Public Health England

Protecting and improving the nation's health

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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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.

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.

0.1i	Healthy life expectancy - at birth and at 65
0.1ii	Life expectancy - at birth and at 65
0.2iii	Inequality in life expectancy
0.2vi	Inequality in healthy life expectancy
1.02i	School Readiness: The percentage of children achieving a good level of development at the end of reception
1.02i	School Readiness: The percentage of children achieving a good level of development at the end of reception with free school meal status
1.02ii	School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check
1.02ii	School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check with free school meal status
1.03	Pupil absence
1.04	First time entrants to the youth justice system
1.05	16-17 year olds not in education, employment or training (NEET) or whose activity is not known
1.06i	Adults with a learning disability who live in stable and appropriate accommodation
1.06ii	Adults in contact with secondary mental health services who live in stable and appropriate accommodation
1.07	People in prison who have a mental illness or a significant mental illness
1.08i	Gap in the employment rate between those with a long-term health condition and the overall employment rate
1.08ii	Gap in the employment rate between those with a learning disability and the overall employment rate
1.08iii	Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate

1.08iv	Percentage of people aged 16-64 in employment
1.09i	Sickness absence - The percentage of employees who had at least one day off in the previous week
1.09ii	Sickness absence - the percentage of working days lost due to sickness absence
1.11	Domestic abuse-related incidents and crimes - current method
1.12i	Violent crime (including sexual violence) - hospital admissions for violence
1.12ii	Violent crime (including sexual violence) - all violence offences per 1,000 population
1.12iii	Violent crime (including sexual violence) - sexual offences per 1,000 population
1.13iii	First time offenders
1.14i	The rate of complaints about noise
1.14ii	The percentage of the population exposed to road, rail and air transport noise of 65 decibels (A-weighted) or more, during the daytime
1.14iii	The percentage of the population exposed to road, rail and air transport noise of 55 decibels (A-weighted) or more during the night-time
1.17	Fuel Poverty
1.18i	Social Isolation: Percentage of adult social care users who have as much social contact as they would like
1.18ii	Social Isolation: Percentage of adult carers who have as much social contact as they would like
2.01	Low birth weight of term babies
2.03	Smoking status at time of delivery
2.04	Under 18 conceptions
2.04	Under 18 conceptions: conceptions in those aged under 16
2.06i	Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds
2.06ii	Child excess weight in 4-5 and 10-11 year olds - 10-11 year olds
2.07i	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)
2.07i	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)
2.07ii	Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)
2.08ii	Percentage of children where there is a cause for concern
2.09iv	Smoking prevalence at age 15 years - regular smokers (Smoking, Drinking and Drug Use Among Young People in England (SDD) survey)
2.09v	Smoking prevalence at age 15 years - occasional smokers (Smoking, Drinking and Drug Use Among Young People in England (SDD) survey)
2.10ii	Emergency hospital admissions for intentional self-harm
2.11i	Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)
2.12	Percentage of adults (aged 18+) classified as overweight or obese
2.13i	Percentage of physically active adults
2.13ii	Percentage of physically inactive adults
2.14	Smoking prevalence in adults - current smokers (Annual Population Survey (APS))
2.15i	Successful completion of drug treatment - Percentage of opiate drug users that left drug treatment successfully who do not re-present to treatment within 6 months
2.15ii	Successful completion of drug treatment - Percentage of non-opiate drug users that left treatment successfully who do not re-present to treatment within 6 months
2.15iii	Successful completion of alcohol treatment - Percentage of alcohol users that left alcohol treatment successfully who do not re-present to treatment within 6 months
2.15iv	Deaths from drug misuse

2.16	Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison
2.17	Estimated diabetes diagnosis rate
2.18	Admission episodes for alcohol-related conditions - narrow definition
2.20i	Cancer screening coverage - breast cancer
2.20iii	Cancer screening coverage - bowel cancer
2.20iv	Abdominal Aortic Aneurysm Screening - Coverage
2.20v	Diabetic eye screening - uptake
2.20vi	Fetal Anomaly Screening
2.20vii	Infectious Diseases in Pregnancy Screening - HIV Coverage
2.20viii	Infectious Diseases in Pregnancy Screening - Syphilis Coverage
2.20ix	Infectious Diseases in Pregnancy Screening - Hepatitis B Coverage
2.20x	Sickle Cell and Thalassaemia Screening - Coverage
2.20xi	Newborn Blood Spot Screening - Coverage
2.20xii	Newborn Hearing Screening - Coverage
2.20xiii	Newborn and Infant Physical Examination Screening - Coverage
2.22iii	Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check
2.22iv	Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check
2.22v	Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check
2.23i	Self-reported wellbeing - people with a low satisfaction score
2.23ii	Self-reported wellbeing - people with a low worthwhile score
2.23iii	Self-reported wellbeing - people with a low happiness score
2.23iv	Self-reported wellbeing - people with a high anxiety score
2.24i	Emergency hospital admissions due to falls in people aged 65 and over (aged 65+)
2.24ii	Emergency hospital admissions due to falls in people aged 65 and over (aged 65-79)
2.24iii	Emergency hospital admissions due to falls in people aged 65 and over (aged 80+)
3.01	Fraction of mortality attributable to particulate air pollution
3.02	Chlamydia detection rate (15-24 year olds)
3.03i	Population vaccination coverage - Hepatitis B (1 year old)
3.03i	Population vaccination coverage - Hepatitis B (2 years old)
3.03ii	Population vaccination coverage - Bacillus Calmette–Guérin (BCG) - areas offering universal BCG only
3.03iii	Population vaccination coverage - Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B (Dtap / IPV / Hib) (1 year old)
3.03iii	Population vaccination coverage - Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B (Dtap / IPV / Hib) (2 years old)
3.03v	Population vaccination coverage – Pneumococcal conjugate vaccine (PCV)
3.03vii	Population vaccination coverage – Pneumococcal conjugate vaccine (PCV) booster
3.03viii	Population vaccination coverage - Measles, mumps and rubella (MMR) for one dose (2 years old)
3.03ix	Population vaccination coverage - Measles, mumps and rubella (MMR) for one dose (5 years old)
3.03x	Population vaccination coverage - Measles, mumps and rubella (MMR) for two doses (5 years old)

3.03xii	Population vaccination coverage - Human papillomavirus (HPV) vaccination coverage for one dose (females 12-13 years old)
3.03xiii	Population vaccination coverage – Pneumococcal polysaccharide vaccine (PPV)
3.03xiv	Population vaccination coverage - Flu (aged 65+)
3.03xv	Population vaccination coverage - Flu (at risk individuals)
3.03xvi	Population vaccination coverage - Human papillomavirus (HPV) vaccination coverage for two doses (females 13-14 years old)
3.03xvii	Population vaccination coverage - Shingles vaccination coverage (70 years old)
3.03xviii	Population vaccination coverage - Flu (2-3 years old)
3.04	HIV late diagnosis
3.05i	Treatment completion for tuberculosis (TB)
3.05ii	Incidence of tuberculosis (TB)
3.06	NHS organisations with a board approved sustainable development management plan
3.08	Adjusted antibiotic prescribing in primary care by the NHS
4.01	Infant mortality
4.03	Mortality rate from causes considered preventable
4.04i	Under 75 mortality rate from all cardiovascular diseases
4.05i	Under 75 mortality rate from cancer
4.06i	Under 75 mortality rate from liver disease
4.07i	Under 75 mortality rate from respiratory disease
4.08	Mortality rate from a range of specified communicable diseases, including influenza
4.10	Suicide rate
4.12i	Preventable sight loss - age related macular degeneration (AMD)
4.12ii	Preventable sight loss - glaucoma
4.12iii	Preventable sight loss - diabetic eye disease
4.12iv	Preventable sight loss - sight loss certifications
4.14i	Hip fractures in people aged 65 and over (age 65 and over)
4.14ii	Hip fractures in people aged 65 and over (age 65-79)
4.14iii	Hip fractures in people aged 65 and over (age 80+)
4.15i	Excess Winter Deaths Index (Single year, all ages)
4.15ii	Excess Winter Deaths Index (Single year, age 85+)
4.16	Estimated dementia diagnosis rate (aged 65+)

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.

Existing indicator number	Indicator description	Detail of change
1.01i	Children in low income families (all dependent children under 20)	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 & Customs (HMRC) will provide details on how the new indicators will be defined.
1.01ii	Children in low income families (under 16s)	
1.10	Killed and seriously injured (KSI) casualties on England's roads	Department for Transport (DfT) has revised the methodology for this indicator to adjust for changes in the way that police forces record severity.
1.13i	Re-offending levels - percentage of offenders who re-offend	These indicators will change data source following a consultation[1] 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.
1.13ii	Re-offending levels - average number of re-offences per offender	
1.15ii	Statutory homelessness - households in temporary accommodation	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'.
2.02i	Breastfeeding - Breastfeeding initiation	The data source for this indicator will change to the Maternity Services Data Set.
2.02ii	Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth	The data source for this indicator will change to the Community Services Data Set.
2.19	Cancer diagnosed at early stage	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.
4.11	Emergency readmissions within 30 days of discharge from hospital	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.

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.

Indicator number	Old indicator	New indicator	Rationale
1.15i	Statutory homelessness - eligible homeless people not in priority need	Homelessness - Number of households owed a duty under the Homelessness Reduction Act	The Homelessness Reduction Act[2] 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.
		Homelessness - Number of Rough Sleepers	This indicator will measure the number of rough sleepers in each local authority on a single night in autumn every year.
2.05i	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)	Percentage of children at or above expected level of development in all five areas of development at 2-2½ years	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[3]. 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.
2.05ii	Proportion of children aged 2-2½ years offered ASQ-3 as part of the Healthy Child Programme or integrated review	Percentage of children at or above expected level of development in communication skills at 2-2½ years	
		Percentage of children at or above expected level of development in personal-social skills at 2 - 2½ years	
2.20ii	Cancer screening coverage - cervical cancer	Cancer screening coverage: cervical screening – coverage (under 50)	National standards for the NHS cervical screening programme[4] (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.
		Cancer screening coverage: cervical screening – coverage (50 years and above)	
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

Indicator number	Old indicator	New indicator	Rationale
	free from dental decay		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.
4.09i	Excess under 75 mortality rate in adults with serious mental illness	Premature mortality rate for people with mental health problems	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.
4.09ii	Proportion of adults in the population in contact with secondary mental health services	Excess premature mortality ratio for people with mental health problems	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.

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.

Indicator number	Indicator description	Rationale for removal
0.2ii	Number of upper tier local authorities (UTLAs) where inequality in life expectancy at birth has decreased	**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.
0.2iv	Gap in life expectancy at birth between each local authority and England as a whole	**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.
1.09iii	Rate of fit notes issued	**The indictor 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.
1.16	Utilisation of outdoor space for exercise/health reasons	**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.
2.08i	Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March	**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.

2.09i	Smoking prevalence at age 15 - current smokers (WAY survey)	**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.
2.09ii	Smoking prevalence at age 15 - regular smokers (WAY survey)	
2.09iii	Smoking prevalence at age 15 - occasional smokers (WAY survey)	
2.10i	Attendances at A&E for self-harm per 100,000 population	**The indictor 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.
2.11ii	Average number of portions of fruit consumed daily (adults)	**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.
2.11iii	Average number of portions of vegetables consumed daily (adults)	
2.11iv	Proportion of the population meeting the recommended "5-a-day" at age 15 (WAY survey)	**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.
2.11v	Average number of portions of fruit consumed daily at age 15 (WAY survey)	
2.11vi	Average number of portions of vegetables consumed daily at age 15 (WAY survey)	
4.04ii	Under 75 mortality rate from cardiovascular diseases considered preventable	**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.
4.05ii	Under 75 mortality rate from cancer considered preventable	
4.06ii	Under 75 mortality rate from liver disease considered preventable	
4.07ii	Under 75 mortality rate from respiratory disease considered preventable	
4.13	Health related quality of life for older people	**Data source is no longer available:** The questions in the GP Patient Survey used to calculate this indicator are no longer being asked.
4.15iii	Excess Winter Deaths Index (3 years, all ages)	**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.
4.15iv	Excess Winter Deaths Index (3 years, age 85+)	

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.

Indicator description	**Rationale for inclusion**
Disability free life expectancy (DFLE)	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[5]. DFLE at birth has been proposed as the metric to measure progress towards achieving this ambition. It will also be presented at age 65.
School readiness - Communication & language: Early Years Foundation Stage Profiles (EYFSP)	The PHE 2018/19 remit letter[6] 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.
School readiness – Communication & language and literacy: Early Years Foundation Stage Profiles (EYFSP)	
Average Attainment 8 score per pupil	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.[7] 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.

Gap in employment rate between disabled people and the overall employment rate	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 Improving lives: the future of work, health and disability[8] – 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.
Loneliness - 1. Loneliness measure Loneliness - 1.1 How often do you feel that you lack companionship? Loneliness - 1.2 How often do you feel left out? Loneliness - 1.3 How often do you feel isolated from others? Loneliness - 2. How often do you feel lonely?	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[9] 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.
Total prescribed long-acting reversible contraception (LARC) (excluding injections) rate per 1,000 females aged 15-44	The National Institute for Health and Care Excellence (NICE) Clinical Guideline CG30 and QS129[10,11] 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[12] (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.

Maternal obesity at booking – from the Maternity Services Data Set	The National Maternity Review[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[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[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.[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.
Smoking prevalence in adults - socio-economic gap in current smokers (Annual Population Survey (APS))	The government's Tobacco Control Plan (Towards a Smoke-free Generation: A Tobacco Control Plan for England[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.
Proportion of opiate users not in treatment	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[17]. Unmet need is one of the indicators in the drug and alcohol section of the recently refreshed PHE Public Health Dashboard.
Proportion waiting over 3 weeks for drug treatment	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.
Deaths in drug treatment, mortality ratio	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.
Proportion of dependant alcohol users not in treatment	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

	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.
Proportion waiting over 3 weeks for alcohol treatment	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.
Deaths in alcohol treatment, mortality ratio	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.
Percentage reporting a long-term musculoskeletal (MSK) problem	In England, the Global Burden of Disease study[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.
Sexually transmitted infections (STI) testing rate (excluding chlamydia in the under 25 year olds)	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[19]. This indicator is in the sexual and reproductive health section of the recently refreshed PHE Public Health Dashboard.
New sexually transmitted infection (STIs) diagnoses (excluding chlamydia in the under 25 years olds)	This indicator measures STI diagnoses (excluding chlamydia in under 25 year 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 & 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.
HIV testing coverage	This indicator measures the number of persons tested for HIV in specialist sexual health services (SHS) in England. HIV testing is

	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[20] and HIV testing in England[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[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 priories 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[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.[24]

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[25] and the NHS public health functions agreement.[26]

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

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