



Department
of Health

Government response to the consultation *Refreshing the Public Health Outcomes Framework (2015)*

Equality Analysis update on the changes to the
Framework

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Government response to the consultation *Refreshing the Public Health Outcomes Framework (2015)*

Equality Analysis update on the changes to the Framework

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1. What are the intended outcomes of this work?

- 1.1. 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 be measured at the moment.
- 1.2. 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, and driving 'sector-led improvement' where a local authority improves by learning from the experiences of peers. Alongside the NHS Outcomes Framework and Adult Social Care Outcomes Framework, the PHOF reflects the Department of Health's 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.
- 1.3. When the PHOF was first published in 2012 there was a commitment not to make any changes for three years to allow it to become established during the transfer of public health responsibilities from the NHS to local authorities. This consultation on the PHOF indicator set has allowed us to make sure that the PHOF is still as relevant and as useful as possible, now that three years has passed.
- 1.4. The Public Sector Equality Duty (under the Equality Act 2010) requires that public bodies have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities. The SofS also has a number of statutory duties under the NHS Act 2006, including as to promoting autonomy, to promote research, reduce health inequalities between the people of England and improve quality of services through continuous improvement.
- 1.5. The objective of this document is to identify and summarise the potential impact that changes to Public Health Outcomes Framework indicators, following the consultation, may have on groups with protected equalities characteristics, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

2. Background

- 2.1 The PHOF consists of 68 public health indicators, comprising a total of 147 indicators/sub-indicators. There are two overarching indicators and 66 more focused indicators grouped into four domains:
1. Improving the wider determinants of health
 2. Health improvement
 3. Health protection
 4. Healthcare public health and preventing premature mortality.
- 2.2 Some of the indicators have sub-indicators and some do not, hence the total of indicators/sub-indicators being larger than the 68 indicators described above.
- 2.3 An [interactive web tool](#) makes the PHOF data available to local authorities and interested parties. This allows local authorities to assess progress in comparison to national averages and their peers, and shape their work plans accordingly.
- 2.4 Before commencing the refresh process the Department undertook an internal review and audit of the PHOF which established there was a general consensus amongst users of the PHOF that it is a useful tool; it is fit for purpose and needs long term stability to continue to be valuable.
- 2.5 The Department engaged with public health leaders, through the Public Health System Group (PHSG) in designing the refresh process. Members included the Local Government Association, the Royal Society of Public Health, the Faculty of Public Health, the Association of Directors of Public Health and the UK Health Forum.
- 2.6 They supported the limited nature of the review, in particular the fact that the Department should not undertake a wholesale overhaul of the existing PHOF structure.
- 2.7 Key stakeholders told us that:
- the PHOF had a good balance of public health indicators across all domains, and

- the Department of Health should prioritise ensuring continuity of data series, and undertake a small-scale review of indicators to identify any that are no longer relevant or effective.

2.8 Therefore, to maintain the balance of areas covered and promote continuity, it was determined that the consultation would not result in a wholesale overhaul of the existing structure of the PHOF. It would focus on reviewing existing indicators with the aim of removing ineffective indicators and replacing or revising others where improvements in data have taken place over the past few years. It would also provide an opportunity to consider adding a small number of new indicators where there are important public health gaps and information is available to fill them.

2.8 The intention was also, where possible, to:

- avoid new 'placeholder' indicators (that is indicators with no available data source) and new data collections, principally for time and cost considerations. It was recognised, however that there might need to be flexibility on these points.
- operate, as far as is possible, a 'one in, one out' principle to ensure that the Department does not increase the reporting burden on local government.

2.9 Consequently the scope of the consultation included consideration of:

- significant gaps in policy priorities, and proposals for a small number of new indicators or sub-indicators;
- indicators that no longer reflect a public health priority, duplicate an existing assurance mechanism, or are not sufficiently robust;
- the extent to which the PHOF, the NHS Outcomes Framework and the Adult Social Care Outcomes Framework could be better aligned.

2.10 The consultation did not consider changing the number and the scope of the domains of the PHOF or adding large numbers of new indicators.

3. The changes and who will be affected

Summary of the changes

- 3.1 In the 2013 PHOF there were a total of 147 indicators/sub-indicators:
- 9 - Overarching indicators
 - 35 - Wider determinants
 - 53 - Health improvement
 - 22 - Health protection
 - 28 - Healthcare and premature mortality
- 3.2 From April 2016, there will be a total of 158 indicators/sub-indicators:
- 9 - Overarching indicators
 - 34 - Wider determinants
 - 60 - Health improvement
 - 25 - Health protection
 - 29 - Healthcare and premature mortality
- 3.3 Within the four domains:
- Wider determinants - gained 2, lost 3
 - Health improvement - gained 10, lost 3
 - Health protection - gained 4, lost 1
 - Healthcare and premature mortality - gained 1, lost 0
- 3.4 There were changes to 23 existing indicators that are not additions or deletions. These included:
- a. changes that were limited to small changes in the wording of indicator or sub-indicator titles without changes to their definition or content (1.01, 1.07, 2.06, 2.07),
 - b. 3 changes that introduced new sub-indicators in order to reflect updates to/ the extension of national screening or vaccination programmes, i.e. changes that were necessary to achieve completeness of data collection for an indicator that was otherwise not changed in scope (2.20/2.21, 3.03, 4.08),

- c. 5 changes that were made to align the methodology of data collection to other sources (e.g. ONS) or to increase comparability across regions (2.03, 4.01, 4.02, 4.10, 4.16),
 - d. 10 changes where renaming of indicators or inclusion of new or replacement of sub-indicators extended the scope or changed the definition of the indicator (1.08, 1.13, 1.15, 2.08, 2.10, 2.11, 2.15, 2.16, 2.17, 4.09),
 - e. 1 change where a new indicator was added (3.08), and
 - f. 3 changes where indicators or sub-indicators were removed (1.19, 2.23, 3.07).
- 3.5 In addition, 2 indicators were merged without reducing the content of what had previously been covered by the relevant separate indicators (2.20 & 2.21).
- 3.6 The following equality analysis focuses on changes in categories d-f, as categorised above.

Potential impact of changes

- 3.7 There are 10 changes where renaming of indicators or inclusion of new or replacement of sub-indicators extended the scope or changed the definition of the indicator (1.08, 1.13, 1.15, 2.08, 2.10, 2.11, 2.15, 2.16, 2.17, 4.09)

1.08 (new sub-indicator added): 1.08iv - Percentage of people aged 16-64 in employment (Persons)

Addition of this sub-indicator helps to better interpret the employment gap for people with long-term health conditions, calculate their employment rate, and put it into the context of employment rates for the general population.

In doing so, it addresses equality by providing data that enables more direct comparison of employment rates for people with long-term conditions to those for the general population over time and geographically, i.e. across local authorities. Many common chronic conditions, such as type 2 diabetes, are more common at older ages, in people with a disability and from certain ethnic backgrounds. The expansion of this indicator will therefore indirectly help to better identify whether these groups at higher risk of long-term conditions are at a disadvantage with regard to their employment opportunities. While this will help to identify inequality overall, only data that allows a further breakdown by age, disability and ethnic group will allow to understand which groups of

patients with long-term conditions contribute the most to the employment gap.

There is no reason to believe that inclusion of this sub-indicator has differential impact with regard to gender reassignment, marriage and civil partnership, pregnancy and maternity, religion and belief, sex, and sexual orientation.

1.13 Levels of offending and re-offending (Title of this indicator has been revised) A new sub-indicator has been added 1.13iii – First Time offenders

The title of the previous indicator addressed re-offending levels through both the proportion of offenders reoffending, and the average number of re-offences per offender. The alteration of this indicator and addition of a sub-indicator to specifically include first time offenders provides a measure of the numbers entering the criminal justice system for the first time. The broader scope of the indicator helps to address inequalities through its potential to instigate earlier intervention to address offending in the first place, thereby further reducing its impact on individuals, their families and the wider community.

Both offending and reoffending are strongly associated with the wider determinants of health such as deprivation. Offenders are affected by significant health inequalities. However there is little literature addressing any differences in these inequalities in first time compared to repeat offenders. In addition there is little information to demonstrate that first time and repeat offenders differ with respect to protected characteristics apart from age. There has been a sharper decrease in juvenile first time offenders compared to adults since 2007 (CJS quarterly statistics June 2016). However there is some evidence that older prisoners are less likely to re-offend (Brunton-Smith, 2013)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/491119/re-offending-release-waves-1-3-spcr-findings.pdf

In using a percentage figure or count of first time offenders, the age profile of individuals would not be captured within this group. This would need to be appreciated by service commissioners and providers in order to avoid inequalities by providing appropriate interventions that cater effectively for offenders of different ages.

There is no reason to believe that the revised title or introduction of the sub-indicator would have a differential impact with regard to disability, gender

reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, belief, sex and sexual orientation.

1.15 (sub-indicator has been replaced): 1.15i - Statutory homelessness – eligible homeless people not in priority need

Homelessness is associated with severe poverty and is a social determinant of health. It is also associated with adverse health, education and social outcomes, particularly for children. The previous sub-indicator ‘Homelessness Acceptances’ included households that are eligible for assistance, unintentionally homeless and in priority need, and hence a vulnerable population with greater public health needs than the general population.

The sub-indicator has been replaced to avoid overlap with the other existing sub-indicators capturing homeless ‘households in temporary accommodation’ awaiting a settled home. By definition, this group is a subset of households ‘accepted’ as homeless and hence both sub-indicators focused only on those in ‘priority need’. The new sub-indicator ‘Eligible Homeless People Not In Priority Need’ now quantifies homeless household not previously captured, i.e. single homeless people not in priority need for settled accommodation but owed advice and assistance from the local authority. By providing a broader picture of statutory homelessness, this change helps to address inequality by focusing on a group with significant health needs that are not considered priority and are less likely to be met through routine local services.

There is no reason to believe that replacement of this sub-indicator has differential impact with regard to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

2.08 Emotional well-being of looked after children (new sub-indicator has been added): 2.08ii percentage of children where there is a cause for concern

The current indicator looks at average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on March 31st. This average can be affected by extreme scores in a few individuals. The new sub-indicator identifies the proportion of children with poor emotional wellbeing where there is cause for concern, amongst all looked after children regardless of time in care, and allows for easier local and national comparison.

Looked after children experience inequalities in both access to health care and in health outcomes. In particular, a high proportion (60%) of looked after children experience some form of emotional or mental health problems (NICE 2010) (Public Health guidance: looked after children and young people). In being more encompassing the new sub-indicator attempts to address this inequality. In more appropriately measuring the extent of emotional well-being problems in looked after children has the potential to capture unmet need for services. Early intervention is particularly important in terms of addressing future health inequalities, given that half of cases of lifelong mental disorder start before the age of 14 years (PMID: 15939837)

There is no reason to believe that addition of this sub-indicator has differential impact with regard to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

2.10 (sub-indicator has been replaced): 2.10ii - Emergency hospital admissions for intentional self-harm.

The existing sub-indicator 'Percentage of A&E for self-harm that had psychosocial assessment' has changed to 'Emergency hospital admissions for intentional self-harm'. The new sub-indicator provides a broader picture of self-harm by quantifying patients requiring emergency hospital admissions and hence self-harm of greater severity and this can help to better target efforts and resources to areas in greater need. Overall, and apart from very young children, people in their early twenties have the highest percentage of A&E attendances. People living in deprived areas also contribute a much greater proportion of overall A&E attendances compared to those living in less deprived areas. Although people of all ages self-harm, it is particularly common among younger people. Self-harm is often a consequence of social problems, trauma or mental health conditions, such as anxiety and depression. In previous years, around 0.7% of all A&E attendances have been due to deliberate self-harm (HSCIC).

With the replacement of the second sub-indicator, the number of people attending A&E for self-harm is still being assessed through the first sub-indicator and can be used to approximate the prevalence of self-harm across England that leads to clinical presentation, which is a small proportion of self-harm in the community (PMID: 12446536). National guidance in England mandates psychosocial assessment after hospital presentations for self-harm and replacement of the related sub-indicator means that this important aspect of the quality of the service cannot be assessed as readily in the future. The

risk of death by suicide is higher among people who have self-harmed and psychosocial assessment of individuals presenting with signs of self-harm is an important opportunity for suicide prevention. In addition, adolescents discharged after an admission for self-inflicted injury have increased risks of subsequent harm up to a decade later (PMID: 26714280) and a high proportion of people requiring A&E treatment due to self-harm will re-present within a year. Psychosocial assessment and appropriate referral therefore has the potential to play an important role in reducing A&E attendances and hospital readmissions for self-harm.

Because of the risk factors for self-harm, replacement of this indicator may therefore mean that there is a higher risk that there may be missed opportunities for assessing/ monitoring NICE recommended timely psychosocial assessment (and hence prevention of re-admission and suicide) will have a greater impact on young people, those that have experienced trauma (for example miscarriage), are coping with cultural, religious or sexual expectations, therefore contributing to inequalities. However, the new sub-indicator is an improvement on the previous sub-indicator as we were not able to collect data for the previous sub-indicator.

New sub-indicators 2.11iv – Proportion of the population meeting the recommended “5-a-day” at age 15, 2.11v – Average number of portions of fruit consumed daily at age 15, 2.11vi – Average number of portions of vegetables consumed daily at age 15

The existing indicator assesses diet through the proportion of the population eating the recommended 5 a day along with the average number consumed of both fruit and vegetables. Poor diet is linked to chronic disease and premature death, both of which are associated with obesity. The same sub-indicators measured at 15 years of age have been added. This supports measurement of diet in this age group, given that diet is a key factor in childhood obesity.

Wide inequalities exist in childhood obesity. For example, data from the national child measurement programme indicates that children from the most deprived decile are around twice as likely to be obese than those in the least deprived decile in reception and year 6 (<http://www.hscic.gov.uk/ncmp>). It also reports substantial variation in obesity rates by ethnic group. In reception, children who are classed as White British have lower obesity prevalence than other groups, whilst prevalence is higher in those classed as Black African

(http://www.noo.org.uk/NCMP/National_report). Changes in obesity related to ethnic group are seen by gender in year 6, with for example high prevalence also seen in boys classed as Bangladeshi, with a lower prevalence in girls in the same group. Disability is a further area where inequalities are seen (Obesity and Disability; children and young people, PHE 2013) with children with a disability more likely to be obese than those without a disability. Whilst this has been linked to physical activity, less healthy nutrition and unusual dietary patterns have also been suggested as a cause. Given the inequalities seen in childhood obesity, changes to this indicator are likely to have a differential beneficial impact on these groups.

The age of 15 years is specified in the new sub-indicators. This provides a picture of intakes by the end of childhood. There is evidence that diets change during earlier stages of childhood, for example the pre-school period (PMID: 26395342). Whilst the indicator is not expected to contribute to inequalities with respect to age, it may be limited in its ability to monitor intake at earlier ages and different stages of childhood so that interventions can be tailored to key periods of risk.

2.15 (the title of the indicator has been revised and two new sub-indicators have been added): 2.15 - Drug and alcohol treatment completion and drug misuse deaths, 2.15iii – Successful completion of alcohol treatment, 2.15iv – Deaths from drug misuse

The indicator title has changed from ‘2.15 Successful completion of drug treatment’ and the existing indicators on successful completion of drug treatment for opiate and non-opiate users have been extended to now cover successful completion of alcohol treatment. Deaths from drug misuse are now also quantified.

The indicator now covers services for drug and alcohol treatment, which are often commissioned and monitoring jointly. Alcohol consumption represents a considerable public health burden in the UK. Excessive consumption is associated with poor physical and mental health outcomes. The introduction of the new sub-indicators and accompanying name change of the overall indicator are addressing equality by enabling a benchmark for alcohol treatment and monitoring drug misuse deaths.

Successful treatment can reduce drug and alcohol related harm, including liver disease, infectious disease transmission (hepatitis, HIV, TB), cancer and deaths. Comparison of treatment success alongside trends in drug related deaths across regions can help to guide actions for local authorities and target funding to those with greater need. Because alcohol misuse differs by age

and sex and other protected characteristics, changes to this indicator are likely to have a differential (beneficial) impact on these groups. For example, the prevalence of both hazardous drinking and alcohol dependence was more than twice as high in men compared to women in the Adult Psychiatric Morbidity Survey, 2007 (hazardous drinking 33.2% vs 15.7%, alcohol dependence 8.7% vs 3.3%), with the highest prevalence of both hazardous and harmful drinking at younger ages (25-34 years in men, 16-24 years in women).

Alcohol dependence is often associated with mental or emotional problems either as a precipitator or a consequence and hence people experiencing such problems can benefit on multiple levels if successfully treated for alcohol misuse. The same is true for pregnant women and new mothers as drinking in pregnancy or while breastfeeding is harmful for the mother and the child. There is no reason to believe that addition of the sub-indicator has a negative impact with regard to any other protected characteristic.

2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison (indicator replaced)

The existing indicator addresses the proportion of people entering prison with substance dependence issues who are not previously known to services. This has proved difficult in assessing performance as, whilst it assesses the engagement of vulnerable groups with services, it does not address their effectiveness in terms of prevention of re-offending.

The replacement indicator addresses whether offenders are engaging with local services on release from prison. This is a key period where individuals are at risk from ongoing substance misuse or relapse. This also has a strong association with re-offending.

Evidence is limited on inequalities in relation to substance abuse or its treatment in prisoners. One survey reported that female offenders have high rates of substance dependence (Home office, 2003) (Differential substance misuse treatment needs of women, ethnic minorities and young offenders in prison: prevalence of substance misuse and treatment needs). Nevertheless 'ever' drug use appears the same in prisoners of both genders (MOJ, 2013) (Gender differences in substance misuse and mental health amongst prisoners).

Female, unlike male, binge drinkers appear to have a higher re-conviction

rate, however few gender differences have been found in terms of prevalence of alcohol misuse amongst prisoners. The new indicator has the potential for benefit for both male and female prisoners so it is therefore unlikely that the gender characteristic will be differentially affected by replacement of this indicator.

Whilst it has been noted that access to prison drug services by prisoners from black and minority ethnic groups is very limited (DH, 2006) (Clinical management of drug dependence in the Adult prison setting), it is unclear whether this applies to access to or engagement with services after release. There is little other data on substance misuse or engagement with services in prisoners in relation to protected characteristics. Given this, there is no current reason to believe that replacement of this indicator has differential impact with regard to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion and belief, and sexual orientation.

2.17 (definition has been revised): 2.17 - Estimated diagnosis rate for people with diabetes mellitus

The existing indicator measures the prevalence of Quality and Outcomes Framework recorded diabetes in the population registered with GP practices aged 17 and over. In addition, there is a large number of people at high risk of or with undiagnosed type 2 diabetes in the community unknown to their GP and hence not recorded and captured by this indicator. Based on the distribution of risk factors for type 2 diabetes in the population, the number of people expected to have diabetes can be estimated and compared to the number known and recorded. Acknowledging limitations in estimating the true number of people with diabetes in a given area, the change in this indicator definition can help to a) quantify the 'real' prevalence of diabetes, b) record the gap between prevalent undiagnosed and recorded diabetes, c) monitor progress in closing this gap and hence d) facilitate better planning and targeting of funds for programmes designed to prevent, identify and treat diabetes. Diabetes has some strong risk factors and these include protected characteristics: the disease is more common at older ages, in men compared to women, and in people with an African-Caribbean, Black African, Chinese or South Asian background.

The change in indicator will therefore benefit these population groups by identifying their need (estimated prevalence) and quantifying the degree to which it is met (prevalence gap), the first step towards appropriate management and secondary prevention.

4.09ii Proportion of adults in the population in contact with secondary mental health services (new sub-indicator added).

Adults with severe mental illness experience inequalities in life expectancy, dying between 15 and 25 years earlier than the general population on average. The existing indicator addresses this excess mortality in adults under 75 year olds with severe mental illness. The new sub-indicator further analyses this by measuring contact of this population with secondary mental health services.

People with mental illness experience inequalities in access to services. Whilst about 75% of people with physical disorders receive treatment for them, 75% of those with mental disorders receive no treatment, demonstrating a significant treatment gap in mental health (PMID: 18450663). There are also inequalities between groups in terms of both prevalence of mental illness and access to services.

Evidence exists that people from black and minority ethnic groups in the UK are disproportionately affected by mental health problems. (Royal College of Psychiatrists 2010). (No health without public mental health the case for action). These groups experience higher rates of suicide, in-patient admissions and admissions under the Mental Health Act. However, as well as cultural influences on seeking care for mental illness, evidence suggests that there is also a greater mistrust of mental health services by people in these groups (PMID: 24636750).

Gender differences exist in prevalence of mental health disorders. For example suicide mortality and personality disorder is higher in men, whilst mental disorder due to substance misuse, the majority of neurotic disorders and suicide attempts is higher in women. Differences also exist with respect to service use. Rates of admission to hospital for mental illness appear equal in men and women. However, this varies by age, with admissions highest in women in those aged 45-85 years, however highest in men in younger age groups (DH, 2008) (The Gender and Access to Health Services Study: Final report). Women are also affected by mental illness in relation to pregnancy and maternity. Postnatal depression is experienced by around 70,000 women in the UK each year. A 2011 survey by 4Children (Suffering in Silence) demonstrated that almost half did not seek medical help. Of those who did seek medical help, this was delayed by over 6 months in over a quarter.

Health inequalities with respect to mental illness are also experienced in relation to sexual orientation and identity. This is both in terms of prevalence and service access.

Evidence suggests that gay men and lesbian women are more likely to have consulted a mental health professional in the past than heterosexual people, although high proportions report negative reactions from health professionals after disclosing their sexual orientation (King and McKeown, 2003) (Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales: A summary of findings). Those who identify as Trans are significantly more likely to have experienced mental health difficulties compared with those who do not identify as Trans. They are also more likely to feel uncomfortable accessing services compared to individuals who identify as gay or lesbian (Browne and Lim, 2008) (Count me in Too: Trans people additional findings report).

Given the inequalities that exist in prevalence of mental illness and access to mental health services, addition of this sub-indicator has the potential for differential effects on these groups. As the indicator is a global proportion, these inequalities alongside the fact that these groups may be under-represented or hard to reach, will need to be appreciated by decision makers. This is essential in order to ensure that the effects are beneficial and gaps are not widened.

3.8 Change where a new indicator has been added (3.08).

3.08 (new indicator): 3.08 Antimicrobial consumption by the NHS, expressed as a defined daily doses of antibiotics per 1,000 inhabitants per day, dispensed in NHS hospitals and community pharmacies.

As a major threat to the prevention and treatment of infections, antimicrobial resistance poses a significant risk to public health and has been included on the 2015 National risk register of civil emergencies. There is no reason to believe that introduction of this indicator has differential impact with regard to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

3.9 There will be three changes where indicators or sub-indicators were removed (1.19, 2.23, 3.07).

1.19 Older people's perception of community safety (indicator removed)

This indicator has been removed as it does not meet the criteria. Given that this indicator specifically addresses older people, any impact of removal of this indicator will differentially affect this age group. However the utility of this indicator has been low as local data is not available due to the survey sample size being too small. It is therefore not useful in supporting local commissioning decisions.

There is no reason to believe that removal of this indicator has differential impact with regard to disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. However there is a recognition that perception of community safety has an effect on other groups (for example children and young people (PMID: 25367253, 26844195), which would not have been encompassed by the previous indicator.

2.23 Sub-indicator has been removed: 2.23v - Average Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) score

This sub-indicator has been removed because it does not meet the criteria. No local data are available as the sample is too small. There is no reason to believe that removal of this sub-indicator has differential impact with regard to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

3.07 Comprehensive, agreed inter-agency plans for responding to public health incidents and emergencies (indicator removed)

This indicator has been removed as it does not meet the indicator criteria. In addition a robust assurance process is now in place.

There is no reason to believe that removal of this indicator has differential impact with regard to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

4. Next steps

- 4.1 In the consultation responders were also asked 'Aside from necessary technical updates, we plan to review the PHOF again in three years to make sure that the indicators are still relevant. 'Do you agree with this proposal?' with a selection of Yes or No answers. There were 47 responses to this question of which the majority (n=42; 89.4%) were Yes. There were 5 responses which did not agree with the proposal.
- 4.2 Almost 90% of respondents answered yes to the proposal to review the PHOF again in three years. One of the five respondents who answered no in fact agreed with the three year cycle and simply expressed a view on possible improvements to the PHOF web tool functionality. Among the four remaining respondents who answered no there was a wide range of views including both timescales longer and shorter than three years.
- 4.3 We therefore propose that the PHOF will be reviewed in three years' time and this would also fit with the implementation of the National Information Board's programme to implement Personalised Health and Care 2020.
- 4.4 Responders were also asked if they had any suggestions on how the alignment across public health, adult social care and the NHS outcome frameworks might be improved. Is there potential to rationalise any of the indicator or sub-indicator definitions in the three frameworks?
- 4.5 A total of 35 responses were received to this question. There was general support for the alignment in terms of the data tool/platform, and some support for a single framework. The Department is currently considering the responses to align frameworks, rationalise indicator processes and consolidate web platforms further.

