



Department  
of Health

# Improving outcomes and supporting transparency

Part 2: Summary technical specifications of public  
health indicators

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Improving outcomes and supporting transparency

# Contents

Indicators corresponding to the overarching outcomes .....	7
0.1 Healthy life expectancy .....	7
0.2 Differences in life expectancy and healthy life expectancy between communities .....	9
Indicators corresponding to the public health domains .....	15
Domain 1: Improving the wider determinants of health .....	16
1.01 Children in low income families .....	16
1.02 School readiness .....	17
1.03 Pupil absence .....	18
1.04 First time entrants to the youth justice system .....	19
1.05 16-18 year olds not in education, employment or training .....	21
1.06 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation .....	23
1.07 Proportion of people in prison aged 18 or over who have a mental illness .....	27
1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services .....	28
1.09 Sickness absence rate .....	34
1.10 Killed and seriously injured casualties on England's roads .....	35
1.11 Domestic abuse .....	38
1.12 Violent crime (including sexual violence) .....	39
1.13 Levels of offending and re-offending .....	41
1.14 The percentage of the population affected by noise .....	43
1.15 Statutory homelessness .....	46
1.16 Utilisation of outdoor space for exercise / health reasons .....	47
1.17 Fuel poverty .....	48
1.18 Social isolation .....	50
Domain 2: Health improvement .....	53
2.01 Low birth weight of term babies .....	53
2.02 Breastfeeding .....	54

2.03 Smoking status at time of delivery .....	55
2.04 Under 18 conceptions .....	57
2.05 Child development at 2 – 2½ years .....	59
2.06 Child excess weight in 4-5 and 10-11 year olds.....	61
2.07 Hospital admissions caused by unintentional and deliberate injuries in under 25's .....	63
2.08 Emotional well-being of looked after children .....	64
2.09 Smoking prevalence – 15 year olds.....	65
2.10 Self-harm.....	68
2.11 Diet.....	69
2.12 Excess weight in adults .....	73
2.13 Proportion of physically active and inactive adults .....	74
2.14 Smoking prevalence – adults (over 18s).....	75
2.15 Drug and alcohol treatment completion and drug misuse deaths .....	77
2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison .....	80
2.17 Estimated diagnosis rate for people with diabetes mellitus .....	81
2.18 Alcohol-related admissions to hospital .....	83
2.19 Cancer diagnosed at stage 1 and 2.....	84
2.20 National screening programmes.....	86
2.22 Take up of the NHS Health Check programme.....	95
2.23 Self-reported well-being.....	97
2.24 Injuries due to falls in people aged 65 and over.....	99
<b>Domain 3: Health protection .....</b>	<b>101</b>
3.01 Fraction of mortality attributable to particulate air pollution .....	101
3.02 Chlamydia detection rate (15-24 year olds) .....	103
3.03 Population vaccination coverage .....	104
3.04 People presenting with HIV at a late stage of infection .....	112
3.05 Treatment completion for Tuberculosis (TB).....	114
3.06 Public sector organisations with a board approved sustainable development management plan .....	116
3.08 Antimicrobial Resistance.....	117
<b>Domain 4: Healthcare public health and preventing premature mortality .....</b>	<b>120</b>
4.01 Infant mortality.....	120

4.02 Proportion of five year old children free from dental decay .....	121
4.03 Mortality rate from causes considered preventable .....	122
4.04 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke).....	125
4.05 Under 75 mortality rate from cancer .....	127
4.06 Under 75 mortality rate from liver disease .....	129
4.07 Under 75 mortality rate from respiratory diseases .....	131
4.08 Mortality rate from a range of specified communicable diseases, including influenza.....	132
4.09 Excess under 75 mortality rate in adults with serious mental illness ....	133
4.10 Suicide rate .....	136
4.11 Emergency readmissions within 30 days of discharge from hospital ...	137
4.12 Preventable sight loss .....	138
4.13 Health-related quality of life for older people .....	141
4.14 Hip fractures in people aged 65 and over .....	142
4.15 Excess winter deaths .....	144
4.16 Estimated diagnosis rate for people with dementia.....	146

# Refresh of the Public Health Outcomes Framework (2015)

Following a consultation carried out between 3 September and 2 October 2015, it was decided that some existing indicators and sub-indicators would be revised, replaced or removed. This document sets out the technical specifications of the indicators in the revised framework. Details of the changes and the reasons behind them are in the government response document.<sup>1</sup>

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<sup>1</sup> Government response to the consultation Refreshing the Public Health Outcomes Framework (2015).

## Indicators corresponding to the overarching outcomes

The two indicators outlined below correspond to the overarching outcomes of:

1. Increased healthy life expectancy (corresponding indicator 0.1)
2. Reduced differences in life expectancy and healthy life expectancy between communities (corresponding indicator 0.2)

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

0.1 Healthy life expectancy	
Rationale	This indicator is an extremely important summary measure of mortality and morbidity in itself. It complements the supporting indicators by showing the overall trends in a major population health measure, setting the context in which local authorities can assess the other indicators and identify the drivers of healthy life expectancy.
Baseline period	2009-11
Indicator definition	<b>0.1i Healthy life expectancy at birth</b>  A measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. The prevalence of good health is derived from responses to a survey question on general health.  For a particular area and time period, it is an estimate of the

0.1 Healthy life expectancy	
	<p>average number of years a newborn baby would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period throughout his or her life.</p> <p>Figures are calculated from deaths from all causes, mid-year population estimates, and self-reported general health status, based on data aggregated over three year periods.</p> <p>The following additional sub-indicator provides context to the healthy life expectancy figures by providing information on the estimated length of life.</p> <p><b>0.1ii Life expectancy at birth</b></p> <p>A measure of the average number of years a person would expect to live based on contemporary mortality rates.</p> <p>For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life.</p> <p>Figures are calculated from deaths from all causes and mid-year population estimates, based on data aggregated over three year periods.</p> <p>Figures for both sub-indicators reflect prevalence of good health and/or mortality among those living in an area in each time period, rather than what will be experienced throughout life among those born in the area. The figures are not therefore the number of years a baby born in the area could actually expect to live, or live in good general health, both because the health prevalence and mortality rates of the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives.</p> <p>Each sub-indicator will be provided for males and females separately.</p>
Data source	<p>Office for National Statistics (ONS)</p> <p>Life expectancy data are based on death registrations and mid-</p>



0.1 Healthy life expectancy	
	<p>year population estimates.</p> <p>Healthy life expectancy data are based on life expectancy data and data on self-reported health status from the Annual Population Survey.</p> <p>In response to the question “How is your health in general; would you say it was...” responses “Very good” and “Good” are categorised as ‘Good’ health and “Fair”, “Bad” or “Very bad” as ‘Not Good’ health.</p>
Publication of source data	<p>ONS reports on healthy life expectancy using self-reported health data from the Annual Population Survey. Figures have been published for healthy life expectancy at birth for upper tier local authorities in England.</p> <p><a href="http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/healthy-life-expectancy-at-birth-for-upper-tier-local-authorities--england/index.html">http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/healthy-life-expectancy-at-birth-for-upper-tier-local-authorities--england/index.html</a></p> <p>ONS reports annually on life expectancy at birth for England as a whole and for English local authorities. Trend data on life expectancy at birth is published for 2000-02 onwards for upper tier LAs and 1991-93 onwards for lower tier LAs:</p> <p><a href="http://www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/index.html">http://www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/index.html</a></p>

0.2 Differences in life expectancy and healthy life expectancy between communities	
Rationale	<p>These are key high-level health inequalities outcomes and are core to the aims of the Department of Health. This is the only indicator in the set that is explicitly a health inequalities indicator. It will show health inequalities across England as a whole and within all local areas, enabling a focus on the small areas of deprivation that exist everywhere, as well as areas where the whole local authority area has comparatively poor average health status. It is also an extremely useful summary</p>

<b>0.2 Differences in life expectancy and healthy life expectancy between communities</b>	
	<p>measure of mortality and morbidity in itself; it shows the overall trends in two major population health measures as well as highlighting area-based health inequalities. Across the set, measures are based on both national and local deprivation deciles, reflecting the distribution of deprivation itself. These indicators will set the context within which local areas can assess the other indicators and determine priorities, by identifying the drivers of life expectancy and health expectancy, especially in areas where these are low.</p>
Baseline period	2009-2011, except 0.2vi: 2009-2013
Indicator definition	<p>Separate indicators will measure differences in life expectancy and healthy life expectancy, both within England as a whole and, where feasible, locally within local authorities. Each indicator will be produced for males and females separately.</p> <p><b><u>Life expectancy</u></b></p> <p><b>0.2i Slope index of inequality (SII) in life expectancy at birth based on national deprivation deciles of Lower Super Output Areas (LSOAs) within England</b></p> <p>This sub-indicator measures inequalities in life expectancy across England as a whole. Life expectancy at birth is calculated for each national deprivation decile and then the slope index of inequality (SII) is calculated based on these figures.</p> <p>Life expectancy at birth is a measure of the average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life.</p> <p><b>0.2ii Number of upper tier local authorities for which the local SII in life expectancy (as defined in 0.2.iii) has decreased</b></p> <p>This indicator is a summary measure of progress towards reducing health inequalities at local level across England. If health inequality gaps narrow consistently, we will see more local SII figures reducing than increasing. If there is no change</p>

0.2 Differences in life expectancy and healthy life expectancy between communities	
	<p>overall, we would expect to see half (75) the local authority SII's increasing and the other half decreasing, as they fluctuate slightly through random variation</p> <p><b>0.2iii SII in life expectancy at birth within each English upper and lower tier local authority, based on local deprivation deciles of LSOAs</b></p> <p>This sub-indicator measures inequalities in life expectancy within upper and lower tier local authorities. For each local authority, life expectancy at birth is calculated for each local deprivation decile within the local authority and then the SII is calculated based on these figures. (In some local authorities a meaningful life expectancy estimate cannot be calculated for every local deprivation decile because of very small populations or large uncertainty in the life expectancy value. In these cases, the SII in life expectancy will not be provided.)</p> <p><b>0.2iv Gap in life expectancy at birth between each local authority and England as a whole</b></p> <p>This local level sub-indicator provides context for the indicator of inequality in life expectancy within each English local authority (0.2iii) by giving the difference between life expectancy at birth in a whole local authority area and the England value for life expectancy at birth. This provides an indication of overall life expectancy in the local authority relative to the level for England, highlighting health inequalities between whole LA areas and England, and the need for areas with comparatively low average life expectancy to focus on their gap with England as well as any within-area inequalities.</p> <p><b>0.2vii SII in life expectancy at birth within each English region, based on regional deprivation deciles of LSOAs</b></p> <p>This sub-indicator measures inequalities in life expectancy within English regions. For each region, life expectancy at birth is calculated for each deprivation decile within the region and then the SII is calculated based on these figures.</p> <p><b><u>Healthy life expectancy</u></b></p> <p><b>0.2v SII in healthy life expectancy at birth based on national deprivation deciles of LSOAs within England</b></p>

<b>0.2 Differences in life expectancy and healthy life expectancy between communities</b>	
	<p>This sub-indicator measures inequalities in healthy life expectancy across England as a whole. Healthy life expectancy at birth is calculated for each national deprivation decile and then the slope index of inequality (SII) is calculated based on these figures.</p> <p>Healthy life expectancy at birth is a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. The prevalence of good health is derived from responses to a survey question on general health. For a particular area and time period, it is an estimate of the average number of years a newborn baby would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period throughout his or her life.</p> <p><b>0.2vi SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas</b></p> <p>This sub-indicator measures inequalities in healthy life expectancy within local authorities. Healthy life expectancy at birth is calculated for each middle super output area and then the slope index of inequality (SII) is calculated based on these figures.</p> <p>Healthy life expectancy is a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. The prevalence of good health is derived from responses to a question on general health in the 2011 Census. Healthy life expectancy is the average number of years a person might expect to live in “good” health in their lifetime.</p> <p><b>Data for 0.2 indicators</b></p> <p><u>Slope index of inequality</u></p> <p>The slope index of inequality (SII) is a measure of the social gradient in life expectancy or healthy life expectancy, i.e. how much life / healthy life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation in an area (England as a whole or individual local authorities) and summarises this in a single number, which represents the range in years of life / healthy life expectancy across the social gradient from most to least deprived, based on</p>

0.2 Differences in life expectancy and healthy life expectancy between communities	
	<p>a statistical analysis of the relationship between life / healthy life expectancy and deprivation across all deprivation deciles.</p> <p><u>National, regional and local deprivation deciles</u></p> <p>Deprivation deciles are formed by grouping together residents of Lower Super Output Areas (small areas with an average population of around 1,500), except for sub-indicator 0.2vi. For the two England level sub-indicators (0.2i and 0.2v) that use national deprivation deciles, all English LSOAs are ranked from most to least deprived. They are then divided into national deprivation deciles: ten groups with approximately equal numbers of LSOAs in each.</p> <p>For the local indicator on differences in life expectancy (0.2iii), LSOAs are ranked from most to least deprived within each upper and lower tier local authority. They are then divided into local deprivation deciles, which each contain approximately equal numbers of LSOAs. The same method is used to create regional deprivation deciles for indicator 0.2vii.</p> <p>Some local authorities do not contain the full range of national deprivation deciles, e.g. some LAs will not have any of their population resident in LSOAs which are classified as amongst the least or most deprived deciles in England. The slope index of inequality figure for England is not considered as a suitable benchmark with which to compare local authority and regional SII figures.</p> <p>For sub-indicator 0.2vi, Middle Super Output Areas (MSOAs) in each local authority were ranked in order of deprivation using overall IMD 2015 scores.</p> <p>For all the SII figures, except 0.2vi, deprivation has been defined using the overall Index of Multiple Deprivation 2010 scores. This allows examination of comparable trends in the SII over time. For sub-indicator 0.2vi, the overall Index of Multiple Deprivation 2015 score was used.</p>
Data source	<p>Underlying data for the calculation of these indicators are derived from:</p> <p>Office for National Statistics (ONS):</p> <ul style="list-style-type: none"> <li>• Life expectancy data are based on death registrations and mid-year population estimates</li> <li>• Healthy life expectancy data are based on life expectancy data and data on self-reported health status from the Annual</li> </ul>

0.2 Differences in life expectancy and healthy life expectancy between communities	
	<p>Population Survey</p> <p>Department for Communities and Local Government:</p> <ul style="list-style-type: none"> <li>• Index of Multiple Deprivation 2010</li> <li>• Index of Multiple Deprivation 2015</li> </ul>
Publication of source data	<p>ONS reports annually on life expectancy at birth for England as a whole and for English local authorities. Trend data on life expectancy at birth is published for 2000-02 onwards for upper tier LAs and 1991-93 onwards for lower tier LAs:  <a href="http://www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/index.html">http://www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/index.html</a></p> <p>ONS reports on healthy life expectancy by area deprivation using self-reported health data from the Annual Population Survey:  <a href="http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/inequality-in-healthy-life-expectancy-at-birth-by-national-deciles-of-area-deprivation--england/index.html">http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/inequality-in-healthy-life-expectancy-at-birth-by-national-deciles-of-area-deprivation--england/index.html</a>.</p> <p>ONS also published healthy life expectancy by MSOA using self-reported health data from the Census 2011:  <a href="http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-by-middle-layer-super-output-areas--england/index.html">http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-by-middle-layer-super-output-areas--england/index.html</a></p>

## Indicators corresponding to the public health domains

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

These indicators are grouped into **four domains**:

**DOMAIN 1. Improving the wider determinants of health**

**DOMAIN 2. Health improvement**

**DOMAIN 3. Health protection**

**DOMAIN 4. Healthcare public health and preventing premature mortality**

Indicators have been included as they cover the full spectrum of what we understand public health to be, and what we can realistically measure at the moment. We have been able to, and will continue to, clarify and expand the technical specifications to reflect ongoing development work.

# Domain 1: Improving the wider determinants of health

1.01 Children in low income families	
Rationale	<p>Children in low income families is an important issue for public health. Inclusion of this indicator emphasises its importance.</p> <p>There is evidence that children from low income families are more likely to suffer premature mortality and poor health outcomes as adults (see the Marmot Review, 2010). Reducing the numbers of children that are in low income families should improve these adult health outcomes and increase healthy life expectancy.</p>
Baseline period	2010
Indicator definition	<p><b>1.01i Children in low income families (all dependent children under 20)</b></p> <p><u>Numerator:</u> Number of all dependent children under the age of 20 living in families in receipt of Child Tax Credits (CTC) whose reported income is less than 60 per cent of the median income or in receipt of Income Support (IS) or (Income-Based) Job Seekers Allowance (JSA).</p> <p><u>Denominator:</u> Number of all dependent children under the age of 20 for whom Child Benefit was received in each local authority.</p> <p><b>1.01ii Children in low income families (under 16s)</b></p> <p>This indicator will be the same as the measure as reported in 1.01i except that a 'dependent child' is defined as an individual aged under 16 only.</p>
Data source	Data derived from tax credit data from HMRC and benefit data from DWP
Publication of source data	<p>Data is published by HMRC, in Personal Tax Credits Statistics: <a href="https://www.gov.uk/government/collections/personal-tax-credits-statistics">https://www.gov.uk/government/collections/personal-tax-credits-statistics</a></p>



1.02 School readiness	
Rationale	This is a key measure of early years development across a wide range of developmental areas. Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life.
Baseline period	1.02i: 2012/13 1.02ii: 2011/12
Indicator definition	<p><b>1.02i The percentage of children achieving a good level of development at the end of reception</b></p> <p>This rating is drawn from the Early Years Foundation Stage Profile (EYFSP). The EYFSP is the assessment carried out by teachers at the end of Reception and is used to inform plans for child development, informing Key Stage 1 teachers and parents about each child's development and needs. It can thus be seen as a measure of 'school readiness'. The EYFSP requires teachers to assess whether children are 'emerging, expected or exceeding' against 17 early learning goals in the EYFS.</p> <p>Children are defined as having reached a good level of development at the end of the EYFS if they achieve at least the expected level in:</p> <ul style="list-style-type: none"> <li>• the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and;</li> <li>• the early learning goals in the specific areas of mathematics and literacy.</li> </ul> <p><b>1.02ii The percentage of Year 1 pupils achieving the expected level in the phonics screening check</b></p> <p>Data from the phonics screening check is designed to show parents and Year 1 teachers whether pupils at the end of Year 1 have grasped the ability to decode words using phonics to an agreed standard or whether further intervention is required to meet this standard. Pupils are deemed to have met the required standard of phonic decoding if they scored 32 or more out of a possible 40 in the test.</p> <p>These indicators are presented for pupils eligible for free school meals (FSM) compared to all other pupils.</p>

1.02 School readiness	
Data source	<p><u>1.02i:</u> Department for Education: Early Years Foundation Stage Profile</p> <p><u>1.02ii:</u> Department for Education: Teacher Assessments</p> <p>Future development of this indicator may make use of the data generated through the Healthy Child Programme developmental review that takes place with all children at age 2 – 2½ years.</p>
Publication of source data	<p>Early Years Foundation Stage Profile attainment data is published by the Department for Education annually.</p> <p>Phonics screening check data, at national and local level, is also published by the Department for Education annually.</p> <p><b>Early Years Foundation Stage Profile statistical series:</b></p> <p><a href="https://www.gov.uk/government/organisations/department-for-education/series/statistics-early-years-foundation-stage-profile">https://www.gov.uk/government/organisations/department-for-education/series/statistics-early-years-foundation-stage-profile</a></p> <p><b>Phonics screening check statistical series:</b></p> <p><a href="https://www.gov.uk/government/organisations/department-for-education/series/statistics-phonics-check">https://www.gov.uk/government/organisations/department-for-education/series/statistics-phonics-check</a></p>

1.03 Pupil absence	
Rationale	<p>Parents of children of compulsory school age (aged 5 to 15 at the start of the school year) are required to ensure that they receive a suitable education by regular attendance at school or otherwise. Education attainment is influenced by both the quality of education they receive and their family socio-economic circumstances. Educational qualifications are determinant of an individual's labour market position, which in turn influences income, housing and other material resources. These are related to health and health inequalities.</p> <p>Improving attendance (i.e. tackling absenteeism) in schools is a crucial part of the Government's commitment to increasing social mobility and to ensuring every child can meet their potential. If we are to improve school attendance (reduce absence), then it is important that all services that work with young people talk to one another and agree local priorities. This indicator should help to achieve this.</p>

1.03 Pupil absence	
Baseline period	2010/11 (school year)
Indicator definition	<p><b>1.03 Percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence)</b></p> <p><u>Numerator</u>: The number of sessions missed due to overall absence</p> <p><u>Denominator</u>: The total number of possible sessions</p> <p>Based on state-funded primary and secondary schools (including maintained primary and secondary schools, city technology colleges and academies) and special schools. Data are based on the geographical location of the school.</p>
Data source	Department for Education, The School Census
Publication of source data	<p>Published by the Department for Education (DfE) at national and local authority level on a termly basis and at school level for the combined Autumn and Spring terms (4 half terms) and the End Year (5 half terms).</p> <p>Information on absence in special schools is published only annually.</p> <p><b>Pupil absence statistical series:</b></p> <p><a href="https://www.gov.uk/government/collections/statistics-pupil-absence">https://www.gov.uk/government/collections/statistics-pupil-absence</a></p>

1.04 First time entrants to the youth justice system	
Rationale	<p>Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children. This indicator is included to ensure that vulnerable children and young people (aged 10-17) at risk of offending, are included in mainstream planning and commissioning.</p> <p>Mapping relevant risk factors associated with youth crime, for</p>

1.04 First time entrants to the youth justice system	
	<p>example school absence and low educational attainment, can help inform local authority and NHS commissioning of evidence-based early intervention, therefore maximising the life chances of vulnerable children and improving outcomes for them. A lack of focus in this area could result in greater unmet health needs, increased health inequalities and potentially an increase in offending and re-offending rates, including new entrants to the system. The impact of incorporating these vulnerable children into mainstream commissioning also has the potential benefit of impacting on a young person's wider family now and in the future, particularly when they themselves may already be parents.</p>
Baseline period	2010
Indicator definition	<p><b>1.04 Rate of 10-17 year olds receiving their first youth caution<sup>2</sup> or conviction per 100,000 population</b></p> <p><u>Numerator</u>: Number of 10-17 year olds receiving their first , youth caution or conviction</p> <p><u>Denominator</u>: ONS mid-year population estimates, ages 10-17</p>
Data source	<p>Ministry of Justice (MoJ) criminal justice statistics dataset (based on data submitted by individual police forces, and extracts from court database administrative systems and from the Police National Computer)</p> <p>Figures for local authorities are estimates. Children are mapped to their local authority of residence using their home address or postcode recorded by the police on the Police National Computer. For those with no address recorded, a small proportion has been assumed to foreign postcodes. For the rest,</p>

<sup>2</sup> Since 8th April 2013 there have been a number of changes in out of court disposals. The previously known reprimand and warning disposal categories for juveniles have been replaced with a new out of court disposal: The Youth Caution for young offenders. The guidance is published at the link <http://www.justice.gov.uk/out-of-court-disposals>.

1.04 First time entrants to the youth justice system	
	a model based on the patterns of offenders dealt with by police stations will be used to allocate offenders to local authorities.
Publication of source data	<p>MoJ publish national (England and Wales) data and local authority data quarterly, in the Offending Histories tables of Criminal Justice Statistics in England and Wales:</p> <p><b>Latest data:</b></p> <p><a href="https://www.gov.uk/government/collections/criminal-justice-statistics-quarterly">https://www.gov.uk/government/collections/criminal-justice-statistics-quarterly</a></p>

1.05 16-18 year olds not in education, employment or training	
Rationale	<p>Young people who are not engaged in education, employment or training (NEET) are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. This indicator is included to encourage services to work together to support young people, particularly the most vulnerable, to engage in education, training and work.</p> <p>To support more young people to study and gain the skills and qualifications that lead to sustainable jobs and reduce the risk of young people becoming NEET, legislation was included in 2013 to raise the participation age as contained within the Education and Skills Act 2008. This required that from 2013 all young people remain in some form of education or training until the end of the academic year in which they turn 17. From 2015, this will rise to their 18th birthday. This means that pupils who left year 11 in summer 2013 need to continue in education or training for at least a further year until 27 June 2014 and pupils who started year 11 or below in September 2013 will need to continue until at least their 18th birthday.</p> <p>Statutory guidance:</p> <p><a href="https://www.gov.uk/government/publications/participation-of-young-people-education-employment-and-training">https://www.gov.uk/government/publications/participation-of-young-people-education-employment-and-training</a></p>

1.05 16-18 year olds not in education, employment or training	
Baseline period	2011
Indicator definition	<p><b>1.05 Percentage of 16-18 year olds not in education, employment or training (NEET)</b></p> <p><u>Numerator</u>: Estimated number of 16-18 year olds who are NEET</p> <p><u>Denominator</u>: Total number of 16-18 year olds known to the local authority whose activity is either NEET or EET.</p> <p>The NEET and EET figures above are adjusted to take account of those whose current activity is not known using an established adjustment factor.</p> <p>This indicator will use the average proportion of 16-18 year olds NEET between November and January each year.</p>
Data source	<p>Data are drawn from the Client Caseload Information System (CCIS) databases maintained by each local authority. These draw together information provided by schools, colleges, partner agencies and young people themselves and is made available on the Department for Education (DfE) website.</p> <p><i>Notes:</i></p> <ol style="list-style-type: none"> <li><i>National data on the proportion of 16-18 year olds NEET are published annually by DfE but these cannot be broken down to local authority level. DfE/BIS also publish a quarterly estimate of 16-24 year olds NEET drawn from the Labour Force Survey.</i></li> <li><i>The data from the client management systems maintained by local authorities made available by DfE are not directly comparable with the national figures published by DfE due to differences in definitions used, specifically:</i> <ul style="list-style-type: none"> <li><i>age is based on actual age rather than academic age</i></li> <li><i>the <u>numerator</u> excludes young people taking a formal gap year or in custody (these may be recorded as NEET in the national data)</i></li> <li><i>the data relate to those young people known to the local authority and whose current activity is known</i></li> </ul> </li> </ol>

1.05 16-18 year olds not in education, employment or training	
Publication of source data	<p>DfE publish local authority data annually:</p> <p><a href="https://www.gov.uk/government/publications/neet-data-by-local-authority-2012-16-to-18-year-olds-not-in-education-employment-or-training">https://www.gov.uk/government/publications/neet-data-by-local-authority-2012-16-to-18-year-olds-not-in-education-employment-or-training</a></p> <p>National level data on 16-18 year olds NEET are published by DfE but these data are not directly comparable with the data to be used for this indicator – see note in data source section.</p>

1.06 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation	
Rationale	<p>The indicator is intended to improve outcomes for adults with mental health problems in stable and appropriate accommodation by improving their safety and reducing their risk of social exclusion. Maintaining stable and appropriate accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care.</p>
Baseline period	2011/12
Indicator definition	<p><b>1.06i Percentage of all adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family</b></p> <p><i>This sub- indicator is shared with indicator 1G in the Adult Social Care Outcomes Framework.</i></p> <p><u>Numerator</u>: Number of working age (aged 18-64) learning disabled clients known to councils with adult social service responsibilities (CASSRs), as described in the denominator, who are living in their own home or with their family during the</p>

**1.06 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation**

financial year.

The numerator should include those living in their own home or with their family irrespective of whether they have had a review during the year, but the information would have to be captured within the current financial year.

Denominator: Number of working-age (aged 18-64) learning disabled clients known to CASSRs during the financial year.

This includes:

- those who are assessed or reviewed in the financial year and have received a service
- those who are assessed or reviewed in the financial year and have not received a service, and;
- those who should have been reviewed in the financial year but were not.

The definition of individuals 'known' to a council is currently restricted to those adults with a learning disability (with a primary client group of LD) who have been assessed or reviewed by the council during the year (irrespective of whether or not they receive a service) or who should have been reviewed but were not.

'Living on their own or with their family' is intended to describe arrangements where the individual has security of tenure in their usual accommodation, for instance because they own the residence or are part of a household whose head holds such security. This has the same definition as 'Living independently, with or without support' in sub-indicator 1.06ii (see below), however different wording is used to capture the emphasis on avoiding residential care homes.

Situations included within the scope of 'living on their own or with their family':

- Owner occupier or shared ownership scheme;
- Tenant (including local authority, arm's-length management organisation, registered social landlord, housing association);
- Tenant – private landlord;
- Settled mainstream housing with family/friends (including flat-sharing);
- Supported accommodation/supported lodgings/supported group home (i.e. accommodation supported by staff or resident caretaker);
- Adult Placement Scheme;
- Approved premises for offenders released from prison or under probation supervision (e.g. probation hostel);



**1.06 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation**

- Sheltered housing/extra care housing/other sheltered housing; and,
- Mobile accommodation for Gypsy/Roma and Traveller communities.

The following circumstances are not included within the scope of 'living on their own or with their family':

- Rough sleeper/squatting;
- Night shelter/emergency hostel/direct access hostel (temporary accommodation accepting self-referrals);
- Refuge;
- Placed in temporary accommodation by council (including homelessness resettlement);
- Staying with family/friends as a short-term guest;
- Acute/long-stay healthcare residential facility or hospital (e.g. NHS independent general hospital/clinic, long-stay hospital, specialist rehabilitation/recovery hospital);
- Registered care home
- Registered nursing home;
- Prison/Young Offenders Institution/detention centre; and,
- Other temporary accommodation.

**1.06ii Percentage of adults receiving secondary mental health services living independently at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting**

*This sub- indicator is shared with indicator 1H in the Adult Social Care Outcomes Framework*

Numerator: Number of adults aged 18-69 who are receiving secondary mental health services on the Care Programme Approach recorded as living independently (with or without support). The most recent record of whether or not the person is in settled accommodation during the financial year is used.

Denominator: Number of adults aged 18-69 who have received secondary mental health services and who were on the Care Programme Approach at any point during the financial year.

Adults 'in contact with secondary mental health services' is defined as those aged 18 to 69 who are receiving secondary

<b>1.06 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation</b>	
	<p>mental health services and who are on the Care Programme Approach (CPA).</p> <p>'Living independently, with or without support' refers to accommodation arrangements where the occupier has security of tenure or appropriate stability of residence in their usual accommodation in the medium- to long-term, or is part of a household whose head holds such security of tenure/residence. These accommodation arrangements are recorded as settled accommodation in the Mental Health Minimum Data Set (MHMDS). This has the same definition as 'Living on their own or with their family' in measure 1.6i (see above), however different wording is used to capture the emphasis on general independence.</p> <p>Accommodation arrangements that are precarious, or where the person has no or low security of tenure/residence in their usual accommodation and so may be required to leave at very short notice, are excluded from the definition of 'living independently, with or without support'. These accommodation arrangements are recorded as non-settled accommodation in the MHMDS.</p>
Data source	<p><u>1.06i</u>: Adult Social Care Combined Activity Return (ASC-CAR), the Health and Social Care Information Centre</p> <p><u>1.06ii</u>: Mental Health Minimum Dataset (MHMDS), the Health and Social Care Information Centre</p>
Publication of source data	<p>ASC-CAR data is reported annually by the Health and Social Care Information Centre.</p> <p><a href="http://www.hscic.gov.uk/social-care">http://www.hscic.gov.uk/social-care</a></p> <p>Measures from the Adult Social Care Outcomes Framework data is reported annually by the Health and Social Care Information Centre:</p> <p><a href="http://www.hscic.gov.uk/searchcatalogue?productid=18979">http://www.hscic.gov.uk/searchcatalogue?productid=18979</a></p>

<b>1.07 Proportion of people in prison aged 18 or over who have a mental illness</b>	
Rationale	<p>Prisoners experience significantly greater psychiatric morbidity than the general population. It has been estimated that over 90% of prisoners have at least one of five psychiatric disorders (psychosis; anxiety or depression; personality disorder; alcohol misuse; drug dependence).</p> <p>Prison can have a detrimental impact on the mental health of prisoners, and those with an existing mental illness in particular. Although for some individuals a custodial sentence will be necessary, it is widely acknowledged that the criminal justice system is not always the best place to manage the problems of less serious offenders where their offending is related to their mental illness.</p> <p>Lord Bradley's April 2009 review of mental health and learning disabilities within the criminal justice system, which recommended the current policy approach of liaison and diversion and early intervention, said that "there are now more people with mental health problems in prison than ever before. While public protection remains the priority...custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide'.</p>
Baseline period	To be decided
Indicator definition	<p><b>1.07 Proportion of people in prison aged 18 or over who have a mental illness</b></p> <p>The proposed definition for this indicator is outlined below.</p> <p><u>Numerator</u>: Number of people in prison aged 18 or over with an identified mental health condition</p> <p><u>Denominator</u>: Total number of prisoners aged 18 or over in prison</p>
Data source	The Health & Justice Indicators of Performance (HJIPs). [data not yet available]
Publication	This uses the new data source 'Health and Justice indicators of

### 1.07 Proportion of people in prison aged 18 or over who have a mental illness

of source data	performance', not yet published.
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### 1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services

Rationale	The 2006 evidence review "Is work good for your health and well-being" concluded that work was generally good for both physical and mental health and well-being. The strategy for public health takes a life course approach and this indicator provides a good indication of the impact of long-term illness on employment among those in the 'working well' life stage. It also provides a link to indicators in the NHS and Adult Social Care Outcomes Frameworks.
Baseline period	<u>1.8i</u> :2013/2014 <u>1.8ii/1.8iii/1.8iv</u> : 2011/12
Indicator definition	<p><b>1.08i Percentage of respondents in the Labour Force Survey (LFS) who have a long-term condition who are classed as employed using the International Labour Organisation (ILO) definition of employment, compared to the percentage of all respondents classed as employed</b></p> <p><i>This indicator is shared with indicator 2.2 in the NHS Outcomes Framework.</i></p> <p>In the Labour Force Survey (LFS), a long-term condition is defined as a physical or mental health conditions or illness lasting or expected to last more than a year. The survey asks:</p> <p>Q1 "Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?"</p> <p>Note that before April 2013 the question asked in the LFS was "Do you have any health problems or disabilities that you expect will last for more than a year?" (<a href="http://www.nomisweb.co.uk/articles/833.aspx">www.nomisweb.co.uk/articles/833.aspx</a>). It is advised that estimates published prior to the April 2013 to March 2014 period</p>

## 1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services

should not be treated as a time series due to these discontinuities.

The indicator is constructed as outlined below:

Numerator for employment rate of people with a long-term condition: Number of people with a health problem or disabilities that they expect will last for more than a year (based on response to Q1 of LFS) **and** who are in employment (either as an employee, self-employed, in government employment and training programmes or an unpaid family worker – ILO definition of basic economic activity) **and** are of working age (aged 16-64)

Numerator for employment rate of population as a whole: Number of people who are in employment (either as an employee, self-employed, in government employment and training programmes or an unpaid family worker – ILO definition of basic economic activity) **and** are of working age (aged 16-64)

Denominator for employment rate of people with a long-term condition: Number of people with a physical or mental health conditions or illness that they expect will last for more than a year (based on response to Q1 in LFS) **and** are of working age (aged 16-64)

Denominator for employment rate of population as a whole: Number of people who are of working age (aged 16-64)

The indicator is constructed by calculating the percentage points gap between the employment rate for those with a long-term condition and the population as a whole.

### 1.08ii Percentage of adults with a learning disability in paid employment, compared to the percentage of all respondents to the Labour Force Survey classed as employed

*This indicator is complementary to indicator 1E in the Adult Social Care Outcomes Framework, which measures the proportion of adults with a learning disability in paid employment.*

The indicator is constructed as outlined below:

### 1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services

Numerator for employment rate of adults with a learning disability: Number of working age (aged 18-64) learning disabled clients known to CASSRs who are in paid employment within the financial year. This includes:

- those who are assessed or reviewed in the financial year and have received a service
- those who are assessed or reviewed in the financial year and have not received a service, and;
- those who should have been reviewed in the financial year but were not.

Numerator for employment rate of population as a whole: Number of people responding to LFS who are in employment (either as an employee, self-employed, in government employment and training programmes or an unpaid family worker – ILO definition of basic economic activity) **and** are of working age (aged 16-64)

Denominator for employment rate of adults with a learning disability: Number of working-age (aged 18-64) learning disabled clients known to councils with adult social service responsibilities (CASSRs) during the financial year. This includes:

- those who are assessed or reviewed in the financial year and have received a service
- those who are assessed or reviewed in the financial year and have not received a service, and;
- those who should have been reviewed in the financial year but were not.

Denominator for employment rate of population as a whole: Number of people responding to LFS who are of working age (aged 16-64)

The indicator is constructed by calculating the percentage points gap between the employment rate for adults with a learning disability and the population as a whole.

Notes on the employment rate of adults with a learning disability:

- The definition of individuals 'known to the council' is restricted to those adults with a learning disability (with a primary client group of LD) who have been assessed or reviewed by the council during the year (irrespective of whether or not they receive a service) or who should have been reviewed but were not.

## 1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services

- The rate is focused on 'paid' employment, to be clear that voluntary work is to be excluded for the purposes of this measure. Paid employment includes working as a paid employee or self-employed (16 or more hours per week) or working as a paid employee or self-employed (up to 16 hours per week)
- Working age is defined as ages 18-64 because the data are collected through adult social care services, who are not responsible for the care of those aged 16 and 17 (and therefore individuals aged 16-17 are not captured in this measure).

### 1.08iii Percentage of adults in contact with secondary mental health services in paid employment, compared to the percentage of all respondents to the Labour Force Survey classed as employed

*This indicator is complementary to:*

- *Indicator 1F in the Adult Social Care Outcomes Framework, which measures the proportion of adults in contact with secondary mental health services in paid employment*
- *Indicator 2.5 in the NHS Outcomes Framework, which measures the percentage of respondents in the Labour Force Survey (LFS) who have a mental illness who are classed as employed compared to the percentage of all respondents classed as employed. [Note: this measure is not used in the PHOF as the sample size for LFS does not allow the calculation of robust local authority level figures for the employment rate of adults who have a mental illness]*

The indicator is constructed as outlined below:

Numerator for employment rate of adults in contact with secondary mental health services: Number of working age adults (aged 18-69) who are receiving secondary mental health services and who are on the Care Programme Approach recorded as being in employment during the financial year. The most recent record of employment status for the person during the financial year is used.

Numerator for employment rate of population as a whole:  
Number of people responding to LFS who are in employment

### 1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services

(either as an employee, self-employed, in government employment and training programmes or an unpaid family worker – ILO definition of basic economic activity) **and** are of working age (aged 16-64)

Denominator for employment rate of adults in contact with secondary mental health services: Number of working age adults (aged 18-69) who have received secondary mental health services and who were on the Care Programme Approach at any point during the financial year.

Denominator for employment rate of population as a whole: Number of people responding to LFS who are of working age (aged 16-64)

The indicator is constructed by calculating the percentage points gap between the employment rate for adults in contact with secondary mental health services and the population as a whole.

Notes on the employment rate of adults in contact with secondary mental health services:

- Adults 'in contact with secondary mental health services' is defined as those aged 18 to 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA).
- The measure is focused on 'paid' employment, to be clear that voluntary work is to be excluded for the purposes of this measure.
- Working age is defined as ages 18-69. This matches the age range for a measure that has been used historically and therefore maintains a time series.

#### 1.08iv Percentage of people aged 16-64 in employment (persons)

Numerator: Number of people who are in employment (either as an employee, self-employed, in government employment and training programmes or an unpaid family worker – ILO definition of basic economic activity) and are of working age (aged 16-64)

Denominator: Number of people responding to LFS who are of working age (aged 16-64)

To help interpretation of the sub- indicators (i) to (iii), the rate of employment for the general population aged 16-64 is being



1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	
	published as a new sub-indicator. This allows comparison of the percentage gap with the percentage of those employed in the general population. E.g. a gap of 10.8 percentage points for those with a long-term condition in relation to 69.0% of people in the general population employed. This also allows calculating the employment rate for those with a long-term condition e.g. 69% minus 10.8 = 58.2%.
Data source	<p><u>1.08i:</u> Annual Population Survey (APS), Office for National Statistics</p> <p><u>1.08ii:</u> Adult Social Care Combined Activity Return (ASC-CAR), the Health and Social Care Information Centre <b>and</b> Annual Population Survey (APS), Office for National Statistics</p> <p><u>1.08iii:</u> Mental Health Minimum Dataset (MHMDS), the Health and Social Care Information Centre <b>and</b> Annual Population Survey (APS), Office for National Statistics</p> <p>1.08iv: Annual Population Survey (APS), Office for National Statistics</p> <p>Note: The Annual Population Survey (APS) combines results from the Labour Force Survey (LFS) and the English, Welsh and Scottish LFS boosts. The increased sample size of the survey provides enhanced local authority and national estimates on key social and socio-economic variables.</p>
Publication of source data	<p>APS data is reported by the Office for National Statistics (ONS) on a quarterly basis</p> <p><a href="http://www.nomisweb.co.uk/">http://www.nomisweb.co.uk/</a></p> <p>ASC-CAR data is reported annually by the Health and Social Care Information Centre.</p> <p><a href="http://www.hscic.gov.uk/catalogue/PUB13187">http://www.hscic.gov.uk/catalogue/PUB13187</a></p> <p>Measures from the Adult Social Care Outcomes Framework data is reported annually by the Health and Social Care Information Centre:</p> <p><a href="http://www.hscic.gov.uk/searchcatalogue?productid=18979">http://www.hscic.gov.uk/searchcatalogue?productid=18979</a></p>

1.09 Sickness absence	
Rationale	<p>The independent review of sickness absence (published December 2011) was commissioned by government to help combat the 140 million days lost to sickness absence every year. The review provided an important analysis of the sickness absence system in the UK; of the impact of sickness absence on employers, the State and individuals; and of the factors which cause and prolong sickness. This is in line with the Government's strategy for public health, which adopts a life-course approach and includes a focus on the working-age population in the 'working well' stage to help people with health conditions to stay in or return to work.</p>
Baseline period	2009-11
Indicator definition	<p><i>Sub-indicator 1.09iii needs further development</i></p> <p><b>1.09i Percentage of employees who had at least one day off due to sickness absence in the previous week</b></p> <p><u>Numerator</u>: The weighted number of employees aged 16 and over who had at least one period of sickness absence in the previous week</p> <p><u>Denominator</u>: The weighted number of employees aged 16 and over who worked at least one day in the previous week</p> <p>A period of sickness absence is at least one day off work because of sickness or injury during an interviewee's reference week.</p> <p><b>1.09ii Percentage of working days lost due to sickness absence</b></p> <p><u>Numerator</u>: The weighted number of days lost in the previous week due to sickness absence</p> <p><u>Denominator</u>: The weighted total number of days due to be worked in the previous week by adults aged 16 and over</p>

1.09 Sickness absence	
	<p><b>1.09iii Rate of Fit Notes issued per quarter (TBC)</b></p> <p><u>Numerator</u>: Number of Electronic Fit Notes issued per quarter to those who are economically active</p> <p><u>Denominator</u>: The economically active population</p> <p>Definition of 1.09iii TBC - DH are working with DWP to explore whether the Electronic Fit Note data can be used to provide a useful measure</p>
Data source	<p><i>The data source needs further development for 1.09iii</i></p> <p><u>Data source for 1.09i and 1.09ii</u>: Labour Force Survey (ONS)</p> <p><u>Data source for 1.09iii</u>: Electronic Fit Note (E-med) data from HSCIC (TBC)</p>
Publication of source data	<p><u>1.09i and 1.09ii</u>: ONS publish sickness absence data at a national level; breakdowns by age and gender are also available. The latest figures can be found at:</p> <p><a href="http://www.ons.gov.uk/ons/rel/lmac/sickness-absence-in-the-labour-market/index.html">http://www.ons.gov.uk/ons/rel/lmac/sickness-absence-in-the-labour-market/index.html</a></p> <p><u>1.09iii</u>: Publication of Electronic Fit Note (E-med) data from HSCIC – data not yet available</p>

1.10 Killed and seriously injured casualties on England's roads	
Rationale	<p>Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups. For children and for men aged 20-64 years, mortality rates for motor vehicle traffic accidents are higher in lower socioeconomic groups.</p> <p>The vast majority of road traffic collisions are preventable and can be avoided through improved education, awareness, road infrastructure and vehicle safety. The public health strategy</p>

1.10 Killed and seriously injured casualties on England's roads	
	<p>"Healthy Lives, Healthy People" (2010) highlighted the need to reduce road injuries in children and address the 'strong social and regional variations'. Reports relating to the earlier cross-government "Staying Safe" strategy such as the "Staying Safe: Action Plan" (2008) and "Accident Prevention Amongst Children and Young People - A Priority Review" (2009) address child road safety issues in more detail.</p> <p>The Department for Transport's new "Strategic Framework for Road Safety" (May 2011) draws together and updates the wide-ranging issues that will need to be addressed to reduce road casualties. The strategy also drops over-arching national targets in favour of a new proposed "Road Safety Outcomes Framework".</p> <p>The need for safer roads is also linked to the recent public health strategy, and existing government-backed initiatives, to increase "active travel" and physical activity.</p>
Baseline period	2009-11
Indicator definition	<p><b>1.10 Number of people reported killed or seriously injured on the roads, all ages, per 100,000 resident population</b></p> <p><u>Numerator</u>: The number of people (all ages) reported killed or seriously injured on the roads</p> <p><u>Denominator</u>: ONS mid-year population estimate</p> <p>Based on casualties who incur an injury on the public highway (including footways) in which at least one road vehicle or a vehicle in collision with a pedestrian is involved and which becomes known to the police within 30 days of its occurrence. The vehicle need not be moving; accidents involving stationary vehicles and pedestrians or other road users are included. One accident may give rise to more than one casualty.</p> <p>This indicator includes only casualties who are fatally or seriously injured and these categories are defined as follows:</p> <ul style="list-style-type: none"> <li>• Fatal casualties are those who sustained injuries which caused death less than 30 days after the accident; confirmed suicides are excluded.</li> <li>• Seriously injured casualties are those who sustained an injury for which they are detained in hospital as an in-patient, or any</li> </ul>

1.10 Killed and seriously injured casualties on England's roads	
	<p>of the following injuries, whether or not they are admitted to hospital: fractures, concussion, internal injuries, crushings, burns (excluding friction burns), severe cuts and lacerations, severe general shock requiring medical treatment and injuries causing death 30 or more days after the accident.</p> <p>A casualty is recorded as seriously or slightly injured by the police on the basis of information available within a short time of the accident. This generally will not reflect the results of a medical examination, but may be influenced according to whether the casualty is hospitalised or not. Hospitalisation procedures will vary regionally.</p> <p>This indicator will use a 3 year average figure.</p>
Data source	<p>Most of the statistics are based on road accidents reported to the police (STATS19 system) and published by the Department for Transport (DfT).</p> <p>Note: Police data are not a complete record of all injury accidents; it is known that a significant proportion of non-fatal accidents are not reported. Further information can be found at: <a href="https://www.gov.uk/government/collections/road-accidents-and-safety-statistics">https://www.gov.uk/government/collections/road-accidents-and-safety-statistics</a></p>
Publication of source data	<p>Figures for single years at national and local authority level are published annually by DfT: <a href="https://www.gov.uk/government/collections/road-accidents-and-safety-statistics">https://www.gov.uk/government/collections/road-accidents-and-safety-statistics</a></p>

1.11 Domestic abuse	
Rationale	Tackling domestic abuse as a public health issue is vital for ensuring that some of the most vulnerable people in our society receive the support, understanding and treatment they deserve. The more we can focus in on interventions that are effective, the more we can treat victims and prevent future re-victimisation. It is also the government's strategic ambition, as set out in <i>Call to end violence against women and girls 2010</i> and successive action plans to do what it can to contribute to a cohesive and comprehensive response.
Baseline period	2010/11
Indicator definition	<p><b>1.11 Rate of domestic abuse incidents reported to the police, per 1,000 population</b></p> <p><u>Numerator</u>: the number of domestic abuse incidents reported to the police. Domestic abuse incidents are defined as any incidence of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 16 and over, who are or have been intimate partners or family members, regardless of gender or sexuality.</p> <p><u>Denominator</u>: ONS mid-year populations estimates, aged 16 and over.</p>
Data source	<p>Police Recorded Crime data – Office for National Statistics</p> <p>This data source is only available at police force area level and will serve as guidance for local authorities within a police force area. Discussions are on-going regarding the longer term refinement of this indicator. It is difficult to obtain reliable information on the extent of domestic abuse as there is a degree of under-reporting of these incidents. Changes in the level of domestic abuse incidents reported to the police are particularly likely to be affected by changes in recording practices. These kinds of changes may in part be due to greater encouragement by the police to victims to come forward and improvements in police recording, rather than an increase in the level of</p>

1.11 Domestic abuse	
	victimisation.
Publication of source data	<p>Domestic abuse incidents reported by the police are collected by the Home Office and published by the Office for National Statistics at police force area level.</p> <p>See Focus on Violent Crime and Sexual Offences - <a href="http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/index.html">http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/index.html</a></p>

1.12 Violent crime (including sexual violence)	
Rationale	<p>The inclusion of this indicator enables a focus on the interventions that are effective and evidence-based including a greater focus on prevention and treatment, which need to be considered alongside criminal justice measures for a balanced response to the issue. The NHS contribution to sexual assault services are a public health function. It is also the government's strategic ambition, as set out in <i>Call to end violence against women and girls 2010</i> and successive action plans to do what it can to contribute to a cohesive and comprehensive response.</p> <p>Public health services have an important role to play in tackling violence. Directors of Public Health, located within local authorities, will be tasked with looking widely at issues including crime reduction, violence prevention, responses to violence and reducing levels of reoffending, which can also prevent health inequalities.</p> <p>With the implementation of the Health and Social Care Bill, Directors of Public Health in local authorities have become responsible for the public health aspects of the promotion of community safety, violence prevention, responses to violence, and local initiatives to tackle social exclusion. These statutory changes took place on 1st April 2013.</p>
Baseline period	<p>1.12i: 2009/10-2011/12</p> <p>1.12ii: 2010/11</p> <p>1.12iii: 2010/11</p>

1.12 Violent crime (including sexual violence)	
Indicator definition	<p><b>1.12i Age-standardised rate of emergency hospital admissions for violence per 100,000 population</b></p> <p><u>Numerator</u>: Number of emergency hospital admissions for violence defined by external cause codes (ICD10 codes X85 to Y09) and emergency hospital admission codes for the resident population.</p> <p><u>Denominator</u>: ONS mid-year population estimates</p> <p><b>1.12ii Rate of violence against the person offences based on police recorded crime data, per 1,000 population</b></p> <p><u>Numerator</u>: Number of violence against the person offences</p> <p><u>Denominator</u>: ONS mid-year population estimates</p> <p><b>1.12iii Rate of sexual offences based on police recorded crime data, per 1,000 population</b></p> <p><u>Numerator</u>: Number of sexual offences excluding code 88E(Exposure and Voyeurism)</p> <p><u>Denominator</u>: ONS mid-year population estimates</p> <p>Note: Indicator 1.12i is based on emergency hospital admissions for a local area's resident population irrespective of the location of the incident whilst Indicators 1.12ii and 1.12iii are based on police recorded crime data for a local area irrespective of the home address of those involved in the violent offence. The definition of violence offences includes homicide.</p>
Data source	<p><u>1.12i</u>: Hospital Episode Statistics (HES) - Health and Social Care Information Centre (HSCIC). Office for National Statistics.</p> <p><u>1.12ii</u>: Police recorded crime, Home Office. Office for National Statistics (ONS)</p> <p><u>1.12iii</u>: Police recorded crime, Home Office. Office for National Statistics (ONS)</p> <p>It is difficult to obtain reliable information on the extent of sexual offences as there is a degree of under-reporting of these incidents. Changes in the level of police recorded sexual</p>



1.12 Violent crime (including sexual violence)	
	<p>offences over time are particularly likely to be affected by changes in recording practices. These kinds of changes may in part be due to greater encouragement by the police to victims to come forward and improvements in police recording, rather than an increase in the level of victimisation.</p>
Publication of source data	<p>Home Office publish police recorded crime annually at Police Force and Community Safety Partnership level:</p> <p><a href="https://www.gov.uk/government/statistics/police-recorded-crime-open-data-tables">https://www.gov.uk/government/statistics/police-recorded-crime-open-data-tables</a></p>

1.13 Levels of offending and re-offending	
Rationale	<p>Offending and re-offending levels are strongly associated with wider determinants of health and deprivation. Reducing offending and re-offending levels requires coordinated action on wider determinants across health and justice organisations. Reducing re-offending is a policy imperative shared by the Department of Health and the Ministry of Justice especially among young people.</p> <p>The PHOF indicator on reducing reoffending is a useful measure to guide coordinated action across health and justice commissioners and service providers on health-related drivers of criminogenic behaviour as well as being of interest to Health &amp; Wellbeing Boards and Community Safety Partnerships to provide evidence of impact of policy and practice locally.</p> <p>The indicator on first time offenders will provide a useful measure on progress on wider coordinated actions to reduce the numbers of individuals entering the Criminal Justice System for the first time.</p>
Baseline period	2010
Indicator definition	<p><b>1.13i Re-offending levels - The percentage of offenders who re-offend from a rolling 12 month cohort</b></p> <p><u>Numerator</u>: The number of offenders in the cohort who reoffend</p> <p><u>Denominator</u>: The number of offenders in the cohort</p>

1.13 Levels of offending and re-offending	
	<p><b>1.13ii Re-offending levels - The average number of re-offences committed per offender from a rolling 12 month cohort</b></p> <p><u>Numerator</u>: The number of re-offences committed</p> <p><u>Denominator</u>: The number of offenders in the cohort</p> <p>Cohort: All offenders in any one year who received a caution (for adults), a final warning or reprimand (for juveniles), a non-custodial conviction or were discharged from custody.</p> <p>Adults who test positive for Class A drugs alone (without receiving conviction or a caution) are not included in the dataset.</p> <p>A proven re-offence is defined as any offence committed in a one year follow-up period and receiving a court conviction, caution, reprimand or warning in the one year follow up or a further six months waiting period.</p> <p>Waiting period: This is the additional time beyond the follow up period to allow for offences committed towards the end of the follow up period to be proved by a court conviction, caution, reprimand or final warning.</p> <p><b>1.13iii- First time offenders- The number of first time entrants to the criminal justice system as a rate per 100,000 of the population</b></p> <p><u>Numerator</u>: Total number of offenders recorded as having received their first conviction, caution or youth caution.</p> <p><u>Denominator</u>: Population has been based on mid-year population estimates for each age group supplied by the Office for National Statistics. The previous year's estimate has been used for calculating the rate in the subsequent year.</p>
Data source	<p>Ministry of Justice (MoJ) dataset (cohort of offenders identified from police, probation and prison records; offending assessed via Police National Computer).</p> <p>ONS mid-year population estimates.</p>
Publication of source data	<p>1.13i and 1.13ii: Published by MoJ at national and local authority level every quarter.</p> <p><a href="https://www.gov.uk/government/collections/proven-reoffending-statistics">https://www.gov.uk/government/collections/proven-reoffending-statistics</a></p> <p>1.13iii: Provided directly by MoJ.</p>

### 1.13 Levels of offending and re-offending

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### 1.14 The percentage of the population affected by noise

Rationale	<p>There are a number of direct and indirect links between exposure to noise and health outcomes such as stress, heart attacks and other health issues. Furthermore, there is clear evidence that exposure to noise is a key determinant of quality of life and well-being. Complaints about noise are the largest single cause of complaint to most local authorities.</p> <p>The Government's policy on noise is set out in the Noise Policy Statement for England [1] (NPSE). The policy's long term vision is to promote good health and a good quality of life (well-being) through the effective management of noise in the context of Government policy on sustainable development [2]. Within this context and through the effective management and control of environmental, neighbour and neighbourhood noise, the policy aims to:</p> <ul style="list-style-type: none"> <li>• avoid significant adverse impacts on health and quality of life;</li> <li>• mitigate and minimise adverse impacts on health and quality of life; and</li> <li>• where possible, contribute to the improvement of health and quality of life.</li> </ul> <p>The Natural Environment White Paper published in June 2011, reiterated the Government's commitment to deliver the Noise Policy Statement for England. The paper also highlights that for many people, a sense of tranquillity contributes to their enjoyment of the natural environment. The Government plans to work with local authorities to establish mechanisms for formally identifying and protecting urban Quiet Areas, so that people living in cities can benefit from access to areas of relative quiet for relaxation and contemplation [3].</p> <p>In 2013, in order to inform the delivery of the Noise Policy Statement for England (NPSE), DEFRA carried out a piece of work to examine the effectiveness of policy measures since 1960 in reducing the impact of the noise problem that they were intended to address. One of the focuses of this was noise legislation, and one of the conclusions it draws specifically from noise complaint data is that reported public dissatisfaction with noise as expressed by complaints has risen rapidly since the</p>
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1.14 The percentage of the population affected by noise	
	<p>introduction of the legislation in the 1960's, and complaints of domestic origin now predominate. While the rate may have levelled-off in the last ten years they continue to run at relatively high levels and have not fallen [4].</p> <p>[1] DEFRA, Noise Policy Statement for England (NPSE) [online]. March 2010. Available from <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/69533/pb13750-noise-policy.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/69533/pb13750-noise-policy.pdf</a></p> <p>[2] Department for Environment, Food and Rural Affairs (DEFRA). 2010 to 2015 government policy: environmental quality: Noise Policy Statement for England [Online]. 2015 [cited June 2015]. Available from URL: <a href="https://www.gov.uk/government/publications/2010-to-2015-government-policy-environmental-quality/2010-to-2015-government-policy-environmental-quality#appendix-8-managing-noise-and-other-nuisances-in-the-local-environment">https://www.gov.uk/government/publications/2010-to-2015-government-policy-environmental-quality/2010-to-2015-government-policy-environmental-quality#appendix-8-managing-noise-and-other-nuisances-in-the-local-environment</a></p> <p>[3] HM Government. Natural Environment White Paper - The Natural Choice: securing the value of nature [Online]. June 2011 [cited September 2012]. Available from URL: <a href="http://www.defra.gov.uk/environment/natural/whitepaper/">http://www.defra.gov.uk/environment/natural/whitepaper/</a></p> <p>4 - Department for Environment, Food and Rural Affairs (DEFRA). An investigation into the effect of historic noise policy interventions [Online]. 23/08/2013 [cited September 2014]. Available from URL: <a href="http://randd.defra.gov.uk/Default.aspx?Menu=Menu&amp;Module=More&amp;Location=None&amp;ProjectID=18090&amp;FromSearch=Y&amp;Publisher=1&amp;Search">http://randd.defra.gov.uk/Default.aspx?Menu=Menu&amp;Module=More&amp;Location=None&amp;ProjectID=18090&amp;FromSearch=Y&amp;Publisher=1&amp;Search</a></p>
Baseline period	<p><u>1.14i</u>: 2010/11</p> <p><u>1.14ii</u>: 2011</p> <p><u>1.14iii</u>: 2011</p>
Indicator definition	<p><b>1.14i Number of complaints per year per local authority about noise per thousand population (according to statistics collected by CIEH)</b></p> <p>Data presented are a combination of actual values and extrapolated data. The data collected by the Chartered Institute of Environmental Health (CIEH) are currently the result of voluntary submissions from local authorities. However, for those local authorities not supplying data an estimate has been made based on their submissions in previous years, the type of authority (i.e. rural / semi-rural or urban) and the trend in complaint numbers for authorities of the same type for which complete data are available.</p>

1.14 The percentage of the population affected by noise	
	<p>Not all complaints about noise are made to the local authority so this may be an underestimate of the actual number of complaints made about noise. Some complaints are made directly to the perceived source of the noise e.g. Network Rail, Airports and Highways Authorities and to other regulators, e.g. the Environment Agency.</p> <p><b>1.14ii The proportion of the population exposed to road and rail transport noise of 65 dB(A) or more, LAeq,16h per local authority (16h is the period 0700 – 2300)</b></p> <p>Noise exposure determined by strategic noise mapping using national calculation methods and input data supplied from the relevant authorities. The results are overlaid on a residential population dataset to determine number of people exposed per authority.</p> <p><b>1.14iii The proportion of the population exposed to road and rail transport noise of 55 dB(A) or more, Lnight (LAeq,8h) per local authority (8h is the period 2300 – 0700)</b></p> <p>Noise exposure determined by strategic noise mapping using national calculation methods and input data supplied from the relevant authorities. The results are overlaid on a residential population dataset to determine number of people exposed per authority.</p>
Data source	<p><u>1.14i</u>: Data collated by CIEH on number of noise complaints. Extrapolation determined by DEFRA in association with CIEH.</p> <p><u>1.14ii and 1.14iii</u>: Data generated by DEFRA on exposure to road and rail transport noise</p> <p>Note: Data for 1.14ii and 1.14iii are currently comprehensively generated only every 5 years.</p>
Publication of source data	<p>Information on complaints made about noise is available at national level on the CIEH website:  <a href="http://noisestats.cieh.org/About/">http://noisestats.cieh.org/About/</a></p> <p>Data on exposure to road and rail traffic noise at agglomeration level is available at:  <a href="http://services.defra.gov.uk/wps/portal/noise">http://services.defra.gov.uk/wps/portal/noise</a></p>

<b>1.15 Statutory homelessness</b>	
Rationale	<p>Homelessness is associated with severe poverty and is a social determinant of health. It is also associated with adverse health, education and social outcomes, particularly for children. To be deemed statutorily homeless a household must have become unintentionally homeless and must be considered to be in priority need. As such, statutorily homeless households contain some of the most vulnerable and needy members of our communities. Preventing and tackling homelessness requires sustained and joined-up interventions by central and local government, health and social care and the voluntary sector.</p> <p>The Public Health Outcomes Framework includes an indicator of homelessness in two parts. Both parts are used by ministers and officials in the DCLG in the formulation and monitoring of policy, the allocation of resources, performance monitoring and to support bids for funding from the Treasury.</p> <p>The first part of the indicator (eligible homeless people not in priority need per thousand households) demonstrates the number of households that have presented themselves to their local authority but under homelessness legislation have been deemed to be not in priority need. The majority of the people that fall under this cohort are single homeless people.</p> <p>The second part of the PHOF indicator (number of households in temporary accommodation per thousand households) is a Department for Communities and Local Government (DCLG) departmental impact indicator. These data demonstrate the number of homeless households in temporary accommodation awaiting a settled home.</p> <p>Households and individuals that are eligible but not in priority need or are in temporary accommodation can have greater public health needs than the population as a whole.</p>
Baseline period	<p>1.5i: 2010/11</p> <p>1.5ii: 2010/11</p>
Indicator	<b>1.15i Eligible homeless people not in priority need.</b>

1.15 Statutory homelessness	
definition	<p><u>Numerator</u>: Count of households who are eligible homeless people but deemed to be not in priority need under part VII of the Housing Act 1996 or part III of the Housing Act 1985. People who fall under these criteria must still be provided with advice and assistance in securing their own accommodation.</p> <p><u>Denominator</u>: Number of households, rounded, latest projections for relevant year.</p> <p><b>1.15ii Households in temporary accommodation (per thousand households)</b></p> <p><u>Numerator</u>: Count of households who are living in temporary accommodation provided under the homelessness legislation.</p> <p><u>Denominator</u>: Total number of households (thousands), mid-year projection</p>
Data source	<p>P1E-Local Authority returns, DCLG</p> <p>Mid-year projection of the number of households, DCLG</p>
Publication of source data	<p>Homelessness statistics are published by DCLG quarterly at England, region, and local authority level:</p> <p><b>Live tables:</b></p> <p><a href="https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness">https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness</a></p>

1.16 Utilisation of outdoor space for exercise / health reasons	
Rationale	<p>Inclusion of this indicator is recognition of the significance of accessible outdoor space as a wider determinant of public health. There is strong evidence to suggest that outdoor spaces have a beneficial impact on physical and mental well-being and cognitive function through both physical access and use.</p>
Baseline period	<p>March 2009 - February 2012</p>

1.16 Utilisation of outdoor space for exercise / health reasons	
Indicator definition	<p><b>1.16 Percentage of people using outdoor space for exercise / health reasons</b></p> <p><u>Numerator</u>: The weighted estimate of the proportion of residents in each area taking a visit to the natural environment for health or exercise purposes over the previous seven days.</p> <p>Time spent "out of doors" is e.g. in open spaces in and around towns and cities, including parks, canals and nature areas; the coast and beaches; and the countryside including farmland, woodland, hills and rivers.</p> <p>This could be anything from a few minutes to all day. It may include time spent close to home or workplace, further afield or while on holiday in England. However this does not include:</p> <ul style="list-style-type: none"> <li>• routine shopping trips or;</li> <li>• time spent in own garden</li> </ul> <p><u>Denominator</u>: Weighted number of respondents to survey</p>
Data source	<p>Monitor of Engagement with the Natural Environment (MENE) survey</p> <p>Data is fully available at England and regional level. Upper tier local authority level data have been generated by modifying the survey weighting.</p>
Publication of source data	<p>Results from the MENE survey (annual report and monthly updates) are published by Natural England:</p> <p><a href="http://www.naturalengland.org.uk/ourwork/research/mene.aspx#p_hof">http://www.naturalengland.org.uk/ourwork/research/mene.aspx#p_hof</a></p>

1.17 Fuel poverty	
Rationale	<p>There is compelling evidence that the drivers of fuel poverty (low income, poor energy efficiency and energy prices) are strongly linked to living at low temperatures (Wilkinson et al 2001) and the recent Marmot Review Team report showed that low temperatures are strongly linked to a range of negative health outcomes. Media coverage of independent Fuel Poverty Review interim report suggested that a conservative estimate of the number of excess winter deaths caused by fuel poverty would be 1 in 10; this equates to 2,700 people per year, more than die</p>



1.17 Fuel poverty	
	on the roads each year.
Baseline period	2011
Indicator definition	<p><b>1.17 The percentage of households estimated to be fuel poor</b></p> <p>At the spending review in October 2010, the Government announced that it would commission an independent review to consider the current fuel poverty target and definition. In March 2012, Professor Hills published the final report of his independent review of fuel poverty, making several recommendations for how fuel poverty should be measured. Professor Hills proposed a new measure: the Low Income High Cost (LIHC) indicator.</p> <p>Under the "Low Income, High Cost" measure, households are considered to be fuel poor where:</p> <ol style="list-style-type: none"> <li>1 - They have required fuel costs that are above average (the national median level)</li> <li>2 - Were they to spend that amount, they would be left with a residual income below the official fuel poverty line.</li> </ol>
Data source	<p>Data for a measure based on the "Low Income, High Cost" definition of fuel poverty is available from the Department for Energy and Climate Change (DECC).</p> <p>Data is available at national and regional level, as well as a number of sub-regional geographies including LSOA, Local Authority and parliamentary constituency level.</p>
Publication of source data	<p>Figures on number of households in fuel poverty are published annually by DECC.</p> <p><b>Fuel Poverty Statistics:</b></p> <p><a href="https://www.gov.uk/government/organisations/department-of-energy-climate-change/series/fuel-poverty-statistics">https://www.gov.uk/government/organisations/department-of-energy-climate-change/series/fuel-poverty-statistics</a></p> <p><b>Sub-regional Fuel Poverty Statistics:</b></p> <p><a href="https://www.gov.uk/government/organisations/department-of-energy-climate-change/series/fuel-poverty-sub-regional-statistics">https://www.gov.uk/government/organisations/department-of-energy-climate-change/series/fuel-poverty-sub-regional-statistics</a></p>

1.18 Social isolation	
Rationale	<p>There is a clear link between loneliness and poor mental and physical health. A key element of the Government's vision for social care, set out in the Care and Support White Paper, is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to friends and family. The White Paper sets out steps to support these aims, and makes a commitment to develop, with local government, suitable measures of loneliness and isolation for inclusion in the Adult Social Care Outcomes Framework (ASCOF) and the Public Health Outcomes Framework (PHOF).</p> <p>This indicator will focus on social care users and carers, rather than the broader population. However, the problems of loneliness and social isolation are not limited to these groups, and all parts of the health and care system have a role to play in preventing and reducing social isolation and loneliness in the broader population. Whilst the Department understands the importance of addressing loneliness to improve public health, it will not be feasible to develop a robust local level measure of loneliness in the lifetime of the current PHOF. However, tackling loneliness and social isolation remains a priority for the Department and we remain interested in exploring more widely how the issue can be measured in the general population in a way that will support local authorities. We will also pursue more direct approaches, such as promotion of the loneliness toolkit and making funding available to local organisations that are tackling loneliness in our communities. In addition, the existing indicator will be used by local authorities to ensure they are addressing this issue at a local level and targeting interventions and services to those who are most in need.</p> <p><i>Note: In January 2012 this indicator 1.18 was a placeholder measure entitled "Social Connectedness". It has since been refined to be focused specifically on levels of social isolation (using levels of social contact as a proxy), in particular to align with the Adult Social Care Outcomes Framework, with which the indicator is shared. The refined indicator will assist local authorities in focusing on some of the most vulnerable people in their communities.</i></p>
Baseline period	<p>1.18i: 2010/11</p> <p>1.18ii: 2012/13</p>

1.18 Social isolation	
Indicator definition	<p>This indicator covers users of social care and carers based on a question in the Adult Social Care Survey and the Carers Survey.</p> <p><b>1.18i Percentage of adults social care users who have as much social contact as they would like</b></p> <p>This indicator is presented as the percentage of respondents who answered A) to question 8a from the Adult Social Care Survey:</p> <p>“Thinking about how much contact you’ve had with people you like, which of the following statements best describes your situation?</p> <ul style="list-style-type: none"> <li>• A) I have as much social contact as I want with people I like</li> <li>• B) I have adequate social contact with people</li> <li>• C) I have some social contact with people, but not enough</li> <li>• D) I have little social contact with people and feel socially isolated”</li> </ul> <p><b>1.18ii Percentage of carers who have as much social contact as they would like (TBC)</b></p> <p>This second indicator is presented as the percentage of respondents who answered A) to question 11 from the Carer’s survey: “By thinking about social contact you’ve had with people you like, which statement best describes your present social situation?</p> <ul style="list-style-type: none"> <li>• A) I have as much social contact as I want with people I like</li> <li>• B) I have some social contact with people but not enough</li> <li>• C) I have little social contact and I feel socially isolated”</li> </ul> <p><i>This indicator is shared with indicator 1I in the Adult Social Care Outcomes Framework</i></p>
Data source	Adult Social Care Survey (annually) and Carers Survey (biennially from 2012/13 onwards)
Publication	The current indicator is based on data from the Adult Social Care Survey, published by HSCIC:

1.18 Social isolation	
of source data	<a href="http://www.hscic.gov.uk/catalogue/PUB12630">http://www.hscic.gov.uk/catalogue/PUB12630</a>

## Domain 2: Health improvement

2.01 Low birth weight of term babies	
Rationale	<p>Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low birth weight births could indicate lifestyle issues of the mothers and/or issues with the maternity services.</p> <p>This indicator is in line with the Government's direction for public health on starting well through early intervention and prevention. It has also been included in the DH Business Plan within the context of addressing issues of premature mortality, avoidable ill health, and inequalities in health, particularly in relation to child poverty (see indicator 1.1).</p>
Baseline period	2010
Indicator definition	<p><b>2.01 Percentage of all live births at term with low birth weight</b></p> <p><u>Numerator</u>: Number of live births at term (<math>\geq 37</math> gestation weeks) with low birth weight (<math>&lt;2500\text{g}</math>)</p> <p><u>Denominator</u>: Number of live births at term (<math>\geq 37</math> gestation weeks) with recorded birthweight</p>
Data source	Office for National Statistics (ONS)
Publication of source data	<p>ONS publish data at national level, but there is currently a reporting time lag of 21 months:</p> <p><a href="http://www.ons.gov.uk/ons/rel/child-health/gestation-specific-infant-mortality-in-england-and-wales/index.html">http://www.ons.gov.uk/ons/rel/child-health/gestation-specific-infant-mortality-in-england-and-wales/index.html</a></p>

2.02 Breastfeeding	
Rationale	<p>This indicator was judged to be a valid and an important measure of public health and was therefore included in the public health outcomes framework. Inclusion of these indicators will encourage the continued prioritisation of breastfeeding support locally. Increases in breastfeeding are expected to reduce illness in young children, have health benefits for the infant and the mother and result in cost savings to the NHS through reduced hospital admission for the treatment of infection in infants (Quigley et al 2007).</p> <p>Breast milk provides the ideal nutrition for infants in the first stages of life.</p> <p>There is evidence that babies who are breast fed experience lower levels of gastro-intestinal and respiratory infection. Observational studies have shown that breastfeeding is associated with lower levels of child obesity.</p> <p>Benefits to the mother include a faster return to pre-pregnancy weight and possibly lower risk of breast and ovarian cancer (BMA Board of Science, 2009)</p> <p>Current national and international guidance recommends exclusive breastfeeding for newborns and for the first six months of infancy.</p> <p><a href="http://www.who.int/nutrition/topics/infantfeeding_recommendation/en/index.html">http://www.who.int/nutrition/topics/infantfeeding_recommendation/en/index.html</a></p> <p><a href="http://www.nice.org.uk/nicemedialive/11943/40097/40097.pdf">http://www.nice.org.uk/nicemedialive/11943/40097/40097.pdf</a></p> <p>Increasing rates of breastfeeding initiation and continuation is also recommended within the DH Healthy Child Programme</p> <p>Breastfeeding initiation and uptake at 6-8 weeks are included in the NICE proposals for the Commissioning Outcomes Framework</p>
Baseline period	2010/11
Indicator definition	<p><b>2.02i Breastfeeding initiation</b></p> <p><u>Numerator</u>: Number of women who initiate breastfeeding in the first 48 hours after delivery</p> <p><u>Denominator</u>: Number of total maternities</p> <p><b>2.02ii Breastfeeding prevalence at 6-8 weeks after birth</b></p>

2.02 Breastfeeding	
	<p><u>Numerator</u>: Number of infants who are totally or partially breastfed at 6-8 week check</p> <p><u>Denominator</u>: Total number of infants due a 6-8 week check</p>
Data source	Data collection and reporting by National Child and Maternal Health Intelligence Network, Public Health England
Publication of source data	<a href="http://www.chimat.org.uk/transfer">www.chimat.org.uk/transfer</a>

2.03 Smoking status at time of delivery	
Rationale	<p>Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes. Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to secondhand smoke by the infant. Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy.</p> <p>The Tobacco Control Plan contains a national ambition to reduce the rate of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth).</p> <p>The inclusion of this indicator will ensure that local tobacco control activity is appropriately focused on pregnant women, in order to try to achieve this national ambition.</p>
Baseline period	2010/11

2.03 Smoking status at time of delivery	
Indicator definition	<p><b>2.03 Rate of smoking at time of delivery per 100 maternities</b></p> <p><u>Numerator</u>: Number of women who currently smoke at time of delivery</p> <p><u>Denominator</u>: Number of total maternities where smoking status is known</p> <p>Note: Quarterly data are published by the Health and Social Care Information Centre (HSCIC), but individual quarters should <u>not</u> be added together to form the annual figures for this indicator.</p> <p>For the 2016-19 refresh, there will be a change of method for reporting this information, by removing those whose smoking status is unknown from the calculation. This will be effective from April 2017.</p> <p>Previously in the Public Health Outcome Framework, women with unknown smoking status have been effectively categorised as non-smokers. However, a number of these will be smokers. This therefore results in deflating the indicator value, and so performance may look better than it actually is. Excluding women with unknown smoking status from the calculation will provide a more accurate representation of the true proportion of women smoking at time of delivery.</p> <p>The overall impact of this change at England level is small, although the impact will be greater for those CCGs who have a high proportion of unknowns. Work is already underway to encourage and support Trusts/CCGs to collect and record accurate information. IT issues are reported as the main reason for high levels of unknowns, which should be resolved as systems embed and improve.</p> <p>Having the new definition effective from April 2017 will allow time to work with CCGs to improve the quality of their data and to co-ordinate the change with the publication of the new Government tobacco control plan for England, expected in 2016.</p> <p>HSCIC will publish this indicator under both definitions during 2016/17 so CCGs can assess what the impact will be of switching to the new definition.</p> <p>Data is collected via CCGs and subsequently configured to local authority level for presentation within PHOF.</p>
Data source	HSCIC smoking status at time of delivery data, collected quarterly and published at CCG level.



2.03 Smoking status at time of delivery	
Publication of source data	<p>Published by the HSCIC at national and CCG level on a quarterly basis: The annual data collected at quarter 4 is used to assess year on year performance.</p> <p><a href="http://www.hscic.gov.uk/searchcatalogue?productid=14841">http://www.hscic.gov.uk/searchcatalogue?productid=14841</a></p> <p>See note in definition section, adding together quarterly data as published by the HSCIC <u>will not</u> create the annual data used for this indicator</p>

2.04 Under 18 conceptions	
Rationale	<p>Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. And while for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.</p> <p>Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.</p>
Baseline period	2010
Indicator definition	<p><b>2.04 Under 18 conception rate per 1,000 population</b></p> <p><u>Numerator:</u> Number of pregnancies that occur to women aged under 18 that result in either one or more live or still births or a legal abortion under the Abortion Act 1967.</p>

2.04 Under 18 conceptions	
	<p><u>Denominator:</u> Number of women aged 15-17</p> <p>Office for National Statistics (ONS) conception statistics are compiled by combining information from birth registrations and abortion notifications.</p> <p>Conception statistics include pregnancies that result in:</p> <ul style="list-style-type: none"> <li>• One or more live or still births; or</li> <li>• A legal abortion under the Abortion Act 1967</li> </ul> <p>Miscarriages and illegal abortions are not included.</p> <p>The date of conception is estimated using recorded gestation for abortions and stillbirths, and assuming 38 weeks gestation for live births. A woman's age at conception is calculated as the number of complete years between her date of birth and the date she conceived.</p> <p>The postcode of the woman's address at time of birth or abortion is used to determine local authority/ward of residence at time of conception.</p> <p>Only about 5% of under 18 conceptions are to girls aged 14 or under and to include younger age groups in the base population would produce misleading results. The 15-17 age group is effectively treated as the "population at risk".</p>
Data source	ONS
Publication of source data	<p>ONS publish annual conception statistics at upper and lower tier local authority level:</p> <p><a href="http://www.ons.gov.uk/ons/rel/vsob1/conception-statistics--england-and-wales/index.html">http://www.ons.gov.uk/ons/rel/vsob1/conception-statistics--england-and-wales/index.html</a>.</p> <p>In addition, ONS publish quarterly conception statistics at upper tier local authority level.</p> <p><a href="http://www.ons.gov.uk/ons/rel/vsob1/quart-conc-to-women-und-18/index.html">http://www.ons.gov.uk/ons/rel/vsob1/quart-conc-to-women-und-18/index.html</a></p>

2.05 Child development at 2 – 2½ years	
Rationale	<p>The Government's Early Years Policy Statement 'Supporting Families in the Foundation Years' (published July 2011) sets out the Government's recognition of the importance of pregnancy and the first years of life and its strong commitment to ensuring all children get the best possible start in life. It also included a commitment to developing an outcome measure of child development at 2-2½ years. This is linked to the Government commitment to increase the number of health visitors, which in turn will help to ensure that more children are offered the Healthy Child Programme review at age 2-2½ years. The indicator will show how many children are receiving this review, as well as provide information on children's development.</p> <p>Children's early life development is strongly related to an individual's life long healthy development. Many factors associated with poor health and well-being in later life have been shown to have their origins in pregnancy and early childhood.</p>
Baseline period	<p>To be confirmed.</p> <p>Coverage information has been collected since 2015/16. Outcomes data is expected to be reported in 2018. Details of baselines are still to be confirmed.</p>
Indicator definition	<p>The child development indicator will be based upon the 'Ages and Stages Questionnaire' (ASQ-3). This tool is commonly used in the US and its use is becoming increasingly common in the UK as part of the Healthy Child Programme. It is intended that data for this measure will be collected during the integrated review for children at age 2 – 2 ½ (which will come into being in 2015, and will bring together the current Healthy Child Programme review at the same age with the Early Years Progress Check at age 2). Where an integrated review is not yet in place, the data for this measure will be collected via the Healthy Child Programme review at age 2-2½. Implementation piloting will take place during 2014/15 ready for implementation in 2015 alongside the integrated review.</p>

2.05 Child development at 2 – 2½ years	
	<p><b>2.5i Proportion of children aged 2-2½yrs who received an assessment as part of the Healthy Child Programme or an integrated review (using any tool)</b></p> <p>The number of children aged 2-2½yrs that complete any Healthy Child Programme or integrated review as a proportion of total number of children within this age group.</p> <p><b>2.5ii Proportion of children aged 2-2½yrs offered ASQ-3 as part of the Healthy Child Programme or integrated review</b></p> <p>The number of children aged 2-2½yrs for whom ASQ-3 is completed as part of the HCP or integrated review as a proportion of total number of children within this age group.</p> <p>The remaining sub-indicator(s) will use the ASQ-3 tool. The tool produces a score for five separate areas of development:</p> <ul style="list-style-type: none"> <li>• Communication</li> <li>• Gross Motor</li> <li>• Fine Motor</li> <li>• Problem solving</li> <li>• Personal-social</li> </ul> <p>The score a child receives can be compared to an expected range of scores for a child of that age, indicating whether further consultation may be required. The 'expected' range of scores for each domain based upon research findings in the US where this tool originates will be used for the implementation piloting in 2014/15. Whether these domain ranges are applicable to children in England will be determined and may be modified accordingly.</p> <p>Example indicator title:</p> <p><b>2.05 iii Proportion of children aged 2-2½yrs who receive an ASQ-3 score within the expected range for this age group (To be confirmed)</b></p> <p>This would be the number of children who complete the ASQ assessment and receive a score (or scores if applied to all ASQ-3 domains) that is within the 'expected' range, as a proportion of all children who complete the assessment.</p> <p>The exact form this indicator will take is subject to further analysis.</p>
Data source	<i>The data source needs further development</i>

2.05 Child development at 2 – 2½ years	
	Coverage information is collected and reported by the National Child and Maternal Health Intelligence Network, Public Health England, through interim arrangements. The long-term source for this indicator will be the HSCIC's Children and Young People's Health Services Dataset.
Publication of source data	To be confirmed.

2.06 Child excess weight in 4-5 and 10-11 year olds	
Rationale	<p>There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age<sup>1,2,3</sup>. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.</p> <p>The National Institute of Health and Clinical Excellence have produced guidelines to tackle obesity in adults and children - Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. Available at <a href="http://guidance.nice.org.uk/CG43">http://guidance.nice.org.uk/CG43</a>.</p> <p>1 Guo SS, Chumlea WC. Tracking of body mass index in children in relation to overweight in adulthood. The American Journal of Clinical Nutrition 1999;70(suppl): 145S-8S.</p> <p>2 Serdula MK, Ivery D, Coates RJ, Freedman DS, Williamson DF, Byers T. Do obese children become obese adults? A review of the literature. Preventative Medicine 1993;22:167-77.</p> <p>3 Starc G, Strel J. Tracking excess weight and obesity from childhood to young adulthood: a 12-year prospective cohort study in Slovenia. Public Health Nutrition 2011;14:49-55.</p>
Baseline period	2010/11 (school year)

2.06 Child excess weight in 4-5 and 10-11 year olds	
Indicator definition	<p>Children are allocated to local authorities based on their postcode of residence. This will align with other indicator sets on child excess weight that are produced by Public Health England.</p> <p><b>2.06i Percentage of children aged 4-5 classified as overweight or obese</b></p> <p><u>Numerator</u>: The number of primary school age children in Reception (aged 4-5 years) with valid height and weight recorded (in a particular school year) based on their postcode of residence who are classified as overweight or obese</p> <p><u>Denominator</u>: The total number of primary school age children in Reception (aged 4-5 years) with valid height and weight recorded, in a particular school year based on their postcode of residence.</p> <p><b>2.06ii Percentage of children aged 10-11 classified as overweight or obese</b></p> <p><u>Numerator</u>: The number of primary school age children in Year 6 (aged 10-11 years) with valid height and weight recorded (in a particular school year), based on their postcode of residence, who are classified as overweight or obese</p> <p><u>Denominator</u>: The total number of primary school age children in Year 6 (aged 10-11 years) with valid height and weight recorded in a particular school year, based on their postcode of residence.</p> <p>The published figures define a child as overweight (including obese) if their BMI is greater than or equal to the 85th centile of the British 1990 (UK90) growth reference.</p>
Data source	National Child Measurement Programme (NCMP)
Publication of source data	<p>Data on the National Child Measurement Programme (NCMP) are published annually by the Health and Social Care Information Centre:</p> <p><a href="http://www.hscic.gov.uk/ncmp">http://www.hscic.gov.uk/ncmp</a></p> <p>Information on children who are “overweight” or “obese” is published as separate items within the NCMP publication.</p>

<b>2.07 Hospital admissions caused by unintentional and deliberate injuries in children and young people under 25.</b>	
Rationale	<p>Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. They are also a source of long-term health issues, including mental health problems related to experience(s) of injury.</p> <p>The inclusion of this indicator is key for cross-sectoral and partnership working to reduce injuries, including child safeguarding.</p>
Baseline period	2010/11
Indicator definition	<p><b>2.07i Crude rate of hospital emergency admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 years, per 10,000 resident population</b></p> <p><u>Numerator</u>: The number of finished in-year emergency admissions of children and young people aged 0-14 years to hospital as a result of unintentional and deliberate injuries (ICD10 codes S00-T79 or V01-Y36 in any of the diagnostic fields).</p> <p><u>Denominator</u>: ONS mid-year population estimate for age 0-14 years.</p> <p><b>2.07ii Crude rate of hospital emergency admissions caused by unintentional and deliberate injuries in children and young people aged 15-24 years, per 10,000 resident population</b></p> <p><u>Numerator</u>: The number of finished in-year emergency admissions of children and young people aged 15-24 years to hospital as a result of unintentional and deliberate injuries (ICD10 codes S00-T79 or V01-Y36 in any of the diagnostic fields).</p> <p><u>Denominator</u>: ONS mid-year population estimate for age 15-24 years.</p>
Data source	Hospital Episode Statistics (HES), Health and Social Care Information Centre

## 2.07 Hospital admissions caused by unintentional and deliberate injuries in children and young people under 25.

Publication of source data	Limited headline data on numbers of hospital episodes for injuries are published in HES tables by the Health and Social Care Information Centre: <a href="http://www.hscic.gov.uk/hes">http://www.hscic.gov.uk/hes</a>
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## 2.08 Emotional well-being of looked after children

Rationale	<p>The mental health of all children is important. With half of adult mental health problems starting before the age of 14, early intervention to support children and young people with mental health and emotional well-being issues is very important. Under Section 10 of the Children Act 2004, local authorities have a duty to co-operate to promote well-being among children and young people.</p> <p>The cross Government Mental Health Strategy, 'No Health without Mental Health', identifies looked after children as one of the particularly vulnerable groups at risk of developing mental health problems. Inclusion of this indicator for looked after children will send out a message that this group of young people are a priority for the NHS and local authorities in their new public health role.</p> <p>Without an indicator covering this group, there would be a risk of an even greater increase in rates of undiagnosed mental health problems, placement breakdown, alcohol and substance misuse, convictions and care leavers not in education, employment or training.</p>
Baseline period	2010/11
Indicator definition	<p><b>2.08 Emotional well-being of looked after children.</b></p> <p><b>2.08i Average total difficulties score for all looked after children aged between 5 and 16 (inclusive) at the date of their latest assessment, who have been in care for at least 12 months on 31 March.</b></p> <p>Data is collected by local authorities through a strengths and difficulties questionnaire (SDQ) and a single summary figure for each child (the total difficulties score), ranging from 0 to 40, is submitted to the Department for Education (DfE) through the</p>



2.08 Emotional well-being of looked after children	
	<p>SSDA903 data return.</p> <p>The Department for Education have recently changed this age range covered by the indicator from 4 to 16, to 5 to 16. Although an SDQ score is now required of all children aged 4-16 on the date of the last assessment, the date of assessment is not collected on the looked after children return and therefore this cohort has been restricted to age 5-16 as at 31 March. Values for this revised age range are available for the years ending the 31st March 2011, 2012 and 2013.</p> <p><b>2.08ii Percentage of children where there is cause for concern</b></p> <p>Numerator: Number of children looked after continuously for at least 12 months and aged 5 to 16 for whom an SDQ score of 17 or over was received via the looked after children return (SSDA903)</p> <p>Denominator: Number of children looked after continuously for at least 12 months and aged 5 to 16 for whom an SDQ score was received via the looked after children return (SSDA903)</p>
Data source	Children Looked After by Local Authorities in England in the year ending 31 March based on the SSDA903 data collection on looked after children.
Publication of source data	<p>Data on looked after children (though not specifically this indicator) are published annually by DfE:</p> <p><a href="http://www.gov.uk/government/statistics/outcomes-for-children-looked-after-by-local-authorities">www.gov.uk/government/statistics/outcomes-for-children-looked-after-by-local-authorities</a></p>

2.09 Smoking prevalence at age 15	
Rationale	<p>Smoking is a major cause of preventable morbidity and premature death. There is a large body of evidence showing that smoking behaviour in early adulthood affects health behaviours later in life. The Tobacco Control Plan sets out the Government's aim to reduce the prevalence of smoking among both adults and children and</p>

2.09 Smoking prevalence at age 15	
	<p>includes a national ambition to reduce rates of regular smoking among 15 year olds in England to 12 per cent or less by the end of 2015.</p> <p>This indicator will ensure that as well as focusing on reducing the prevalence of smoking among adults (primarily through quitting) local authorities will also address the issue of reducing the uptake of smoking among children.</p>
Baseline period	<p>2.09i-iii: 2014/15</p> <p>2.09iv-v: 2010</p>
Indicator definition	<p><b>2.09i Smoking prevalence at age 15 – current smokers (WAY survey)</b></p> <p><u>Numerator</u>: The number of 15 year olds who responded to Q17 in the What About YOUTH? (WAY) survey ("Now read the following statements carefully, and tick the box next to the one that best describes you") with the answers "I sometimes smoke cigarettes now but I don't smoke as many as one a week", "I usually smoke between one and six cigarettes per week" or "I usually smoke more than six cigarettes per week".</p> <p><u>Denominator</u>: The total number of valid responses to Q17 in the WAY survey</p> <p><b>2.09ii Smoking prevalence at age 15 – regular smokers (WAY survey)</b></p> <p><u>Numerator</u>: The number of 15 year olds who responded to Q17 in the What About YOUTH? survey ("Now read the following statements carefully, and tick the box next to the one that best describes you") with the answers "I usually smoke between one and six cigarettes per week" or "I usually smoke more than six cigarettes per week".</p> <p><u>Denominator</u>: The total number of valid responses to Q17 in the WAY survey</p> <p><b>2.09iii Smoking prevalence at age 15 – occasional smokers (WAY survey)</b></p> <p><u>Numerator</u>: The number of 15 year olds who responded to Q17 in the What About YOUTH? survey ("Now read the following statements carefully, and tick the box next to the one that best describes you") with the answer "I sometimes smoke cigarettes now but I don't smoke as many as one a week".</p> <p><u>Denominator</u>: The total number of valid responses to Q17 in the</p>

2.09 Smoking prevalence at age 15	
	<p>WAY survey</p> <p><b>2.09iv Smoking prevalence at age 15 – regular smokers (SDD survey)</b></p> <p><u>Numerator</u>: Number of 15 year olds classified as regular smokers (at least one cigarette per week)</p> <p><u>Denominator</u>: Number of 15 year olds surveyed in the Smoking, Drinking and Drug Use Among Young People in England survey</p> <p><b>2.09v Smoking prevalence at age 15 – occasional smokers (SDD survey)</b></p> <p><u>Numerator</u>: Number of 15 year olds classified as occasional smokers (defined as usually smoking less than one cigarette per week)</p> <p><u>Denominator</u>: Number of 15 year olds surveyed in the Smoking, Drinking and Drug Use Among Young People in England survey</p>
Data source	<p>2.09i, 2.09ii, 2.09iii What about YOUth? survey. A newly-established survey (2014) designed to provide robust estimates at local authority level on a range of health behaviours among 15 year olds.</p> <p>2.9iv, 2.9v Smoking, Drinking and Drug Use Among Young People in England survey. Information on smoking for 11-15 year olds is collected in the Survey of Smoking, Drinking and Drug Use Among Young People, the sample size for 15 year olds is sufficient to obtain robust estimates only at national level</p>
Publication of source data	<p>Smoking prevalence for 15 year olds is currently reported by the Health and Social Care Information Centre;</p> <p>At national and regional level, based on the Survey of Smoking, Drinking and Drug Use Among Young People:</p> <p><a href="http://www.hscic.gov.uk/article/2021/Website-Search?q=Smoking%2C+Drinking+and+Drug+Use+Among+Young+People+in+England&amp;go=Go&amp;area=both">http://www.hscic.gov.uk/article/2021/Website-Search?q=Smoking%2C+Drinking+and+Drug+Use+Among+Young+People+in+England&amp;go=Go&amp;area=both</a></p> <p>At local authority level, based on the What About YOUth? Survey:</p> <p><a href="http://www.hscic.gov.uk/article/2021/Website-Search?q=Health+and+Wellbeing+of+15+year+olds+in+England%3A+Smoking+Prevalence+-+Findings+from+the+What+About+YOUth%3F&amp;go=Go&amp;area=both">http://www.hscic.gov.uk/article/2021/Website-Search?q=Health+and+Wellbeing+of+15+year+olds+in+England%3A+Smoking+Prevalence+-+Findings+from+the+What+About+YOUth%3F&amp;go=Go&amp;area=both</a></p>

2.10 Self-harm	
Rationale	<p>Self-harm is a sign of serious emotional distress. There are an estimated 300,000 attendances at A&amp;E for self-harm each year, and we know that this represents only a small proportion of self-harming in the community and the related health and well-being burden of self-harm.</p> <p>Significant local authority and NHS resources are required for mental health promotion, prevention, early intervention and to deal with the assessment and management of self-harm.</p> <p>People who self-harm describe contact with health services as often difficult, characterised by ignorance, negative attitudes and, sometimes, punitive behaviour by professionals towards people who self-harm. With the risk of death by suicide being considerably higher among people who have self-harmed and with their high rates of mental health problems, and alcohol and substance misuse, it is essential that services address the experience of care by people who self-harm.</p> <p>Those who self-harm have a 1 in 6 chance of repeat attendance at A&amp;E within the year. Early intervention when individuals present with signs of self-harm can reduce the harm of behaviour escalating to suicidal behaviour. This therefore would support the wider work of the suicide prevention strategy.</p> <p>We will be using the number of people attending A&amp;E for self-harm as a proxy for the prevalence of self-harm across England. By including emergency admissions as well, we will be able to also obtain a picture of the severity of those presenting at A&amp;E and requiring admission.</p> <p>Indicator 2.10ii has previously been published in Health Profiles with data from 2012/13 to 2014/15</p>
Baseline period	<p>2.10i – To be confirmed.</p> <p>2.10ii – 2012/13</p>
Indicator definition	<p>The indicator will have two elements:</p> <p><b>2.10i Attendances at A&amp;E for self-harm per 100,000 population</b></p> <p><u>Numerator</u>: Number of A&amp;E attendances with patient group as 'Deliberate self-harm' in the respective financial year</p> <p><u>Denominator</u>: Number of people based on ONS mid-year</p>

2.10 Self-harm	
	<p>population estimates</p> <p><b>2.10ii Age-sex standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population</b></p> <p><u>Numerator</u>: Number of hospital admissions for intentional self-harm classified by external cause (ICD10 external cause code in the range X60-X84) and with an emergency admission code. Counted by first finished episode in the respective financial year</p> <p><u>Denominator</u>: Number of people based on ONS mid-year population estimates</p>
Data source	<p>2.10i Expert input from HSCIC analysts is required in relation to the data improvements that would be needed to the HES A&amp;E experimental data collection in order to support calculation of this indicator at local authority level.</p> <p>2.10ii Hospital Episode Statistics (HES), Health and Social Care Information Centre</p>
Publication of source data	<p>Limited headline data on numbers of hospital episodes for self-harm are published in HES tables by the Health and Social Care Information Centre:</p> <p><a href="http://www.hscic.gov.uk/hes">http://www.hscic.gov.uk/hes</a></p>

2.11 Diet	
Rationale	<p>The importance of diet as a major contributor to chronic disease and premature death in England is recognised in the White Paper 'Healthy Lives, Healthy People'.</p> <p>Poor diet is a public health issue as it increases the risk of some cancers and cardiovascular disease (CVD), both of which are major causes of premature death. These diseases, and type II diabetes (which increases CVD risk) are associated with obesity, which has a very high prevalence in England. The costs of diet related chronic diseases to the NHS and more broadly to society are considerable. Poor diet is estimated to account for about one third of all deaths from cancer and CVD.</p> <p>A quarter of adults in England are obese. Average intakes of saturated fat, sugar, and salt are above recommendations while intakes of fruit and vegetables, fibre and some vitamins and minerals are below recommendations. Average intake of artificial</p>

2.11 Diet	
	<p>trans fatty acids are within recommendations. Calorie intake is difficult to measure but evidence shows that intake exceeds recommendations.</p> <p>Tackling obesity and improving people's health through good nutrition continues to be a major priority for this Government. Diet quality is a key factor in childhood obesity.</p>
Baseline period	<p>2.11i-iii: 2014</p> <p>2.11iv-vi: 2014/15</p>
Indicator definition	<p>The diet indicators for 2.11i-iii will use information taken from the Active People Survey. The Active People Survey will ask the following questions:</p> <ul style="list-style-type: none"> <li>• How many portions of fruit did you eat yesterday? Please include all fruit, including fresh, frozen dried or tinned fruit, stewed fruit or fruit juices and smoothies.</li> <li>• How many portions of vegetables did you eat yesterday? Please include fresh, frozen, raw or tinned vegetables, but do not include any potatoes you ate.</li> </ul> <p><b>2.11i Proportion of the population meeting the recommended '5-A-Day' (adults)</b></p> <p>Proportion of the population who, when surveyed, reported that they had eaten the recommended 5 portions of fruit and vegetables on the previous day.</p> <p><u>Numerator:</u> Of the denominator all respondents whose responses to the two questions sum to 5 portions or more.</p> <p><u>Denominator:</u> All respondents to the Active People Survey who answered both of the two questions above.</p> <p><b>2.11ii Average number of portions of fruit consumed daily (adults)</b></p> <p>Mean number of portions of fruit reported by survey respondents when asked how many portions of fruit they ate on the previous day.</p> <p><u>Numerator:</u> The total number of portions of fruit reported by the survey respondents in the denominator. All responses reporting greater than 10 portions were recoded as 10 portions for calculation of the mean.</p> <p><u>Denominator:</u> All respondents to the Active People Survey who answered question 1 above.</p>

## 2.11 Diet

### 2.11iii Average number of portions of vegetables consumed daily (adults)

Numerator: The total number of portions of vegetables reported by the survey respondents in the denominator. All responses reporting greater than 10 portions were recoded as 10 portions for calculation of the mean.

Denominator: All respondents to the Active People Survey who answered question 2 above.

The diet indicators for 2.11iv-vi will use the What About YOUTH (WAY) survey responses to the following questions:

Q3 - Thinking just about YESTERDAY can you tell me how many portions of beans or pulses (baked beans, haricot beans, kidney beans, cannellini beans, butter beans, lentils or chickpeas) you ate?

Q4 - Thinking just about YESTERDAY can you tell me how many portions of vegetables – including salad, fresh, frozen or tinned vegetables you ate?

Q5 - Thinking just about YESTERDAY can you tell me how many portions of fruit juice (pure juice / 100% freshly squeezed / fruit smoothies / juice from concentrate BUT NOT juice based drinks such as squash) you had?

Q6 - Thinking just about YESTERDAY can you tell me how many portions of fruit - fresh, frozen, tinned or dried you ate?

Note, Q3 portions are counted as either 0 or 1 (if 1 or more portions of beans and pulses) as the current 5-a-day guidelines. Q5 portions are counted as either 0 or 1 (if 1 or more portions of smoothies/juices) as the current 5-a-day guidelines.

### 2.11iv Proportion of the population meeting the recommended '5-A-Day' at age 15

The percentage of 15 year olds that consumed at least 5 portions of fruit or vegetables across the questions Q3 - Q6 in the What About YOUTH survey:

Numerator: The number of 15 year olds who responded to Q3, Q4, Q5 and Q6 with a total sum of portions of 5 or more, in the What About YOUTH (WAY) survey.

Denominator: The total number of valid respondents to Q3, Q4,

2.11 Diet	
	<p>Q5 and Q6 in the WAY survey</p> <p><b>2.11v- Average number of portions of fruit consumed daily at age 15</b></p> <p>The Mean number of daily portions of fruit consumed by 15 year olds in the What About YOUTH (WAY). Calculated as based on responses to questions Q5 and Q6.</p> <p>Numerator: The total number of portions of fruit reported by the survey respondents in the denominator.</p> <p>Denominator: All respondents to the What About YOUTH (WAY) survey who answered Q5 and Q6.</p> <p><b>2.11vi- Average number of portions of vegetables consumed daily at age 15.</b></p> <p>The mean number of the portions of vegetables consumed by 15 year olds yesterday in the What About YOUTH (WAY). Calculated as based on responses to question Q4.</p> <p><u>Numerator:</u> The total number of portions of vegetables consumed yesterday reported by the survey respondents in the denominator.</p> <p><u>Denominator:</u> All respondents to the What About YOUTH (WAY) survey, 2014/15 who answered the question Q4.</p>
Data source	<p>2.11i-iii: Sport England Active People Survey. The survey has a large sample size which enables measurement of local area estimates and analysis by a broad range of demographic information, such as gender, social class, ethnicity, household structure, age and disability.</p> <p>2.11iv-vi: What about YOUTH? survey. A newly-established survey (2014) designed to provide robust estimates at local authority level on a range of health behaviours among 15 year olds.</p>
Publication of source data	<p>Sport England publishes results from the APS every six months on a rolling basis:</p> <p><a href="http://www.sportengland.org">http://www.sportengland.org</a></p> <p>The Health and Social Care Information Centre published results</p>



2.11 Diet	
	<p>from the What About YOUTH? Survey:</p> <p><a href="http://www.hscic.gov.uk/article/3742/What-About-Youth-Study">http://www.hscic.gov.uk/article/3742/What-About-Youth-Study</a></p>

2.12 Excess weight in adults	
Rationale	Obesity is a priority area for Government. The Government's "Call to Action" on obesity (published Oct 2011) included national ambitions relating to excess weight in adults, which is recognised as a major determinant of premature mortality and avoidable ill health.
Baseline period	Local authority level: 2012/14
Indicator definition	<p><b>2.12 Proportion of adults classified as overweight or obese</b></p> <p><u>Numerator</u>: Number of adults who are classified as overweight or obese</p> <p><u>Denominator</u>: Number of adults with valid height and weight recorded</p> <p>Adults are defined as overweight (including obese) if their BMI is greater than or equal to 25kg/m<sup>2</sup></p>
Data source	Sport England's Active People Survey (self-reported height and weight adjusted to account for reporting bias to obtain an estimate of the true height and weight of each individual). Note this indicator uses three years of APS data combined.
Publication of source data	Active People Survey data is published for national and local levels at six monthly intervals. However the data on self-reported height and weight is not currently published.

2.13 Proportion of physically active and inactive adults	
Rationale	<p>Physical inactivity is the 4th leading risk factor for global mortality accounting for 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health. In older adults physical activity is associated with increased functional capacities. The estimated direct cost of physical inactivity to the NHS across the UK is over £0.9 billion per year.</p> <p>The Chief Medical Officer currently recommends that adults undertake 150 minutes (2.5 hours) of moderate activity per week, in bouts of 10 minutes or more. The overall amount of activity is more important than the type, intensity or frequency. (1) Since January 2009, the Department of Health has commissioned Sport England to include a number of questions on wider participation in physical activity in the Active People Survey in order to be able to monitor the CMO recommendations.</p> <p>Evidence for the effectiveness of interventions to increase the population levels of physical activity is summarised by Kahn et al.(2)</p> <p>1. Department of Health, 2011. Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers see: <a href="http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152108/dh_128210.pdf">http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152108/dh_128210.pdf</a></p> <p>2. Kahn E, Ramsey L, Brownson R, Heath G, Howze E, Powell K, et al. 'The Effectiveness of Interventions to Increase Physical Activity: A Systematic Review'. Am J Prev Med 2002; 22 (4S).</p>
Baseline period	2012
Indicator definition	<p><b>2.13i Proportion of adults achieving at least 150 minutes of physical activity per week in accordance with UK CMO recommended guidelines on physical activity</b></p> <p><u>Numerator</u>: Number of adults (16+) doing at least 150 "equivalent" minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more*</p> <p><u>Denominator</u>: Number of respondents (aged 16+) with valid responses to questions on physical activity.</p>

## 2.13 Proportion of physically active and inactive adults

	<p><b>2.13ii Proportion of adults classified as ‘inactive’</b></p> <p><u>Numerator</u>: Number of adults (16+) who do less than 30 “equivalent” minutes of moderate intensity physical activity per week in bouts of 10 minutes or more*</p> <p><u>Denominator</u>: Number of respondents (aged 16+) with valid responses to questions on physical activity.</p> <p>“Equivalent” minutes of moderate intensity activity would be calculated as the sum of all minutes of moderate intensity activity and 2x all minutes of vigorous intensity activity, accumulated across a week. This is based on the recognition that one minute of vigorous intensity activity can be counted as two minutes of moderate intensity activities (e.g. 15 minutes of vigorous activities would be counted as equivalent to 30 minutes of moderate activities).</p> <p>* Based on 2011 CMO report ‘Start active, stay active’</p>
Data source	Sport England’s Active People Survey (APS)
Publication of source data	<p>APS data is published for national and local levels at six monthly intervals:</p> <p><a href="http://www.sportengland.org/research/about-our-research/what-is-the-active-people-survey/">http://www.sportengland.org/research/about-our-research/what-is-the-active-people-survey/</a></p>

## 2.14 Smoking prevalence – adults (over 18s)

Rationale	<p>Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.</p> <p>In 2008/09, some 463,000 hospital admissions in England</p>
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2.14 Smoking prevalence – adults (over 18s)	
	<p>among adults aged 35 and over were attributable to smoking, or some 5 per cent of all hospital admissions for this age group (NHS Information Centre (2010). Statistics on Smoking: England, 2010, NHS Information Centre, Leeds). Illnesses among children caused by exposure to second-hand smoke lead to an estimated 300,000 general practice consultations and about 9,500 hospital admissions in the UK each year (Royal College of Physicians (2010). Passive Smoking and Children. Royal College of Physicians, London).</p> <p>Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population. The Government's Tobacco Control Plan (Healthy Lives, Healthy People: A Tobacco Control Plan for England) published in March 2011 sets out the Government's strategy to reduce smoking prevalence among adults and young people, and to reduce smoking during pregnancy.</p> <p>The Government's Tobacco Control Plan (Healthy Lives, Healthy People: A Tobacco Control Plan for England), <a href="https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england">https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england</a> published in March 2011 sets out the Government's strategy to reduce smoking prevalence among adults and young people, and to reduce smoking during pregnancy.</p>
Baseline period	2012
Indicator definition	<p><b>2.14 Prevalence of smoking among persons aged 18 years and over – current smokers (APS)</b></p> <p><u>Numerator</u>: The number of persons aged 18 + who are self-reported smokers in the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.</p> <p><u>Denominator</u>: Total number of respondents (with valid recorded smoking status) aged 18+ from the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.</p> <p><b>2.14 Prevalence of smoking among persons aged 18 years and over - routine and manual – current smokers (APS)</b></p> <p><u>Numerator</u>: The number of persons aged 18 + who are self-reported smokers in the Annual Population Survey in a subset of</p>

2.14 Smoking prevalence – adults (over 18s)	
	<p>the routine and manual group.</p> <p><u>Denominator:</u> Total number of respondents (with valid recorded smoking status) aged 18+ in the routine and manual group from the Annual Population Survey.</p> <p>Each eligible participant (18 years and over) in the Annual Population Survey (APS) was asked whether they had ever smoked a cigarette and whether they currently smoked. From this smoking status was derived as “current”, “ex-smoker” or “non-smoker”.</p> <p>*The number of respondents is weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.</p>
Data source	Annual Population Survey (APS)
Publication of source data	Public Health England (PHE) will publish annual data

2.15 Drug and alcohol treatment completion and drug deaths	
Rationale	<p>Individuals achieving this outcome demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health.</p> <p>It aligns with the ambition of both public health and the Government's drug strategy of increasing the number of individuals recovering from addiction. It also aligns well with the reducing re-offending outcome [Indicator 1.13] as offending behaviour is closely linked to substance use and it is well demonstrated that cessation of drug use reduces re-offending significantly. This in turn will have benefits to a range of wider services and will address those who cause the most harm in local communities.</p> <p>The indicator now measures the local rates of completion for drug <i>and</i> alcohol treatment and benchmarks activity. It is used as the basis to identify areas that may need additional support from Public Health England to help improve outcomes. Public Health England also provides a range of toolkits to</p>

2.15 Drug and alcohol treatment completion and drug deaths	
	<p>commissioners and providers to help them do this.</p> <p>The indicator also supports reductions in inequalities and helps improve return on investment for local authorities as well as for the national public health grant.</p> <p>In addition to adding alcohol as a sub indicator, deaths from drug misuse have also now been included as there has been a rising trend in drug related deaths over the last few years. Local authority action, including the quality and accessibility of the drug services they commission and how deaths are investigated and responded has an impact on drug misuse death rates. Including this sub-indicator alongside those on treatment outcomes will help local authorities and others to consider the impact of treatment in addiction to recovery outcomes.</p> <p>Public Health England is committed to continue to improve recovery rates for both drug and alcohol treatment and to reduce health-related harms, HIV, hepatitis, TB transmission and drug-related deaths. This action was included with the Public Health England's Annual Plan 2015/16 and this indicator directly contributes.</p>
Baseline period	<p>2.15i and 2.15ii: 2010</p> <p>2.15iii: 2010</p> <p>2.15iv: 2010</p>
Indicator definition	<p><b>2.15i Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number of opiate users in treatment.</b></p> <p><u>Numerator</u>: The number of adults that successfully complete treatment for opiates in a year and who do not re-present to treatment within 6 months.</p> <p><u>Denominator</u>: The total number of adults in treatment for opiate use in a year.</p> <p><b>2.15ii Number of users of non-opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number of non-opiate users in treatment</b></p> <p><u>Numerator</u>: The number of adults that successfully complete</p>

2.15 Drug and alcohol treatment completion and drug deaths	
	<p>treatment for non-opiates in a year and who do not re-present to treatment within 6 months.</p> <p><u>Denominator:</u> The total number of adults in treatment for non-opiate use in a year.</p> <p><b>2.15iii Number of alcohol only clients that left substance misuse treatment successfully who do not then re-present to treatment within 6 months as a proportion of the total number of alcohol only clients in treatment</b></p> <p><u>Numerator:</u> the number of adults that successfully complete alcohol treatment in a year and do not re-represent to treatment within 6 months</p> <p><u>Denominator:</u> The total number of adults in alcohol treatment in a year.</p> <p><b><u>2.15iv The rate of drug misuse deaths per million population over a three year period</u></b></p> <p><u>Numerator:</u> The number of drug misuse* deaths in a rolling three year period.</p> <p><u>Denominator:</u> Pooled ONS mid-year estimates for the same three year period</p> <p>*Deaths where the underlying cause of death has been coded to one of the following categories <b>and</b> where a drug controlled under the Misuse of Drugs Act 1971 was mentioned on the death certificate</p> <p>Accidental poisoning by drugs, medicaments and biological substances (X40–X44)</p> <p>Intentional self-poisoning by drugs, medicaments and biological substances (X60–X64)</p> <p>Poisoning by drugs, medicaments and biological substances, undetermined intent (Y10–Y14)</p> <p>Assault by drugs, medicaments and biological substances (X85)</p> <p>Mental and behavioural disorders due to drug use (excluding alcohol and tobacco)(F11-F16, F18-F19)</p>
Data source	<p>2.15i-iii: National Drug Treatment Monitoring System (NDTMS)</p> <p>2.15iv: Office for National Statistics</p>

## 2.15 Drug and alcohol treatment completion and drug deaths

Publication of source data	<p>Public Health England publish monthly data for drug and alcohol treatment::</p> <p><a href="https://www.ndtms.net/Reports.aspx">https://www.ndtms.net/Reports.aspx</a></p> <p>ONS publish deaths related to drug poisoning:</p> <p><a href="http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Drug-related+Deaths">http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Drug-related+Deaths</a></p>
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## 2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison

Rationale	<p>This indicator supports a priority under the National Partnership Agreement between NHS England, National Offender Management Service and Public Health England to strengthen integration of services and continuity of care between custody and the community.</p> <p>The indicator measures the proportion of adults released from prison with a substance misuse treatment need who go on to engage in structured treatment interventions in the community within 3 weeks of release. The indicator would directly measure whether offenders with a substance misuse treatment need are engaging with local treatment services on release from custody. Individuals released from prison with an on-going substance misuse treatment need are at heightened risk in the days following release and local community-based treatment services should be working with prison treatment services to maximise their engagement in services post-release.</p>
Baseline period	2015/16
Indicator definition	<p><b>2.16 Adults with a substance misuse treatment need who successfully engage in community-based structured treatment following release from prison'</b></p> <p><u>Numerator</u>: Number of adults released from prison with a substance misuse treatment need who go on to engage in structured treatment interventions in the community within 3 weeks of release.</p> <p><u>Denominator</u>: Number of adults released from prison with</p>



## 2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison

	substance misuse treatment need
Data source	Calculated by Public Health England: Evidence Application Team using data from National Drug Treatment Monitoring System (NDTMS)
Publication of source data	Public Health England (PHE) will publish annual data

## 2.17 Estimated diagnosis rate for people with diabetes mellitus

Rationale	<p>For clinical commissioning groups and local health and well-being boards to understand the scope for prevention and make headway in tackling the rising numbers of people with or at risk of diabetes, they need to understand not only how many people have diabetes (recorded diabetes as currently collected) but also the estimated number of people expected to have diabetes given the characteristics of their populations. This will enable them to have a better idea of the scale of the challenge in terms of numbers and costs in developing diabetes identification and prevention programmes. And it will also help them monitor the progress that they are making towards closing the gap (i.e. meeting previously unmet need) between observed prevalence (number of cases of diabetes recorded) and actual prevalence in identifying people at high risk or with hitherto undiagnosed diabetes.</p> <p>Diabetic complications (including cardiovascular, kidney, foot and eye diseases) result in considerable morbidity and have a detrimental impact on quality of life.</p> <p>Type 2 diabetes (approximately 90% of diagnosed cases) is partially preventable – it can be prevented or delayed by lifestyle changes (exercise, weight loss, health eating). Earlier detection of Type 2 diabetes followed by effective treatment reduces the risk of developing diabetic complications.</p> <p>The 13 quality statements of the 'Diabetes in adults quality standard' (2011) were informed by a range of NICE clinical guidelines and the 'National Service Framework for Diabetes'</p>
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2.17 Estimated diagnosis rate for people with diabetes mellitus	
	<p>that covered all aspects of diabetes care and prevention. Specifically, it is expected that achieving the high quality care set out in this quality standard will reduce the complications associated with diabetes.</p> <p>NICE guidelines for diabetes include those for children and young people, pregnancy, type 1 diabetes, prevention of type 2 diabetes, risk identification and interventions for individuals at high risk. All aim to improve the prevention, identification and management of those people at risk of developing diabetes and those with the condition.</p> <p><a href="https://www.nice.org.uk/guidance/qs6">https://www.nice.org.uk/guidance/qs6</a></p>
Baseline period	To be decided.
Indicator definition	<p><b>2.17 Estimated diagnosis rate for people with diabetes mellitus</b></p> <p><u>Numerator</u>: Total number of patients registered with GP practices, aged 17 and over at midnight on the 31st March in a particular year that have been diagnosed with diabetes mellitus (QOF DM19)</p> <p><u>Denominator</u>: The estimated number of people aged 17 years or over who have diabetes (diagnosed and undiagnosed) adjusted for age, sex, ethnic group and deprivation.</p> <p>The diabetes prevalence model is produced for adults aged 16 years and over whereas QOF is for adults aged 17 years and over. QOF covers registered population while the LA estimates produced by the prevalence model use resident populations. While it is expected that this should have minimal impact on the majority of LAs, in order for consistency in approach, LA diabetes prevalence estimates have also been produced for 17 years and over by LA registered population for use in this indicator.</p> <p>QOF data is updated every year. The diabetes prevalence model is updated every two years, and uses the previous three years' data from the Health Survey for England. Therefore, data to produce the model will be older than QOF data, and there will be a lag in capturing any changes in prevention activity and performance levels. This may exert a slight downward pressure on the diagnosis rate (towards 0), which could result in a perceived degradation in diagnosis performance. This lag may also result in the diagnosis rate of some LAs moving above 1, as improved prevention measures and diagnosis could lead to a higher number of individuals being diagnosed than was</p>

## 2.17 Estimated diagnosis rate for people with diabetes mellitus

	<p>estimated by the model.</p> <p>GP practices are apportioned to Local Authorities (LAs) based on their postcodes. The allocation method may have incorrectly apportioned patients to LAs; patients are counted as part of the LA of the GP practice where they are registered, not the LA they reside in.</p>
Data source	<p><u>Numerator</u>: QOF, Health and Social Care Information Centre.</p> <p>QOF information is derived from the Quality Management Analysis System (QMAS), a national system developed by NHS Connecting for Health.</p> <p><u>Denominator</u>: Diabetes prevalence model for local authorities and CCGs – National Cardiovascular Intelligence Network (NCVIN), Public Health England</p>
Publication of source data	<p>QOF information is published online annually by the Health and Social Care Information Centre (HSCIC) at GP practice level:</p> <p><a href="http://www.qof.ic.nhs.uk/">http://www.qof.ic.nhs.uk/</a></p> <p>The diabetes prevalence model is updated every two years :</p> <p><a href="http://www.ncvin.org.uk">www.ncvin.org.uk</a></p>

## 2.18 Alcohol-related admissions to hospital

Rationale	<p>Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually.</p> <p>The Government has said that everyone has a role to play in reducing the harmful use of alcohol – this indicator is one of the key contributions by the Government (and the Department of Health) to promote measurable, evidence based prevention activities at a local level, and supports the national ambitions to reduce harm set out in the Government's Alcohol Strategy. This ambition is part of the monitoring arrangements for the Responsibility Deal Alcohol Network.</p>
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2.18 Alcohol-related admissions to hospital	
	Alcohol-related admissions can be reduced through local interventions to reduce alcohol misuse and harm.
Baseline period	2010/11
Indicator definition	<p><b>2.18 Hospital admissions for alcohol-related conditions (narrow definition), all ages, directly age standardised rate per 100,000 population European standard population.</b></p> <p><u>Numerator</u>: Admissions to hospital where the primary diagnosis is an alcohol-related condition or a secondary diagnosis is an alcohol-related external cause.</p> <p><u>Denominator</u>: ONS mid-year population estimates</p> <p>The number is estimated by assigning an attributable fraction to each relevant admission, based on the diagnosis codes and age and sex of the patient. The attributable fractions represent the proportion of cases of conditions that can be attributed to alcohol and are based on the latest review of research undertaken by Public Health England.</p>
Data source	Hospital Episode Statistics, Health and Social Care Information Centre.
Publication of source data	<p>National and local authority figures will be made available on the Local Alcohol Profiles for England national indicator web site:</p> <p><a href="http://www.lape.org.uk/">http://www.lape.org.uk/</a></p>

2.19 Cancer diagnosed at stage 1 and 2	
Rationale	<p>Cancer is a major cause of death, accounting for around a quarter of deaths in England. More than 1 in 3 people will develop cancer at some point in their life.</p> <p>In January 2011 the Government published Improving Outcomes – a Strategy for Cancer. This document sets out how the Government plans to improve cancer outcomes, including improving survival rates through tackling late diagnosis of</p>

2.19 Cancer diagnosed at stage 1 and 2	
	<p>cancer.</p> <p>Diagnosis at an early stage of the cancer's development leads to dramatically improved survival chances. Specific public health interventions, such as screening programmes and information/education campaigns aim to improve rates of early diagnosis. An indicator on the proportion of cancers diagnosed at an early stage is therefore a useful proxy for assessing improvements in cancer survival rates.</p>
Baseline period	2012 (Experimental Statistics)
Indicator definition	<p><b>2.19 The proportion of invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin, diagnosed at stage 1 or 2</b></p> <p><u>Numerator:</u> Cases of cancer diagnosed at stage 1 or 2, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin.</p> <p><u>Denominator:</u> All new cases of cancer diagnosed at any stage or unknown stage, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin.</p>
Data source	National Cancer Registry - Data from this source will continue to evolve to improve quality – the data for calendar year 2012 will act as a useful proxy to help establish the baseline.
Publication of source data	Public Health England

## 2.20 National Screening Programmes

<p>Rationale</p>	<p>Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complication arising from the disease or condition. High population coverage and uptake are required to increase benefits of screening, save lives and reduce burden of disability.</p> <p>This indicator will provide an opportunity to track and monitor uptake levels of a variety of screening programmes that have a significant impact on the health and well-being of the population. These include:</p> <p>The NHS abdominal aortic aneurysm (AAA) Screening Programme detects over 3,500 aneurysms per year, approximately 500 of which are referred to have surgery. The programme aims to reduce AAA related mortality among men aged 65 to 74.</p> <p>About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying from it each year. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%.</p> <p>Breast screening supports early detection of cancer and is estimated to save 1,400 lives in England each year. Inclusion of this indicator will provide an opportunity to incentivise screening promotion and other local initiatives to increase coverage of cancer screening. Improvements in coverage would mean more breast cancers are detected at earlier, more treatable stages.</p> <p>Cervical cancer screening supports detection of symptoms that may become cancer and is estimated to save 4,500 lives in England each year. Inclusion of this indicator will provide an opportunity to incentivise screening promotion and other local initiatives to increase coverage of cancer screening. Improvements in coverage would mean more cervical cancer is prevented or detected at earlier, more treatable stages.</p> <p>Diabetic retinopathy is the leading cause of preventable sight loss in working age people in the UK and early detection through screening halves the risk of blindness. Over 6,000 urgent referrals are made annually.</p> <p>Fetal anomaly screening allows at much time as possible for pregnant woman to think through the options available. Over 15,000 women are annually given a result that their baby had a greater than 1 in 150 chance of being born with Down's syndrome.</p>
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2.20 National Screening Programmes	
	<p>Infections disease screening in pregnancy aims to identify women with hepatitis B, HIV or syphilis so they can be offered appropriate follow-on tests and treatments so the risk of the infection being passed on to the child can be substantially reduced. It has almost eliminated HIV positive babies.</p> <ul style="list-style-type: none"> <li>• Over a 1,000 HIV positive pregnant women are identified annually.</li> <li>• Approximately 1,000 pregnant women infected by syphilis are identified annually</li> <li>• Over 2,500 hepatitis B positive pregnant women are identified annually</li> </ul> <p>Sickle cell and thalassaemia screening aims to identify pregnancies at risk of sickle cell disease or thalassaemia and give parents time to think through the options available. It also means that babies who have either condition can be given the best support and treatment from the very start. Over 14,000 screen positive pregnant women are identified each year with approximately 300 affected babies annually.</p> <p>Newborn blood spot screening uses a heel prick test to collect spots of blood which are tested to find babies who have one of 9 conditions (sickle cell disease, cystic fibrosis, congenital hypothyroidism, and 6 inherited metabolic disease – phenylketonuria, medium-chain acyl-CoA dehydrogenase deficiency, maple syrup urine disease, isovaleric acidaemia, glutaric aciduria type 1, homocystinuria). Babies who test positive (over 1,000 annually) can then be treated early improving their health and, in some cases, preventing severe disability or even death.</p> <p>The NHS newborn hearing screening programme (NHSP) aims to identify moderate, severe and profound deafness and hearing impairment in newborn babies. The programme offers all parents in England the opportunity to have their baby's hearing tested shortly after birth. Early identification of hearing impairment gives children a better chance of developing speech and language skills, and of making the most of social and emotional interaction from an early age.</p>
Baseline period	<p>2.20i and 2.20ii: 2010</p> <p>2.20iii : 2015</p> <p>2.20iv: 2013/14</p> <p>2.20v: 2013/14</p> <p>2.20vi: To be confirmed</p>

2.20 National Screening Programmes	
	<p>2.20vii: 2013/4</p> <p>2.20viii, 2.20ix: 2013</p> <p>2.20x- 2.20xii: 2013/4</p> <p>2.20xiii: TBC.</p>
Indicator definition	<p><b>2.20i Breast screening: Coverage - The percentage of women in a population eligible for breast screening who were screened adequately within the previous three years on 31 March</b></p> <p><u>Numerator:</u> Number of women aged 53–70 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous three years</p> <p><u>Denominator:</u> Number of women aged 53–70 resident in the area (determined by postcode of residence) who are eligible for breast screening at a given point in time</p> <p><b>2.20ii Cervical screening – coverage: The percentage of women in the resident population eligible for cervical screening who were screened adequately within the previous 3.5 years or 5.5 years, according to age (3.5 years for women aged 25-49 and 5.5 years for women aged 50-64) on 31 March</b></p> <p><u>Numerator:</u> Number of women aged 25–49 resident in the area (determined by postcode of residence) with an adequate screening test in the previous 3½ years plus the number of women aged 50-64 resident in the area with an adequate screening test in the previous 5½ years</p> <p><u>Denominator:</u> Number of women aged 25–64 resident in the area (determined by postcode of residence) who are eligible for cervical screening at a given point in time</p> <p><b>2.20iii Bowel cancer screening – coverage: The percentage of people in the resident population eligible for bowel screening who were screened adequately within the previous 2½ years on 31 March</b></p> <p><u>Numerator:</u> Number of people aged 60–74 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous 2½ years</p> <p><u>Denominator:</u> Number of people aged 60–74 resident in the area (determined by postcode of residence) who are eligible for bowel screening at a given point in time</p>



## 2.20 National Screening Programmes

### **2.20iv Abdominal aortic aneurysm screening - coverage: The percentage of men eligible for abdominal aortic aneurysm screening who are conclusively tested**

Numerator: Number of men eligible for the initial screen who have had a conclusive scan result within the screening year plus an additional 3 months (in the event of non-attendance and cancellations at the end of the year this allows men to be reinvited and screened)

A conclusive test is one where the aorta could be visualised such that measurements in the both the transverse and longitudinal planes can be taken.

Denominator: Number of eligible men in their 65th year to whom the screening programme propose that a screening encounter during the reporting period should be offered. When calculated annually, this indicator must report all eligible men in their 65th year, excluding any who die or move out of the area of responsibility for the local screening service before screening can be offered.

### **2.20v Diabetic eye screening – Uptake: The percentage of those offered a routine diabetic eye screening appointment who attend and complete a routine digital screening encounter/event**

Numerator: The number of subjects offered screening who attended a routine digital screening encounter/event during the reporting period

Denominator: The number of eligible people with diabetes offered a routine digital screening encounter/event which was due to take place within the reporting period

Where no specific digital screening encounter/event date was proposed, the date at which the invitation was sent should be used, and where a range of dates were proposed, the first date in the range should apply

A digital screening event is a screening encounter/event where an attempt is made to image the subject's retinas by digital photography.

### **2.20vi Fetal anomaly screening - (18<sup>+0</sup> to 20<sup>+6</sup> fetal anomaly ultrasound) – coverage: The percentage of pregnant women**

## 2.20 National Screening Programmes

**eligible for fetal anomaly screening for whom a conclusive screening result is available within the designated timescale.**

Numerator: The number of eligible women for whom a completed screening result was available from the 18<sup>+0</sup> to 20<sup>+6</sup> week fetal anomaly scan on the day of report, including women who required a single further scan by 23 weeks to complete the screening examination if the image quality of the first examination is compromised by one of the following:

- increased maternal body mass index (BMI)
- uterine fibroids
- abdominal scarring
- sub-optimal fetal position

Denominator: is the total number of pregnant women booked for antenatal care during the reporting period, **excluding:**

- women who miscarry between booking and testing
- women who opt for termination between booking and testing
- women who transfer out between booking and testing, i.e. do not have a result
- women who transfer in who have a result from a screening test performed elsewhere in this pregnancy
- women who book later than 23<sup>+0</sup> weeks of pregnancy

**2.20vii Infectious disease in pregnancy screening - HIV coverage: The percentage of pregnant women eligible for HIV screening for whom a confirmed screening result is available at the day of report**

Numerator: The total number of eligible women for whom a confirmed screening result was available for HIV at the day of report, including: women who were known to be HIV positive at booking and not retested

Denominator: The total number of pregnant women booked<sup>3</sup> for antenatal care during the reporting period, or presenting in

<sup>3</sup> 'Booking' is the point at which a pregnant woman first sees a midwife to book for maternity care. At the booking appointment the maternity records are completed and antenatal screening is offered.

## 2.20 National Screening Programmes

labour without previously having booked for antenatal care, **excluding:**

- women who miscarry between booking and testing
- women who opt for termination between booking and testing
- women who transfer out between booking and testing and therefore do not have a result
- women who transfer in who have a result from a screening test performed elsewhere in this pregnancy

**2.20viii Infectious diseases in pregnancy screening - syphilis coverage: The percentage of pregnant women eligible for syphilis screening for whom a confirmed result is available at the day of report**

Numerator: The total number of eligible women for whom a confirmed screening result was available for syphilis at the day of report.

Denominator: The total number of pregnant women booked for antenatal care during the reporting period, or presenting in labour without previously having booked for antenatal care, **excluding:**

- women who miscarry between booking and testing
- women who opt for termination between booking and testing
- women who transfer out between booking and testing and therefore do not have a result
- women who transfer in who have a result from a screening test performed elsewhere in this pregnancy

**2.20ix Infectious diseases in pregnancy screening - hepatitis B coverage: The percentage of pregnant women eligible for hepatitis B screening for whom a confirmed result is available at the day of report**

Numerator: The total number of eligible women for whom a confirmed screening result was available for hepatitis B at the day of report including:

## 2.20 National Screening Programmes

- women who were known to be hepatitis B positive and were not retested

**Denominator:** The total number of pregnant women booked for antenatal care during the reporting period, or presenting in labour without previously having booked for antenatal care, **excluding:**

- women who miscarry between booking and testing
- women who opt for termination between booking and testing
- women who transfer out between booking and testing and therefore do not have a result
- women who transfer in who have a result from a screening test performed elsewhere in this pregnancy

**2.20x Sickle cell and thalassemia screening – coverage: The percentage of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report**

**Numerator:** The total number of eligible women for whom a conclusive screening result was available for sickle cell and thalassaemia at the day of report, including: women who were known carriers who were not retested and had direct access to pre-natal diagnosis.

**Denominator:** The total number of pregnant women booked for antenatal care during the reporting period, or presenting in labour without previously having booked for antenatal care, **excluding:**

- women who miscarry between booking and testing
- women who opt for termination between booking and testing
- women who transfer out between booking and testing and therefore do not have a result
- women who transfer in who have a result from a screening test performed elsewhere in this pregnancy

**2.20xi Newborn blood spot screening – coverage (CCG responsibility at birth): The percentage of babies registered within the clinical commissioning group (CCG) both at birth and on the last day of the reporting period who are eligible for newborn blood spot (NBS) screening and have a conclusive result recorded on the child health information system by 17 days of age**

## 2.20 National Screening Programmes

Numerator: The total number of eligible babies for whom a conclusive screening result for phenylketonuria (PKU) was available within an effective timeframe

Denominator: The total number of babies born within the reporting period, excluding any baby who died before the age of 8 days. For this KPI, the cohort includes only babies for whom the CCG were responsible at birth and are still responsible for on the last day of the reporting period.

‘Responsible CCG’ refers to all babies that are registered with a General Practitioner (GP) within the CCG; the data should be grouped and reported per CCG responsible population or UK equivalent using the baby’s, or if not available, mother’s GP practice code.

‘Effective timeframe’ is where a conclusive result for PKU is recorded on the CHIS by 17 days of age.

A conclusive result for PKU is one of the following newborn screening status codes: 04 (not suspected), 07 (not suspected - other disorders follow up); 08 (suspected)

**2.20xii Newborn hearing screening – coverage: The percentage of babies eligible for newborn hearing screening for whom the screening process is complete by 4 weeks corrected age (hospital programmes: well babies, NICU babies) or 5 weeks corrected age (community programmes: well babies)**

Numerator: The total number of eligible babies for whom a decision about referral or discharge from the screening programme is been made within an effective timeframe.

This includes:

- babies for whom a conclusive screening result was available by 4 weeks corrected age (hospital programmes: well babies, NICU babies); or by 5 weeks corrected age (community programmes: well babies)
- babies referred to an audiology department because a newborn hearing screening encounter/event was inconclusive or contraindicated.

The ‘screening outcomes’ relating to a complete screen are:

- Clear response – no follow up required

## 2.20 National Screening Programmes

- Clear response – targeted follow up required
- No clear response – bilateral referral, unilateral referral
- Incomplete – baby/equipment reason, equipment malfunction, equipment not available, baby unsettled
- Incomplete – screening contraindicated

Denominator: The total number of babies born within the reporting period whose mother was registered with a GP practice within the CCG, or (if not registered with any practice) resident within the area covered by the provider newborn hearing screening programme (NHSP) site or CCG area, excluding:

- any baby who died before screening could be completed
- babies that have not reached **4 weeks corrected age** (hospital programmes: well babies, NICU babies) or **5 weeks corrected age** (community programmes: well babies) at the time of the report
- babies born in England and have had their record transferred electronically to Wales or another home country

Corrected age is used for babies born at <40 weeks gestation.

For NHSP, coverage is defined as a screening outcome being set on the national software solution, accepting that the screen may be incomplete.

**2.20xiii Newborn and infant physical examination – coverage: The percentage of babies eligible for the newborn physical examination who are tested for all 4 components (3 components in female infants) of the newborn examination within 72 hours of birth.**

Numerator: The total number of eligible babies for whom a decision about referral (including a decision that no referral is necessary as a result of the newborn examination) for each of 4 conditions screened was made within an effective timeframe.

Denominator: The total number of babies born within the reporting period whose mother was registered with a GP practice within the CCG, or (if not registered with any practice) resident within the CCG area, excluding any baby who died

2.20 National Screening Programmes	
	<p>before an offer of screening could be made.</p> <p>The 'effective timeframe' for the newborn physical examination is that a conclusive screening result should be available within 72 hours of birth</p>
Data source	<p>2.20i, 2.20ii and 2.20iii: Calculated by Public Health England using data from Health and Social Care Information Centre 'Open Exeter' system.</p> <p>2.20iv: National AAA screening programme (NAAASP) database</p> <p>2.20v: Local DES service</p> <p>2.20vi: Ultrasound information systems</p> <p>2.20vii: Maternity Service</p> <p>2.20viii: Maternity Service</p> <p>2.20ix: Maternity Service</p> <p>2.20x: Maternity units and antenatal screening laboratory</p> <p>2.20xi: CHIS</p> <p>2.20xii: National software solution for newborn hearing screening</p> <p>2.20xiii: NIPE SMART (where providers have not implemented NIPE SMART, local processes will need to be in place to enable reporting of this KPI).</p>
Publication of source data	<p>Monthly reports on 2.20i and 2.20ii screening programmes coverage are available via the NHS Connecting for Health 'Open Exeter' system (accessible by registered users only):</p> <p><a href="https://nww.openexeter.nhs.uk/nhsia/index.jsp">https://nww.openexeter.nhs.uk/nhsia/index.jsp</a></p> <p>Annual and quarterly data on screening coverage at national, regional and provider level is published by Public Health England:</p> <p><a href="https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting">https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting</a></p>

2.22 Take up of the NHS Health Check programme	
Rationale	<p>The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been</p>

2.22 Take up of the NHS Health Check programme	
	<p>diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess, raise awareness and support them to manage their risk of cardiovascular disease. A high take up of NHS Health Check is important to identify early signs of poor health leading to opportunities for early interventions.</p> <p>Local authorities in England have a legal duty to deliver the NHS Health Check programme to 100% of the eligible population over a five year period and to achieve continuous improvement in uptake. Data collected for this indicator provides information on the NHS Health Checks offered and those taken up, providing an indication of reach and accessibility. Further information on the NHS Health Check programme can be found at: <a href="http://www.healthcheck.nhs.uk/">www.healthcheck.nhs.uk/</a></p> <p>Offering the NHS Health Check programme to around 20% of the eligible population each year so that delivery to 100% of the eligible population can be achieved over five years, and securing high uptake is important to prevent people developing vascular disease and to identify early signs of poor health leading in turn to opportunities for early intervention and for driving down health inequalities.</p>
Baseline period	2.22iii, 2.22iv, 2.22v – 2013/14
Indicator definition	<p>Indicators 2.22i and 2.22ii have been discontinued and replaced by indicators 2.22iii and 2.22iv, respectively.</p> <p><b>2.22iii Cumulative percentage of eligible population aged 40-74 offered an NHS Health Check in the five year period 2013/14 - 2017/18 (replaced indicator 2.22i)</b></p> <p><u>Numerator</u>: Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check in the five year period</p> <p><u>Denominator</u>: Number of people aged 40-74 eligible for an NHS Health Check in the five year period</p> <p><b>2.22iv Cumulative percentage of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check in the five year period 2013/14 - 2017/18. (replaced indicator 2.22ii)</b></p> <p><u>Numerator</u>: Number of people aged 40-74 eligible for an NHS Health Check who have received an NHS Health Check in the five year period</p> <p><u>Denominator</u>: Number of people aged 40-74 eligible for an NHS</p>



2.22 Take up of the NHS Health Check programme	
	<p>Health Check who were offered an NHS Health Check in the five year period</p> <p><b>2.22v Cumulative percentage of eligible population aged 40-74 who received an NHS Health Check in the five year period 2013/14 – 2017/18.</b></p> <p><u>Numerator</u>: Number of people aged 40-74 eligible for an NHS Health Check who received an NHS Health Check in the five year period</p> <p><u>Denominator</u>: Number of people aged 40-74 eligible for an NHS Health Check in the five year period</p>
Data source	<p><u>2013/14 onwards</u>: Responsibility for commissioning the NHS Health Check programme and reporting data on the programme transferred to local authorities in April 2013. Public Health England (PHE) publish these data quarterly on the NHS Health Check website.</p>
Publication of source data	<p><u>2013/14 onwards</u>: Data are published by PHE on the NHS Health Check website:</p> <p><a href="http://www.healthcheck.nhs.uk/public/interactive_map/">http://www.healthcheck.nhs.uk/public/interactive_map/</a></p>

2.23 Self-reported well-being	
Rationale	<p>Well-being is a key issue for the Government and ONS are leading a programme of work to develop new measures of national well-being. People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.</p> <p>Local data on well-being is likely to be a key component of local Joint Strategic Needs Assessments and form an important part of the work of local Health and Well-being Boards.</p>
Baseline period	<p>2.23i to 2.23iv: 2011/12</p>
Indicator	<p>The definitions for all sub-indicators 2.23i to 2.23iv (see below) are in line with ONS's Measuring National Well-being</p>

2.23 Self-reported well-being	
definition	<p>Programme.</p> <p>ONS are currently measuring individual/subjective well-being for adults (aged 16 and over) based on four questions included on the Annual Population Survey:</p> <ol style="list-style-type: none"> <li>1. Overall, how satisfied are you with your life nowadays?</li> <li>2. Overall, how happy did you feel yesterday?</li> <li>3. Overall, how anxious did you feel yesterday?</li> <li>4. Overall, to what extent do you feel the things you do in your life are worthwhile?</li> </ol> <p>Responses are given on a scale of 0-10 (where 0 is “not at all satisfied/happy/anxious/worthwhile” and 10 is “completely satisfied/happy/anxious/worthwhile”)</p> <p><b>2.23i The percentage of respondents scoring 0-4 to the question “Overall, how satisfied are you with your life nowadays?”</b></p> <p><b>2.23ii The percentage of respondents scoring 0-4 to the question "Overall, to what extent do you feel the things you do in your life are worthwhile?"</b></p> <p><b>2.23iii The percentage of respondents who answered 0-4 to the question "Overall, how happy did you feel yesterday?"</b></p> <p><b>2.23iv The percentage of respondents scoring 6-10 to the question "Overall, how anxious did you feel yesterday?"</b></p>
Data source	Annual Population Survey – Office for National Statistics
Publication of source data	<a href="http://www.ons.gov.uk/ons/rel/wellbeing/measuring-subjective-wellbeing-in-the-uk/first-annual-ons-experimental-subjective-well-being-results/first-ons-annual-experimental-subjective-well-being-results.html">http://www.ons.gov.uk/ons/rel/wellbeing/measuring-subjective-wellbeing-in-the-uk/first-annual-ons-experimental-subjective-well-being-results/first-ons-annual-experimental-subjective-well-being-results.html</a>

2.24 Injuries due to falls in people aged 65 and over	
Rationale	<p>Falls are the largest cause of emergency hospital admissions for older people, and have a significant impact on long term outcomes, e.g. being a major cause of people moving from their own home to long term nursing or residential care.</p> <p>Interventions for recently retired and active older people are likely to be different in provision and uptake for frailer older people.</p> <p>A measure which reflects the success of services in preventing falls will give an indication of how the NHS, public health and social care are working together to tackle issues locally.</p>
Baseline period	2010/11
Indicator definition	<p><b>2.24i Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population</b></p> <p><u>Numerator</u>: Number of hospital admissions for falls classified by first diagnosis code (ICD10 code S00 -T98X) and external cause (ICD10 code W00-W19) and with an emergency admission code in people aged 65 and over. Counted by first finished consultant episode in the respective financial year</p> <p><u>Denominator</u>: Number of people aged 65 and over based on ONS mid-year population estimates</p> <p>This indicator will have 2 further sub-indicators covering two different age splits (with numerators and denominators as for 2.24i but restricted to the age ranges specified):</p> <p><b>2.24ii Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 to 79 per 100,000 population</b></p> <p><b>2.24iii Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 80 and over per 100,000 population</b></p>
Data source	Hospital Episode Statistics (HES), Health and Social Care Information Centre

2.24 Injuries due to falls in people aged 65 and over	
Publication of source data	<p>The Health and Social Care Information Centre have published limited analysis (counts) of falls hospital admissions on their HES online website, using the external cause codes defined as ICD10 W00-W19, at national and SHA level. However, these data do not match the definition for this indicator.</p> <p>The Older Peoples Health Atlas produced by Public Health England (PHE) publishes falls admission rates for local authorities:</p> <p><a href="http://www.wmpho.org.uk/olderpeopleatlas/atlas/atlas.html">http://www.wmpho.org.uk/olderpeopleatlas/atlas/atlas.html</a></p> <p>In addition, the Injury Profiles produced by PHE publish falls and falls injuries emergency admission rates for ages 65 and over by local authorities:</p> <p><a href="http://www.apho.org.uk/default.aspx?QN=INJURY_DEFAULT">http://www.apho.org.uk/default.aspx?QN=INJURY_DEFAULT</a></p>

## Domain 3: Health protection

3.01 Fraction of mortality attributable to particulate air pollution	
Rationale	<p>Poor air quality is a significant public health issue. The burden of particulate air pollution in the UK was estimated to be equivalent to nearly 29,000 deaths in 2008 at typical ages and an associated loss of population life of 340,000 life years lost.</p> <p>Inclusion of this indicator in the Public Health Outcomes Framework will enable Directors of Public Health to prioritise action on air quality in their local area to help reduce the health burden from air pollution.</p>
Baseline period	2010
Indicator definition	<p><b>3.01 Fraction of annual all-cause adult mortality attributable to long-term exposure to current levels of anthropogenic particulate air pollution (measured as fine particulate matter, PM<sub>2.5</sub>*)</b></p> <p>Mortality burden associated with long-term exposure to anthropogenic particulate air pollution at current levels, expressed as the percentage of annual deaths from all causes in those aged 30+.</p> <p>* PM<sub>2.5</sub> means the mass (in micrograms) per cubic metre of air of particles with an aerodynamic diameter generally less than 2.5 micrometers. PM<sub>2.5</sub> is also known as fine particulate matter.</p> <p>An increase of 10 µg/m<sup>3</sup> in population-weighted annual average background concentration of PM<sub>2.5</sub> is assumed to increase all-cause mortality rates by a unit relative risk (RR) factor of 1.06. For a population-weighted modelled annual average anthropogenic background PM<sub>2.5</sub> concentration x, RR is calculated as <math>(1.06)^{(x/10)}</math> (Committee on the Medical Effects of Air Pollutants [COMEAP], 2010). The fraction of deaths attributable to PM<sub>2.5</sub> is expressed as a percentage, calculated as <math>100 \times (RR - 1) / RR</math>.</p> <p>Population-weighted annual average concentrations of anthropogenic PM<sub>2.5</sub> are provided by AEA for all lower tier and unitary local authorities within England. These are combined to produce figures at upper tier, regional and national level so that attributable fractions can be calculated at those scales also.</p>

3.01 Fraction of mortality attributable to particulate air pollution	
	<p>Concentrations of anthropogenic, rather than total, PM<sub>2.5</sub> are used as the basis for this indicator, as burden estimates based on total PM<sub>2.5</sub> might give a misleading impression of the scale of the potential influence of policy interventions (COMEAP, 2012).</p> <p>Note: this definition is different from that published in January 2012. Attributable fraction has several benefits as the metric of an indicator of the mortality effect associated with long-term exposure to current levels of air pollution: it is independent of the age-structure of the local population, is easy to interpret, is useful for prioritisation and comparison and is easy to calculate.</p>
Data source	<p>This indicator is calculated using population-weighted annual average background concentrations of anthropogenic PM<sub>2.5</sub>. These were calculated for 2010 by AEA (details below); The Department for the Environment and Rural Affairs (DEFRA) intends to make these figures available on its website in future years.</p> <p>Background annual average PM<sub>2.5</sub> concentrations for the year of interest are modelled on a 1km x 1km grid using an air dispersion model, and calibrated using measured concentrations taken from background sites in DEFRA's Automatic Urban and Rural Network (<a href="http://uk-air.defra.gov.uk/interactive-map">http://uk-air.defra.gov.uk/interactive-map</a>). Data on primary emissions from different sources from the National Atmospheric Emissions Inventory and a combination of measurement data for secondary inorganic aerosol and models for sources not included in the emission inventory (including re-suspension of dusts) are used to estimate the anthropogenic (human-made) component of these concentrations.</p> <p>By approximating local authority boundaries to the 1km by 1km grid, and using ONS census population data, population weighted background PM<sub>2.5</sub> concentrations for each lower tier local authority are calculated. This work is completed under contract to DEFRA, as a small extension of its obligations under the Ambient Air Quality Directive (2008/50/EC). The current contractor for this work is AEA.</p>
Publication of source data	<p>Methods for calculation of mortality effects, together with national estimates of the mortality burden of anthropogenic PM<sub>2.5</sub> in 2008 (and the predicted impact of reductions in PM<sub>2.5</sub>) are published in: COMEAP (2010) The Mortality Effects of Long-Term Exposure to Particulate Air Pollution in the United Kingdom. Available at : <a href="http://www.comeap.org.uk/subgroups/51-the-mortality-effects-of-long-term-exposure-to-particulate-air-pollution-in-the-united-">http://www.comeap.org.uk/subgroups/51-the-mortality-effects-of-long-term-exposure-to-particulate-air-pollution-in-the-united-</a></p>

3.01 Fraction of mortality attributable to particulate air pollution	
	<p><a href="#">kingdom</a></p> <p>COMEAP's views on estimating the mortality burden attributable to PM<sub>2.5</sub> at a local (e.g. local authority) level, and simplified methods for doing so, are published in: COMEAP (2012) Statement on Estimating the Mortality Burden of Particulate Air Pollution at the Local Level:</p> <p><a href="http://www.comeap.org.uk/documents/statements/39-page/linking/46-mortality-burden-of-particulate-air-pollution">http://www.comeap.org.uk/documents/statements/39-page/linking/46-mortality-burden-of-particulate-air-pollution</a></p> <p>Modelled background PM<sub>2.5</sub> data are published on a 1km x 1km grid square basis by DEFRA:</p> <p><a href="http://uk-air.defra.gov.uk/data/pcm-data">http://uk-air.defra.gov.uk/data/pcm-data</a></p>

3.02 Chlamydia detection rate (15-24 year olds)	
Rationale	<p>Chlamydia is the most commonly diagnosed sexually transmitted infection. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. The chlamydia detection rate amongst under 25 year olds is a measure of chlamydia control activities. It represents infections identified (reducing risk of sequelae in those patients and interrupting transmission on to others). Increasing diagnostic rates indicates increased control activity: it is not a measure of morbidity. Inclusion of this indicator in the Public Health Outcomes Framework allows monitoring of progress to control chlamydia.</p>
Baseline period	2012
Indicator definition	<p>Indicator 3.2ii has been renamed 3.2.</p> <p><b>3.02 Crude rate of chlamydia diagnoses detection per 100,000 young adults aged 15-24year olds attending GUM clinics, primary care and community services who are residents in England</b></p> <p><u>Numerator:</u> The number of people aged 15-24 diagnosed with chlamydia in England through publicly funded testing (does not</p>

3.02 Chlamydia detection rate (15-24 year olds)	
	<p>include tests paid for privately).</p> <p><u>Denominator</u>: Office for National Statistics mid-year resident population estimate for age 15-24 years</p> <p>PHE recommends that local authorities should be working towards achieving a diagnosis rate of at least 2,300 per 100,000 population. The PHOF detection rate was set by the Department of Health as a level that would encourage high volume screening and diagnoses, and:</p> <p>would be ambitious but achievable (one-third of primary care trusts were receiving this rate in 2011) was high enough to encourage community screening, rather than GUM only diagnoses, and</p> <p>would be likely to result in a continued chlamydia prevalence reduction, according to mathematical modelling.</p>
Data source	Public Health England (PHE)
Publication of source data	<p>Data are reported via Chlamydia Testing Activity Dataset (CTAD) <a href="https://www.gov.uk/government/collections/chlamydia-surveillance-data-screening-and-management">https://www.gov.uk/government/collections/chlamydia-surveillance-data-screening-and-management</a> - a mandatory laboratory based surveillance system for chlamydia tests and Genitourinary Medicine Clinic Activity Dataset (GUMCADv2) <a href="https://www.gov.uk/guidance/genitourinary-medicine-clinic-activity-dataset-gumcadv2">https://www.gov.uk/guidance/genitourinary-medicine-clinic-activity-dataset-gumcadv2</a> the mandatory STI surveillance system for all GUM (including integrated GUM &amp; Sexual and Reproductive Health (SRH)) services in England. Data are collected and collated by the HIV &amp; STI Department, National Infections Service, PHE, Colindale.</p>

3.03 Population vaccination coverage	
Rationale	<p>Vaccination coverage is the best routinely available indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely related to levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.</p> <p>This indicator will cover vaccination programmes across the life course as previous evidence shows that highlighting vaccination programmes encourages improvements in uptake levels.</p>



3.03 Population vaccination coverage	
Baseline period	<p><u>3.03i</u>: 2010/11</p> <p><u>3.03ii</u>: TBD (Experimental data may be published for those LAs that have a universal programme for 2015/6. It will then be determined if this is of appropriate quality to be used as the baseline)</p> <p><u>3.03iii to 3.03x inclusive</u>: 2010/11 (except for the 5 year old figures for 3.03vi as data only began to be collected part way through 2010/11 so the first full year of data available will be 2011/12)</p> <p><u>3.03xi</u>: TBD (Data for the first year (2014/15) has been requested. However, it may be incomplete as not available for all LAs. It will then be determined if this is of appropriate quality to be used as the baseline)</p> <p><u>3.03xii to 3.03xv inclusive</u>: 2010/11</p> <p><u>3.03xvi</u>: 2015/16</p> <p><u>3.03xvii</u>: 2014/15</p> <p><u>3.03xviii</u>: 2014/15</p>
Indicator definition	<p>This indicator provides a proxy for the level of protection a population will have against vaccine preventable communicable diseases and covers:</p> <ul style="list-style-type: none"> <li>• Targeted vaccination for neonates, infants and young children - Hepatitis B, influenza and BCG</li> <li>• Childhood immunisation programme - Diphtheria (D/d), tetanus (T), pertussis (aP), polio (IPV), <i>Haemophilus influenzae</i> type b (Hib), meningococcal serogroup C (MenC), pneumococcal (PCV), measles, mumps and rubella (MMR)</li> <li>• Adolescent immunisation programme - Diphtheria (D/d), tetanus (T) and polio (IPV), and Human papillomavirus (HPV) [girls only]</li> <li>• Adults aged 65+ years and 'at risk' programmes - seasonal influenza (Flu), shingles and pneumococcal polysaccharide vaccine (PPV)</li> </ul> <p><b>3.03i Hepatitis B vaccination coverage (1 and 2 year olds) – selective neonatal programme</b></p> <p><u>Numerator</u>: Number of children at age 1 and 2 years who have received the complete course of hepatitis B vaccine in the eligible population within each reporting area [at present former PCTs expected to change to LA resident population]</p>

### 3.03 Population vaccination coverage

Denominator: Eligible children defined as babies born to mothers who are chronically infected with HBV or to mothers who have had acute hepatitis B during pregnancy, in the hepatitis B chapter of the immunisation against infectious diseases 'Green Book' resident within each reporting area [at present former PCTs, expected to change to LA resident population]

#### **3.03ii Selective neonatal BCG vaccination coverage (aged under 1 year) – areas offering universal BCG only**

*Note: Since the definition published in January 2012, the age range for this indicator has been amended from 1-16 year olds to those aged under 1 year as most vaccinations are given opportunistically above this age.*

*After reporting on the KC50 was suspended following a review in 2013, PHE has proposed that BCG vaccinations for children will be incorporated into the current COVER collection. PHE released a new COVER user guide in December 2015 that lists BCG as one of the immunisations that has to be submitted. There is also anticipation that BCG coverage data quality will improve once moved to COVER.*

*There is likely to be some experimental data published for those LAs that have a universal programme for 2015/16. However, it is yet to be determined whether this will be of suitable completeness to form the baseline.*

*There is an on-going BCG vaccine shortage which will be reflected in the data for 2016/17 (children offered vaccine during the shortage). However, due to the uncertainty around the accuracy of the 15/16 data, it will be difficult to determine how much of any difference in coverage between 15/16 and 16/17 will be due to vaccine shortage, and how much to lack of accuracy in the 15/16 data.*

Numerator: Number of children at age 1 who have received the BCG vaccination within the reporting area [at present LA responsible population (for those running a universal neonatal programme), expected to change to LA resident population]

Denominator: Number of children at age 1 resident within each reporting area [at present LA responsible population (for those running a universal neonatal programme), expected to change to LA resident population]

#### **3.03iii DTaP / IPV / Hib vaccination coverage (1 and 2 year olds)**

### 3.03 Population vaccination coverage

Numerator: Number of children at age 1 and 2 years who have received the complete course of DTaP / IPV / Hib vaccine within each reporting area [at present LA responsible population, expected to change to LA resident population]

Denominator: Number of children at age 1 and 2 years resident within each reporting area [at present LA responsible population, expected to change to LA resident population]

#### 3.03iv MenC vaccination coverage (1 year olds)

*Note: Since the definition published in January 2012, the age range for this indicator has been amended from 1, 2 and 5 year olds to just 1 year olds as after a child's first birthday. MenC is also monitored with Hib coverage (covered by sub-indicator 3.3vi). From 1st July 2016 the dose of MenC offered at 3 months is to be discontinued and so the 1 year evaluation 3.03iv indicator will become obsolete within the next two years (data for 2015/16 collected for publication Sept 2016; data for 2016/17 will be the last collection).*

Numerator: Number of children at age 1 year who have received the completed course of MenC vaccine within each reporting area [at present LA responsible population, expected to change to LA resident population]

Denominator: Number of children at age 1 year resident within each reporting area [at present LA responsible population, expected to change to LA resident population]

#### 3.03v PCV vaccination coverage (1 year olds)

*Note: Since the definition published in January 2012, the age range for this indicator has been amended from 1, 2 and 5 year olds to just 1 year olds as a PCV booster is offered at age 2 years (covered by sub-indicator 3.3vii) and PCV vaccination is not offered beyond this age*

Numerator: Number of children at age 1 year who have received the completed primary course of PCV vaccine within each reporting area [at present LA responsible population, expected to change to LA resident population]

Denominator: Number of children at age 1 year resident within each reporting area [at present LA responsible population, expected to change to LA resident population]

### 3.03 Population vaccination coverage

#### **3.03vi Hib / MenC booster vaccination coverage (2 and 5 year olds)**

*Note: From 1st July 2016 the dose of MenC offered at 3 months is to be discontinued and so MenC dose included in the Hib/MenC vaccination will no longer be a booster dose, but a first dose. A change in the indicator name, removing the mention of booster, should be considered from 17/18*

Numerator: Number of children at age 2 and 5 years who have received one booster dose of Hib/MenC vaccine within each reporting area [at present LA responsible population, expected to change to LA resident population]

Denominator: Number of children at age 2 and 5 years resident within each reporting area [at present LA responsible population, expected to change to LA resident population]

#### **3.03vii PCV booster vaccination coverage (2 year olds)**

*Note: Since the definition published in January 2012, the age range for this indicator has been amended from 2 and 5 year olds to just 2 year olds as a PCV booster is not offered beyond the age of 2 years*

Numerator: Number of children at age 2 years who have received one booster dose of PCV vaccine within each reporting area [at present LA responsible population, expected to change to LA resident population]

Denominator: Number of children at age 2 years resident within each reporting area [at present LA responsible population, expected to change to LA resident population]

#### **3.03viii MMR vaccination coverage for one dose (2 year olds)**

Numerator: Number of children at age 2 years who have received one dose of MMR vaccine within each reporting area [at present LA responsible population, expected to change to LA resident population]

Denominator: Number of children at age 2 years resident within each reporting area [at present LA responsible population, expected to change to LA resident population]

#### **3.03ix MMR vaccination coverage for one dose (5 year olds)**

Numerator: Number of children at age 5 years who have received one dose of MMR vaccine within each reporting area

3.03 Population vaccination coverage	
	<p>[at present LA responsible population, expected to change to LA resident population]</p> <p><u>Denominator</u>: Number of children at age 5 years resident within each reporting area [at present LA responsible population, expected to change to LA resident population]</p> <p><b>3.03x MMR vaccination coverage for two doses (5 year olds)</b></p> <p><u>Numerator</u>: Number of children at age 5 years who have received two doses of MMR vaccine within each reporting area [at present LA responsible population, expected to change to LA resident population]</p> <p><u>Denominator</u>: Number of children at age 5 years resident within each reporting area [at present PCT responsible population, expected to change to LA resident population]</p> <p><b>3.03xi Td / IPV booster vaccination coverage (13-14 year olds)</b></p> <p><u>Numerator</u>: Number of children in year 9 (aged 13-14) who have received the Td / IPV booster vaccination within each reporting area [at present LA school population]</p> <p><u>Denominator</u>: Number of children in year 9 (aged 13-14) resident within each reporting area [at present LA school population]</p> <p><b>3.03xii HPV vaccination coverage for one dose (females 12-13 year olds)</b></p> <p><i>Note: Since the definition published in January 2012, the age range for this indicator has been amended from 12-17 year olds to just 12-13 year olds as this is the age when the vaccination is routinely offered. In 2014, the 3 dose schedule delivered in one academic year changed to a 2 dose schedule delivered over 2 academic years. This means that data for only the first (priming) dose is available at 12-13 years. A new indicator, 3.03 xvi provides data for the completed 2-dose course (not available for publication until after September 2016)</i></p> <p><u>Numerator</u>: Number of females in year 8 (aged 12-13) who have received the priming dose of HPV vaccine within each reporting area [at present LA school population]</p> <p><u>Denominator</u>: Number of females in year 8 (aged 12-13) resident within each reporting area [at present LA school population]</p>

### 3.03 Population vaccination coverage

#### 3.03xiii PPV vaccination coverage (aged 65 and over)

Numerator: Number of adults aged 65 years and over who have received one dose of PPV within each reporting area [at present LA responsible population]

Denominator: Number of adults aged 65 years and over resident within each reporting area [at present LA responsible population]

#### 3.03xiv Flu vaccination coverage (aged 65 and over)

Numerator: Number of GP registered adults aged 65 years and over on the 31st March who have received Flu vaccine between the 1st September to the 31st January e.g. for 2014/15 it will cover all vaccinations administered from the 1st September 2014 to the 31st January 2015 for all those aged 65 years and over on the 31st March 2015. Each patient is only counted once, if they have had more than one dose to avoid double counting.

Denominator: Number of GP registered adults aged 65 years and over on the 31st March.

#### 3.03xv Flu vaccination coverage (at risk individuals from age six months to under 65 years, excluding otherwise 'healthy' pregnant women and carers)

*Note: Since the definition published in January 2012, the age range for this indicator has been clarified – it was previously presented as “at risk individuals aged over six months”*

Numerator: Number of GP registered individuals aged 6 months to under 65 and in a clinical risk group [as defined in the immunisation against infectious diseases 'Green Book' and detailed in a READ-code specification currently produced by PRIMIS] who have received Flu vaccine between the 1st September to the 31st January e.g. for 2014/15 it will cover all vaccinations administered from the 1st September 2014 to the 31st January 2015 for all those aged 6 months to under 65 years and in a clinical risk group on the day of extraction. Each patient is only counted once, if they have had more than one dose to avoid double counting.

Denominator: Number of GP registered individuals aged 6 months to under 65 and in a clinical risk group [as defined in the immunisation against infectious diseases 'Green Book' and detailed in a READ-code specification currently produced by PRIMIS] on the day of extraction within each reporting area.

### 3.03 Population vaccination coverage

*Note: sub-indicators 3.03xvi, 3.03xvii and 3.03xviii are new sub-indicators.*

#### **3.03xvi HPV vaccination for two doses (females 13-14 years old).**

*In 2014, the 3 dose schedule delivered in one academic year changed to a 2 dose schedule delivered over 2 academic years. This means that in 2015/2016 data for only the first (priming) dose is available at 12-13 years. Indicator, 3.03xvi provides data for the completed 2-dose course and will be available after September 2016.*

Numerator: Number of females in year 9 (aged 13-14) who have received the completed 2-dose course of HPV vaccine resident within each reporting area [at present LA school population]

Denominator: Number of females in year 9 (aged 13-14) resident within each reporting area [at present LA school population]

#### **3.03xvii Shingles vaccination coverage (70 years old)**

Numerator: Number of 70 year olds who have received a dose of shingles vaccine within each reporting area [at present LA responsible population]

Denominator: Number of 70 year olds within each reporting areas [at present LA responsible population]

#### **3.03xviii Flu vaccination coverage (2-4 years old)**

Numerator: the number of vaccinations administered during the influenza season between 1st September and 31st January. Data is collected for 2, 3 and 4 year olds separately and aggregated for the purposes of PHOF. 2, 3 and 4 years GP registered population is determined by the patient's age on the 31st August, e.g. for 2015/16, the birth cohort for those aged 2 years on the 31st August e.g. aged 2 from 1st September 2012 to 31st August 2013. This is to coincide with the academic school year. Each patient is only counted once, if they have had more than one dose to avoid double counting

Denominator: the GP registered population of 2, 3 and 4 years



3.03 Population vaccination coverage	
	on the 31st August. Data is collected for 2, 3 and 4 year olds separately and aggregated for the purposes of PHOF. 2, 3 and 4 years GP registered population is determined by the patient's age on the 31st August, e.g. for 2015/16, the birth cohort for those aged 2 years on the 31st August e.g. aged 2 from 1st September 2012 to 31st August 2013. This is to coincide with the academic school year.
Data source	<p><b>COVER</b> – data for the majority of childhood vaccinations including neonatal hepatitis B, DTaP / IPV / Hib, MenC, PCV, neonatal BCG, and MMR</p> <p><b>ImmForm system</b> – data for HPV, Td/IPV booster, Shingles, PPV and flu vaccinations</p>
Publication of source data	<p>Immunisation coverage data on the childhood immunisation programme for DTaP / IPV / Hib, MenC, PCV, BCG, MMR, and neonatal hepatitis B are published quarterly as official statistics by Public Health England:</p> <p><a href="https://www.gov.uk/government/collections/vaccine-uptake">https://www.gov.uk/government/collections/vaccine-uptake</a></p> <p>and annually as national statistics by the Health and Social Care Information Centre (HSCIC):</p> <p><a href="http://www.hscic.gov.uk/searchcatalogue">http://www.hscic.gov.uk/searchcatalogue</a></p> <p>HPV vaccine coverage data are published for each academic year. PPV vaccine coverage data are published for each financial year. Shingles coverage data are published as provisional cumulative data each quarter and then later as final annual data (Sep to Aug). Influenza vaccine coverage data are published as provisional data for each of the four months of the influenza season (Nov to Dec) and then later as final data.</p> <p>Data and guidance for each of these are produced by Public Health England:</p> <p><a href="https://www.gov.uk/government/collections/vaccine-uptake">https://www.gov.uk/government/collections/vaccine-uptake</a></p>

3.04 HIV late diagnosis	
Rationale	<p>HIV key strategic priorities are to (i) reduce the proportion of late HIV diagnoses and, (ii) increase the proportion of HIV infections diagnosed. Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection and is essential to evaluate the success of expanded HIV testing. This indicator directly measures late diagnoses; over time it will show</p>



3.04 HIV late diagnosis	
	whether there is a trend towards earlier diagnosis. This indicator, as a measure of the time between infection and diagnosis, also indirectly informs our understanding of the proportion of HIV infections undiagnosed.
Baseline period	2009-11
Indicator definition	<p><b>3.04 Percentage of adults (aged 15 or above) newly diagnosed with HIV with a CD4 count less than 350 cells per mm<sup>3</sup></b></p> <p><u>Numerator</u>: Number of adults (aged 15 years or more) newly diagnosed with HIV infection with a CD4 count less than 350 cells per mm<sup>3</sup> within 91 days and known residence-based information available*</p> <p><u>Denominator</u>: Number of adults (aged 15 years or more) newly diagnosed with HIV infection with CD4 counts available within 91 days and known residence-based information</p> <p>Data are reported annually but only three-year-combined data are shown in the 'Sexual and Reproductive Health Profiles' web resources due to small numbers in an individual year.</p> <p>*Since January 2012, the definition has been updated from a CD4 count &lt;200 cells/mm<sup>3</sup> within 91 days of diagnosis to &lt;350 cells/mm<sup>3</sup>. This reflects the 2008 BHIVA treatment guidelines which recommend patients should begin anti-retroviral therapy when CD4 cells counts drop &lt;350 cells/mm<sup>3</sup>.</p>
Data source	<p>Integrated HIV surveillance data: Survey Of Prevalent HIV Infections Diagnosed (SOPHID), HIV and AIDS New Diagnoses Database (HANDD), CD4 Surveillance Scheme (CD4) and the new HIV and AIDS reporting system (HARS) held by the HIV &amp; STI Department, National Infection Service, Public Health England (PHE)</p> <p><a href="https://www.gov.uk/government/collections/hiv-surveillance-data-and-management">https://www.gov.uk/government/collections/hiv-surveillance-data-and-management</a></p>
Publication	National HIV data are available at:

**3.04 HIV late diagnosis**

of source data	<a href="https://www.gov.uk/government/statistics/hiv-data-tables">https://www.gov.uk/government/statistics/hiv-data-tables</a>
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**3.05 Treatment completion for Tuberculosis (TB)**

Rationale	<p>TB re-emerged as a serious public health problem in the UK over the last two decades, with TB incidence rising above the European average.</p> <p>Timely treatment for TB is key to saving lives and preventing long-term ill health, as well as reducing the number of new infections and development of drug resistance. Preventing the development of drug resistant TB is particularly important as it has more severe health consequences and is considerably more expensive to treat.</p>
Baseline period	<p><u>3.05i</u>: 2010</p> <p><u>3.05ii</u>: 2009-11</p>
Indicator definition	<p><b>3.05i: Annual proportion of drug sensitive tuberculosis (TB) cases expected to complete treatment within 12 months who had completed treatment within 12 months of treatment start date</b> (exclusions: cases with rifampicin resistance or MDR-TB, and cases with CNS, spinal, miliary or disseminated TB who may require longer than the standard 6 month treatment course)</p> <p><u>Numerator</u>: Annual number of drug sensitive tuberculosis (TB) cases notified to Enhanced Tuberculosis Surveillance System (ETS) <b>who had completed a full course of treatment within 12 months of treatment start date</b> (exclusions: cases with rifampicin resistance or MDR-TB, and cases with CNS, spinal, miliary or disseminated TB who may require longer than the standard 6 month treatment course).</p> <p><u>Denominator</u>: Annual number of drug sensitive tuberculosis (TB) cases notified to Enhanced Tuberculosis Surveillance System (ETS) (exclusions: cases with rifampicin resistance or MDR-TB, and cases with CNS, spinal, miliary or disseminated TB who may require longer than the standard 6 month treatment course).</p>

3.05 Treatment completion for Tuberculosis (TB)	
	<p>Due to data suppression, some local authorities will not have data presented for TB treatment completion. A decision was taken to suppress treatment completion for upper level local authorities if the annual number of cases was under 20 to avoid deductive disclosure. Count data is also suppressed for local authorities with count data &lt;5. Proportions and confidence intervals are still displayed.</p> <p>The following supporting indicator is provided relating to the TB incidence rate to help local authorities understand why treatment completion data may not be published for their area due to low incidence, and to provide local authorities with information about levels of TB in their area and surrounding areas:</p> <p><b>3.05ii Rate of reported new cases of TB per year per 100,000 population</b></p> <p><u>Numerator</u>: Sum of the number of new tuberculosis (TB) cases notified to the Enhanced Tuberculosis Surveillance System (ETS) over a three year time period</p> <p><u>Denominator</u>: Office for National Statistics mid-year population (sum of the mid-year population estimates for each year of the three-year time period)</p>
Data source	Enhanced Tuberculosis Surveillance System (ETS), Public Health England and Office for National Statistics mid-year population estimates.
Publication of source data	<p>Data are published nationally on an annual basis by the Public Health England:</p> <p><b>HPA annual TB report:</b></p> <p><a href="https://www.gov.uk/government/collections/tuberculosis-and-other-mycobacterial-diseases-diagnosis-screening-management-and-data">https://www.gov.uk/government/collections/tuberculosis-and-other-mycobacterial-diseases-diagnosis-screening-management-and-data</a></p>

<b>3.06 Public sector organisations with a board approved sustainable development management plan</b>	
Rationale	<p>The Climate Change Act (2008) identifies an 80% reduction in carbon emissions by 2050 to reduce the UK contribution to climate change and requires regular assessment and adaptation to reduce the impacts of a changing climate. The Stern Review <a href="http://www.hm-treasury.gov.uk/sternreview_index.htm">http://www.hm-treasury.gov.uk/sternreview_index.htm</a> outlines the impacts of climate change as a cause of premature mortality and avoidable ill health.</p> <p>Sustainable development provides a framework for balancing economic, social and environmental considerations, including climate change – this supports public health through strengthening community resilience and reducing health inequalities in addition to adapting for the years ahead. Achievement of a sustainable, low carbon, public sector will not be possible without monitoring and measuring progress. The first step to monitoring sustainability is a process measure for board approved sustainable development management plans for public sector organisations.</p>
Baseline period	2010/11 - status as at 31 <sup>st</sup> March 2011
Indicator definition	<p><b>3.06 Percentage of NHS organisations with a board approved sustainable development management plan that has been signed off at board level</b></p> <p><u>Numerator</u>: For a given date, the number of NHS organisations assigned to a local authority where the board approved a sustainable development management plan in the preceding 12 months</p> <p><u>Denominator</u>: For a given date, the total number of NHS organisations assigned to that local authority includes SHA and ambulance Trusts have been allocated on the basis of area served; Acute Trusts have been allocated based on patient flow data derived from Hospital Episode Statistics; Community and mental health Trusts have been allocated based on area served as published by NHS Choices and the Trusts themselves - see caveat on specialist services; and Specialist Trusts have been allocated to a single LA based on the geographic location of the Trust as defined by postcode.</p> <p>A sustainable development management plan is a board approved document that assists organisations to clarify their</p>

<b>3.06 Public sector organisations with a board approved sustainable development management plan</b>	
	<p>objectives on sustainable development (including mitigation and adaptation to climate change) and sets out a plan of action. Experience and empirical evidence from working with NHS boards suggests that organisations who have not considered the legal, policy and reputational drivers for sustainability will not have a sound operational approach to sustainable development.</p> <p>The mapping of NHS organisations to LA has been done on the basis of best available information. NHS organisations can appear in the denominator of more than one LA. All NHS organisations appear in the denominator of at least one LA. Where organisations provide very specialist services distant to their main area of provision this has been discounted from the mapping.</p> <p>Note: the definition for this indicator is restricted to NHS organisations only. The intention is that in future further indicators should be developed to cover all public sector organisations that have an influence on the public health of the population. Services provided on behalf of the public sector could also be included in this study.</p>
Data source	Based on responses to the question: "Has your board approved a sustainable development management plan in the last 12 months?" asked in the NHS Sustainability reporting template – this has been mandatory since 2011.
Publication of source data	To be confirmed.

<b>3.08 Antimicrobial Resistance</b>	
Rationale	Antimicrobial Resistance (AMR) is on the 2015 National risk register of civil emergencies. The UK five year AMR strategy 2013 to 2018 set out actions to slow the development and spread of antimicrobial resistance with a focus on antibiotics. The strategy is overseen by a cross government multi-agency steering group.

3.08 Antimicrobial Resistance	
	<p>Within an international context AMR has been highlighted by G7 and the World Health Organisation refers to AMR as a threat to global health security that is endangering the prevention and treatment of infections.</p> <p>Therefore it has been decided to add an indicator on antimicrobial resistance into the PHOF, which encompasses prescribing, cleanliness, healthcare associated infections, and resistance data.</p> <p>Reductions in antibiotic consumption is a well-recognised target in AMR policies across PHE, the NHS, DH and internationally, including WHO. This can be used as an overall metric for benchmarking across Local Authorities, bringing together a whole health economy approach with NHS prescriptions from all types of hospitals (including Acute, Mental Health, Community etc.), General Practices, other Community Locations (Urgent care, Walk-in-Centres). Data from Dentists is only available at NHS area team at present but will be added to this metric when available.</p>
Baseline period	2013/14
Indicator definition	<p><b>Antibiotic consumption by the NHS, expressed as Defined Daily Doses of Antibiotics per 1000 inhabitants per day, dispensed in NHS hospitals and community pharmacies.</b></p> <p><u>Numerator:</u> Antibiotic consumption is reported as defined daily dose (DDD). The DDD is the internationally recognised unit of measurement of medicine consumption, recommended by the World Health Organisation (WHO), which allows comparison of use of medicines over time and between different countries/locations. This is a measure of activity to sustain or reduce total levels of antibiotic consumption.</p> <p><u>Denominator:</u> Office of National Statistics (ONS) mid-year population estimates multiplied by the number of days in the period under survey</p>
Data source	ESPAUR (English surveillance programme antimicrobial utilisation and resistance) collects and validates antibiotic consumption data at CCG, Trust and primary care level and this will be available on the Fingertips website by March 2016.
Publication of source	Information on the use of antibiotics prescribed in general practice, and other community prescribing (GP out-of-hours

### 3.08 Antimicrobial Resistance

data	<p>services, walk-in centres, urgent emergency care, community health services, hospital services, nursing homes, public health services, hospices and custody services) will be obtained from the NHS Business Services Authority (NHSBSA) database via the Health &amp; Social Care Information Centre (HSCIC).</p> <p>Use of antibiotics in secondary care was obtained directly from NHS Acute Trusts to PHE.</p>
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## Domain 4: Healthcare public health and preventing premature mortality

4.01 Infant mortality	
Rationale	<p>This indicator is in line with the Government's direction for public health on starting well through early intervention and prevention. Reducing the risk of infant mortality will improve the life chances, health and well-being of both the mother and the baby.</p> <p>This is a shared indicator with the NHS Outcomes Framework, addressing issues of premature mortality, which are influenced by both the NHS and public health interventions.</p>
Baseline period	2009-11
Indicator definition	<p><b>4.01 Crude rate of infant deaths (persons aged less than 1 year) per 1,000 live births</b></p> <p><i>This indicator is shared with indicator 1.6i in the NHS Outcomes Framework.</i></p> <p>Rates are based on pooled data for three year periods.</p> <p><u>Numerator</u>: The number of infant deaths (aged under 1 year) registered in the respective calendar years</p> <p><u>Denominator</u>: The number of live births in the respective calendar years</p>
Data source	Office for National Statistics (ONS) births and deaths data
Publication of source data	<p>Data on infant mortality is published annually by ONS:</p> <p>Summary data based on death registrations</p> <p><a href="http://www.ons.gov.uk/ons/rel/vsob1/death-reg-sum-tables/index.html">http://www.ons.gov.uk/ons/rel/vsob1/death-reg-sum-tables/index.html</a></p> <p>More detailed data for England and Wales based on death occurrences</p> <p><a href="http://www.ons.gov.uk/ons/rel/vsob1/child-mortality-statistics--childhood--infant-and-perinatal/index.html">http://www.ons.gov.uk/ons/rel/vsob1/child-mortality-statistics--childhood--infant-and-perinatal/index.html</a></p>



4.01 Infant mortality	
	<p>Breakdown by social and biological factors for England and Wales based on death occurrences</p> <p><a href="http://www.ons.gov.uk/ons/rel/child-health/infant-and-perinatal-mortality-in-england-and-wales-by-social-and-biological-factors/index.html">http://www.ons.gov.uk/ons/rel/child-health/infant-and-perinatal-mortality-in-england-and-wales-by-social-and-biological-factors/index.html</a></p> <p>Local authority level figures are published annually in the Local Authority Health Profiles and on the Health and Social Care Information Centre (HSCIC) Indicator Portal:</p> <p><a href="http://www.healthprofiles.info">http://www.healthprofiles.info</a></p> <p><a href="https://indicators.ic.nhs.uk/webview/">https://indicators.ic.nhs.uk/webview/</a></p>

4.02 Proportion of five year old children free from dental decay	
Rationale	<p>Tooth decay is a predominantly preventable disease. Significant levels remain (31% of 12 –year old children have observable decay), resulting in pain, sleep loss, time off school and in a few cases treatment under general anaesthetic.</p> <p>Inclusion of this indicator in the Public Health Outcomes Framework will encourage local authorities to focus on and prioritise oral health and oral health improvement initiatives to reduce tooth decay.</p> <p>Decay levels at age five can give an indication of the success of early life interventions to improve parenting, infant feeding, hygiene and other home care habits that impact on the health of young children and their readiness to learn.</p>
Baseline period	2011/12
Indicator definition	<p><b>4.02 Proportion of five year old children free from dental decay</b></p> <p><u>Numerator</u>: Total number of five year old children in survey sample free from dental decay</p> <p><u>Denominator</u>: Total number of five year old children in survey sample.</p>

4.02 Proportion of five year old children free from dental decay	
Data source	<p>National Dental Epidemiology Programme for England, Oral Health Survey of five year old children</p> <p>Coordinated and standardised fieldwork surveys of random samples of children for whom consent to dental examination has been given</p>
Publication of source data	<p>Main page of the publication:</p> <p><a href="http://www.nwph.net/dentalhealth/">http://www.nwph.net/dentalhealth/</a></p> <p><a href="http://www.nwph.net/dentalhealth/survey-results%205(14_15).aspx">http://www.nwph.net/dentalhealth/survey-results%205(14_15).aspx</a></p>

4.03 Mortality rate from causes considered preventable	
Rationale	<p>Preventable mortality can be defined in terms of causes that are considered to be preventable through individual behaviour or public health measures limiting individual exposure to harmful substances or conditions. Examples include lung cancer, illicit drug use disorders, land transport accidents and certain infectious diseases.</p> <p>The inclusion of this indicator in the Public Health Outcomes Framework (alongside an indicator on mortality from causes amenable to healthcare in the NHS Outcomes Framework) sends out a clear signal of the importance of prevention as well as treatment in reducing avoidable deaths.</p>
Baseline period	2009-11
Indicator definition	<p>The indicator is based on the preventable mortality component of avoidable mortality as defined by the Office for National Statistics (ONS) in April 2012. A death is considered preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense.</p> <p><b>4.03 Age-standardised rate of mortality from causes</b></p>

#### 4.03 Mortality rate from causes considered preventable

##### considered preventable per 100,000 population

*This indicator is complementary to indicator 1a in the NHS Outcomes Framework, which measures Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare.*

Rates are based on pooled data for three year periods.

Numerator: Number of deaths that are considered preventable (classified by underlying cause of death recorded as ICD10 codes set out in the table below, and for the age groups shown) registered in the respective calendar years

ICD10 codes	Condition group and cause	Ages included
<b>Infections</b>		
A15-A19, B90	Tuberculosis	0-74
B17.1, B18.2	Hepatitis C	0-74
B20-B24	HIV/AIDS	All
<b>Neoplasms</b>		
C00-C14	Malignant neoplasm of lip, oral cavity and pharynx	0-74
C15	Malignant neoplasm of oesophagus	0-74
C16	Malignant neoplasm of stomach	0-74
C18-C21	Malignant neoplasm of colon and rectum	0-74
C22	Malignant neoplasm of liver	0-74
C33-C34	Malignant neoplasm of trachea, bronchus and lung	0-74
C43	Malignant melanoma of skin	0-74
C45	Mesothelioma	0-74
C50	Malignant neoplasm of breast	0-74
C53	Malignant neoplasm of cervix uteri	0-74
<b>Nutritional, endocrine and metabolic</b>		

4.03 Mortality rate from causes considered preventable			
	E10-E14	Diabetes mellitus	0-49
	<b>Drug use disorders</b>		
	F10, G31.2, G62.1, I42.6, K29.2, K70, K73, K74 (excl. K74.3-K74.5), K86.0	Alcohol related diseases, excluding external causes	0-74
	F11-F16, F18-F19	Illicit drug use disorders	0-74
	<b>Cardiovascular diseases</b>		
	I20-I25	Ischaemic heart disease	0-74
	I26, I80.1-I80.3, I80.9, I82.9	DVT with pulmonary embolism	0-74
	I71	Aortic aneurysm and dissection	0-74
	<b>Respiratory diseases</b>		
	J09-J11	Influenza (including swine flu)	0-74
	J40-J44	Chronic obstructive pulmonary disorder	0-74
	<b>Unintentional injuries</b>		
	V01-V99	Transport Accidents	All
	W00-X59	Accidental Injury	All
	<b>Intentional injuries</b>		
	X60-X84, Y10-Y34	Suicide and self-inflicted injuries	All
	X85-Y09, U50.9	Homicide/Assault	All
	Y60-Y69, Y83-Y84	Misadventures to patients during surgical and medical care	All
	<u>Denominator:</u> ONS mid-year population estimates aggregated across three years		
Data source	Office for National Statistics (ONS) death registrations and mid-year population estimates		
Publication of source	ONS publish annual data on avoidable mortality, including preventable mortality, at national level:		

4.03 Mortality rate from causes considered preventable	
data	<a href="http://www.ons.gov.uk/ons/rel/subnational-health4/avoidable-mortality-in-england-and-wales/index.html">http://www.ons.gov.uk/ons/rel/subnational-health4/avoidable-mortality-in-england-and-wales/index.html</a>

4.04 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)	
Rationale	<p>Cardiovascular disease (CVD) is one of the major causes of death in under 75s in England. There have been huge gains over the past decades in terms of better treatment for CVD and improvements in lifestyle, but to ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment.</p> <p>The inclusion of this as a shared indicator in the Public Health Outcomes Framework and NHS Outcomes Framework sends out a clear signal of the importance of prevention as well as treatment of CVD.</p>
Baseline period	2009-11
Indicator definition	<p><b>4.04i Age-standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years of age per 100,000 population</b></p> <p><i>This indicator is shared with indicator 1.1 in the NHS Outcomes Framework.</i></p> <p>Rates are based on pooled data for three year periods.</p> <p><u>Numerator:</u> Number of deaths from all cardiovascular diseases (classified by underlying cause of death recorded as ICD10 codes I00-I99) registered in the respective calendar years, in people aged under 75</p> <p><u>Denominator:</u> Office for National Statistics (ONS) mid-year population estimates aggregated across three years, for people aged under 75</p>

#### 4.04 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)

##### 4.04ii Age-standardised rate of mortality that is considered preventable from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years of age per 100,000 population

This indicator is based on the preventable mortality component of avoidable mortality as defined by ONS in April 2012.

Rates are based on pooled data for three year periods.

Numerator: Number of deaths that are considered preventable from all cardiovascular diseases (classified by underlying cause of death recorded as ICD10 codes set out in the table below) registered in the respective calendar years, in people aged under 75

Denominator: ONS mid-year population estimates aggregated across three years, for people aged under 75

ICD10 codes	Condition group and cause	Ages included
I20-I25	Ischaemic heart disease	0-74
I26, I80.1-I80.3, I80.9, I82.9	DVT with pulmonary embolism	0-74
I71	Aortic aneurysm and dissection	0-74
I42.6	Alcoholic cardiomyopathy	0-74

Data source	ONS death registrations and mid-year population estimates
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Publication of source data	The Health and Social Care Information Centre (HSCIC) publish annual data on mortality rates from all cardiovascular diseases at national and local authority level on the HSCIC Indicator
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#### 4.04 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)

Portal: <https://indicators.ic.nhs.uk/webview/>

#### 4.05 Under 75 mortality rate from cancer

Rationale	<p>Cancer is the highest cause of death in England in under 75s. To ensure that there continues to be a reduction in the rate of premature mortality from cancer, there needs to be concerted action in both prevention and treatment.</p> <p>The inclusion of this as a shared indicator in the Public Health Outcomes Framework and NHS Outcomes Framework sends out a clear signal of the importance of prevention as well as treatment of cancer.</p>
Baseline period	2009-11
Indicator definition	<p><b>4.05i Age-standardised rate of mortality from all cancers in persons less than 75 years of age per 100,000 population</b></p> <p><i>This indicator is shared with indicator 1.4.vii in the NHS Outcomes Framework.</i></p> <p>Rates are based on pooled data for three year periods.</p> <p><u>Numerator:</u> Number of deaths from all cancers (classified by underlying cause of death recorded as ICD10 codes C00-C97) registered in the respective calendar years, in people aged under 75</p> <p><u>Denominator:</u> Office for National Statistics (ONS) mid-year population estimates aggregated across three years, for people aged under 75</p> <p><b>4.05ii Age-standardised rate of mortality that is considered preventable from all cancers in persons less than 75 years of age per 100,000 population</b></p> <p>This indicator is based on the preventable mortality component of avoidable mortality as defined by ONS in April 2012.</p>

4.05 Under 75 mortality rate from cancer			
	Rates are based on pooled data for three year periods.		
	<u>Numerator:</u> Number of deaths that are considered preventable from all cancers (classified by underlying cause of death recorded as ICD10 codes set out in the table below) registered in the respective calendar years, in people aged under 75		
	<b>ICD10 codes</b>	<b>Condition group and cause</b>	<b>Ages included</b>
	C00-C14	Malignant neoplasm of lip, oral cavity and pharynx	0-74
	C15	Malignant neoplasm of oesophagus	0-74
	C16	Malignant neoplasm of stomach	0-74
	C18-C21	Malignant neoplasm of colon and rectum	0-74
	C22	Malignant neoplasm of liver	0-74
	C33-C34	Malignant neoplasm of trachea, bronchus and lung	0-74
	C43	Malignant melanoma of skin	0-74
	C45	Mesothelioma	0-74
	C50	Malignant neoplasm of breast	0-74
	C53	Malignant neoplasm of cervix uteri	0-74
<u>Denominator:</u> ONS mid-year population estimates aggregated across three years, for people aged under 75.			
Data source	ONS death registrations and mid-year population estimates.		
Publication of source data	The Health and Social Care Information Centre (HSCIC) publish annual data on mortality rates from all cancers at national and local authority level on the HSCIC Indicator Portal: <a href="https://indicators.ic.nhs.uk/webview/">https://indicators.ic.nhs.uk/webview/</a>		



4.06 Under 75 mortality rate from liver disease																									
Rationale	<p>Liver disease is one of the top causes of death in England and people are dying from it at younger ages. Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence, which are both amenable to public health interventions.</p> <p>The inclusion of this as a shared indicator in the Public Health Outcomes Framework and NHS Outcomes Framework sends out a clear signal of the importance of prevention as well as treatment of liver disease, and will provide an impetus for local authorities to prioritise action on the drivers of liver disease.</p>																								
Baseline period	2009-11																								
Indicator definition	<p><b>4.06i Age-standardised rate of mortality from liver disease in persons less than 75 years of age per 100,000 population</b></p> <p><i>This indicator is shared with indicator 1.3 in the NHS Outcomes Framework.</i></p> <p>Rates are based on pooled data for three year periods.</p> <p><u>Numerator:</u> Number of deaths from liver disease (classified by underlying cause of death recorded as ICD10 codes set out in the table below) registered in the respective calendar years, in people aged under 75</p> <table> <tr> <th>ICD10 codes</th><th>Condition group and cause</th></tr> <tr> <td>K70</td><td>Alcoholic liver disease</td></tr> <tr> <td>K71</td><td>Toxic liver disease</td></tr> <tr> <td>K72</td><td>Hepatic failure, not elsewhere classified</td></tr> <tr> <td>K73</td><td>Chronic hepatitis, not elsewhere classified</td></tr> <tr> <td>K74</td><td>Fibrosis and cirrhosis of liver</td></tr> <tr> <td>K75</td><td>Other inflammatory liver diseases</td></tr> <tr> <td>K76</td><td>Other diseases of liver</td></tr> <tr> <td>K77</td><td>Liver disorders in diseases classified elsewhere</td></tr> <tr> <td>B15</td><td>Acute hepatitis A</td></tr> <tr> <td>B16</td><td>Acute hepatitis B</td></tr> <tr> <td>B17</td><td>Other acute viral hepatitis</td></tr> </table>	ICD10 codes	Condition group and cause	K70	Alcoholic liver disease	K71	Toxic liver disease	K72	Hepatic failure, not elsewhere classified	K73	Chronic hepatitis, not elsewhere classified	K74	Fibrosis and cirrhosis of liver	K75	Other inflammatory liver diseases	K76	Other diseases of liver	K77	Liver disorders in diseases classified elsewhere	B15	Acute hepatitis A	B16	Acute hepatitis B	B17	Other acute viral hepatitis
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4.06 Under 75 mortality rate from liver disease														
	<p>           B18 Chronic viral hepatitis            B19 Unspecified viral hepatitis            C22 Malignant neoplasm of liver            I81 Portal vein thrombosis            I85 Oesophageal varices            T86.4 Liver transplant failure and rejection         </p> <p> <u>Denominator:</u> Office for National Statistics (ONS) mid-year population estimates aggregated across three years, for people aged under 75         </p> <p> <b>4.06ii Age-standardised rate of mortality that is considered preventable from liver disease in persons less than 75 years of age per 100,000 population</b> </p> <p>           This indicator is based on the preventable mortality component of avoidable mortality as defined by ONS in April 2012.         </p> <p>           Rates are based on pooled data for three year periods.         </p> <p> <u>Numerator:</u> Number of deaths that are considered preventable from liver disease (classified by underlying cause of death recorded as ICD10 codes set out in the table below) registered in the respective calendar years, in people aged under 75         </p> <table> <tr> <th>ICD10 codes</th><th>Condition group and cause</th><th>Ages included</th></tr> <tr> <td>K70, K73, K74 (excl. K74.3-K74.5)</td><td>Alcohol related diseases, excluding external causes</td><td>0-74</td></tr> <tr> <td>B17.1, B18.2</td><td>Hepatitis C</td><td>0-74</td></tr> <tr> <td>C22</td><td>Malignant neoplasm of liver</td><td>0-74</td></tr> </table> <p> <u>Denominator:</u> ONS mid-year population estimates aggregated across three years, for people aged under 75.         </p>	ICD10 codes	Condition group and cause	Ages included	K70, K73, K74 (excl. K74.3-K74.5)	Alcohol related diseases, excluding external causes	0-74	B17.1, B18.2	Hepatitis C	0-74	C22	Malignant neoplasm of liver	0-74	
ICD10 codes	Condition group and cause	Ages included												
K70, K73, K74 (excl. K74.3-K74.5)	Alcohol related diseases, excluding external causes	0-74												
B17.1, B18.2	Hepatitis C	0-74												
C22	Malignant neoplasm of liver	0-74												
Data source	ONS death registrations and mid-year population estimates													
Publication of source	The Health and Social Care Information Centre (HSCIC) publish annual data on mortality rates from all liver disease at national and local authority level as part of the NHS Outcomes													

4.06 Under 75 mortality rate from liver disease	
data	Framework indicator data on the HSCIC Indicator Portal: <a href="https://indicators.ic.nhs.uk/webview/">https://indicators.ic.nhs.uk/webview/</a>

4.07 Under 75 mortality rate from respiratory diseases	
Rationale	<p>Respiratory disease is one of the top causes of death in England in under 75s and smoking is the major cause of chronic obstructive pulmonary disease (COPD), one of the major respiratory diseases. This indicator will focus public health attention on the prevention of smoking and other environmental factors that contribute to people getting respiratory disease.</p> <p>The inclusion of this as a shared indicator in the Public Health Outcomes Framework and NHS Outcomes Framework sends out a clear signal of the importance of prevention as well as treatment of respiratory diseases.</p>
Baseline period	2009-11
Indicator definition	<p><b>4.07i Age-standardised rate of mortality from respiratory diseases in persons less than 75 years of age per 100,000 population</b></p> <p><i>This indicator is shared with indicator 1.2 in the NHS Outcomes Framework.</i></p> <p>Rates are based on pooled data for three year periods.</p> <p><u>Numerator:</u> Number of deaths from respiratory diseases (classified by underlying cause of death recorded as ICD10 codes J00-J99) registered in the respective calendar years, in people aged under 75</p> <p><u>Denominator:</u> Office for National Statistics (ONS) mid-year population estimates aggregated across three years, for people aged under 75</p> <p><b>4.07ii Age-standardised rate of mortality that is considered preventable from respiratory diseases in persons less than 75 years of age per 100,000 population</b></p>

4.07 Under 75 mortality rate from respiratory diseases			
	This indicator is based on the preventable mortality component of avoidable mortality as defined by ONS in April 2012.		
	Rates are based on pooled data for three year periods.		
	<u>Numerator:</u> Number of deaths that are considered preventable from respiratory disease (classified by underlying cause of death recorded as ICD10 codes set out in the table below) registered in the respective calendar years, in people aged under 75		
	<b>ICD10 codes</b>	<b>Condition group and cause</b>	<b>Ages included</b>
	J09-J11	Influenza (including swine flu)	0-74
	J40-J44	Chronic obstructive pulmonary disorder	0-74
	<u>Denominator:</u> ONS mid-year population estimates aggregated across three years, for people aged under 75		
Data source	ONS death registrations and mid-year population estimates		
Publication of source data	The Health and Social Care Information Centre (HSCIC) publish annual data on mortality rates from all respiratory diseases at national and local authority level as part of the NHS Outcomes Framework indicator data on the HSCIC Indicator Portal: <a href="https://indicators.ic.nhs.uk/webview/">https://indicators.ic.nhs.uk/webview/</a>		

4.08 Mortality rate from a range of specified communicable diseases, including influenza	
Rationale	<p>Inclusion of this indicator in the Public Health Outcomes Framework reinforces how seriously the Government takes the control of communicable diseases and prevention of avoidable deaths. Prevention of spread of communicable diseases is an important issue for Public Health. There is evidence that rapid identification, treatment and prevention of spread can reduce mortality.</p>

<b>4.08 Mortality rate from a range of specified communicable diseases, including influenza</b>	
Baseline period	2009-11
Indicator definition	<p><b>4.8 Age-standardised mortality rate from a range of specified communicable diseases (including influenza) per 100,000 population</b></p> <p>Rates are based on pooled data for three-year periods.</p> <p><u>Numerator:</u> Number of deaths from certain infectious and parasitic diseases (classified by underlying cause of death recorded as ICD10 codes A00-B99, J09-J11) registered in the respective calendar years</p> <p><u>Denominator:</u> Office for National Statistics (ONS) mid-year population estimates aggregated across three years</p>
Data source	ONS death registrations and mid-year population estimates
Publication of source data	<p>The Health and Social Care Information Centre (HSCIC) publish annual data on mortality rates from infectious and parasitic diseases (based on ICD10 codes A00-B99) and from influenza (ICD10 J09-J11) – i.e. not for the exact indicator defined above - at national and local authority level on the HSCIC Indicator Portal:</p> <p><a href="https://indicators.ic.nhs.uk/webview/">https://indicators.ic.nhs.uk/webview/</a></p>

<b>4.09 Excess under 75 mortality rate in adults with serious mental illness</b>	
Rationale	<p>The Disability Rights Commission has reported on the serious inequalities experienced (in terms of reduced life expectancy) by those with severe mental illness. For example, people with serious mental illness are estimated to be twice as likely to die from coronary heart disease and four times as likely to die from respiratory disease as the general population.</p>

4.09 Excess under 75 mortality rate in adults with serious mental illness	
	<p>4.09i is a shared indicator with the NHS Outcomes Framework – its inclusion in this and the Public Health Outcomes Framework reflects the importance of such high-level priorities being joined up between the public health and NHS / health service agendas.</p> <p>4.09ii measures the proportion of the population in contact with secondary mental health services in each local authority.</p> <p>This sub-indicator has been added to help local authorities understand their figures for the main indicator. This can be calculated from the data currently published in the HSCIC Indicator Portal for NHSOF 1.5i.</p>
Baseline period	2010/11
Indicator definition	<p><b>4.09i The ratio (expressed as a percentage) of the observed number of deaths in adults in contact with secondary mental health services to the expected number of deaths in that population based on age-specific mortality rates in the general population of England.</b></p> <p><i>This indicator is shared with indicator 1.5 in the NHS Outcomes Framework.</i></p> <p>Premature mortality in adults with serious mental illness (SMI) is compared to premature mortality in adults in the general population.</p> <p>‘Adults with serious mental illness’ are defined as anyone aged 18 or over who has been in contact with the secondary mental care services in the current financial year or in either of the two previous financial years who is alive at the beginning of the current financial year.</p> <p>Those aged 75 and over are excluded to align this indicator with the other premature mortality indicators in Domain 4, and those aged under 18 are excluded because children under 18 are not covered by the main data source (MHMDs). There is no evidence that children with SMI are at particularly high risk of death by disease.</p> <p>The mortality rate for adults with serious mental illness is directly standardised by age and sex to the general population of the relevant geographical area (i.e. England or individual local authority as appropriate). The general population mortality rate is the crude rate for people aged 18 to 74.</p> <p><u>Numerator:</u> For each local authority, the numerator is the</p>

4.09 Excess under 75 mortality rate in adults with serious mental illness	
	<p>observed count of deaths occurring amongst people with serious mental illness as defined on the MHMDS.</p> <p><u>Denominator</u>: For each local authority, the denominator is the number of deaths expected to occur amongst people with serious mental illness as defined on the MHMDS. England average mortality rates for each age group are applied to the local population from the MHMDS to obtain an expected number of deaths. This is the number of deaths that would be expected in the population with serious mental illness, if the death rates were exactly the same as in the general national population.</p> <p><b>4.09ii The percentage of the population in contact with Secondary Mental Health Services</b></p> <p>The Disability Rights Commission has reported on the serious inequalities experienced (in terms of reduced life expectancy) by those with severe mental illness. For example, people with serious mental illness are estimated to be twice as likely to die from coronary heart disease and four times as likely to die from respiratory disease as the general population.</p> <p>Numerator: The number of people aged between 18 and 74 in contact with secondary mental health services</p> <p>Denominator: the total population</p>
Data source	<p>Mental Health Minimum Dataset (MHMDS) data linked to mortality data in the Primary Care Mortality Database (PCMD), The Health and Social Care Information Centre.</p> <p>Office for National Statistics (ONS) death registrations and mid-year population estimates.</p>
Publication of source data	<p>Annual data on excess under 75 mortality in adults with serious mental illness at national and local authority level is published by The Health and Social Care Information Centre (HSCIC) as part of the NHS Outcomes Framework indicator data on the IC Indicator Portal:</p> <p><a href="https://indicators.ic.nhs.uk/webview/">https://indicators.ic.nhs.uk/webview/</a></p>

4.10 Suicide rate	
Rationale	<p><i>Preventing suicide in England: A cross-government outcomes strategy to save lives</i> (published September 2012) has the overall aim of reducing the suicide rate in the general population in England.</p> <p>The inclusion of this indicator in the Public Health Outcomes Framework reflects the importance of sustained efforts to keep the suicide rate at or below current levels.</p>
Baseline period	2009-11
Indicator definition	<p><b>4.10 Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population</b></p> <p>Rates are based on pooled data for three year periods.</p> <p>The Public Health Outcomes Framework and National Statistics definitions will now be aligned. This means that in the numerator, for codes X60-X84, only ages of 10 years or more will be included and for codes Y10-Y34, only ages of 15 years or more will be included. The population denominator will now be for ages 10 years or more.</p> <p><u>Numerator:</u> Number of deaths from suicide and injury of undetermined intent (classified by underlying cause of death recorded as ICD10 codes X60-X84 (ages 10 years or over) and Y10-Y34 (for ages 15 and over)) registered in the respective calendar years.</p> <p><u>Denominator:</u> Office for National Statistics (ONS) mid-year population estimates aggregated across three years for those aged 10 years or over.</p>
Data source	ONS death registrations and mid-year population estimates.
Publication of source data	<p>The Health and Social Care Information Centre (HSCIC) publish annual data on rates of mortality from suicide and injury of undetermined intent at national and local authority level on the HSCIC Indicator Portal (based on ICD10 codes X60-X84, Y10-Y34 (all ages) excluding Y33.9) – note this is not directly comparable to this indicator:</p> <p><a href="https://indicators.ic.nhs.uk/webview/">https://indicators.ic.nhs.uk/webview/</a></p>



4.11 Emergency readmissions within 30 days of discharge from hospital	
Rationale	<p>This indicator follows individuals discharged from hospital to monitor success in avoiding emergency readmissions. Health interventions and social care can play roles in putting in place the right re-ablement, rehabilitation and intermediate care services to support individuals to return home or regain their independence, so avoiding crisis in the short-term.</p> <p>This indicator is also included within the NHS Outcomes Framework under the domain 'Helping people to recover from episodes of ill health or following injury'.</p>
Baseline period	2010/11
Indicator definition	<p><b>4.11 Indirectly standardised percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission</b></p> <p><i>This indicator is shared with indicator 3b in the NHS Outcomes Framework.</i></p> <p>Readmissions for cancer and obstetrics are excluded.</p> <p><u>Numerator:</u> The number of finished and unfinished continuous inpatient (CIP) spells that are emergency admissions within 0-29 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main specialty upon readmission coded under obstetric; and those where the readmitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy for cancer coded anywhere in the spell</p> <p><u>Denominator:</u> The number of finished CIP spells within selected medical and surgical specialties, with a discharge date up to March 31st within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days prior to admission are excluded.</p>
Data source	Hospital Episode Statistics (HES), Health and Social Care Information Centre

4.11 Emergency readmissions within 30 days of discharge from hospital	
Publication of source data	<p>The Health and Social Care Information Centre (HSCIC) publish annual readmissions data at national and local authority level on the HSCIC Indicator Portal:</p> <p><a href="https://indicators.ic.nhs.uk/webview/">https://indicators.ic.nhs.uk/webview/</a></p>

4.12 Preventable sight loss	
Rationale	<p>Prevention of avoidable sight loss is recognised as a key priority for the WHO's global initiative for the elimination of avoidable blindness by 2020 – Vision 2020 – The Right To Sight to which the UK is a signatory and which is also a key priority for Vision 2020UK and the UK Vision Strategy. It is a particularly important issue in the context of an aging population.</p> <p>Inclusion of this indicator will ensure that avoidable sight loss is recognised as a critical and modifiable public health issue. Research by the Royal National Institute of Blind People (RNIB) suggests that 50% of cases of blindness and serious sight loss could be prevented if detected and treated in time. Prevention of sight loss will help people maintain independent lives as far as possible and reduce needs for social care support, which would be necessary if sight was lost permanently.</p>
Baseline period	2010/11
Indicator definition	<p><b>4.12i Crude rate of sight loss due to Age Related Macular Degeneration (AMD) in persons aged 65 and over per 100,000 population</b></p> <p>This indicator relates to AMD, the most prevalent of the three main eye diseases, which can result in blindness or partial sight if not diagnosed and treated in time.</p> <p><u>Numerator:</u> Count of new certifications of visual impairment (CVI) with a main cause of sight loss of AMD or where no main cause is attributed where AMD is a contributory cause, for</p>

## 4.12 Preventable sight loss

people aged 65 and over

Denominator: Office for National Statistics (ONS) mid-year population estimate, for people aged 65 and over

### 4.12ii Crude rate of sight loss due to glaucoma in persons aged 40 and over per 100,000 population

This indicator relates to glaucoma, one of the three main eye diseases, which can result in blindness or partial sight if not diagnosed and treated in time. The advice given for early detection of glaucoma, particularly if an individual is at high risk, is that they should be regularly reviewed by their optometrist from around age 40 years as this is when it may be clinically detectable or glaucomatous damage may develop.

Numerator: Count of new CVIs with a main cause of sight loss of glaucoma or where no main cause is attributed where glaucoma is a contributory cause, for people aged 40 and over

Denominator: ONS mid-year population estimate, for people aged 40 and over

### 4.12iii Crude rate of sight loss due to Diabetic Eye Disease in persons aged 12 and over per 100,000 population

This indicator relates to Diabetic Eye Disease, one of the three main eye diseases, which can result in blindness or partial sight if not diagnosed and treated in time. Diabetic retinopathy is the leading cause of preventable sight loss in working age people in the UK and early detection through screening halves the risk of blindness. By providing data on blindness due to diabetic retinopathy the indicator will also provide valuable information for the national diabetic retinopathy screening programme.

Numerator: Count of new CVIs with a main cause of sight loss of Diabetic Eye Disease or where no main cause is attributed where Diabetic Eye Disease is a contributory cause, for people aged 12 and over

Denominator: ONS mid-year population estimate, for people aged 12 and over

### 4.12iv Crude rate of sight loss certifications per 100,000 population

This indicator relates to completions of CVI (all causes both preventable and non-preventable) by a consultant

4.12 Preventable sight loss	
	<p>ophthalmologist - this initiates the process of registration with a local authority and leads to access to services</p> <p><u>Numerator:</u> New CVIs in the respective financial year</p> <p><u>Denominator:</u> ONS mid-year population estimate</p> <p>For further information on the methodology used for this indicator please see the descriptive metadata which accompanies the data.</p>
Data source	<p><u>Numerator:</u> The Database for Epidemiological data on Visual Impairment Certificates (DEVICE), the Certifications Office, the Royal College of Ophthalmologists, at Moorfields Eye Hospital NHS Foundation Trust, supported by a grant from RNIB. The Department of Health and the Royal College of ophthalmologists have jointly contracted Moorfields to be responsible for the data.</p> <p>Completion of a CVI (certificate of visual impairment) by a consultant ophthalmologist initiates the process of registration with a local authority and leads to access to services. Certification (CVI) and registration are voluntary.</p> <p>For information on caveats to the data please see the descriptive metadata which accompanies the data.</p> <p><u>Denominator:</u> ONS mid-year population estimates</p>
Publication of source data	<p>These indicators have been defined for the Public Health Outcomes Framework and have not been previously published.</p> <p>However, Moorfields Eye Hospital NHS Foundation Trust do publish CVI data specifically for diabetic eye disease annually by PCT – these data can be accessed by registered users only. Data for 2008/9 and 2009/10 are in the public domain - hosted on Moorfields website with access by request:</p> <p><a href="http://ecvi.moorfields.nhs.uk/Default.aspx">http://ecvi.moorfields.nhs.uk/Default.aspx</a></p> <p>The Health and Social Care Information Centre publish data on people registered Blind and Partially Sighted every three years at council level.</p> <p><a href="http://www.hscic.gov.uk/social-care">http://www.hscic.gov.uk/social-care</a></p>

4.13 Health-related quality of life for older people	
Rationale	<p>1 in 5 people are over 65 and this is set to rise to 1 in 3 by 2033. The number of "oldest old" (over 85) has doubled in the past decade and the percentage of people dying before 65 has remained constant for the past 20 years. Older people are the biggest and costliest users of health and social care – those with complex needs, long-term conditions, functional, sensory or cognitive impairment are the highest cost and volume group of service users. Dementia alone accounts for more expenditure than heart disease and cancer combined.</p> <p>This indicator will provide a greater focus on preventing ill health, preserving independence and promoting well-being in older people – this is key to keep systems functioning and to ensure that the needs of this large group of users are addressed.</p>
Baseline period	2011/12
Indicator definition	<p><b>4.13 Average health status score for adults aged 65 and over</b></p> <p>Health status is derived from responses to Q34 on the GP Patient Survey, which asks respondents to describe their health status using the five dimensions of the EuroQol 5D (EQ-5D) survey instrument:</p> <ul style="list-style-type: none"> <li>• Mobility</li> <li>• Self-care</li> <li>• Usual activities</li> <li>• Pain/discomfort</li> <li>• Anxiety/depression</li> </ul> <p>This indicator assesses whether health-related quality of life is changing over time, while controlling for potential measurable confounders (age, sex, long-term conditions, caring responsibility, etc.). The definition and the methodology for producing this indicator aligns as far as possible with the similar indicator on "Health-related quality of life for people with long-term conditions" in the NHS Outcomes Framework</p> <p>(<a href="https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014">https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014</a>)</p>

4.13 Health-related quality of life for older people	
	EQ-5D™ is a registered trademark of EuroQol. Further details are available from : <a href="http://www.euroqol.org/">http://www.euroqol.org/</a>
Data source	GP Patient Survey (GPPS)
Publication of source data	The most recent GP Patient Survey data covering 2012/13, is available at: <a href="https://gp-patient.co.uk/">https://gp-patient.co.uk/</a>

4.14 Hip fractures in people aged 65 and over	
Rationale	<p>Hip fracture is a debilitating condition - only 1 in 3 sufferers return to their former levels of independence and 1 in 3 end up leaving their own home and moving to long term care (resulting in social care costs). Hip fractures are almost as common and costly as strokes and the incidence is rising.</p> <p>There is evidence of interventions to treat osteoporosis, to prevent falls and to prevent fractures in people who have already suffered one fragility fracture. Interventions for recently retired and active older people are likely to be different in provision and uptake for frailer older people. Inclusion of this indicator in the Public Health Outcomes Framework will encourage prioritisation of such interventions.</p>
Baseline period	2010/11
Indicator definition	<p><b>4.14i Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 65 and over per 100,000 population</b></p> <p><u>Numerator</u>: Number of emergency hospital admissions classified by first diagnosis code (ICD10 primary diagnosis of S72.0, S72.1, S72.2) and with an emergency admission code in people aged 65 and over. Counted by first finished episode in the respective financial year.</p> <p><u>Denominator</u>: Number of people aged 65 and over based on</p>

4.14 Hip fractures in people aged 65 and over	
	<p>Office for National Statistics mid-year population estimates</p> <p>ICD10 codes for fractured proximal femur refer to the following primary diagnoses:</p> <ul style="list-style-type: none"> <li>• S72.0 Fracture of neck of femur</li> <li>• S72.1 Pertrochanteric fracture</li> <li>• S72.2 Subtrochanteric fracture</li> </ul> <p>This indicator will have two further sub-indicators covering two different age splits (with numerators and denominators as for 4.14i but restricted to the age ranges specified):</p> <p><b>4.14ii Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 65 to 79 per 100,000 population</b></p> <p><b>4.14iii Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 80 and over per 100,000 population</b></p> <p>Further work is needed to investigate the effect of transfers between hospitals on admission rates.</p>
Data source	<p>Hospital Episode Statistics (HES), Health and Social Care Information Centre</p> <p>Figures can be corroborated with the National Hip Fracture Database</p>
Publication of source data	<p>Limited headline data on numbers of hospital episodes for hip fractures are published in HES tables by the Health and Social Care Information Centre:</p> <p><a href="http://www.hscic.gov.uk/hes">http://www.hscic.gov.uk/hes</a></p> <p>Local authority data for this indicator is published annually in the Local Authority Health Profiles</p> <p><a href="http://www.healthprofiles.info">http://www.healthprofiles.info</a></p>

4.15 Excess winter deaths	
Rationale	<p>There are significantly more deaths in winter than in the rest of the year, particularly amongst older people and those on low incomes. Cold weather exacerbates minor and pre-existing medical conditions, and mental health is negatively affected by fuel poverty and cold housing.</p> <p>Excess winter deaths were identified as a public health challenge in Healthy Lives, Healthy People, the Marmot Review and the CMO annual report 2009. The Excess Winter Deaths Index is a key measure for the Cold Weather Plan for England.</p>
Baseline period	2010/11 for Single year data and 2009/12 for 3 years aggregated data
Indicator definition	<p><b>4.15i Excess Winter Deaths Index (single year, 01/08/YYYY to 31/07/YYYY+1): The ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths.</b></p> <p><u>Numerator</u>: Number of excess winter deaths, i.e. number of deaths occurring in December in year YYYY and January to March in year YYYY+1 minus half the number of deaths in the non-winter months (preceding August to November in year YYYY and following April to July in year YYYY+1).</p> <p><u>Denominator</u>: The average number of deaths per quarter occurring in the non-winter months, i.e. half the number of deaths occurring in the preceding August to November in year YYYY and the following April to July in year YYYY+1.</p> <p><b>4.15ii Excess Winter Deaths Index (single year, ages 85+): The ratio of extra deaths from all causes that occur in all those aged 85 and over in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths in those aged 85 and over.</b></p> <p><u>Numerator</u>: Number of excess winter deaths in those aged 85 and over, i.e. number of deaths occurring in December in year YYYY and January to March in year YYYY+1 minus half the number of deaths in the non-winter months (preceding August to November in year YYYY and following April to July in year YYYY+1).</p>



## 4.15 Excess winter deaths

YYYY+1).

Denominator: The average number of deaths in those aged 85 and over per quarter occurring in the non-winter months, i.e. half the number of deaths occurring in the preceding August to November in year YYYY and the following April to July in year YYYY+1.

**4.15iii Excess Winter Deaths Index (three years aggregated, 01/08/YYYY to 31/07/YYYY+3): The ratio of extra deaths from all causes that occur in the aggregated winter months compared with the expected number of deaths, based on the average of the number of aggregated non-winter deaths.**

Numerator: Number of excess winter deaths, i.e. number of deaths occurring in December in years (YYYY, YYYY+1, YYYY+2) and January to March in years (YYYY+1, YYYY+2, YYYY+3) minus half the number of deaths in the non-winter months (August to November in years (YYYY, YYYY+1, YYYY+2) and from April to July in years (YYYY+1, YYYY+2, YYYY+3).

Denominator: The average number of deaths per quarter occurring in the non-winter months, i.e. Half the number of deaths occurring in the non-winter months (August to November in years (YYYY, YYYY+1, YYYY+2) and in April to July in years (YYYY+1, YYYY+2, YYYY+3).

**4.15iv Excess Winter Deaths Index (three years aggregated, ages 85+): The ratio of extra deaths from all causes that occur in all those aged 85 and over in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths in those aged 85 and over.**

Numerator: Number of excess winter deaths in those aged 85 and over, i.e. number of deaths occurring in December in years (YYYY, YYYY+1, YYYY+2) and January to March in years (YYYY+1, YYYY+2, YYYY+3) minus half the number of deaths in the non-winter months (August to November in years (YYYY, YYYY+1, YYYY+2) and from April to July in years (YYYY+1, YYYY+2, YYYY+3).

Denominator: The average number of deaths in those aged 85 and over per quarter occurring in the non-winter months, i.e. Half the number of deaths occurring in the non-winter months (August to November in years (YYYY, YYYY+1, YYYY+2) and in

4.15 Excess winter deaths	
	April to July in years (YYYY+1, YYYY+2 YYYY+3).
Data source	Office for National Statistics (ONS) death registrations
Publication of source data	<p>ONS publish data on excess winter deaths annually at national and regional level by age group:</p> <p><a href="http://www.ons.gov.uk/ons/rel/subnational-health2/excess-winter-mortality-in-england-and-wales/index.html">http://www.ons.gov.uk/ons/rel/subnational-health2/excess-winter-mortality-in-england-and-wales/index.html</a></p> <p>Local authority level data are published by Public Health England in the annual Local Authority Health Profiles (three year pooled) and the Excess Winter Deaths in England Atlas (three year pooled and single year)</p> <p><a href="http://www.healthprofiles.info">http://www.healthprofiles.info</a></p> <p><a href="http://www.wmpho.org.uk/excesswinterdeathsInEnglandatlas/">http://www.wmpho.org.uk/excesswinterdeathsInEnglandatlas/</a></p>

4.16 Estimated diagnosis rate for people with dementia	
Rationale	<p>A timely diagnosis enables people living with dementia, and their carers/families to access treatment, care and support, and to plan in advance in order to cope with the impact of the disease. A timely diagnosis enables primary and secondary health and care services to anticipate needs, and working together with people living with dementia, plan and deliver personalised care plans and integrated services, thereby improving outcomes.</p>
Baseline period	2014/15
Indicator definition	<p>This indicator measures the number of people aged 65 and over who have been diagnosed with dementia as a proportion of the number who are estimated to have the condition.</p> <p><b>4.16 Estimated diagnosis rate for people with dementia: number of people diagnosed with dementia as a percentage of estimated dementia prevalence</b></p> <p><u>Numerator:</u> Number of people diagnosed with dementia,</p>

4.16 Estimated diagnosis rate for people with dementia	
	<p>restricted to those aged 65 years of age and older, by age and gender.</p> <p><u>Denominator:</u> Estimated prevalence of dementia</p> <p>The 2013 report by Mathews, F.E et al provides a two decade comparison of prevalence of dementia in individuals aged 65 years plus from three geographical areas in England and this is the source used to estimate dementia prevalence.</p>
Data source	<p><u>Numerator:</u> Dementia register for England in the Quality and Outcomes Framework (QOF). The number of people in this register is published monthly by the Health and Social Care Information Centre (HSCIC) in the Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses</p> <p><u>Denominator:</u> Prevalence rates for the denominator are from the Cognitive Function Aging Study II) CFAS II that published data on prevalence rates in 2011:</p> <p>Mathews, F.E. et al. (2013). A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II. <i>Lancet</i>; 382: 1405–12</p>
Publication of source data	<p>Data at England level has been published as part of the NHS Outcomes Framework on the Health and Social Care Information Centre's Indicator Portal:</p> <p><a href="https://indicators.ic.nhs.uk/webview/">https://indicators.ic.nhs.uk/webview/</a></p>