS Foundation Trust	School of Public Health North East
Booktrust	Leeds, Bradford and Airedale, Calderdale and Kirklees Local Pharmaceutical Committees	Scottish Collaboration for Public Health Research and Policy
Borough of Poole	Leicester City Community Children's Health Service	Scottish Health Protection Advisory Group
Borough of Rochdale	Leicester City Council	Seniors Show The Way, Bradford
Borough of Wigan	Leicester-Shire & Rutland Sport's	Sevenoaks District Council
Bournemouth 2026 Partnership	Leicestershire Staying Healthy Partnership	Sexual Health Commissioners Group
Bournemouth University	Lesbian & Gay Foundation	SHA
Bow Group	Lesley de Meza Limited	Sheffield Centre for Independent Living, Partners for Inclusion, Sheffield Learning Disabilities Partnership Board & Sheffield Mental Health Partnership Board
Bowel Cancer UK	Lewes District Council	Sheffield City Council
Bradford LINk Care Quality working group	LGBTory The Conservative LGBT Group	Sheffield City Council and NHS Sheffield
Bradford Resource Centre and Community Statistics Project	Lighter life	Sheffield Hallam University - Public Health Hub
Braintree District Council	Lincolnshire County Council	Sheffield Local Involvement Network (LINk)
Breakthrough UK	Lincolnshire sports partnership	Sheffield Wellbeing Consortium
Breast Cancer Campaign	LINk in Cornwall	Sherwood Forest Hospitals
Breast Cancer Care	Link Lecturer East & North Herts NHS Trust	Shropshire CIEH Branch
Breastfeeding manifesto coalition	Liverpool Community Health NHS Trust	Shropshire County Primary Care Trust
Breckland Council	Liverpool Joint Health Unit	SignHealth
Brent Multi-Faith Forum	Living Street	Sitra
Brighton & Hove Citizens Advice Bureau	Local Government Association	Skills for Health

Brighton and Hove Breastfeeding Steering Group	Local Government Group	Slimming World
Brighton and Hove LINk	Local Pharmaceutical Committee	Smoke Free Cornwall
Bristol City Council	London Borough of Barking and Dagenham	Smoke Free Greater Manchester
Bristol Myers Squibb	London Borough of Brent	Smokefree Devon Alliance
Bristol Public Health , NHS Bristol	London Borough of Enfield	Smokefree NorthWest
Bristol Social Marketing Centre	London Borough of Havering & NHS Havering	Smokefree South West
British Acupuncture Council	London Borough of Hillingdon	Social Care Institute for Excellence
British American Tobacco	London Borough of Lewisham and NHS Lewisham	Society of Radiographers
British Association for Community Child Health	London Borough of Sutton	Solihull Local Involvement Network
British Association for Parenteral and Enteral Nutrition (BAPEN)	London Borough of Tower Hamlets	Solihull Metropolitan Borough Council
British Association for Sexual Health and HIV (BASHH)	London Borough of Tower Hamlets Health Scrutiny Panel	Solihull NHS Care Trust
Medical Foundation for AIDS and Sexual Health	London Climate Change Partnership	Somerset College
British HIV Association	London Councils	Somerset Community Health, NHS Somerset
National HIV Nurses Association	London Dental Public Health Consultants Group	Somerset Strategic Housing Officers Group
Terence Higgins Trust	London Forum of Pharmaceutical Committees	South Bucks District Council
Faculty of Sexual and Reproductive Healthcare	London Health Forum	South Cambridgeshire District Council
National AIDS Trust	London Infant Feeding Network	South Central Public Health Executive
Brook, the young people's sexual health charity	London Public Health Analysts Consultation Team	South Central Strategic Health Authority
British Cycling	London School of Hygiene and Tropical Medicine	South East Essex Locality of the Essex and Southend Local Involement Network
British Dental Association	London Sexual Health Commissioning Network	South East Strategic Leaders
British Dietetic Association	London Sexual Health Programme	South Essex Primary Care Trust Cluster
British Geriatrics Society	London Specialised Commissioning Group	South Hams District Council
British Heart Foundation	London Voluntary Service Council	South Kesteven District Council
British Medical Association	Long Term Conditions Delivery Support Team	South London and Maudsley NHS Foundation Trust
British Nutrition Foundation	Lords Cricket Ground	South Oxfordshire and Vale of White Horse District Councils
British Pregnancy Advisory Service	Lundbeck Limited	South Ribble Council
British Society of Gastroenterology	Macmillan Cancer Support	South Staffordshire Council Health Scrutiny Panel
British Specialist Nutrition Association	Making Every Adult Matter (MEAM)	South Staffordshire Local Pharmaceutical Committee
British Thoracic Society	Maldon District Council	South Staffordshire Primary Care Trust
Broadland Community Partnership	Manchester Local Medical Committee	South Tyneside Council
Bromsgrove District Council	Manchester Local Pharmaceutical Committee	South West England Public Health Specialty Registrars
Brunel Centre for Sport Health and Wellbeing	Manchester Partnership	South West Forum
Brunel University	Mansfield District Council	South West Office for Sexual Health
Buckinghamshire County Council	Marmot Review Team	South West Regional Public Health Groups
Bucks Sport (County Sport Partnership Buckinghamshire and Milton Keynes)	Medical Foundation for AIDS & Sexual Health	South Yorkshire Transport Plan Partnership
Bungay Medical Practice's Patient Participation Group	Medical Research Council , Economic and Social Research Council	Southampton Centre for Independent Living
Bupa	Medical Schools Council	Southend NHS
Burnley Borough Council	Medway NHS Foundation Trust	Southmead Hospital maternity department
Bury Council	Melton Community Partnership	Southport and Formby PBC Consortium
Calderdale Primary Care Trust	Mencap	Southwark Council

Cambridge and District Citizens Advice Bureau	MEND Central Limited	Southwark Health & Social Care
Cambridge City Council	Meningitis Research Foundation	Specialised Healthcare Alliance
Cambridge Older People's Reference Group	Meningitis Trust	Sport and Recreation Alliance
Cambridge Regional College (FE)	Men's Health Forum	Sport Cheshire
Cambridgeshire County Council	Mental Health Foundation	Sport Hampshire and Isle of Wight Advisory Board
Cambridgeshire Domestic Abuse Partnership	Mentor UK	Sporta
Cambridgeshire PCT	Merseyside Disability Federation	Sporting Equals
Camden PCT	Merseyside Network	SSAFA-Forces Help Kent
Campaign Company	MidSussex District Council	St Albans City and District Council
Campaign to End Loneliness	Milton Keynes Council	St Edmundsbury Borough Council
Cancer Research UK	Mind	St Mungo's
Cantral Lancashire Local Pharmaceutical Committee	Mindapples	St. Helens Council
Care & Repair England	Myzone	Stafford Borough Council
Care Quality Commission	National Association of British Market Authorities (NABMA)	Staffordshire Primary Care Trust
Carers Association in South Tyneside	Nacro and Action for Prisoners Families	Standing Commission on Carers
Carers Together	National Aids Trust (NAT)	Standing Together
Carers UK	National Association for Voluntary and Community Action	Stevenage Borough Council
Catch22	National Association of British Market Authorities	Stockport Managed Care
Central and Eastern Cheshire Primary Care Trust	National Childbirth Trust	Stockton Hels All
Central Lancashire Local Pharmaceutical Committee	National Children's Bureau	Stockton-on-Tees Health and Wellbeing Partnership Board
Central Lancashire Primary Care Trust	National Chlamydia Screening Programme	Stoke-on-Trent City Council
Central YMCA	National Heart Forum	Stoke-on-Trent Primary Care Trust
Centre for Action on Rape & Abuse	National Housing Federation	Stonewall
Centre for Mental Health	National Information Governance Board	Stratford on Avon District Council
Centre for the Advancement of Interprofessional Education	National Institute for Health and Clinical Excellence	StreetGames
Centre for Wellbeing and Quality of Life Bournemouth University	National LGB&T Partnership	Suffolk and Great Yarmouth Local Pharmaceutical Committee
Centrepoint	National Maternity Support Foundation (NMSF)	Suffolk Coastal & Waveney District Councils
NHS Plymouth	National Obesity Observatory	Suffolk Primary Care Trust
chances4change	National Osteoporosis Society	Suffolk Sport
Chartered Insititute of Housing	Naz Project London	Sunderland City Council
Chartered Institute of Environmental Health	National Children's Bureau - Sex Education Forum	Sunderland Local Pharmaceutical Committee
Chartered Institute of Library and Information Professionals	National Chlamydia screening advisory Group (NCSAG)	Sunderland LPC
Chartered Society for Radiological Protection	NCSP Board (National Chlamydia Screening Programme)	Sunderland Teaching Primary Care Trust
Chartered Society of Physiotherapy	New Forest District Council	Surrey Harm Reduction Outreach Team
Chelmsford Local Strategic Partnership	Newcastle City Council	Sustainable Development Commission
CHEM Trust (Chemicals, Health and Environment Monitoring Trust	Newcastle Primary Care Trust	Sustrans
Cheshire and Merseyside Tobacco Alliance	NHS Alliance	Tameside and Glossop Health Partnership
Cheshire East Council	NHS Ashton	Tameside CDRP
Cheshire West and Chester Council	NHS Ashton, Leigh and Wigan	Tameside Crime Disorder Reduction Partnership
Chichester District Council	NHS Barnsley	Target Ovarian Cancer
Child Accident Prevention Trust	NHS Barnsley / Barnsley Metropolitan Borough Council	Taunton Deane Borough Council

Child Growth Foundation and National Obesity Forum	NHS Berkshire West	TB alert
Child public health interest group	NHS Bolton	Teenage Cancer Trust
Childhood Bereavement Network	NHS Bournemouth and Poole	Tees Valley Sport
Children and Young People's Mental Health Coalition	NHS Bradford and Airedale	Teesside Positive Action Ltd
Chiltern District Council	NHS Brighton and Hove	Teignbridge District Council
Choices Advocacy	NHS Bristol	Telford and Wrekin council
Chorley Council	NHS Bury	Telford and Wrekin NHS
Christchurch Borough council	NHS Business Services Authority	Terrence Higgins Trust
Christian Science Committees on Publication	NHS Calderdale and Calderdale MBC's Health and Social Care Partnership Board	Thames Reach
Citizens Advice	NHS Cambridgeshire	Thames Valley Occupational Health Nurse (TVOHN) Group
City & Hackney Health & Social Care Forum	NHS Camden	The Academy of Medical Science
City of London Corporation	NHS Camden and London Borough of Camden	The Acorms Public Health Research Unit
City of Stoke-on-Trent	NHS Central Lancashire	Association of Directors of Adult Social Services
Civil Service Pensioners' Alliance	NHS City and Hackney	The Breastfeeding Network
Collaboration for Leadership in Applied Health Research - South Yorkshire (CLAHRC-SY)	NHS Commissioning Support for London	The British Association for the Study of Community Dentistry
Clapham Park West Residents Association	NHS confederation	The British Association for the Study of the Liver , The British Society of Gastroenterology , The British Liver Trust , The Hepatitis C Trust , Alcohol Concern
Colchester Borough Council	NHS Cornwall and Isles of Scilly	The British Lung Foundation
Colchester Borough Council and NHS North East Essex	NHS County Durham	The British Psychological Society
An alliance on hearing loss and deafness	NHS County Durham and Darlington	The Brunswick Centre
College of Occupational Therapists	NHS Coventry	The Campaign Company
Committee on the medical effects of air pollutants	NHS Derby City	The Cancer Prevention Education Society
Communication Trust	NHS Derbyshire County	The Care Forum Voluntary Sector Health and Social Care Network
Communities that Work	NHS Devon / Devon County Council	The Challenging Behaviour Foundation
Community Action on Health	NHS Doncaster and Doncaster Metropolitan Council	The Chartered Society of Physiotherapy
Community Base	NHS Dorset	The Cheshire and Merseyside Directors of Public Health
Community Links Bromley	NHS Ealing	The Cheshire and Warrington Health and Wellbeing Commission
Community Safety Team	NHS East Midlands	The Chief Environmental Health Officers' of Sussex
Concordia Health	NHS East of England	The Chief Fire Officers Association
Consultants in dental public health	NHS East Riding	The College of Emergency Medicine
Consumer Financial Education Body	NHS East Sussex Community Health Services	The College of Occupational Therapists
Copeland Borough Council	NHS East Sussex Downs and Weald PCT and NHS Hastings and Rother	The College of Optometrists
Core Cities	NHS Eastern and Coastal Kent	The Communication Council
Core Cities Chief Executive Network	NHS Great Yarmouth and Waveney	The Community & Voluntary Forum: Eastern Region
Cornwall and Isles of Scilly Local Pharmaceutical Committee	NHS Greenwich	The Crescent
Cornwall Council, NHS Cornwall and Isles of Scilly, and the Council of the Isles of Scilly	NHS Halton and St Helens	The Eddystone Trust

Cornwall Sports Partnership	NHS Hampshire	The Foundation for Genomics and Population Health
Cotswold District Council	NHS Haringey/London Borough of Haringey	The Greater Manchester Transport Walking Sub Group
Council for Healthcare Regulatory Excellence	NHS Hertfordshire	the Health & Wellbeing Shadow Board
Council of Deans of Health	NHS Hull & NHS East Riding	The Hepatitis C Trust
Council of the Isles of Scilly	NHS Information Centre for Health and Social Care	The HIV and Sexual Health Commissioners Group for England
County Councils Network	NHS Islington	The Home Adaptations Consortium
County Sports Partnership Network	NHS Kingston	The Housing Action Charity
Coventry City Council	NHS Kirklees and council	The Hyperactive Children's Support Group
CRIPACC (The Centre for Research in Primary and Community Care) University of Hertfordshire	NHS Lambeth / LB Lambeth	The Institute of Home Safety
Crisis	NHS Leicester City	The James Cook University Hospital
Crossroads Care and The Princess Royal Trust for Carers	NHS Leicestershire County & Rutland	The Kidney Alliance
CTC the UK's National Cyclists' Organisation	NHS Lewisham and the London Borough of Lewisham	The King's Fund
Cumbria - The Sport and Physical Activity Partnership	NHS Lincolnshire	The Lesbian & Gay Foundation
Cumbria Tobacco Alliance	NHS Lincolnshire and Lincolnshire County Council	The Liverpool City Region Safer Healthier Communities Board
Darlington Borough Council Health and Well Being Scrutiny Committee	NHS Luton	The London Assembly
Darlington Drug and Alcohol Action Team	NHS Medway and Medway Council	The National Child and Maternal Health Observatory (chiMat)
Daycare Trust	NHS Merton and Sutton	The National Council for Palliative Care
Defence Medical Services	NHS Milton Keynes, Milton Keynes PCT	The National LBG&T Partnership
Dental Public Health NHS Southampton, Hampshire, Isle of Wight and Portsmouth	NHS National Services Scotland	The Nationwide Foundation
Department of Health East Midlands	NHS Newham	The Norfolk Tobacco Control Alliance
Department of Public Health	NHS North Lancashire	the NSMC, Strategic Marketing joint Response, The Advisory Group on the Evaluation of Value for Money in Behavior Change
Department of Public Health and Primary Care, Eastern Region Public Health Observatory, the Medical Research Council Epidemiology Unit, The Public Health Genetics Foundation, GPRU and Centre for Health Services Research and the Centre for Diet and Activity Research (CEDAR).	NHS North of Tyne	The Nutrition Society
Dept Epidemiology and Public Health	NHS North West	The Pharmaceutical Services Negotiating Committee
Derbyshire County Council	NHS North Yorkshire & York	The Princes Trust
Derbyshire County Primary Care Trust	NHS North Yorkshire & York	The Roy Castle Lung Cancer Foundation
Derbyshire Dales & High Peak Local Strategic Partnership (DD&HP LSP)	NHS Northamptonshire	The Royal Pharmaceutical Society
Derbyshire Dales District Council	NHS Nottingham City	The School Food Trust
Derbyshire Public Health Directorate	NHS Nottinghamshire County	The Society for Radiological Protection
Derbyshire Sport	NHS Oxfordshire	The Stroke Association
Devon Local Pharmaceutical Committee	NHS Plus	The Whitehouse Consultancy Ltd
DH East Midlands	NHS Plymouth	Thurrock Council

DH third sector strategic partners	NHS Richmond	Tobacco Control
Diabetes UK	NHS Rotherham	Tobacco Free Lancashire
District Councils Network	NHS Salford	Tommy's (Let's talk baby)
Doncaster and Nottinghamshire Local Pharmaceutical Committees	NHS Salford Public Health Directorate	Tomorrows People
Doncaster CVS	NHS Sefton and Sefton District Council	Tonbridge and Malling Borough Council
Doncaster Metropolitan Borough Council	NHS Sheffield	Torbay Care Trust
Dorset Local Pharmaceutical Committee	NHS Sheffield and Sheffield City Council	Torbay Council
NHS Greenwich	NHS Somerset and Somerset County Council	Trade Sexual Health
Dream team	NHS South Birmingham	Trading Standards Institute
Drinking Water Inspector	NHS South Central	Trading Standards North West
DrugScope	NHS South East Coast	Trafford Council
Dudley District Council	NHS South Gloucestershire and South Gloucestershire council	Trafford Council - Overview and Scrutiny
Dudley Metropolitan Borough Council	NHS South West	Trafford Director of Public Health
Dudley Primary Care Trust	NHS Southampton	Transition Leicester
Durbin PLC	NHS Stoke on Trent	Transition Oversight Group - North West
Durham Council	NHS Suffolk	Tunbridge Wells Borough Council
Durham County Council	NHS Surrey and Surrey County Council	Tunstall Healthcare (UK) Ltd
Durham University	NHS Sustainable Development Unit	Turning Point
David Burnby & Associates	NHS Tameside & Glossop	UK Immunisation Programme
Ealing Hospital NHS Trust	NHS Telford and Wrekin	UK National Screening Committee
Early Childhood Forum	NHS Tower Hamlets & London Borough of Tower Hamlets	UK Public Health Association
East 7	NHS Trafford	UK Public Health Register
East Cambridgeshire District Council	NHS Walsall	UK Society for Behavioural Medicine (UKSBM)
East Kent Healthwalks	NHS Waltham Forest	UK Specialised Commissioning Group Public Health Network
East Lindsey District Council	NHS Wandsworth	UKDPC (UK Drug Policy Commission)
East London and the City Alliance	NHS Warwickshire and Warwickshire County Council	UNICEF UK
East Midlands Communities for Health Network	NHS West Sussex	Unison
East Midlands Council	NHS Western Cheshire	Unite the Union
East Midlands Infant Feeding Network	NHS Westminster	University College London, Department of Epidemiology and Public Health
East Midlands Public Health Intelligence Network	NHS Wiltshire and Wiltshire Council	University of Bristol Students for Public Health
East Midlands Public Health Observatory	NHS Wirrall	University of Cambridge
East of England Physical Activity Alliance	NHS Worcestershire	University of Cambridge Institute of Public Health
East of England, Evidence Adoption Centre	NHS Worcestershire and Worcestershire County Council	University of Leicester
East Riding and Hill LPC	NHS Yorkshire & Humber	University of Manchester
East Riding of Yorkshire Council	Noise Direct	Unseen University
East Sussex Seniors' Association	Norfolk Local Pharmaceutical Committee	UWE
Elders Council of Newcastle	Norfolk Tobacco Control Alliance	VCS Community Wellbeing Strategy Group
Elmbridge Borough Council	North East Derbyshire District Council	Vielife

Environmental Health Team, Merton Borough Council	North East Derbyshire District Council and Derbyshire County PCT	Vista (Royal Leicestershire, Rutland and Wycliffe Society for the Blind)
Environmental Protection UK	North East Lincolnshire Care Trust Plus/ North East Lincolnshire Council	Voluntary Action Camden
ERoSH, The Essential Role of Sheltered Housing	North East Public Protection Partnership	Voluntary Action Leicestershire: VCS Adult Health and Social Care Forum Leicester, Leicestershire & Rutland
Essex County Council	North East Region Public Health Specialty Registrars Group	Voluntary Action Westminster
Essex Local Pharmaceutical Committee	North East Sector Health and Social Care Forum	Voluntary and community sector in the West Midlands
European Federation of Organisations for Medical Physics	North Lincolnshire Council	Voluntary Sector North West
European Medicines Group	North Lincolnshire Primary Care Trust	Vonne
Expert Advisory group on AIDs	North Lincolnshire Wellbeing and Health Improvement Partnership	Wakefield Community Health Champions
Faculty of Homeless Healthcare	North Somerset Health and Wellbeing Partnership Board	Wakefield Local Pharmaceutical Committee
Faculty of Occupational Medicine	North Tyneside Council	Walsall Teaching Primary Care Trust
Faculty of Pharmaceutical Medicine	North Tyneside LINk	Wandsworth Borough Council
Faculty of Public Health	North Warwickshire Borough council	Warrington Borough Council/NHS Warrington
Faculty of Public Health National Board	North West Forum on Ageing	Warrington Partnership
Faculty of Public Health Specialty Registrars' Committee	North West Regional Youth Work Unit	Warrington Primary Care Trust
Faculty of Public Health, Royal Society for Public Health and UK Public Health Register	North Yorkshire County Council	Warwick District Council
Faculty of Sexual and Reproductive healthcare	North Yorkshire Local Pharmaceutical Committee	Weight Watchers UK
FaithAction	Northamptonshire County Council	Wellcome Trust
Family Action	Northamptonshire LINk	Welwyn Hatfield Borough Council
Family and Parenting Institute	North-East London Local Pharmaceutical Committee Office	Wessex Deanery
Federation of Irish Societies	Northern College	West and East Midlands and East of England School Travel Adviser Networks
Federation of Sports and Play Associations	Northern Housing Consortium	West Essex Primary Care Trust
Fellows' Associates	Northumberland Care Trust	West Midlands Fire Service
Fitness Industry Association	Northumberland County Council	West Midlands Public Health
Food Dudes	Northumberland LINk	West Midlands Regional Food and Nutrition Policy Group
Forest of Dean District Council & the Forest of Dean Local Strategic Partnership.	Nottingham City Council, Executive Director of Public Health for Nottingham City and One Nottingham	West Midlands Regulatory Services Partnership
Foyer Federation	Nottingham City Local Involvement Network	West Midlands Specialised Commissioning Team
FPA (Family Planning Association)	Nottinghamshire Fire & Rescue Service	West Midlands Tobacco Control Network
FRESH- Smoke Free North East	Notts County Link	West of England Consultants in Public Health
Freshwinds	Novartis Vaccines and Diagnostics Limited	West Oxfordshire District Council
Future North West	Novo Nordisk Ltd	West Yorkshire Health Protection Unit
Gateshead Council	NPC	Western Cheshire and Cheshire West and Chester
Gay and Lesbian Association of Doctors and Dentists	NSCST	Westminster City Council
Gay and Lesbian Youth in Calderdale	Nuffield Council on bioethics	Weymouth and Portland Borough Council
Gedling Borough Council	Nuffield Health	Weymouth GU Medicine
Genetic Alliance UK	Nuffield Trust	Whitworth Chemists Ltd
Girlguiding UK	Nuneaton and Bedworth Borough	WHO CollaboratingCentre for Healthy Cities and Urban Policy

GlaxoSmithKline	Nursing & Midwifery Council	Wiltshire Local Safeguarding Children Board
Gloucestershire County Council	NW London Consultants in Public Health	Winchester and Eastleigh Healthcare Trust
Gloucestershire LinK	Office for National Statistics	Winchester City Council/NHS Hampshrie
Gloucestershire NHS Public Health Team	Office of the Communication Champion	Wirral & Deeside Standing Conference of Women's Organisations
Gloucestershire Primary Care Trust	Oldham Council and NHS Oldham	Wirral Council
Greater London Authority	Oldham Link	Wirral Older People's Parliament
Greater Manchester Cervical Screening Group	One East Midlands and the Third Sector Health & Social Care Network	Wokingham Borough Council
Greater Manchester Health Protection Unit	Optical Confederation	Wolfson Institute of Preventative Medicine
Greater Manchester Voluntary Sector Infrastructure	Oxford City Council	Wolverhampton City Council
Greater Midlands Cancer Network Patient Partnership	Oxfordshire Primary Care Trust	Women’s Health and Equality Consortium
GreenSpace	British Dietetic Association, Paediatric Group	Women's Aid
Greenwich Primary Care Trust	PAGB	Women's Centre, ORH Trust
Grunenthal Ltd	Parenting UK	World Cancer Research Fund
Guild of Healthcare Pharmacists	Parkinson's UK	WSFF
Hackney Council	Parliamentary and Health Service Ombudsman	Wycombe District Council
Hackney Local Involvement Network	Patients and Friends of Athroposophic Medicine	Xenhealth Ltd
Haemochromatosis Society Merseyside and North West Support Group	Patients Association	York Drug and Alcohol Action Team
Halifax and District Irish Society	Pendle Partnership	Yorkshire & Humber Improvement Partnership
Halton and St Helens Primary Care Trust	Pentathlon GB	Yorkshire and Humber Dental Public Health Network
Halton Borough Council	Leeds Metropolitan University, Centre for Health Promotion Research	Yorkshire and Humber Public Health Observatory
Halve It	Peterborough Primary Care Trust	Yorkshire and Humber vaccinations and immunisations regional network
Hampshire and Isle of Wight Local Pharmaceutical Committee	Pfizer	Yorkshire and the Humber Postgraduate School of Public Health Specialty Registrars' Committee
Hampshire County Council	Pharmaceutical Services Negotiating Committee	Yorkshire Council
Haringey Council	Pharmacy Voice	Young Minds
	PHAST (Public Health Action Support Team)	Youth Access
		Youth Sport Trust
		Zacchaeus 2000 Trust

Annex B: Template used in assessment of suitability of indicator measures

Please read the "Guidance" page for full details of how to complete this template

EXAMPLE
COMPLETED BY EXAMPLE ONLY

SECTION 1 - ASSESSMENT AGAINST SIFTING CRITERIA

ASSIGN A RANKING (Y, P, N, ?) AGAINST EACH OF THE CRITERIA IN COLUMN C AND PROVIDE SUPPORTING COMMENTS IN COLUMN D

Measure of health outcome or factor closely correlated to a health outcome	Y	Measure of health outcome
Aligns with the government's direction for public health	P	This is in line with the government's direction for public health (justify why) but is not explicitly named in the PH national ambitions, NHS or local government mandates
Aligns with OGD priorities / strategies	Y	Aligns with DfE strategy to ...
Evidence-based interventions to support the measure	Y	Examples include... (not just restricted to public health interventions) E.g. Reducing smoking, increasing breastfeeding initiation
Amenable to public health intervention, e.g. by PH professionals, Local Authorities, PHE, NHS	Y	Reducing smoking is the most important factor in making progress against this measure
Major cause of premature mortality or avoidable ill health	Y	Large number of deaths each year (indicate numbers / proportion of all deaths)
Improvements in this measure will improve health-related quality of life (including mental health)	P	Some evidence that improvements will improve health-related quality of life, e.g. small study in the North West showed... (explain briefly)
Improvement in this measure will help reduce inequalities in health	Y	Indicate what groups experience inequalities relating to this measure - what sort of numbers are involved and how serious is the impact?
Improvement in this measure will help improve healthy life expectancy	?	Not sufficient evidence to make this judgement
Meaningful to, and likely to be perceived as important by, the public	Y	The public understand the principle of this measure and are see it as an important issue. [Give evidence of how you know this]
Meaningful to, and likely to be perceived as important by, local authorities	N	Local authorities do not understand the principle of this measure and therefore would struggle to understand how to make improvements
Existing system to collect data required to monitor the measure	Y	Indicate source of data, e.g. ONS mortality statistics
Statistically appropriate, fit for purpose* **NB. See checklist on guidance page to assess against this criterion and in the supporting comments please indicate which items on the checklist the measure did / did not satisfy**	P	Only satisfies two of the criteria on the checklist as data only available every 5 years so data not available annually **and** progress is not measurable from year to year

SECTION 2 - ADDITIONAL INFORMATION

PLEASE INDICATE WHICH OF THE FOLLOWING GEOGRAPHICAL AND INEQUALITIES / EQUALITIES BREAKDOWNS ARE / WILL BE AVAILABLE

Which geographical levels can this measure be disaggregated by? For each breakdown please indicate whether data is **available now / will be available by 2013 / feasible in future / not feasible / unsure**	
National level	Available now
Local Authority level	Available now but may be issues with small numbers
Clinical Commissioning Group	Feasible in future but may be issues with small numbers
Middle Super Output Area (MSOA)	Feasible in future but may be issues with small numbers
Lower Super Output Area (LSOA)	Not feasible

Which inequalities and equalities dimensions can this measure be disaggregated by? For each breakdown please indicate whether data is **available now / will be available by 2013 / feasible in future / not feasible / unsure**	
Socio-economic group	Available now
Area deprivation (or postcode)	Will be available by 2013
Age	Available now
Disability	Unsure
Ethnicity	Feasible in future
Gender	Available now
Religion	Not feasible
Sexual Orientation	Unsure

PLEASE INDICATE INDICATE UNDER WHICH DOMAIN THE MEASURE WOULD BE PRIMARILY CLASSIFIED

Would the measure be **primarily** classified under: - Health Improvement - Health Protection - Healthcare Public Health - Wider determinants of health	Health improvement

Annex 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, e.g. lower tier local authorities, 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 the Department has considered the impact of its introduction and that steps are taken to ensure that groups are not 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 LA level.

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 (e.g. Y*) indicates that although a breakdown is available, it should be treated with caution, e.g. may be issues with reliability of the data or the statistical validity of a particular breakdown

	Geographical		**Equalities strands (national level)**						**Inequalities (national level)**	
	National	Upper tier LA	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
Indicators corresponding to the overarching outcomes										

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier LA	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
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**
Domain 1: Improving the wider determinants of health										
1.1: Children in poverty	**Y**	**Y**	**P**	**Y**	**Y**	**N**	**N**	**N**	**N/A**	**N/A**
1.2: School readiness (Placeholder)	**P**	**P**	**Y**	**P**	**P**	**P**	**N**	**N**	**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**	**TBC**	**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**
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 / 1.9ii: *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	**Y**	**P**	**Y**	**N**	**N**	**Y**	**N**	**N**	**N**	**N**

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier LA	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
absence										
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**
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**
Domain 2: Health improvement										
2.1: Low birth weight of term babies	**Y**	**P**	**P**	**N**	**P**	**P**	**N**	**N**	**P**	**P**

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier LA	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
2.2: Breastfeeding	**Y**	**N**	**N**	**N**	**N**	**Y**	**N**	**N**	**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**	**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 well-being 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**
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	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier LA	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
a substance dependence issue who are previously not known to community treatment										
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**
2.20: Cancer screening coverage	**Y**	**P**	**Y**	**N**	**TBC**	**Y**	**N**	**N**	**TBC**	**P**
2.21i & 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**
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	**Y**	**N**	**P**	**N**	**N**	**N**	**N**	**N**	**N**	**N**

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier LA	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
eligible										
2.23: Self reported well-being (based on current measure of 7 item WEMWBS)	**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**
Domain 3: Health protection										
3.1: Air pollution	**Y**	**P***	**N**	**N**	**N**	**N**	**N**	**N**	**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 TB	**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**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**
Domain 4: Healthcare public health and preventing premature mortality										
4.1: Infant mortality	**Y**	**Y**	**P**	**N**	**Y**	**Y**	**N**	**N**	**Y**	**P**
4.2: Tooth decay in children aged 5 years	**Y**	**Y**	**Y**	**N**	**P**	**N**	**N**	**N**	**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**

	Geographical		Equalities strands (national level)						Inequalities (national level)	
	National	Upper tier LA	Age	Disability	Ethnicity	Gender	Religion or belief	Sexual orientation	Socioeconomic group	Area deprivation (or postcode)
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**
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**

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