Department of Health

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

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Contact details: **Public Health Policy and Strategy Unit** Department of Health Richmond House 79 Whitehall London SW1A 2NS PHOF-Referesh2015@dh.gsi.gov.uk

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

Prepared by:

Department of Health – Public Health Policy and Strategy Unit
Public Health England

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1. Introduction

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. The PHOF is published under section 73B of the NHS Act 2006 as guidance that local authorities must have regard to.

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 Alongside this document we have published an equality analysis update on the changes to the PHOF.

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 What we did

3.1 The consultation was live on Citizen Space from 3 September to 2 October 2015. Proposals were invited on existing indicators or sub-indicators, setting out how they might be:

- Revised - how an existing indicator might be improved by a change to the definition, data source, method or other means;
- Replaced - with another indicator which would provide a better outcome measure for the same policy area, for example if a new data set has been developed since 2012; or
- Removed - if an existing indicator or sub-indicator is no longer valid, sufficiently robust or supports a policy area which is no longer a priority.

3.2 There was also a facility to propose new indicators to be added in policy areas not currently covered by the PHOF, or additional sub-indicators for the areas already covered.

3.3 In addition to questions on the specific indicators the Department took the opportunity to seek views on wider alignment across health and social care and specifically in relation to the NHS Outcomes Framework and the Adult Social Care Outcomes Framework. Finally a question was asked about the frequency of PHOF refreshes in the future.

3.4 Alongside the consultation the Department of Health and Public Health England undertook an extensive programme of engagement with colleagues across Government and in our Arms-Length Bodies.

3.5 A full list of the questions in the consultation is set out at Annex A.

4 Who Responded

4.1 There were 118 individual responses to the Citizen Space consultation. Responders were asked 'What is your organisation?' from a selection. The following table shows these results:

Organisation selection	Number	Percentage
Local Authority	39	33.1
Health and wellbeing board	0	-
Voluntary organisation or charity	29	24.6
NHS organisation	15	12.7
Private company	7	5.9
Other	16	13.6
I am responding in a personal capacity	12	10.2

4.2 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. 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.

4.3 A text box was given asking 'If you do not agree, how frequently should the PHOF be reviewed, and why' The following comments were given:

"*The developments in Integrated Care and the Greater Manchester Devolution deal mean that the landscape is rapidly changing - we would prefer an annual review to ensure that the content and format of the PHOF remains relevant.*" – **Local authority organisation**

"*We think that with the integrated care programmes and the introduction of Devolution Manchester the PHOF consultation should be carried out at a minimum of every 2 years to keep up to speed with the changing environment we work in.*" – **Local authority organisation**

"*We believe there should be a broader discussion around how we may integrate all three outcomes frameworks to ensure outcomes are more person-centred, and services are encouraged to work more closely together around individuals' needs. As part of this, it would be important to take steps to involve the public – including service users and carers –*

throughout the process of measuring performance and reviewing the framework to ensure outcomes are effectively improving on the ground and in the long term. On the whole, we would also recommend a greater emphasis on the longer-term vision for public health, which may include setting a timeline of 5-10 years with a set of key milestones to achieve. The frameworks should set out a clear roadmap for achieving this long-term vision as well as an expectation of continuous improvement." – **Voluntary organisation or charity**

"*This should be an annual review to ensure that any organisational changes in health and local government are reflected.*" – **NHS organisation**

"*I agree to 3 years for large scale review of the indicators. However, it would be very useful if top tier county local authorities could select the data for their county and districts only using the PHOF tool and it would be helpful for us to be able to build our own selections of areas. It would also be useful to have benchmarking data in PHOF - so the new ONS comparator areas and/or CIPFA groups.*" – **Personal capacity response**

4.4 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. 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.

4.5 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?

(i) Are there alternative or new indicators or sub-indicators which might be shared across two or all three, of the outcome frameworks?

(ii) Please give the source of any alternative data requirement (including the web link(s))

(iii) If this is a new data collection please set out how it will be funded.

4.6 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 following comments were given:

"*I think it is important that now they have been established, to continue with the existing PHOF indicators and their definitions so as facilitate longer term trend monitoring. In the past there have been a wealth of health indicators that have had their definitions changed or have been discontinued (e.g. the Health Service Indicators of the 1990s) which means it has not been possible to monitor and measure changes over time accurately. This is particularly important for Public Health, given its focus on populations over time and geographical space*". **Local authority organisation**

"*Produce a single framework including all indicators and identify if they are 'owned' by Public Health, NHS or adult social care*". **Local authority organisation**

"*The PHOF, NHS Outcomes Framework (NHSOF) and Adult Social Care Outcomes Framework could be merged, although it was noted that this reduces the ability of the frameworks to promote accountability for distinct funding streams*". **NHS organisation**

"*In general, I personally think that there is a good mix of indicators which form the PHOF. We have done a lot of additional work on the indicators and have produced a sophisticated template as well as analyse our own data from a number of indicators to look at trends over time. Therefore, as a result, we have used the PHOF indicators in depth. Therefore, it would be very unhelpful to us if a number of indicators change in the way of definitions, data sources, so that we cannot analyse trends over time*". **Local authority organisation**

"*Although some progress has been made between the three outcome frameworks to present indicators in the most logical format for each organisation whilst also attempting to align indicators between the outcome frameworks, more can be done*". **Local authority organisation**

4.7 The Department is currently considering the responses to align frameworks, rationalise indicator processes and consolidate web platforms further.

5 What will change

5.1 From April 2016, there will be 67 public health indicators, which will consist of a total of 158 indicators/sub-indicators. One new indicator has been added, two indicators have been removed and a total of 17 indicators/sub-indicators have been added and 7 have been removed. A full list of the indicators and sub-indicators from April 2016 is available at Annex B. A copy of the criteria for including indicators is at Annex C.

5.2 The changes that have been made are as follows:

Existing Indicator	**What has changed**
1.01 Children in poverty	This has been revised to: **1.01 Children in low income families** 1.01i - Children in low income families (all dependent children under 20) 1.01ii - Children in low income families (under 16s)
Reason for change	This indicator has been renamed Children in Low-Income Families. This is a name change to better align these statistics to their source: "The children in low-income families" publication.

Existing Indicator	**What has changed**
1.07 People in prison who have a mental illness or a significant mental illness	This has been revised to: **1.07 Proportion of people in prison aged 18 or over who have a mental illness.** The data behind this indicator comes from a new data source (Health and Justice Indicators of performance, initiated in April 2015). The numerator will now include all prisoners with an identified mental health condition, and not just those on a Care Programme Approach
Reason for change	The name of the indicator has been changed to define the scope of the indicator i.e. adult prisoners in England, and to move anyway from a 'forced differentiation' between 'mental illness' and 'significant mental illness' which was not meaningful in practice and data did not support. The Health & Justice Indicators of Performance (HJIPs) also allow some differentiation in terms of services provided in response to need including those patients on a Care Programme Approach as well as access to group and individual therapies. The HJIPs and associated Quality Outcomes Frameworks are the primary data source for this indicator. Prisoners experience significantly greater psychiatric morbidity than the general population. It has been estimated that over 90% of prisoners have at least one of five psychiatric disorders (psychosis; anxiety or depression; personality disorder; alcohol misuse; drug dependence). Prison can have a detrimental impact on the mental health of

	prisoners, and those with an existing mental illness in particular. Although for some individuals a custodial sentence will be necessary, it is widely acknowledged that the criminal justice system is not always the best place to manage the problems of less serious offenders where their offending is related to their mental illness. Lord Bradley's April 2009 review of mental health and learning disabilities within the criminal justice system, which recommended the current policy approach of liaison and diversion and early intervention, said that "there are now more people with mental health problems in prison than ever before. While public protection remains the priority, custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide". This indicator measures the prevalence of people with a mental health condition in the prison population. The outcome sought is the reduction in the proportion of people going into prison with a mental healthcare need, with a view to both improving services in prison and supporting engagement at earlier point in the care pathway to divert them.

Existing Indicator	**What has changed**
1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services 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	A new sub-indicator has been added: **1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services** 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 (Persons)
Reason for change	The gap in percentage points in employment does not inform how the employment rates for those in the general population and in the populations covered by indicator 1.08 have changed over time or even compare across Local Authorities. For

	example, • the gap may remain the same from one year to the next but employment may have increased or decreased similarly for both the general population and the target population; • the gap may increase due to a higher increase in the employment rate for the general population than for the target population, but there have been increases for both populations. To help interpretation of the indicator, the rate of employment for the general population aged 16-64 is being published as a new sub-indicator. This allows comparison of the percentage gap with the percentage of those employed in the general population – e.g. a gap of 10.8 percentage points for those with a long-term condition in relation to 69.0% of people in the general population employed (the new sub-indicator). This also allows calculating the employment rate for those with a long-term condition – e.g. 69% minus 10.8 = 58.2%.

Existing Indicator	**What has changed**
1.13 Re-offending levels 1.13i - Re-offending levels - percentage of offenders who re-offend 1.13ii - Re-offending levels - average number of re-offences per offender	The title of this indicator has been revised and a new sub-indicator has been added: **1.13 Levels of offending and re-offending** 1.13i - Re-offending levels - percentage of offenders who re-offend 1.13ii - Re-offending levels - average number of re-offences per offender 1.13iii – First time offenders
Reason for change	Offending and re-offending levels are strongly associated with wider determinants of health and deprivation. Preventing individuals from offending in the first place and reducing re-offending levels requires coordinated action on wider determinants across health and justice organisations. Tackling the factors that increase an individual's likelihood of offending is a policy imperative for the Ministry of Justice, Department of Health and other Government Departments. Reducing re-offending is a policy imperative shared by the Department of Health and the Ministry of Justice especially among young people. The PHOF indicator on reducing re-offending is currently a useful measure to guide coordinated action across health and justice commissioners and service providers on health-related drivers of criminogenic behaviour as well as being of interest to Health & Wellbeing Boards and Community Safety Partnerships to provide evidence of impact of policy and practice locally. The addition of a measure on first time offenders will provide a useful measure on progress on wider coordinated actions to reduce the numbers of individuals entering the Criminal Justice System for the first time.

Existing Indicator	**What has changed**
1.15 Statutory	Sub indicator 1.15i has been replaced:

homelessness 1.15i - Statutory homelessness - homelessness acceptances 1.15ii - Statutory homelessness - households in temporary accommodation	**1.15 Statutory homelessness** 1.15i - Statutory homelessness – eligible homeless people not in priority need 1.15ii - Statutory homelessness - households in temporary accommodation
Reason for change	'Homelessness Acceptances' indicator has been replaced with 'Eligible Homeless People Not In Priority Need'. This will help provide a rounded picture of single homeless people, who often have significant health needs and are not entitled to statutory housing support. Evidence suggests that this group can fall through the gaps of local service provision and their needs become more complex as a result. 'Homelessness Acceptances' was replaced as an indicator as it was difficult to demonstrate whether a high or low figure was good or bad in terms of public health outcomes. Homelessness Acceptance also overlaps with the 'households in temporary accommodation' indicator and broadly speaking measures the same household twice. In order to be placed in temporary accommodation a person will need to be accepted as homeless.

Existing Indicator	**What has changed**
2.03 Smoking status at time of delivery	There will be a change of method for reporting this information from April 2017, removing those whose smoking status is unknown from the calculation. Data collection/submission requirements will remain the same.
Reason for change	In the current definition, women with unknown smoking status are effectively categorised as non-smokers. However, a number of these will be smokers. This therefore serves to deflate the indicator value meaning performance looks better than it is. Excluding women with unknown smoking status from the calculation will provide a more accurate representation of the true proportion of women smoking at time of delivery. The overall impact of this change at England level is small, although the impact will be greater for those Clinical Commissioning Groups (CCGs) who have a high proportion of unknowns. Work is already underway to encourage and support Trusts/CCGs to collect and record accurate information. IT issues are reported as the main reason for high levels of unknowns, which should be resolved as systems embed and improve. Having the new definition effective from April 2017 will allow time to work with CCGs to improve the quality of their data and to co-ordinate the change with the publication of the new Government tobacco control plan for England, expected in 2016. HSCIC will publish this indicator under both definitions during 2016/17 so CCGs can assess what the impact will be of switching to the new definition. Data is collected via CCGs and subsequently configured to local authority level for presentation within PHOF.

Existing Indicator	What has changed
2.06 Excess weight in 4-5 and 10-11 year olds 2.06i – Excess weight in 4-5 and 10-11 year olds - 4-5 year olds 2.06ii – Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	The main title has been revised: **2.06 Child excess weight in 4-5 and 10-11 year olds** 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 The method has been changed to use data that are based on postcode of residence and not of school. Children will be allocated to local authorities on their postcode of residence.
Reason for change	This will align with other indicator sets on child excess weight that are produced by Public Health England.

Existing Indicator	What has changed
2.07 Hospital admissions caused by unintentional and deliberate injuries in under 18's 2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) 2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	The title has been revised: **2.07 Hospital admissions caused by unintentional and deliberate injuries in under 25's** 2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) 2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)
Reason for change	The age has been changed from "18" to "25" to match the age ranges in the sub-indicators.

Existing Indicator	What has changed
2.08 Emotional well-being of looked after children	A new sub-indicator has been added: **2.08 Emotional well-being of looked after children** 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 (the current indicator) 2.08ii Percentage of children where there is a cause for concern
Reason for change	The new sub-indicator indicates the proportion of looked after children who are affected by poor emotional wellbeing. The existing indicator gives an overall average score for looked after children's wellbeing in the area, but only gives an idea collectively. Because it's an average score it isn't clear whether it is a small group of looked after children with very high scores but the majority have lower scores or if almost all of them are just over the 'cause for concern' boundary. The new sub-indicator will address this and allow for comparisons with other local authorities and England.

Existing Indicator	What has changed
2.10 Self-harm 2.10i – A&E attendances for self-harm 2.10ii – Percentage of A&E attendances for self-harm that had psychosocial assessment	Sub-indicator 2.10ii has been replaced: **2.10 Self-harm** 2.10i A&E attendances for self-harm 2.10ii Emergency hospital admissions for intentional self-harm
Reason for change	These indicators will be used as a measure of prevalence for self-harm across England. This will provide the Department with valuable data when developing mental health policy, and means that the Department can more effectively target areas of high prevalence of self-harm. It is estimated that 1 in 6 people who require treatment in Emergency Departments due to self-harm will be back again within a year. The risk of death by suicide is higher among people who have self-harmed. Early intervention when individuals present with signs of self-harm can reduce the harm of behaviour escalating to suicidal behaviour. Therefore this would support the wider work of the suicide prevention strategy. The indicator will enable us to develop a better understanding of the scale of the issue and will enable us to target interventions. The desired outcome of our preventative interventions would be that as the Department develops better community and crisis response teams and people have appropriate services to turn to, the Department would expect there to be a reduction in the number of attendances at A&E and admissions for self-harm. The Department will be using the number of people attending A&E for self-harm as a proxy for the prevalence of self-harm across England. By including emergency admissions as well, the Department will be able to also obtain a picture of the severity of those presenting at A&E and requiring admission.

Existing Indicator	What has changed
2.11 Diet 2.11i - Fruit and Veg '5-a-day' 2.11ii - Average number of portions of fruit eaten 2.11iii - Average number of portions of vegetables eaten	Three new sub-indicators have been added: **2.11 Diet** 2.11i - Fruit and Veg '5-a-day' (adults) 2.11ii - Average number of portions of fruit eaten (adults) 2.11iii - Average number of portions of vegetables eaten (adults) 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
Reason for change	Tackling obesity and improving people's health through good nutrition continues to be a major priority for this Government. Diet quality is a key factor in childhood obesity. Until now there have been no data on intakes in 15 year olds that can be broken down to local authority level. Now the What about YOUth? Survey data (2014) has been published a PHOF

	indicator would allow comparisons between local authorities and against the national position. These sub-indicators will not be comparable with those for adults, which are from a different survey – the Active People Survey.

Existing Indicator	What has changed
2.15 Successful completion of drug treatment 2.15i - Successful completion of drug treatment - opiate users 2.15ii - Successful completion of drug treatment - non-opiate users	The title of the indicator has been revised and two new sub-indicators added: **2.15 Drug and alcohol treatment completion and drug misuse deaths** 2.15i - Successful completion of drug treatment - opiate users 2.15ii - Successful completion of drug treatment - non-opiate users 2.15iii – Successful completion of alcohol treatment 2.15iv – Deaths from drug misuse
Reason for change	Successful completion of alcohol treatment has been added as an additional sub indicator to reflect the fact that drug and alcohol services are increasingly commissioned together and the data that is used to report on access and provision all comes from the same monitoring system. It therefore makes sense that this indicator reports on outcomes on the full range of substances that bring people into treatment and recovery services, particularly given the health harms associated with the heavy use of alcohol. The indicator now measures the local rates of completion for drug *and* alcohol treatment and benchmarks activity. It is used as the basis to identify areas that may need additional support from Public Health England to help improve outcomes. Public Health England also provides a range of toolkits to commissioners and providers to help them do this. The indicator also supports reductions in inequalities and helps improve return on investment for local authorities as well as for the national public health grant. In addition to adding alcohol as a sub indicator, deaths from drug misuse has also now been included to the indicator as there has been a rising trend in drug related deaths over the last few years. Local authority action, including the quality and accessibility of the drug services they commission and how deaths are investigated and responded has an impact on drug misuse death rates. Including this sub-indicator alongside those on treatment outcomes will help local authorities and others to consider the impact of treatment in addiction to recovery outcomes. Public Health England is committed to continue to improve recovery rates for both drug and alcohol treatment and to reduce health-related harms, HIV, hepatitis, TB transmission and drug-related deaths. This action was included with the Public Health England's Annual Plan 2015/16 and this indicator directly contributes.

Existing Indicator	What has changed
2.16 People	The indicator has been replaced:

entering prison with substance dependence issues who are not previously known to community treatment	**2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison**
Reason for change	The current indicator is challenging in terms of judging performance. If performance for a given local authority is low, this implies good engagement of vulnerable groups in local treatment services; however this opens up questions about the effectiveness of local services in helping to reduce/prevent offending. This replacement indicator supports a priority under the National Partnership Agreement between NHS England, National Offender Management Service and Public Health England to strengthen integration of services and continuity of care between custody and the community. The indicator measures the proportion of adults released from prison with substance misuse treatment need, who go on to engage in structured treatment interventions in the community within 3 weeks of release. The indicator would directly measure whether offenders with substance misuse treatment need are engaging with local treatment services on release from custody. Individuals released from prison with ongoing substance misuse treatment need are at heightened risk in the days following release and local community-based treatment services should be working with prison treatment services to maximise their engagement in services post-release.

Existing Indicator	What has changed
2.17 Recorded diabetes	The definition has been revised: **2.17 Estimated diagnosis rate for people with diabetes mellitus**
Reason for change	The current PHOF only measures recorded diabetes. However, for clinical commissioning groups and local health and well-being boards to understand the scope for prevention and make headway in tackling the rising numbers of people with or at risk of diabetes, they need to understand not only how many people have diabetes (recorded diabetes as currently collected) but also the estimated number of people expected to have diabetes given the characteristics of their populations. This will enable them to have a better idea of the scale of the challenge in terms of numbers and costs in developing diabetes identification and prevention programmes. And it will also help them monitor the progress that they are making towards closing the gap (i.e. meeting previously unmet need) between observed prevalence (number of cases of diabetes recorded) and actual prevalence in identifying people at high risk or with hitherto undiagnosed diabetes.

Existing Indicator	What has changed
2.20 Cancer screening	These two indicators have now been combined and the title of the indicator has been revised. A bowel cancer screening sub-

coverage 2.20i - Cancer screening coverage - breast cancer 2.20ii - Cancer screening coverage - cervical cancer **2.21 Access to non-cancer screening programmes** 2.21i - Antenatal infectious disease screening – HIV coverage 2.21iii - Antenatal Sickle Cell and Thalassaemia Screening - coverage 2.21iv - Newborn bloodspot screening - coverage 2.21v - Newborn Hearing screening - Coverage 2.21vii - Access to non-cancer screening programmes - diabetic retinopathy 2.21viii - Abdominal Aortic Aneurysm Screening	indicator was added in November 2015 as Public Health England are now able to access robust bowel cancer screening coverage data. A new sub indicator on Fetal Anomaly screening (2.20vi) has been added as robust data will be available from April 2016. The sub-indicator for Abdominal Aortic Aneurysm screening (2.20iv) has been changed and the previous sub-indicators on infections in pregnancy screening disease (2.20vii, viii and ix) have been amended into individual sub indicators for Syphilis, Hepatitis B and HIV screening coverage. These changes provide a more consistent approach to measuring uptake. Screening for rubella susceptibility has been removed from the infectious diseases in pregnancy screening sub indicator as screening will cease from April 2016: **2.20 National Screening Programmes** 2.20i – Breast Cancer Screening - Coverage 2.20ii – Cervical Cancer Screening – Coverage 2.20iii – Bowel Cancer Screening – Coverage 2.20iv – Abdominal Aortic Aneurysm Screening – Coverage 2.20v – Diabetic Eye Screening – Uptake 2.20vi – Fetal Anomaly Screening – Coverage 2.20vii - Infectious Diseases in Pregnancy Screening – HIV Coverage 2.20viii – Infectious Diseases in Pregnancy Screening – Syphillis 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
Reason for change	This will move all of the national screening programme indicators into one place. The proposed amendments to the sub-indicators are mainly for consistency. For infectious diseases in pregnancy, screening is for four different conditions, HIV, Hep B, syphilis and rubella susceptibility. This was split into two sub-indicators – one for HIV and the other for syphilis, Hep B and rubella susceptibility which was odd. The Department is now ceasing rubella susceptibility screening and it seemed sensible to have separate sub-indicators for each of the three remaining conditions Hep B and syphilis. For AAA and Fetal Anomaly screening, data is now collected to support the inclusion of sub indicators in the PHOF.

Existing Indicator	**What has changed**
2.23 Self-reported well-being 2.23i - Self-reported well-being - people with a low satisfaction score 2.23ii - Self-	Sub-indicator 2.23v has been removed: **2.23 Self-reported well-being** 2.23i - Self-reported well-being - people with a low satisfaction score 2.23ii - Self-reported well-being - people with a low worthwhile score

reported well-being - people with a low worthwhile score 2.23iii - Self-reported well-being - people with a low happiness score 2.23iv - Self-reported well-being - people with a high anxiety score 2.23v - Average Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) score	2.23iii - Self-reported well-being - people with a low happiness score 2.23iv - Self-reported well-being - people with a high anxiety score
Reason for change	This sub-indicator has been removed. This is because it does not meet the indicator criteria because there is no local data available as the sample size is too small.

Existing Indicator	**What has changed**
3.03 Population vaccination coverage 3.03i - Population vaccination coverage - Hepatitis B (1 year old/2 years old) 3.03ii – Population vaccination coverage – BCG (1 year old) 3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old/2 years old) 3.03iv - Population vaccination coverage - MenC 3.03v - Population vaccination coverage - PCV 3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old/5 years) 3.03vii - Population vaccination coverage - PCV booster 3.03viii - Population vaccination coverage - MMR for one dose (2 years old) 3.03ix - Population	Sub-indicator 3.xii has been revised and three new sub-indicators have been added: **3.03 Population vaccination coverage** 3.03i - Population vaccination coverage - Hepatitis B (1 year old/2 years old) 3.03ii – Population vaccination coverage – BCG (1 year old) 3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old/2 years old) 3.03iv - Population vaccination coverage - MenC 3.03v - Population vaccination coverage - PCV 3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old/5 years) 3.03vii - Population vaccination coverage - PCV booster 3.03viii - Population vaccination coverage - MMR for one dose (2 years old) 3.03ix - Population vaccination coverage - MMR for one dose (5 years old) 3.03x - Population vaccination coverage - MMR for two doses (5 years old) 3.03xi – Population vaccination coverage – Td/IPV booster (13-18 years old) 3.03xii - Population vaccination coverage – HPV vaccination coverage for one dose (females 12-13 years old) 3.03xiii - Population vaccination coverage - PPV 3.03xiv - Population vaccination coverage - Flu (aged 65+) 3.03xv - Population vaccination coverage - Flu (at risk individuals) 3.03xvi – Population vaccination coverage – HPV vaccination for two doses (females 13-14 years old) 3.03xvii – Population vaccination coverage – Shingles vaccination coverage (70years old) 3.03xviii – Population vaccination coverage – Flu (2-4 years old)

vaccination coverage - MMR for one dose (5 years old) 3.03x - Population vaccination coverage - MMR for two doses (5 years old) 3.03xi – Population vaccination coverage – Td/IPV booster (13-18 years old) 3.03xii - Population vaccination coverage - HPV 3.03xiii - Population vaccination coverage - PPV 3.03xiv - Population vaccination coverage - Flu (aged 65+) 3.03xv - Population vaccination coverage - Flu (at risk individuals)	
Reason for change	The revision to this indicator means it now accurately reflects the immunisation schedule available in England throughout the life course.

Existing Indicator	**What has changed**
4.01 Infant Mortality	There has been a change in definition:
Reason for change	There is a slight change in the definition. This is to change from using death occurrences (i.e. the year in which the death took place) to death registrations (i.e. the year in which the death was registered). This will align the indicator with routinely available data including from the Health and Social Care Information Centre (HSCIC) indicators portal, it is what Office for National Statistics submit to Eurostat for their infant mortality analyses, and is also the method most familiar to the bulk of users of the PHOF tool: those based in local authorities. The change in definition will also reduce the number of queries that the PHOF team receives, as many of them centre around the differences between what is published in the PHOF for this indicator and other sources of this data.

Existing Indicator	**What has changed**
4.02 Tooth decay in children aged 5	The definition of this indicator has now changed and the title has been revised: **4.02 Proportion of five year old children free from dental decay.**
Reason for change	Oral health is an integral part of overall health. Dental caries contributes substantially to the burden of preventable ill health

	and poor quality of life. It causes pain, infections, anxiety, and in children, absence from school. The number one reason for children of this age being admitted to hospital is for multiple tooth extractions due to decay. This indicator will help to identify problems in children's teeth early. There is also an established relationship between deprivation and dental decay; this indicator is therefore central to any strategy to tackle inequalities. Decay levels at age five can give an indication of the success of early life interventions to improve parenting, infant feeding, hygiene and other home care habits that impact on the health of young children and their readiness to learn. This new prevalence measure is easier to interpret than the previous outcome indicator on decayed, missing and filled teeth (dmft) for non-dental experts. It brings the indicator in line with others in the framework, uses data that is already collected, and can be retrieved from previous surveys.

Existing Indicator	**What has changed**
4.08 Mortality rate from communicable diseases	There has been a change in definition: **4.08 Mortality rate from a range of specified communicable diseases, including influenza**
Reason for change	Certain causes of death relating to pneumonia have been removed. Bronchopneumonia is a common terminal event in patients with other underlying conditions and so inclusion of all deaths coded to pneumonia may include a large number of deaths that are not truly attributable to infection. There may however be a risk of excluding some less common forms of pneumonia that should qualify as communicable but this is a small number in comparison.

Existing Indicator	**What has changed**
4.09 Excess under 75 mortality rate in adults with serious mental illness	A new sub-indicator has been added: **4.09 Excess under 75 mortality rate in adults with serious mental illness** 4.09i Excess under 75 mortality rate in adults with serious mental illness (the current indicator) 4.09ii Proportion of adults in the population in contact with secondary mental health services
Reason for change	The current indicator is indirectly standardised to the England. To help local authorities understanding their figures for the main indicator, a contextual indicator on the proportion of people in the population in contact with secondary mental health services in each local authority has been added, which can be calculated from the data currently published in the HSCIC Indicator Portal for NHSOF 1.5i.

Existing Indicator	**What has changed**
4.10 Suicide rate	There has been a change in definition.
Reason for change	The PHOF and National Statistics definitions will now be aligned. This means that for codes X60-X84 only ages 10+ will be

	included and for codes Y10-Y34 only ages 15+ will be included. The population denominator will be ages 10+.

Existing Indicator	What has changed
4.16 Estimated diagnosis rate for people with dementia	There has been a change in definition.
Reason for change	This indicator is shared with the NHS Outcomes Framework (NHSOF) indicator 2.6i, for which a change in the methodology is being discussed. It is proposed to calculate diagnosis rates for dementia (the indicator) by using a more recent and robust source of prevalence estimates for dementia in the England population (1). The corresponding PHOF indicator will be changed in alignment with the changes in the NHSOF indicator. (1). Mathews, F.E. et al. (2013). A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II. *Lancet*; 382: 1405–12.

5.3The following two indicators have been removed:

Existing Indicator	What has changed
1.19 Older people's perception of community safety 1.19i - Older people's perception of community safety - safe in local area during the day 1.19ii - Older people's perception of community safety - safe in local area after dark 1.19iii - Older people's perception of community safety - safe in own home at night	This indicator and sub-indicators have been removed.
Reason for removal	This indicator does not meet indicator criteria. Data are only available at national level (survey sample size is not large enough to permit local data) so this is not useful for supporting local commissioning decisions.

Existing Indicator	What has changed
3.07 Comprehensive, agreed inter-agency plans for responding to public health	This indicator has been removed.

incidents and emergencies	
Reason for removal	It does not meet the indicator criteria. A different robust assurance process for emergency response is now in place. The definition as stated makes it clear that it is intended to be used at regional or national level. At local authority level the indicator can only be 0% or 100% and it is not statistically robust to compare local authorities on this basis, or meaningful alongside the other PHOF indicators, which operate on a scale.

5.4 There was strong support that these two indicators should be removed.

5.5 The following new indicator has been added:

New Indicator	**What has changed**
3.08 Antimicrobial Resistance	This is a new indicator. An indicator on antibiotic consumption by the NHS has been added. **Antibiotic consumption by the NHS, expressed as defined daily doses of antibiotics per 1,000 inhabitants per day, dispensed in NHS hospitals and community pharmacies**
Reason for inclusion	Antimicrobial Resistance (AMR) is on the 2015 National risk register of civil emergencies. The UK five year AMR strategy 2013 to 2018 set out actions to slow the development and spread of antimicrobial resistance with a focus on antibiotics. The strategy is overseen by a cross government multi-agency steering group. Within an international context AMR has been highlighted by G7 and the World Health Organisation refers to AMR as a threat to global health security that is endangering the prevention and treatment of infections. Therefore it has been decided to add an indicator on antimicrobial resistance into the PHOF.

5.6 A number of respondents asked that the Department include a new indicator on education attainment at age 16. The Department agrees that education attainment is a suitable indicator, but it is not feasible to include an education attainment indicator at this time due to accountability and qualification reforms. The Department hopes to include something in the next refresh in 2019.

Annex A Consultation Questions

Consultation questions

Your details

1. What's your name?
2. What's your email address?
3. What's your organisation? (required)
4. What's your job title?

Existing indicator questions

5. What change would you like to make to this indicator?
   - Revise - please answer parts (i), (iii), (iv), (v) and (vi)
   - Replace - please answer parts (ii), (iii), (iv), (v) and (vi)
   - Remove - please answer part (vii)

   (i) Please describe your proposed change, including how this REVISION will improve, strengthen or better align the indicator or sub-indicator? (change data source, change definition, change methodology, other)

   (ii) What should REPLACE this indicator? How will this new indicator or sub-indicator improve our understanding of the policy objective? How will it contribute to reducing inequalities?

   (iii) Please set out how the revised indicator meets the essential criteria (see PHOF Indicator Criteria in 'Related documents' section of this consultation)

   (iv) Please give the source of any alternative data requirement (including the web link).

   (v) If this is a new data collection please set out how this will be funded. Please set out the reason for your suggestion

   (vi) Is this data available at upper tier local authority level (ie county, unitary authority, London borough or metropolitan county district)? (y/n)

   (vii) Please set out the rationale for REMOVING this indicator or sub-indicator.

<u>These questions are repeated throughout the consultation for each of the existing indicators</u>

Proposals for new indicators [questions 26, 51, 59 and 76]

26. Please define the new indicator (and sub-indicator(s) if appropriate) which you propose should be added in policy areas not covered by the PHOF

   (i) What is the policy objective this new indicator (and sub-indicator(s) if appropriate) would address? What is the rationale for its inclusion, including how it would contribute to reducing inequalities?

(ii) Please set out how the new indicator (and sub-indicator(s) if appropriate) meets the essential criteria (See 'PHOF Indicator Criteria' in the 'Related documents' section of this consultation)

(iii) Please give the sources of the new data for the proposed indicator (and sub-indicator(s) if appropriate), including web links. If this is a new data collection please set out how this will be funded.

(iv) Is this data available at upper tier local authority level (ie county, unitary authority, London borough or metropolitan county district)?

Questions on framework alignment

77. Do you have 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?

(i) Are there alternative or new indicators or sub-indicators which might be shared across two or all three of the outcome frameworks? If there are, please define them.
(ii) Please give the source of any alternative data requirement (including the web link(s))
(iii) If this is a new data collection please set out how it will be funded.

Questions on future PHOF review

78. 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? (y/n)

(i) If you do not agree, how frequently should the PHOF be reviewed, and why?

Full list of indicators questions

5. Overarching indicator 0.1: Healthy life expectancy
6. Overarching indicator 0.2: Differences in life expectancy and healthy life expectancy between communities
7. Wider determinants indicator 1.01: Children in poverty
8. Wider determinants indicator 1.02: School readiness
9. Wider determinants indicator 1.03: Pupil absence
10. Wider determinants indicator 1.04: First time entrants to the youth justice system
11. Wider determinants indicator 1.05: 16-18 year olds not in education, employment or training
12. Wider determinants indicator 1.06: People with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation
13. Wider determinants indicator 1.07; People in prison who have a mental illness
14. Wider determinants indicator 1.08: Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services
15. Wider determinants indicator 1.09: Sickness absence rate

16. Wider determinants indicator 1.10: Killed and seriously injured casualties on England's roads
17. Wider determinants indicator 1.11: Domestic abuse
18. Wider determinants indicator 1.12: Violent crime (including sexual violence)
19. Wider determinants indicator 1.13: Re-offending levels
20. Wider determinants indicator 1.14: The percentage of the population affected by noise
21. Wider determinants indicator 1.15: Statutory homelessness
22. Wider determinants indicator 1.16: Utilisation of outdoor space for exercise/health reasons
23. Wider determinants indicator 1.17: Fuel poverty
24. Wider determinants indicator 1.18: Social isolation
25. Wider determinants indicator 1.19: Older people's perception of community safety
26. Adding a NEW wider determinants indicator
27. Health improvement indicator 2.01: Low birth weight of term babies
28. Health improvement indicator 2.02: Breastfeeding
29. Health improvement indicator 2.03: Smoking status at time of delivery
30. Health improvement indicator 2.04: Under 18 conceptions
31. Health improvement indicator 2.05: Child development at 2-2.5 years
32. Health improvement indicator 2.06 Excess weight in 4-5 and 10-11 year olds
33. Health improvement indicator 2.07: Hospital admissions caused by unintentional and deliberate injuries in under 18s
34. Health improvement indicator 2.08: Emotional well-being of looked after children
35. Health improvement indicator 2.09: Smoking prevalence - 15 year olds (Placeholder)
36. Health improvement indicator 2.10: Self-harm
37. Health improvement indicator 2.11: Diet
38. Health improvement indicator 2.12: Excess weight in adults
39. Health improvement indicator 2.13: Proportion of physically active and inactive adults
40. Health improvement indicator 2.14: Smoking prevalence - adults (over 18s)
41. Health improvement indicator 2.15: Successful completion of drug treatment
42. Health improvement indicator 2.16: People entering prison with substance dependence issues who are not previously known to community treatment
43. Health improvement indicator 2.17: Recorded diabetes
44. Health improvement indicator 2.18: Alcohol-related admissions to hospital
45. Health improvement indicator 2.19: Cancer diagnosed at stage 1 and 2
46. Health improvement indicator 2.20: Cancer screening coverage
47. Health improvement indicator 2.21: Access to non-cancer screening programmes
48. Health improvement indicator 2.22: Take up of the NHS Health Check programme - by those eligible
49. Health improvement indicator 2.23: Self-reported well-being
50. Health improvement indicator 2.24: Injuries due to falls in people aged 65 and over
51. Adding a NEW health improvement indicator
52. Health protection indicator 3.01: Fraction of mortality attributable to particulate air pollution
53. Health protection indicator 3.02: Chlamydia detection (15-24 year olds)
54. Health protection indicator 3.03: Population vaccination coverage
55. Health protection indicator 3.04: People presenting with HIV at a late stage of infection
56. Health protection indicator 3.05: Treatment completion for TB

57. Health protection indicator 3.06: Public sector organisations with board approved sustainable development management plan
58. Health protection indicator 3.07: Comprehensive, agreed inter-agency plans for responding to public health incidents and emergencies
59. Adding a NEW health protection indicator
60. Healthcare public health indicator 4.01: Infant mortality
61. Healthcare public health indicator 4.02: Tooth decay in children aged 5
62. Healthcare public health indicator 4.03: Mortality rate from causes considered preventable
63. Healthcare public health indicator 4.04: Under 75 mortality rate from all cardiovascular diseases
64. Healthcare public health indicator 4.05: Under 75 mortality rate from cancer
65. Healthcare public health indicator 4.06: Under 75 mortality rate from liver disease
66. Healthcare public health indicator 4.07: Under 75 mortality rate from respiratory diseases
67. Healthcare public health indicator 4.08: Mortality rate from communicable diseases
68. Healthcare public health indicator 4.09: Excess under 75 mortality rate in adults with serious mental illness
69. Healthcare public health indicator 4.10: Suicide rate
70. Healthcare public health indicator 4.11: Emergency readmissions within 30 days of discharge from hospital
71. Healthcare public health indicator 4.12: Preventable sight loss
72. Healthcare public health indicator 4.13: Health-related quality of life for older people
73. Healthcare public health indicator 4.14: Hip fracture in people age 65 and over
74. Healthcare public health indicator 4.15: Excess winter deaths
75. Healthcare public health indicator 4.16: Estimated diagnosis rate for people with dementia
76. Adding a NEW healthcare public health indicator

Annex B Indicators from April 2016

OVERARCHING INDICATORS	
0.1 Healthy life expectancy	0.1i - Healthy life expectancy at birth 0.1ii - Life Expectancy at birth
0.2 Differences in life expectancy and healthy life expectancy between communities	0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England 0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased 0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area 0.2iv - Gap in life expectancy at birth between each local authority and England as a whole 0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England 0.2vi – Inequality in local healthy life expectancy 0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area
IMPROVING THE WIDER DETERMINANTS OF HEALTH	
1.01 Children in low income families	1.01i - Children in low income families (all dependent children under 20) 1.01ii - Children in low income families (under 16s)
1.02 School readiness*	1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception 1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check
1.03 Pupil absence	
1.04 First time entrants to the youth justice system	
1.05 16-18 year olds not in education, employment or training	
1.06 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation	1.06i - Adults with a learning disability who live in stable and appropriate accommodation 1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation
1.07 Proportion of people in prison aged 18 or over who have a mental illness	

1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	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 (Persons)
1.09 Sickness absence rate	1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week 1.09ii - Sickness absence - The percent of working days lost due to sickness absence 1.09iii – Sickness absence – Rate of fit notes issued
1.10 Killed and seriously injured casualties on England's roads	
1.11 Domestic abuse	
1.12 Violent crime (including sexual violence)	1.12i - Violent crime (including sexual violence) - hospital admissions for violence 1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population 1.12iii- Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population
1.13 Levels of offending and re-offending	1.13i - Re-offending levels - percentage of offenders who re-offend 1.13ii - Re-offending levels - average number of re-offences per offender 1.13iii – First time offenders
1.14 The percentage of the population affected by noise	1.14i - The rate of complaints about noise 1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime 1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time
1.15 Statutory homelessness	1.15i - Statutory homelessness – eligible homeless people not in priority need 1.15ii - Statutory homelessness - households in temporary accommodation
1.16 Utilisation of outdoor space for exercise / health reasons	
1.17 Fuel poverty	
1.18 Social isolation	1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like

	1.18ii - Social Isolation: % of adult carers who have as much social contact as they would like
HEALTH IMPROVEMENT	
2.01 Low birth weight of term babies	
2.02 Breastfeeding	2.02i - Breastfeeding - Breastfeeding initiation 2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth
2.03 Smoking status at time of delivery	
2.04 Under 18 conceptions	
2.05 Child development at 2-2½ years	
2.06 Child excess weight in 4-5 and 10-11 year olds	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
2.07 Hospital admissions caused by unintentional and deliberate injuries in under 25's	2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) 2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)
2.08 Emotional well-being of looked after children	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 (the current indicator) 2.08ii Percentage of children where there is a cause for concern
2.09 Smoking prevalence - 15 year olds	2.09i - Smoking prevalence at age 15 - current smokers (WAY survey) 2.09ii - Smoking prevalence at age 15 - regular smokers (WAY survey) 2.09iii - Smoking prevalence at age 15 - occasional smokers (WAY survey) 2.09iv - Smoking prevalence at age 15 - regular smokers (SDD survey) 2.09v - Smoking prevalence at age 15 - occasional smokers (SDD survey)
2.10 Self-harm	2.10i – A&E attendances for self- harm 2.10ii - Emergency hospital admissions for intentional self-harm
2.11 Diet	2.11i - Fruit and Veg '5-a-day' (adults) 2.11ii - Average number of portions of fruit eaten (adults) 2.11iii - Average number of portions of vegetables eaten (adults) 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
2.12 Excess weight in adults	

2.13 Proportion of physically active and inactive adults	2.13i - Percentage of physically active and inactive adults - active adults 2.13ii - Percentage of active and inactive adults - inactive adults
2.14 Smoking prevalence - adults (over 18s)	
2.15 Drug and alcohol treatment completion and drug misuse deaths	2.15i - Successful completion of drug treatment - opiate users 2.15ii - Successful completion of drug treatment - non-opiate users 2.15iii – Successful completion of alcohol treatment 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 diagnosis rate for people with diabetes mellitus	
2.18 Alcohol-related admissions to hospital	
2.19 Cancer diagnosed at stage 1 and 2	
2.20 National Screening Programmes	2.20i – Breast Cancer Screening - Coverage 2.20ii – Cervical Cancer Screening – Coverage 2.20iii – Bowel Cancer Screening – Coverage 2.20iv – Abdominal Aortic Aneurysm Screening – Coverage 2.20v – Diabetic Eye Screening – Uptake 2.20vi – Fetal Anomaly Screening – Coverage 2.20vii - Infectious Diseases in Pregnancy Screening – HIV Coverage 2.20viii – Infectious Diseases in Pregnancy Screening – Syphillis 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
2.22 Take up of the NHS Health Check programme - by those eligible	2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check 2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check

	2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS Health check
2.23 Self-reported well-being	2.23i - Self-reported well-being - people with a low satisfaction score 2.23ii - Self-reported well-being - people with a low worthwhile score 2.23iii - Self-reported well-being - people with a low happiness score 2.23iv - Self-reported well-being - people with a high anxiety score
2.24 Injuries due to falls in people aged 65 and over	2.24i - Injuries due to falls in people aged 65 and over 2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 2.24iii - Injuries due to falls in people aged 65 and over - aged 80+
HEALTH PROTECTION	
3.01 Fraction of mortality attributable to particulate air pollution	
3.02 Chlamydia diagnoses (15-24 year olds)	
3.03 Population vaccination coverage	3.03i - Population vaccination coverage - Hepatitis B (1 year old/2 years old) 3.03ii – Population vaccination coverage – BCG (1 year old) 3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old/2 years old) 3.03iv - Population vaccination coverage - MenC 3.03v - Population vaccination coverage - PCV 3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old/5 years) 3.03vii - Population vaccination coverage - PCV booster 3.03viii - Population vaccination coverage - MMR for one dose (2 years old) 3.03ix - Population vaccination coverage - MMR for one dose (5 years old) 3.03x - Population vaccination coverage - MMR for two doses (5 years old) 3.03xi – Population vaccination coverage – Td/IPV booster (13-18 years old) 3.03xii - Population vaccination coverage – HPV vaccination coverage for one dose (females 12-13 years old) 3.03xiii - Population vaccination coverage - PPV 3.03xiv - Population vaccination coverage - Flu (aged 65+) 3.03xv - Population vaccination coverage - Flu (at risk individuals) 3.03xvi – Population vaccination coverage

	– HPV vaccination for two doses (females 13-14 years old) 3.03xvii – Population vaccination coverage – Shingles vaccination coverage (70years old) 3.03xviii – Population vaccination coverage – Flu (2-4 years old)
3.04 People presenting with HIV at a late stage of infection	
3.05 Treatment completion for TB	3.05i - Treatment completion for TB 3.05ii - Incidence of TB
3.06 Public sector organisations with board approved sustainable development management plan	
3.08 Antimicrobial Resistance	
HEALTHCARE PUBLIC HEALTH AND PREVENTING PREMATURE MORTALITY	
4.01 Infant mortality	
4.02 Proportion of five year old children free from dental decay	
4.03 Mortality rate from causes considered preventable	
4.04 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)	4.04i - Under 75 mortality rate from all cardiovascular diseases 4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable
4.05 Under 75 mortality rate from cancer	4.05i - Under 75 mortality rate from cancer 4.05ii - Under 75 mortality rate from cancer considered preventable
4.06 Under 75 mortality rate from liver disease	4.06i - Under 75 mortality rate from liver disease 4.06ii - Under 75 mortality rate from liver disease considered preventable
4.07 Under 75 mortality rate from respiratory diseases	4.07i - Under 75 mortality rate from respiratory disease 4.07ii - Under 75 mortality rate from respiratory disease considered preventable
4.08 Mortality rate from a range of specified communicable diseases, including influenza	
4.09 Excess under 75 mortality rate in adults with serious mental illness	4.09i Excess under 75 mortality rate in adults with serious mental illness 4.09ii Proportion of adults in the population in contact with secondary mental health services
4.10 Suicide rate	
4.11 Emergency readmissions within 30 days of discharge from hospital	
4.12 Preventable sight loss	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
4.13 Health-related quality of life for older people	
4.14 Hip fractures in people aged 65 and over	4.14i - Hip fractures in people aged 65 and over 4.14ii - Hip fractures in people aged 65 and over - aged 65-79 4.14iii - Hip fractures in people aged 65 and over - aged 80+
4.15 Excess winter deaths	4.15i - Excess Winter Deaths Index (Single year, all ages) 4.15ii - Excess Winter Deaths Index (single year, ages 85+) 4.15iii - Excess Winter Deaths Index (3 years, all ages) 4.15iv – Excess Winter Deaths Index (3 years, ages 85+)
4.16 Estimated diagnosis rate for people with dementia	

*Early Years Foundation Stage Profile data will continue to be collected for the academic year 2015/16.

Annex C PHOF Indicator Criteria

Public Health Outcomes Framework indicator criteria

Essential [required for all indicators]
Clarity - clear what it measures, outcomes or activities **Rationale -** why, addresses a specific policy issue or draws attention to a particular outcome **Relevance -** relevant to the policy and action available to improve **Attributable -** Measures progress attributable to the interventions/activities **Interpretation -** is meaningful to the intended audience(s) **Validity -** has an unambiguous definition, is methodologically and technically sound from a reliable data source which is available at an appropriate level (eg LA/ CCG) to make it meaningful and sustainable **Construction -** the methods used support the stated purpose of the indicator and there is transparency about how they have been tested and justified **Risks -** any limitations, risks or perverse incentives identified and stated with any mitigating actions **Availability -** collected at sufficient level of geographical or organisational split **Affordability & value for money -** benefits without disproportionate costs and where new burdens created these will be estimated and sustainable funding identified
Desirable [wherever possible]
Timeliness - with sufficient frequency (ideally can be reported quarterly) and data time lag (ideally less than one year but may vary for surveys) **Comparable** - suitable UK or international metrics available for making meaningful direct or proxy comparisons **Disaggregates** - potential to break down by equalities / inequalities characteristics to measure impacts on different groups **Supports alignment** across the health and care system via the other outcome frameworks