Public Health England

Protecting and improving the nation's health

Public Health Outcomes Framework – May 2016

Summary

Overarching indicators

0.1i – Healthy life expectancy at birth – Between 2011-13 and 2012-14 there was a small increase in healthy life expectancy at birth for both males (from 63.3 years to 63.4 years) and females (from 63.9 to 64 years) in England. These increases were, however, not statistically significant, and there have been no significant changes in healthy life expectancy in either males or females since 2009-11 (figure 1). There remains wide variation among local authorities in England; 15.5 years between the local authorities with the highest and lowest healthy life expectancy among males (Wokingham 70.5 years, Blackpool 55 years) and 17.8 years for females (Richmond-upon-Thames 72.2 years, Manchester 54.4 years).

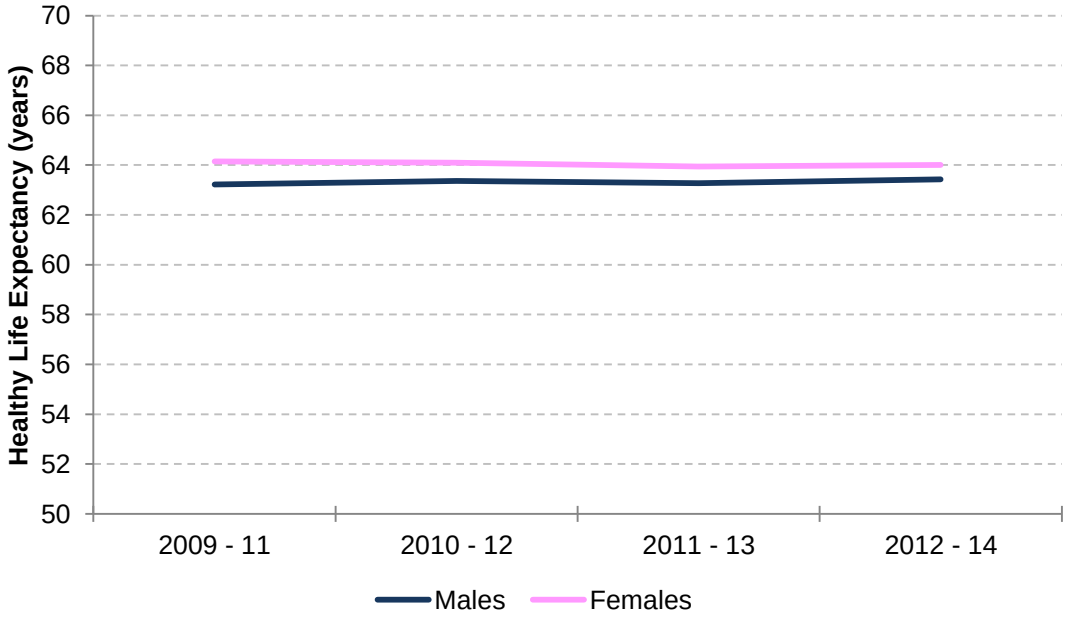

Figure 1: Healthy life expectancy at birth in males and females, England, 2009-11 to 2012-14

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0.2v – Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England – In 2012-14, the difference in healthy life expectancy at birth across the social gradient from the most deprived to the least deprived was 19 years for males. For females the difference was even greater at 20.2 years. Compared to 2011-13, this figure has reduced slightly for males (from 19.2 years) but increased slightly for females (from 19.5 years). These differences were not statistically significant.

Wider determinants of health

1.09 – Sickness absence: 1.09i – the percentage of employees that had at least one day off due to sickness absence in the previous week & 1.09ii – the percentage of working days lost due to sickness absence – Between 2010-12 and 2011-13 there was a small (but not statistically significant) reduction in the percentage of employees that had at least one day off due to sickness absence in the previous week from 2.5% to 2.4%. Regionally, in 2011-13, there was little difference with values ranging from 2.3% in the West Midlands (the lowest) to 2.6% in the East Midlands (the highest). The percentage of working days lost due to sickness absence also fell slightly between 2010-12 and 2011-13 from 1.6% to 1.5%. Again this reduction was not statistically significant. Regionally, London has the lowest percentage of working days lost due to sickness absence (1.2%) and the five local authorities with the lowest percentage of working days lost are all in London (Harrow, Haringey, Wandsworth, Brent and Richmond-upon-Thames).

1.11 – Domestic abuse – Between 2013/14 and 2014/15, the rate of domestic abuse incidents recorded per 1,000 resident population increased significantly in England from 19.4 reported incidents per 1,000 population to 20.4 reported incidents per 1,000 population. Regionally, the rates vary from 27.4 per 1,000 in the North East to 17.6 per 1,000 in the South West. An increase in this indicator could represent an increase in the willingness of the public to report such crimes, and greater commitment on behalf of the different police forces around the country to encourage victims to come forward and to improve recording of such crimes rather than an increase in the prevalence of domestic abuse.

1.12i – Violent crime (including sexual violence): hospital admissions for violence – between the period 2011/12-2013/14 and 2012/13-2014/15, there was a statistically significant reduction in the directly standardised rate of hospital admissions for violence in England from 52.4 admissions per 100,000 population to 47.5 admissions per 100,000. This is the third period in a row where there has been a statistically significant reduction. Although the rates vary across the country (ranging from 74.6 per 100,000 in the North West to 29.3 in the South East in the period 2012/13-2014/15) each region in the country has seen a reduction over the last 3 time periods which mirrors the national trend.

1.16 – Utilisation of outdoor space for exercise/health reasons – In the period March 2014 to February 2015, 17.9% of those surveyed for Natural England's *Monitor of*

Engagement with the Natural Environment (MENE) survey said that they took a visit to the natural environment for exercise or health reasons in the previous 7 days. Although not statistically significant, this is an improvement on the previous year. In fact, since the survey result were first reported in 2011/12, the percentage of those using the natural environment for exercise or health reasons has increased every year. Inequalities do exist between the different regions within England: the percentage of those using outdoor space for exercise or health reasons was more than twice as high in the South West compared to London (25.4% compared to 12.3%).

Health improvement

2.04 – Under 18 conceptions and conceptions in those aged under 16 – In 2014 the rate of under 18 conceptions fell from 24.3 per 1,000 females aged 15-17 to 22.8 per 1,000 females aged 15-17. This is the seventh year in a row that there has been a statistically significant improvement in the rate of under 18 conceptions. Compared to 1998 (the first time-point contained within the PHOF data tool), the rate has more than halved (figure 2). This trend is also seen in the rate of conceptions in those aged under 16. In 2014, the rate was 4.4 per 1,000 females aged 13-15. In 2009, the first year of data in the PHOF data tool, the rate was 7.3 conceptions per 1,000 females aged 13-15. Since then a statistically significant reduction has occurred every year.

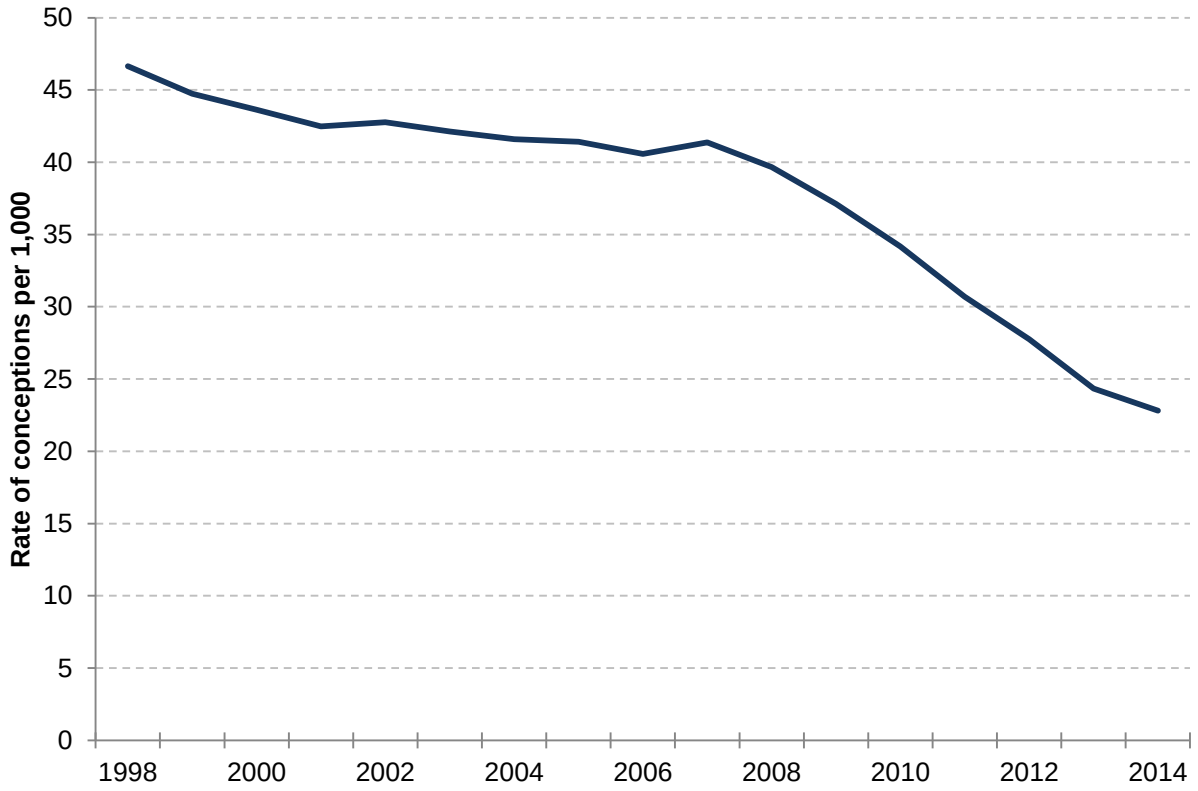

Figure 2: Rate of conceptions per 1,000 females aged 15-17, England, 1998 to 2014

2.07 – Hospital admissions caused by unintentional and deliberate injuries in children and young people: 2.07i – in children aged 0-14 and 0-4 & 2.07ii – in young people aged 15-24 – Between 2013/14 and 2014/15, the crude rate of hospital admissions for unintentional and deliberate injuries in children aged 0-14 fell from 112.2 per 10,000 to 109.6 per 10,000. This was a statistically significant reduction, and the pattern was also seen in the rate of hospital admissions in children aged 0-4 (from 140.8 admissions per 10,000 to 137.5 admissions per 10,000) and in young people aged 15-24 (from 136.7 admissions per 10,000 to 131.7 admissions per 10,000). There remain significant differences between different areas of the country however. For example, the rate of hospital admissions for unintentional and deliberate injuries in children aged 0-4 was more than double in the North West (205.7 per 10,000) in 2014/15 compared with London (100.4 admissions per 10,000) while in the same time period, the rate in Blackpool (287.1 per 10,000) for young people aged 15-24 was more than four times that in Reading (67.1 per 10,000).

2.08 – Emotional wellbeing of looked after children – In 2014/15, the average Strengths and Difficulties Questionnaire (SDQ) score for looked after children aged 5-16 was 13.9. A score of 14 or below on this test is considered 'normal', a score of 15 or 16 considered 'borderline cause for concern', while a score of 17 and over is considered 'cause for concern'. This average score has remained constant in England since 2010/11 (which is the first time point for this particular indicator within the PHOF data tool).

2.11 – Diet: 2.11i – Proportion of the population meeting the recommended '5-a-day', 2.11ii – Average number of portions of fruit consumed daily & 2.11iii – Average number of portions of vegetables consumed daily – In 2015, the percentage of adults in England who had eaten the recommended 5 or more portions of fruit and vegetables a day was 52.3% according to the Active People Survey. This was a statistically significant reduction compared to 2014 (53.5%). According to the same survey, there was also a statistically significant reduction in the average number of portions of fruit consumed daily, from 2.58 to 2.51 in the same period, while the average number of portions of vegetables consumed remained constant at 2.27. For all three indicators there exist significant inequalities between ethnic groups, age groups, gender and deprivation. For example, those aged 55-79 are more likely to consume more portions of fruit and vegetables and hence meet the '5-a-day' target than either older or younger age groups. On average, females consume more fruit and vegetables than males; as do those of White ethnicity when compared to other ethnic groups; and those who live in more affluent local authorities compared with those who live in more deprived local authorities.

These indicators use data from the Sport England Active People Survey (APS). These indicators were not intended to be, and should not be, compared directly with other sources of diet data. The APS questions are more simplistic than those used in other sources e.g. National Diet and Nutrition Survey (NDNS) or Health Survey for England (HSE). The APS survey asks respondents for their estimate of whole numbers of portions and there is no

explanation of portion size. Composite foods (fruit/vegetables used in recipes) are not explicitly included in the APS nor are beans and pulses included in the question text. Furthermore, the survey method which uses telephone interviews rather than a food diary or face to face interview is different and it is not unexpected that different survey methods give different results.

2.18 – Admission episodes for alcohol related conditions (narrow definition) – In 2014/15, the directly age standardised rate in England of hospital admission episodes for alcohol related conditions fell slightly from 645 admissions per 100,000 population to 641 admissions per 100,000 population. Although an improvement, this fall was not statistically significant. There were also improvements in the rate of admissions in both males and females. For males, this was a statistically significant improvement (from 835 admissions per 100,000 to 827 admissions per 100,000) but for females (from 475 admissions per 100,000 to 474 admissions per 100,000) it was not. Those local authorities with, on average, greater levels of deprivation have higher rates of admissions compared with more affluent local authorities. There are also disparities by geography. For example, in 2014/15, 16 out of 19 local authorities in the South East and 28 out of 33 local authorities in London had rates of admission that were significantly below the England average, while 19 out of 23 local authorities in the North West and 12 out of 12 local authorities in the North East had rates of admission that were significantly higher than the England average.

2.19 – Cancer diagnosed at an early stage (experimental statistics) – Between 2013 and 2014 there was a significant increase in the percentage of cancers that were diagnosed at an early stage (N.B. for the purposes of this indicator, not all cancers are included. For more information, please see here). This increased from 45.7% to 50.7%.It is difficult to tell whether this increase is a genuine improvement in the process of diagnosing cancers earlier or an improvement in the recording of such data. This is why this indicator is classed as 'experimental statistics'. Supporting information presented alongside this indicator shows that coverage continues to improve. Only a handful of local authorities have missing data indicating that for residents of these areas fewer than 70% of cancers had staging data submitted to the National Cancer Registration Service in Public Health England. For the whole of England, 87.6% of new cancers had staging information known, a significant increase from 2013, where 79.2% of new cancers had staging information.

Health Protection

3.06 – NHS organisations with a board approved sustainable development management plan – between 2013/14 and 2014/15 there was an increase in the percentage of NHS organisations with a board approved sustainable development management plan, from 41.6% to 56.5%. However, the current figure is lower than the high of 84.1% in 2011/12.

Healthcare and premature mortality

4.13 – Health related quality of life for older people – In 2013/14, the average EQ-5D score for adults aged 65 and over according to the GP Patient Survey was 0.727. The EQ-5D is a survey instrument which asks respondents to describe their health status across 5 dimensions (mobility, self-care, usual activities, pain/discomfort, anxiety/depression) and a composite score calculated, with a score closer to 1 being better than a score closer to 0. The value for this indicator shows very little change from the previous two years (0.726 in 2011/12 and 2012/13). There are some marked differences however by the different equalities and inequalities characteristics available for this indicator. For example, those who describe their ethnicity as Gypsy or Irish traveller, Indian, Bangladeshi, Pakistani, Chinese or Arab have a significantly worse average EQ-5D score than the average score. Those who describe their religion as Christian, Muslim, Sikh or Hindu also have a significantly worse average EQ-5D score than the average, but those who describe their sexuality as heterosexual, or gay or lesbian have a significantly better average EQ-5D score.

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