Proposed changes to the Public Health Outcomes Framework from 2019/20: a consultation
About Public Health England

Public Health England exists to protect and improve the nation’s health and wellbeing and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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Glossary

DHSC Department of Health and Social Care
OGDs Other Government Departments
PHE Public Health England
PHOF Public Health Outcomes Framework

Have your say

We are inviting feedback on this proposal from professionals and the public. The easiest way to get involved is to complete the online survey. The survey will run for 4 weeks from 21 January 2019 and close on 22 February 2019. PHE aim to publish the results in summer 2019.
Executive summary

An update of the Public Health Outcomes Framework (PHOF) and its indicators is planned for summer 2019, to ensure that it continues to be relevant and meets the needs of users.

This document outlines the proposals for indicators that are to be revised, added or removed, with a rationale for each.

In its current format the PHOF is made up of 66 high level indicator categories which include 159 individual indicators across 4 domains. Given the current size and complexity of the framework, if indicators are no longer relevant we have proposed that they be removed. We have used web analytics and analysis of associations between indicators to inform our decisions.

In the proposal a large number of indicators remain the same, but it is proposed that some indicators be removed to allow for the addition of new indicators that may be more relevant.

This proposal document is divided into 6 themes:

1. Indicators that will remain the same
2. Indicators that will remain but will have a change to either the method or data source
3. Indicators that will be replaced with an alternative indicator(s) on the same topic
4. Indicators proposed for removal from 2019/20
5. Indicators proposed for inclusion from 2019/20
6. Indicators added, replaced or removed to reflect the changes in the immunisation/vaccination schedule

PHE would like feedback from users on this proposal to ensure the changes are helpful and appropriate. You can have your say by completing our online survey. The survey will run for 4 weeks from 21 January 2019 and close on 22 February 2019.

PHE will use the results of the survey to inform the review and final decisions.
Background

The Public Health Outcomes Framework (PHOF) sets out a high-level overview of public health outcomes, at national and local level, supported by a broad set of indicators.

The indicators cover the full spectrum of what is understood as public health and what can currently be measured. The PHOF is published under section 73B of the NHS Act 2006 as guidance that local authorities must have regard to.

The PHOF is used as a tool for local transparency and accountability, providing a means for benchmarking progress within each local authority and across authorities. Alongside the NHS Outcomes Framework and Adult Social Care Outcomes Framework, the PHOF reflects the focus on improving health outcomes for the population and reducing inequalities in health, setting expectations for what the system as a whole wants to achieve.

The PHOF was first published in 2012 and at that time there was a commitment not to make any changes for 3 years to allow it to become established during the transfer of public health responsibilities from the NHS to local authorities. There was a review and refresh of the PHOF indicators during 2015 in order to ensure that the PHOF remained relevant and useful.

PHE is responsible for formally reviewing and refreshing the indicators included in the framework every 3 years.

This proposal document sets out how PHE has reviewed the 2016/19 PHOF indicators and the proposed changes to indicators from 2019/20. Stakeholders will be consulted on the proposed changes within this document via an online survey.

The Public Health Outcomes Framework tool

An interactive web tool makes the PHOF data available publicly. This allows local authorities to assess progress in comparison to national averages and their peers, and develop their work plans accordingly.

The PHOF consists of 66 high level indicator categories which include 159 individual indicators.
Proposed changes to the Public Health Outcomes Framework from 2019/20

The indicators are grouped into overarching indicators and 4 supporting domains:

- overarching indicators (high level outcomes of life expectancy)
- improving the wider determinants of health
- health improvement
- health protection
- healthcare public health and premature mortality.
Method

PHE has worked with colleagues from the Department of Health and Social Care (DHSC), and other government departments (OGDs) to review the framework indicators\(^1\) and identify existing indicators where:

- the data source has changed or the way in which data are recorded or reported has changed
- the indicator could be improved with a different method
- the data source is obsolete or was a one-off
- data are no longer available to produce the indicator
- data have not become available for placeholder indicators, or an appropriate source or methodology has not been identified
- the treatment or intervention has changed, eg vaccination schedules
- new topic areas that require measurement have been identified, and it is feasible to add a new indicator ie if data source exists and appropriate method can be defined

Web usage statistics from Google Analytics and statistical analysis of associations between indicators were used to inform the decision making process. Those indicators that are less frequently used or where the correlation analysis showed that indicators were providing similar results were considered for removal.

Indicators were then categorised into 6 themes to produce this proposal.

\(^1\) Note that each indicator has its own method and these details are provided alongside the indicators in the PHOF web tool. Indicator methods are not covered within this document.
The proposed framework indicators

This proposal is presented under 6 themes for consultation:

1. Indicators that will remain the same
2. Indicators that will remain but will have a change to either the method or data source
3. Indicators that will be replaced with an alternative indicator(s) on the same topic
4. Indicators proposed for removal from 2019/20
5. Indicators proposed for inclusion from 2019/20
6. Indicators added, replaced or removed to reflect the changes in the immunisation/vaccination schedule

Under each heading is a table of the indicators affected and the rationale for their change, removal or addition from 2019/20.

1. Indicators that will remain the same

The following indicators will be retained. Respondents to the consultation survey will be asked for their general comments on these proposals.

<table>
<thead>
<tr>
<th></th>
<th>Indicator</th>
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</thead>
<tbody>
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<td>0.1i</td>
<td>Healthy life expectancy - at birth and at 65</td>
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<td>0.1ii</td>
<td>Life expectancy - at birth and at 65</td>
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<td>0.2iii</td>
<td>Inequality in life expectancy</td>
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<td>0.2vi</td>
<td>Inequality in healthy life expectancy</td>
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<tr>
<td>1.02i</td>
<td>School Readiness: The percentage of children achieving a good level of development at the end of reception</td>
</tr>
<tr>
<td>1.02i</td>
<td>School Readiness: The percentage of children achieving a good level of development at the end of reception with free school meal status</td>
</tr>
<tr>
<td>1.02ii</td>
<td>School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check</td>
</tr>
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<td>1.02ii</td>
<td>School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check with free school meal status</td>
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<td>1.03</td>
<td>Pupil absence</td>
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<td>1.04</td>
<td>First time entrants to the youth justice system</td>
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<td>1.05</td>
<td>16-17 year olds not in education, employment or training (NEET) or whose activity is not known</td>
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<tr>
<td>1.06i</td>
<td>Adults with a learning disability who live in stable and appropriate accommodation</td>
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<td>1.06ii</td>
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<td>1.07</td>
<td>People in prison who have a mental illness or a significant mental illness</td>
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<tr>
<td>1.08i</td>
<td>Gap in the employment rate between those with a long-term health condition and the overall employment rate</td>
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<td>Population vaccination coverage - Measles, mumps and rubella (MMR) for one dose (5 years old)</td>
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<td>3.03x</td>
<td>Population vaccination coverage - Measles, mumps and rubella (MMR) for two doses (5 years old)</td>
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<td><strong>3.03xiii</strong> Population vaccination coverage – Pneumococcal polysaccharide vaccine (PPV)</td>
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<td><strong>3.03xvi</strong> Population vaccination coverage - Human papillomavirus (HPV) vaccination coverage for two doses (females 13-14 years old)</td>
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<td><strong>3.03xvii</strong> Population vaccination coverage - Shingles vaccination coverage (70 years old)</td>
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<td><strong>4.04i</strong> Under 75 mortality rate from all cardiovascular diseases</td>
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<td><strong>4.05i</strong> Under 75 mortality rate from cancer</td>
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<tr>
<td><strong>4.06i</strong> Under 75 mortality rate from liver disease</td>
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<td><strong>4.07i</strong> Under 75 mortality rate from respiratory disease</td>
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<td><strong>4.12ii</strong> Preventable sight loss - glaucoma</td>
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<td><strong>4.12iv</strong> Preventable sight loss - sight loss certifications</td>
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<td><strong>4.14ii</strong> Hip fractures in people aged 65 and over (age 65-79)</td>
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<td><strong>4.15i</strong> Excess Winter Deaths Index (Single year, all ages)</td>
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<td><strong>4.15ii</strong> Excess Winter Deaths Index (Single year, age 85+)</td>
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<tr>
<td><strong>4.16</strong> Estimated dementia diagnosis rate (aged 65+)</td>
<td></td>
</tr>
</tbody>
</table>
2. Indicators that will remain but will have a change to either the method or data source

The methods or data sources for the following indicators will be revised. Respondents to the consultation survey will be asked for their general comments on these proposals.

<table>
<thead>
<tr>
<th>Existing indicator number</th>
<th>Indicator description</th>
<th>Detail of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.01i</td>
<td>Children in low income families (all dependent children under 20)</td>
<td>Due to changes in the way low income data are collected and classified, aligned to the introduction of Universal Credit, the measures for this indicator will change. HM Revenues &amp; Customs (HMRC) will provide details on how the new indicators will be defined.</td>
</tr>
<tr>
<td>1.01ii</td>
<td>Children in low income families (under 16s)</td>
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<tr>
<td>1.10</td>
<td>Killed and seriously injured (KSI) casualties on England's roads</td>
<td>Department for Transport (DfT) has revised the methodology for this indicator to adjust for changes in the way that police forces record severity.</td>
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<tr>
<td>1.13i</td>
<td>Re-offending levels - percentage of offenders who re-offend</td>
<td>These indicators will change data source following a consultation by the Ministry of Justice (MoJ) proposing various changes to the Proven Reoffending National Statistics, in order to support reforms to the system. Indicator 1.13ii will change definition and name to Average number of re-offences per re-offender.</td>
</tr>
<tr>
<td>1.13ii</td>
<td>Re-offending levels - average number of re-offences per offender</td>
<td></td>
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<tr>
<td>1.15ii</td>
<td>Statutory homelessness - households in temporary accommodation</td>
<td>The data source for this indicator will change to the new data collection from the Ministry of Housing, Communities and Local Government (MHCLG) Homelessness Case Level Information Collection (H-CLIC). The indicator name will change to 'Homelessness - households in temporary accommodation'.</td>
</tr>
<tr>
<td>2.02i</td>
<td>Breastfeeding - Breastfeeding initiation</td>
<td>The data source for this indicator will change to the Maternity Services Data Set.</td>
</tr>
<tr>
<td>2.02ii</td>
<td>Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth</td>
<td>The data source for this indicator will change to the Community Services Data Set.</td>
</tr>
<tr>
<td>2.19</td>
<td>Cancer diagnosed at early stage</td>
<td>The denominator for this indicator will change and will include staged cancers only rather than all cancers. Including only staged cancers in the denominator will make this indicator more reliable as a measure of variation between local authorities. The modification aligns with the National Cancer Registration and Analysis Service (NCRAS) work programme to update and align all early stage indicators.</td>
</tr>
<tr>
<td>4.11</td>
<td>Emergency readmissions within 30 days of discharge from hospital</td>
<td>NHS England is developing a new definition of this indicator which should be published via the NHS Outcomes Framework and will be included in PHOF following the 2019/20 refresh.</td>
</tr>
</tbody>
</table>
3. Indicators that will be replaced with an alternative indicator(s) on the same topic

The existing indicators will be replaced with a new indicator that provides a better measure of the public health outcome of interest. Respondents to the consultation survey will be asked for their general comments on these proposals.

<table>
<thead>
<tr>
<th>Indicator number</th>
<th>Old indicator</th>
<th>New indicator</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.15i</td>
<td>Statutory homelessness - eligible homeless people not in priority need</td>
<td>Homelessness - Number of households owed a duty under the Homelessness Reduction Act</td>
<td>The Homelessness Reduction Act was introduced on 3rd April 2018. It gives more responsibility to local authorities to take reasonable steps to prevent and relieve homelessness for eligible individuals, regardless of priority need category.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Homelessness - Number of Rough Sleepers</td>
<td>This indicator will measure the number of rough sleepers in each local authority on a single night in autumn every year.</td>
</tr>
<tr>
<td>2.05i</td>
<td>Proportion of children aged 2-2½ years who received an assessment as part of the Healthy Child Programme or an integrated review (using any tool)</td>
<td>Percentage of children at or above expected level of development in all five areas of development at 2-2½ years</td>
<td>The original aim of the PHOF in 2012/13 was to measure child development outcomes at age 2-2½ years. In 2012/13 it was only possible to measure whether or not the assessment had been completed. 2.05i and 2.05ii were interim output measures. These can now be replaced as data are available at national and local level from the Ages and Stages Questionnaire (ASQ) assessment. ASQ-3 provides an objective measure of child development, allows comparisons to be made, and helps to identify children who are not developing as expected. It supports decisions on closer monitoring of progress or early intervention services.</td>
</tr>
<tr>
<td>2.05ii</td>
<td>Proportion of children aged 2-2½ years offered ASQ-3 as part of the Healthy Child Programme or integrated review</td>
<td>Percentage of children at or above expected level of development in communication skills at 2-2½ years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percentage of children at or above expected level of development in personal-social skills at 2 - 2½ years</td>
<td></td>
</tr>
<tr>
<td>2.20i</td>
<td>Cancer screening coverage - cervical cancer</td>
<td>Cancer screening coverage: cervical screening – coverage (under 50)</td>
<td>National standards for the NHS cervical screening programme (NHS CSP) have been updated. This indicator will be split into two age groups to reflect this change. This applies for data collected from 1 April 2018.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cancer screening coverage: cervical screening – coverage (50 years and above)</td>
<td></td>
</tr>
</tbody>
</table>
| 4.02             | Proportion of five year old children | Proportion of five year old children with dental decay | The indicator will be reversed from “disease-free” to “presence of
<table>
<thead>
<tr>
<th>Indicator number</th>
<th>Old indicator</th>
<th>New indicator</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>free from dental decay</td>
<td></td>
<td>disease” to align with other health indicators which report prevalence of a condition. This will reduce confusion and ensure consistency with other measures related to dental caries reported in other public health tools produced by PHE.</td>
</tr>
<tr>
<td>4.09i</td>
<td>Excess under 75 mortality rate in adults with serious mental illness</td>
<td>Premature mortality rate for people with mental health problems</td>
<td>The current PHOF indicator 4.09i only allows for meaningful comparison at national level. The current indicator uses Standardised Mortality Ratios (SMRs), which are indirectly standardised and therefore values for local authorities cannot be compared with each other. Inclusion of an indicator measuring the directly age-standardised rate of premature mortality in adults with mental health problems will address this issue and aid understanding of inequality in premature mortality for people with mental health problems.</td>
</tr>
<tr>
<td>4.09ii</td>
<td>Proportion of adults in the population in contact with secondary mental health services</td>
<td>Excess premature mortality ratio for people with mental health problems</td>
<td>This replacement supporting indicator to 4.09i will compare the mortality rate for people with diagnosed mental health problems (as identified through service and/or primary care data), with the rate in people with no diagnosed mental health problems (as identified through service and/or primary care data). This indicator is a useful measure of inequalities in mortality between people who have been diagnosed with mental health problems and people who have not.</td>
</tr>
</tbody>
</table>
4. Indicators proposed for removal from 2019/20

It is proposed that the following indicators will be removed. The rationale for each is highlighted. Respondents to the consultation survey will be asked if they agree or disagree and for their additional comments on these proposals.

<table>
<thead>
<tr>
<th>Indicator number</th>
<th>Indicator description</th>
<th>Rationale for removal</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.2ii</td>
<td>Number of upper tier local authorities (UTLAs) where inequality in life expectancy at birth has decreased</td>
<td>Data are for England only: This indicator has two figures per year for England only – one for males and one for females. PHOF is designed as a local area framework. These data can still be made available as part of the slope of index of inequality in life expectancy supporting data.</td>
</tr>
<tr>
<td>0.2iv</td>
<td>Gap in life expectancy at birth between each local authority and England as a whole</td>
<td>Indicator analysis showed little additional benefit or use: The correlation analysis showed that this indicator shows the same information as indicators 0.1ii. This indicator can be calculated from the other measures in the framework by a simple calculation of the difference between the local value and the England value.</td>
</tr>
<tr>
<td>1.09iii</td>
<td>Rate of fit notes issued</td>
<td>The indicator was a placeholder and has never been produced: The indicator cannot be produced from the existing data source as the definition is to measure those who are economically active and ‘economic activity’ is not collected on the fit notes data. No alternative data source has been identified.</td>
</tr>
<tr>
<td>1.16</td>
<td>Utilisation of outdoor space for exercise/health reasons</td>
<td>Insufficient sample size: The data for this indicator are supplied by the Monitor of Engagement with the Natural Environment (MENE) survey. However, the recent survey (2016/17) sample size is around 10,000 in England and is not sufficient to produce reliable estimates at the local authority level. Natural England are reviewing the MENE. The sample size of the survey is being considered as part of the review. If the sample size is increased sufficiently the indicator could be reconsidered for inclusion.</td>
</tr>
<tr>
<td>2.08i</td>
<td>Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March</td>
<td>Indicator analysis showed little additional benefit or use: Interpretation is difficult - the score is not easy to understand, and feedback shows that the accompanying indicator on the proportion of children where there is cause for concern is of more use. This latter indicator (2.08ii) will be retained.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>2.09i</td>
<td>Smoking prevalence at age 15 - current smokers (WAY survey)</td>
<td>Data source is no longer available: The ‘What About Youth Survey’ was a one off data collection in 2014/15 and will not be re-run. These indicators therefore cannot be updated. Indicators 2.09iv and 2.09v, smoking prevalence at age 15 years, from the Smoking, Drinking and Drug Use Among Young People in England survey (SDD) are proposed to remain and are updated bi-annually.</td>
</tr>
<tr>
<td>2.09ii</td>
<td>Smoking prevalence at age 15 - regular smokers (WAY survey)</td>
<td></td>
</tr>
<tr>
<td>2.09iii</td>
<td>Smoking prevalence at age 15 - occasional smokers (WAY survey)</td>
<td></td>
</tr>
<tr>
<td>2.10i</td>
<td>Attendances at A&amp;E for self-harm per 100,000 population</td>
<td>The indicator was a placeholder and has never been produced: A workable definition has not been produced for this indicator since the 2015 PHOF refresh due to several methodological issues and problems with data quality.</td>
</tr>
<tr>
<td>2.11ii</td>
<td>Average number of portions of fruit consumed daily (adults)</td>
<td>Indicator analysis show little additional benefit or use: These two indicators are currently sub indicators of the overall adult 5-a-day indicator (2.11i) which is proposed to remain. These sub-indicators are not as relevant to users as the overall 2.11i indicator.</td>
</tr>
<tr>
<td>2.11iii</td>
<td>Average number of portions of vegetables consumed daily (adults)</td>
<td></td>
</tr>
<tr>
<td>2.11iv</td>
<td>Proportion of the population meeting the recommended &quot;5-a-day&quot; at age 15 (WAY survey)</td>
<td>Data source is no longer available: These three indicators were compiled from the results of the ‘What About Youth’ survey in 2014/15. This was a one-off survey which will not be re-run.</td>
</tr>
<tr>
<td>2.11v</td>
<td>Average number of portions of fruit consumed daily at age 15 (WAY survey)</td>
<td></td>
</tr>
<tr>
<td>2.11vi</td>
<td>Average number of portions of vegetables consumed daily at age 15 (WAY survey)</td>
<td></td>
</tr>
<tr>
<td>4.04ii</td>
<td>Under 75 mortality rate from cardiovascular diseases considered preventable</td>
<td>Indicator analysis show little additional benefit or use: The correlation analysis showed that these sub-indicators are highly correlated with their corresponding indicator for under 75 mortality (eg 4.04ii is highly correlated with under 75 mortality rate from cardiovascular disease) and do not provide additional value. These sub-indicators are not as well used as the under 75 disease specific mortality indicators.</td>
</tr>
<tr>
<td>4.05ii</td>
<td>Under 75 mortality rate from cancer considered preventable</td>
<td></td>
</tr>
<tr>
<td>4.06ii</td>
<td>Under 75 mortality rate from liver disease considered preventable</td>
<td></td>
</tr>
<tr>
<td>4.07ii</td>
<td>Under 75 mortality rate from respiratory disease considered preventable</td>
<td></td>
</tr>
<tr>
<td>4.13</td>
<td>Health related quality of life for older people</td>
<td>Data source is no longer available: The questions in the GP Patient Survey used to calculate this indicator are no longer being asked.</td>
</tr>
<tr>
<td>4.15iii</td>
<td>Excess Winter Deaths Index (3 years, all ages)</td>
<td>Indicator analysis show little additional benefit or use: These particular indicators are not as highly valued as the indicators based on a single winter – 4.15i and 4.15ii which are proposed to remain.</td>
</tr>
<tr>
<td>4.15iv</td>
<td>Excess Winter Deaths Index (3 years, age 85+)</td>
<td></td>
</tr>
</tbody>
</table>
5. Indicators proposed for inclusion from 2019/20

The following indicators have been proposed for inclusion but it will not be possible to include all of them. Therefore, when completing the associated survey, respondents will need to consider the relative priority of each measure. The survey question asks responders to identify those indicators (indicators on a single issue) or group of indicators (alcohol treatment, drug treatment, maternity, sexual health) that they consider the top 5 most important for inclusion in the PHOF.

<table>
<thead>
<tr>
<th>Indicator description</th>
<th>Rationale for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability free life expectancy (DFLE)</td>
<td>DFLE is proposed as a new indicator for PHOF to provide more information on healthy ageing and to complement the existing PHOF indicator on healthy life expectancy. The government ‘grand challenge’ for our ageing society, has a mission to ensure that people can enjoy at least 5 extra healthy, independent years of life by 2035, while narrowing the gap between the experience of the richest and poorest. DFLE at birth has been proposed as the metric to measure progress towards achieving this ambition. It will also be presented at age 65.</td>
</tr>
<tr>
<td>School readiness - Communication &amp; language: Early Years Foundation Stage Profiles (EYFSP)</td>
<td>The PHE 2018/19 remit letter states that it expects PHE to drive improvements in ‘best start in life’ outcomes at scale with a particular focus on child health, speech, language and communication needs, and school readiness. Disparities in child language capabilities are recognisable in the second year of life and are clearly having an impact by the time children finish the Early Years Foundation Stage, at the end of the reception year. If left unsupported, these children are less likely to achieve their full potential. These are outcome indicators used to measure the development of children’s communication, language and literacy skills at the end of the reception year. They are also used in public health settings to monitor the impact of early years services (including the universal and non-universal aspects of health visiting) and are regarded as an important social determinant of mental health, wellbeing, education and later life chances.</td>
</tr>
<tr>
<td>Average Attainment 8 score per pupil</td>
<td>Attainment 8 forms part of the Department for Education’s (DfE) secondary school accountability system that was introduced in 2016. This indicator measures the average achievement of pupils in up to 8 qualifications including English (double weighted if both language and literature are taken), maths (double weighted), three further qualifications that count in the English Baccalaureate (EBacc) and three further qualifications that can be GCSE qualifications (including EBacc subjects) or any other non-GCSE qualifications on the DfE approved list. Further information can be found in Secondary accountability measures. Children’s education and development of skills are important for their own wellbeing. Learning ensures that children develop the knowledge and understanding, skills, capabilities and attributes that they need for mental, emotional, social and physical wellbeing, now and in the future.</td>
</tr>
</tbody>
</table>
## Proposed changes to the Public Health Outcomes Framework from 2019/20

<table>
<thead>
<tr>
<th>Gap in employment rate between disabled people and the overall employment rate</th>
<th>The inclusion of this indicator will enable the measurement of the government policy to increase the number of disabled people in work as set out in the policy paper <em>Improving lives: the future of work, health and disability</em> – which has a goal to see 1 million more disabled people in work by 2027. This indicator complements existing indicators that measure the gap in employment rate for those with long term conditions, those in contact with secondary mental health services and those with learning disabilities compared with the overall employment rate. This is not the same indicator as the government’s preferred standalone measure for the disability employment gap which compares employment rates between disabled and non-disabled people, as although data are available for this calculation, comparable data are not available for the other population groups mentioned above.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loneliness measure</td>
<td>At the beginning of 2018, the Prime Minister highlighted the issue of loneliness, announcing a Minister for Loneliness and committing to develop a national strategy to help tackle loneliness and a national measure for loneliness. The national strategy was published on 15 October 2018. Loneliness can affect anyone of any age and background and has been identified to be a serious public health concern, as harmful as smoking and obesity, and is reflected in the commitments made by DHSC and NHS England in the strategy. However, the evidence base on prevalence and effective interventions is still very much in development. A key challenge is that we have not had prevalence data that can be broken down to local authority level. This creates challenges for local bodies in understanding and tackling loneliness. The newly published strategy includes the commitment to use these four questions as the new national measure, which will also be measured at local authority level, allowing greater read-across between national surveys and academic research in future. The measure was developed by ONS, with the help of a technical advisory group of over 30 experts. The inclusion of the loneliness measures in the PHOF will help inform and focus future work on loneliness at both a national and local level, providing a focus to support strategic leadership, policy decisions and service commissioning.</td>
</tr>
<tr>
<td>Loneliness measure 1.1 How often do you feel that you lack companionship?</td>
<td>Loneliness measure 1.1 How often do you feel that you lack companionship?</td>
</tr>
<tr>
<td>Loneliness measure 1.2 How often do you feel left out?</td>
<td>Loneliness measure 1.2 How often do you feel left out?</td>
</tr>
<tr>
<td>Loneliness measure 1.3 How often do you feel isolated from others?</td>
<td>Loneliness measure 1.3 How often do you feel isolated from others?</td>
</tr>
<tr>
<td>Loneliness measure 2. How often do you feel lonely?</td>
<td>Loneliness measure 2. How often do you feel lonely?</td>
</tr>
<tr>
<td>Total prescribed long-acting reversible contraception (LARC) (excluding injections) rate per 1,000 females aged 15-44</td>
<td>The National Institute for Health and Care Excellence (NICE) Clinical Guideline CG30 and QS129 advises that LARC methods, such as contraceptive injections, implants, the intra-uterine system (IUS) and the intrauterine device (IUD), are highly effective as they do not rely on daily adherence and are more cost effective than condoms and combined oral contraceptives. The Department of Health and Social Care’s Framework for Sexual Health Improvement in England (2013) includes the ambition to reduce unwanted pregnancies among all women of fertile age through increased knowledge, awareness and access to all methods of contraception. This indicator excludes injections because they rely on timely repeat visits/administration within the year and consequently have a higher failure rate than the other LARC methods. LARC prescribing is one of the indicators in the sexual and reproductive health section of the recently refreshed PHE Public Health Dashboard.</td>
</tr>
</tbody>
</table>
### Maternal obesity at booking – from the Maternity Services Data Set

The National Maternity Review\(^\text{13}\) found that obesity among women of reproductive age is increasingly linked to risk of complications during pregnancy and health problems of the child. There is strong evidence of an association between maternal obesity, stillbirth and infant mortality. Reduction in maternal obesity will improve health outcomes for the woman and her child, and the ability to assess variance and track trends in maternal body mass index will be essential to this.

### Alcohol use at booking – from the Maternity Services Data Set

The UK Chief Medical Officers (CMOs) recommend that pregnant women avoid drinking any alcohol at all to keep risks to a minimum. Long-term health risks for the baby are greater the more alcohol is drunk. Drinking alcohol, especially in the first three months of pregnancy, increases the risk of miscarriage, premature birth and low birth weight. Reducing alcohol consumption during pregnancy will improve the outcomes of new-borns and help prevent learning difficulties and behavioural problems in later life. The data are currently not of sufficient quality to be used for analysis but is expected to improve over time.

### Smoking at booking - from the Maternity Services Data Set

Reducing smoking in pregnancy is a key element of the Maternity Transformation Programme’s work on prevention. Smoking during pregnancy is associated with the foetus growing at a slower rate in the womb and can result in babies being small for gestational age (small given the number of weeks of pregnancy) and having a low birth weight at term. Smoking during pregnancy is also associated with higher rates of stillbirth and infant mortality. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes. The Tobacco Control Plan\(^\text{14}\) contains a national ambition to reduce the prevalence of smoking throughout pregnancy to 6% or less by the end of 2022 (measured at time of giving birth). The inclusion of this indicator will ensure that the local tobacco control activity is appropriately focused on pregnant women, in order to try to achieve this national ambition.

### Percentage of completed New Birth Visits (NBV)

The new birth visit was one of 5 health visitor reviews which was mandated during the transfer of responsibilities for children’s public health to local authorities. Evidence shows that it is valued by commissioners, health care professionals and by women, and that local areas prioritise it as a way to support women and families in the early days in feeding, infant health, promotion of sensitive parenting and health promotion opportunities. Completed NBV is one of the indicators in the best start in life section of the recently refreshed PHE Public Health Dashboard.

### Percentage of children aged 5-16 sufficiently physically active for good health

The UK CMOs recommend that children and young people (5-16 years) are physically active for at least 60 minutes every day. The evidence suggests, however, that a significant proportion of adolescents do not meet this minimum standard. Regular moderate-to-vigorous physical activity (MVPA) improves health and fitness, strengthens muscles and bones, develops co-ordination, maintains healthy weight, improves sleep, makes you feel good, builds confidence and social skills and improves concentration and learning. Good physical activity habits established in childhood and adolescence are also likely to be carried through into adulthood. If we
can help children and young people to establish and maintain high volumes of physical activity into adulthood, we will reduce the risk of morbidity and mortality from chronic non-communicable diseases later in their lives and deliver benefits against the other outcomes noted above, for example mental wellbeing. Physical activity is at the heart of the government's sport and physical activity strategy Sporting Future\textsuperscript{15} which places tackling inactivity and using physical activity to achieve a range of outcomes at its core. Physical activity also forms a key component of the government’s plan for action to significantly reduce childhood obesity by supporting healthier choices, as outlined in Childhood obesity: a plan for action.\textsuperscript{16} One of the main aspects of the plan is to reduce childhood obesity by encouraging primary school children to eat more healthily and stay active.

<table>
<thead>
<tr>
<th>Smoking prevalence in adults - socio-economic gap in current smokers (Annual Population Survey (APS))</th>
<th>The government’s Tobacco Control Plan (Towards a Smoke-free Generation: A Tobacco Control Plan for England\textsuperscript{14}), published in July 2017 sets out the government’s strategy to reduce smoking prevalence among adults and young people, including to “reduce the inequality gap in smoking prevalence, between those in routine and manual occupations and the general population”. This indicator is designed to help local authorities monitor the extent of the difference in smoking prevalence between their residents in routine and manual occupations compared with other occupations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of opiate users not in treatment</td>
<td>Services delivering evidence-based and effective structured drug treatment interventions are vital components of a local authority’s response to drug misuse and dependence. Such interventions can improve the lives of individuals, the life chances of their children and family, and community stability. They also have a significant impact on reducing the spread of blood-borne viruses, reducing drug related deaths and reducing crime. The harmful effects of drugs are greater in poorer communities and effective treatment services can play an important role in addressing these inequalities. The proposed indicator identifies how comparatively well the need for drug treatment is being met in local areas. Unmet need is one the headline indicators in the government’s Drug Strategy\textsuperscript{17}. Unmet need is one of the indicators in the drug and alcohol section of the recently refreshed PHE Public Health Dashboard.</td>
</tr>
<tr>
<td>Proportion waiting over 3 weeks for drug treatment</td>
<td>Numbers in substance misuse treatment have fallen in recent years. This indicator complements the indicator on unmet need by helping local authorities assess how effectively they are meeting the need of their treatment seeking population and whether they should increase provision. Proportion waiting over 3 weeks for drug treatment is one of the indicators in the drug and alcohol section of the recently refreshed PHE Public Health Dashboard.</td>
</tr>
<tr>
<td>Deaths in drug treatment, mortality ratio</td>
<td>This indicator identifies local authorities where deaths in drug treatment are higher or lower than expected. It is indicative of the safety, effectiveness and protection afforded by drug treatment services. Deaths in drug treatment is one of the indicators in the drug and alcohol section of the recently refreshed PHE Public Health Dashboard.</td>
</tr>
<tr>
<td>Proportion of dependant alcohol users not in treatment</td>
<td>Services delivering evidence-based and effective structured alcohol treatment interventions are vital components of a local authority’s response to alcohol misuse and dependence. Such interventions can improve the lives of individuals, the life chances of their children and family, and community stability. They also have a significant impact in</td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Proportion waiting over 3 weeks for alcohol treatment</td>
<td>Numbers in substance misuse treatment have fallen in recent years (especially among alcohol clients). This indicator complements the indicator on unmet need by helping local authorities assess how effectively they are meeting the need of their treatment seeking population and whether they should increase provision. Proportion waiting over 3 weeks for alcohol treatment is one of the indicators in the drug and alcohol section of the recently refreshed PHE Public Health Dashboard.</td>
</tr>
<tr>
<td>Deaths in alcohol treatment, mortality ratio</td>
<td>This indicator identifies local authorities where deaths in alcohol treatment are higher or lower than expected. It is indicative of the effectiveness and protection against premature mortality afforded by alcohol treatment services. Deaths in alcohol treatment is one of the indicators in the drug and alcohol section of the recently refreshed PHE Public Health Dashboard.</td>
</tr>
<tr>
<td>Percentage reporting a long-term musculoskeletal (MSK) problem</td>
<td>In England, the Global Burden of Disease study\textsuperscript{18} shows that low back and neck pain was ranked as the leading cause of years lived with a disability, and other musculoskeletal (MSK) conditions was ranked as number 10. MSK conditions are known to impact quality of life by increasing pain, limiting range of motion, and increasing disability. They impact on the ability to carry out activities relating to daily life and on the ability to gain suitable employment and financial stability.</td>
</tr>
<tr>
<td>Sexually transmitted infections (STIs) testing rate (excluding chlamydia in the under 25 year olds)</td>
<td>This indicator measures the STI testing rate for syphilis, HIV, gonorrhoea (all ages) and chlamydia (ages over 25 years) among people accessing specialist and non-specialist sexual health services in England. This indicator is a key component to understanding the indicator on all STI diagnoses (excluding chlamydia in under 25 year olds figure), an outcome measure which is also proposed as a new PHOF indicator. Testing rates and diagnosis rates are closely linked. Sexual health is a key public health issue and increased testing has been shown to reduce the risk of STI transmissions, enable early diagnosis and therefore prevent STI complications. The Department of Health and Social Care has outlined its ambition for good sexual health in A Framework for Sexual Health Improvement in England\textsuperscript{19}. This indicator is in the sexual and reproductive health section of the recently refreshed PHE Public Health Dashboard.</td>
</tr>
<tr>
<td>New sexually transmitted infection (STIs) diagnoses (excluding chlamydia in the under 25 years olds)</td>
<td>This indicator measures STI diagnoses (excluding chlamydia in under 25 years olds) among people accessing specialist and non-specialist sexual health services in England. Diagnosis rates of STIs should be interpreted alongside the corresponding testing rate and positivity which can influence local diagnosis rates and are also available within the Sexual &amp; Reproductive Health Profiles tool. A high diagnosis rate is indicative of a high burden of infection, however a low diagnosis rate may be explained by other factors as well.</td>
</tr>
<tr>
<td>HIV testing coverage</td>
<td>This indicator measures the number of persons tested for HIV in specialist sexual health services (SHS) in England. HIV testing is reducing alcohol related deaths and in reducing crime, and health and social care costs. The harmful effects of alcohol are greater in poorer communities and effective treatment services can play an important role in addressing these inequalities. The proposed indicator identifies how well need is being met in local areas. Unmet need is one of the indicators in the drug and alcohol section of the recently refreshed PHE Public Health Dashboard.</td>
</tr>
</tbody>
</table>
integral to the treatment and management of HIV. Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of HIV transmission. There are national standards for the offer and uptake of HIV testing in SHSs. HIV test coverage is used to monitor the recommendations made in the most recent *Towards elimination of HIV transmission, AIDS, and HIV-related deaths in the UK*\textsuperscript{20} and HIV testing in England\textsuperscript{21} reports.

**Under 75 mortality - all causes**

Premature mortality is a good high-level indicator of the overall health of a population. There are significant differences between the premature death rates in different areas, reflecting a wide range of underlying differences between populations. Two thirds of deaths under 75 years are avoidable, and around 80% of those are preventable. To ensure that there continues to be a reduction in the rate of premature mortality, and that inequalities between areas are reduced, there needs to be concerted action on prevention, diagnosis and treatment.

The *NHS Long Term Plan*\textsuperscript{22} has a focus on prevention and reducing health inequalities.

**Avoidable cardiovascular (CVD) deaths amenable to health care**

A number of current policy and project initiatives are focused on improving the prevention and treatment of cardiovascular disease (CVD) through primary healthcare. An indicator highlighting the inequalities in CVD deaths amenable to health care would help influence equitable decisions to be made when setting priorities in this area.

**Prevalence of patients classified as moderately or severely frail**

The identification of patients living with moderate or severe frailty was mandated as part of the *General Medical Services (GMS) contract 2017/18*\textsuperscript{23}. This indicator supports the delivery of stratified population health management programmes to prevent, halt progression and even reverse frailty. This indicator explicitly addresses the frailty workstream of the forthcoming NHS plan. It is also strongly aligned with emerging physical activity priorities around muscle and bone strengthening and balance physical activity, and the strategic direction of falls and fracture prevention as outlined in PHE’s *Falls and fracture consensus statement*.\textsuperscript{24}
Proposed changes to the Public Health Outcomes Framework from 2019/20

6. Indicators added, replaced or removed to reflect the changes in the immunisation/vaccination schedule

The following changes are not included in the consultation survey as they are a result of changes to immunisation/vaccination programmes and the NHS public health functions agreement.

<table>
<thead>
<tr>
<th>Existing indicator number</th>
<th>Action</th>
<th>Indicator description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.03iv</td>
<td>Removal</td>
<td>Population vaccination coverage - Meningococcal group C (MenC)</td>
</tr>
<tr>
<td>3.03vi</td>
<td>Removal</td>
<td>Population vaccination coverage - Haemophilus influenzae type b and meningococcal group C (Hib / MenC) booster (2 years old)</td>
</tr>
<tr>
<td>3.03vi</td>
<td>Removal</td>
<td>Population vaccination coverage - Haemophilus influenzae type b and meningococcal group C (Hib / Men C) booster (5 years old)</td>
</tr>
<tr>
<td>3.03xi</td>
<td>Replaced</td>
<td>Population vaccination coverage - Tetanus, diphtheria and polio (Td/IPV) booster (13-18 year olds)</td>
</tr>
<tr>
<td>--</td>
<td>Replaces Td/IPV booster</td>
<td>Population vaccination coverage - Meningococcal groups A, C, W and Y disease (MenACWY) (14-15 yrs old)</td>
</tr>
<tr>
<td>--</td>
<td>New</td>
<td>Population vaccination coverage - Meningococcal group B (MenB) (1 year)</td>
</tr>
<tr>
<td>--</td>
<td>New</td>
<td>Population vaccination coverage - Rotavirus (1 year)</td>
</tr>
<tr>
<td>--</td>
<td>New</td>
<td>Population vaccination coverage - Meningococcal group B (MenB) booster (2 years)</td>
</tr>
<tr>
<td>--</td>
<td>New</td>
<td>Population vaccination coverage - Diphtheria, tetanus, pertussis and polio (DTaP/IPV) (5 years old)</td>
</tr>
<tr>
<td>--</td>
<td>New</td>
<td>Population vaccination coverage - Flu (primary school aged children (reception to year 6))</td>
</tr>
</tbody>
</table>
References

19 Department of Health (2013) A Framework for Sexual Health Improvement in England
23 NHS Employers (2017) Identification and management of patients with frailty a summary of requirements.
24 Public Health England with the National Falls Prevention Coordination Group member organisations (2017) Falls and fracture consensus statement - Supporting commissioning for prevention.