Department of Health

Improving outcomes and supporting transparency

Part 2: Summary technical specifications of public health indicators

Updated December 2014

December 2014

Title: Public Health Outcomes Framework
Author: Directorate/ Division/ Branch acronym / cost centre PHPSU/HIAT/12341
Document Purpose: Policy
Publication date: December 2014
Target audience: Local government, public health and health care professionals
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Published to gov.uk, in PDF format only.

www.gov.uk/dh

Improving outcomes and supporting transparency

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Indicators corresponding to the overarching outcomes

The two indicators outlined below correspond to the overarching outcomes of:

1. Increased healthy life expectancy (corresponding indicator 0.1)
2. Reduced differences in life expectancy and healthy life expectancy between communities (corresponding indicator 0.2)

These outcomes reflect the focus we wish to take not only on how long we live – our *life expectancy*, but on how well we live – our *healthy life expectancy*, at all stages of the life-course. Our second outcome focuses attention on reducing health inequalities between people in our society. We are using both a measure of life expectancy and healthy life expectancy so that we are able to use the most reliable information available to understand the nature of health inequalities both within areas and between areas.

0.1 Healthy life expectancy	
Rationale	This indicator is an extremely important summary measure of mortality and morbidity in itself. It complements the supporting indicators by showing the overall trends in a major population health measure, setting the context in which local authorities can assess the other indicators and identify the drivers of healthy life expectancy.
Baseline period	2009-11
Indicator definition	**0.1i Healthy life expectancy at birth** A measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. The prevalence of good health is derived from responses to a survey question on general health. For a particular area and time period, it is an estimate of the average number of years a newborn baby would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and

0.1 Healthy life expectancy	
	time period throughout his or her life. Figures are calculated from deaths from all causes, mid-year population estimates, and self-reported general health status, based on data aggregated over three year periods. The following additional sub-indicator provides context to the healthy life expectancy figures by providing information on the estimated length of life. **0.1ii Life expectancy at birth** A measure of the average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life. Figures are calculated from deaths from all causes and mid-year population estimates, based on data aggregated over three year periods. Figures for both sub-indicators reflect prevalence of good health and/or mortality among those living in an area in each time period, rather than what will be experienced throughout life among those born in the area. The figures are not therefore the number of years a baby born in the area could actually expect to live, or live in good general health, both because the health prevalence and mortality rates of the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives. Each sub-indicator will be provided for males and females separately.
Data source	Office for National Statistics (ONS) Life expectancy data are based on death registrations and mid-year population estimates.

0.1 Healthy life expectancy	
	Healthy life expectancy data are based on life expectancy data and data on self-reported health status from the Annual Population Survey. In response to the question "How is your health in general; would you say it was…" responses "Very good" and "Good" are categorised as 'Good' health and "Fair", "Bad" or "Very bad" as 'Not Good' health.
Publication of source data	ONS reported on healthy life expectancy using self-reported health data from the Annual Population Survey in September 2013. Figures have been published for healthy life expectancy at birth for upper tier local authorities in England for 2009-11: http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/healthy-life-expectancy-at-birth-for-upper-tier-local-authorities--england/2009-11/index.html ONS reports annually on life expectancy at birth for England as a whole and for English local authorities. Trend data on life expectancy at birth is published for 2000-02 to 2010-12 for upper tier LAs and 1991-93 to 2010-12 for lower tier LAs. 2010-12 data: http://www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/2010-12/rft-table-1.xls

0.2 Differences in life expectancy and healthy life expectancy between communities	
Rationale	These are key high-level health inequalities outcomes and are core to the aims of DH. This is the only indicator in the set that is explicitly a health inequalities indicator. It will show health inequalities across England as a whole and within all local areas, enabling a focus on the small areas of deprivation that exist everywhere, as well as areas where the whole local authority area has comparatively poor average health status. It

0.2 Differences in life expectancy and healthy life expectancy between communities	
	is also an extremely useful summary measure of mortality and morbidity in itself; it shows the overall trends in two major population health measures as well as highlighting area-based health inequalities. Across the set, measures are based on both national and local deprivation deciles, reflecting the distribution of deprivation itself. These indicators will set the context within which local areas can assess the other indicators and determine priorities, by identifying the drivers of life expectancy and health expectancy, especially in areas where these are low.
Baseline period	2009-2011
Indicator definition	*The indicator definition is ready but sub-indicator 0.2vi needs further development* Separate indicators will measure differences in life expectancy and healthy life expectancy, both within England as a whole and, where feasible, locally within local authorities. Each indicator will be produced for males and females separately. **<u>Life expectancy</u>** **0.2i Slope index of inequality (SII) in life expectancy at birth based on national deprivation deciles of Lower Super Output Areas (LSOAs) within England** This sub-indicator measures inequalities in life expectancy across England as a whole. Life expectancy at birth is calculated for each national deprivation decile and then the slope index of inequality (SII) is calculated based on these figures. Life expectancy at birth is a measure of the average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age-specific mortality rates

0.2 Differences in life expectancy and healthy life expectancy between communities	
	for that area and time period throughout his or her life. **0.2ii Number of upper tier local authorities for which the local SII in life expectancy (as defined in 0.2.iii) has decreased** This sub-indicator is a summary measure at national level of the number of local authorities for which local within-area inequalities in life expectancy (as measured by sub-indicator 0.2iii) have decreased since the baseline period (2009-11). **0.2iii SII in life expectancy at birth within each English upper and lower tier local authority, based on local deprivation deciles of LSOAs** This sub-indicator measures inequalities in life expectancy within upper and lower tier local authorities. For each local authority, life expectancy at birth is calculated for each local deprivation decile within the local authority and then the SII is calculated based on these figures. In some local authorities a meaningful life expectancy estimate cannot be calculated for every local deprivation decile because of very small populations or large uncertainty in the life expectancy value. In these cases, the SII in life expectancy will not be provided. **0.2iv Gap in life expectancy at birth between each local authority and England as a whole** This local level sub-indicator provides context for the indicator of inequality in life expectancy within each English local authority (0.2iii) by giving the difference between life expectancy at birth in a whole local authority area and the England value for life expectancy at birth. This provides an indication of overall life expectancy in the local authority relative to the level for England, highlighting health inequalities between whole LA areas and England, and the need for areas with comparatively low average life expectancy to focus on their gap with England as well as any within-area inequalities. **Healthy life expectancy**

0.2 Differences in life expectancy and healthy life expectancy between communities	
	0.2v SII in healthy life expectancy at birth based on national deprivation deciles of LSOAs within England This sub-indicator measures inequalities in healthy life expectancy across England as a whole. Healthy life expectancy at birth is calculated for each national deprivation decile and then the slope index of inequality (SII) is calculated based on these figures. Healthy life expectancy at birth is a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. The prevalence of good health is derived from responses to a survey question on general health. For a particular area and time period, it is an estimate of the average number of years a newborn baby would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period throughout his or her life. **0.2vi Local measure of healthy life expectancy at birth** Further work is required to assess the feasibility of adding an additional local level sub-indicator (0.2vi) looking at inequalities in healthy life expectancy within upper tier local authorities – currently data are not available to monitor this. **Data for 0.2 indicators** <u>Revision of provisional data</u> Figures for indicators 0.2i and 0.2iii were revised in May 2014, and are now final, since they are based on mid-year population estimates for the relevant time periods derived from the 2011 Census. These supersede the provisional figures released in November 2013. <u>Slope index of inequality</u> The slope index of inequality (SII) is a measure of the social gradient in life expectancy or healthy life expectancy, i.e. how

0.2 Differences in life expectancy and healthy life expectancy between communities	
	much life / healthy life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation in an area (England as a whole or individual local authorities) and summarises this in a single number, which represents the range in years of life / healthy life expectancy across the social gradient from most to least deprived, based on a statistical analysis of the relationship between life / healthy life expectancy and deprivation across all deprivation deciles. <u>National and local deprivation deciles</u> Deprivation deciles are formed by grouping together residents of Lower Super Output Areas (small areas with an average population of around 1,500). For the two England level sub-indicators (0.2i and 0.2v) that use national deprivation deciles, all English LSOAs are ranked from most to least deprived. They are then divided into national deprivation deciles: ten groups with approximately equal numbers of LSOAs in each. For the local indicator on differences in life expectancy (0.2iii), LSOAs are ranked from most to least deprived within each upper and lower tier local authority. They are then divided into local deprivation deciles, which each contain approximately equal numbers of LSOAs. Some local authorities do not contain the full range of national deprivation deciles, e.g. some LAs do not have any of their population resident in LSOAs which are classified as amongst the least or most deprived deciles in England. The slope index of inequality figure for England is not considered as a suitable benchmark with which to compare local authority SII figures. For all the SII figures, deprivation has been defined using the overall Index of Multiple Deprivation 2010 scores. This allows examination of comparable trends in the SII over time.
Data source	Underlying data for the calculation of these indicators are derived from:

0.2 Differences in life expectancy and healthy life expectancy between communities	
	Office for National Statistics (ONS): • Life expectancy data are based on death registrations and mid-year population estimates • Healthy life expectancy data are based on life expectancy data and data on self-reported health status from the Annual Population Survey Department for Communities and Local Government: • Index of Multiple Deprivation 2010 Further development work is required to identify a data source for an additional local level sub-indicator (0.2vi) looking at differences in healthy life expectancy within upper tier local authorities.
Publication of source data	ONS reports annually on life expectancy at birth for England as a whole and for English local authorities. Trend data on life expectancy at birth is published for 2000-02 to 2010-12 for upper tier LAs and 1991-93 to 2010-12 for lower tier LAs. 2010-12 data: http://www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/2010-12/rft-table-1.xls ONS began reporting on healthy life expectancy by area deprivation using self- reported health data from the Annual Population Survey in March 2014. 2009-11 data: http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/inequality-in-healthy-life-expectancy-at-birth-by-national-deciles-of-area-deprivation--england/2009-11/index.html

Indicators corresponding to the public health domains

Whilst we will be able to provide information on performance against the overarching outcomes, the nature of public health is such that the improvements in these outcomes will take years, even decades to see marked change. So we have developed a set of supporting **public health indicators** that help focus our understanding of how well we are doing year by year nationally and locally on those things that matter most to public health that we know will help improve the outcomes stated above.

These indicators are grouped into **four domains**:

DOMAIN 1. Improving the wider determinants of health

DOMAIN 2. Health improvement

DOMAIN 3. Health protection

DOMAIN 4. Healthcare public health and preventing premature mortality

Indicators have been included as they cover the full spectrum of what we understand public health to be, and what we can realistically measure at the moment. We have been able to, and will continue to, clarify and expand the technical specifications to reflect ongoing development work.

Domain 1: Improving the wider determinants of health

1.1 Children in poverty	
Rationale	Child poverty is an important issue for public health. Inclusion of this indicator emphasises its importance. There is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults (see the Marmot Review, 2010). Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.
Baseline period	2010/11
Indicator definition	**1.1i Percentage of children in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs)** National level definition Numerator: Estimated number of children living in households where income is less than 60 per cent of median household income before housing costs. Denominator: Estimated total number of children A dependent child is defined as an individual aged under 16. A person will also be defined as a child if they are 16 to 19 years old and they are: • Not married nor in a Civil Partnership nor living with a partner; and • living with parents; and • in full-time non-advanced education or in unwaged government training. Local authority area level For local authority level data, the definition is different and attempts to provide a broad proxy of the relative child poverty measure, however it is not the same as the national measure of child poverty. The proportion of children living in low income families is defined as the percentage of children in families in receipt of out of work benefits or tax credits where their reported

1.1 Children in poverty	
	income is less than 60% median income Numerator: Number of children of families in receipt of either out of work benefits, or tax credits where their reported income is less than 60% median income Denominator: Total number of children in families in receipt of child benefit for each Local Authority area The definition of 'child' is the same as for the national data set. **1.1ii Percentage of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income) for under 16s only.** This indicator will be the same as the local authority area measure as reported in 1.1i except that a 'dependent child' is defined as an individual aged under 16 only. These data match that which is published in the PHE 'Health Profiles'. Under 16 year olds are not available at the national level.
Data source	National level: Households Below Average Income data, DWP, based on the Family Resources Survey Local Authority level: Data derived from tax credit data from HMRC and benefit data from DWP
Publication of source data	National level data is published annually by DWP in the Households Below Average Income series, the latest data available is for 2011/12 and can be found here: https://www.gov.uk/government/collections/households-below-average-income-hbai--2 Local authority level data is published by HMRC, the latest data available is for 2011 and can be found on the HMRC website, as well as being published in the Local Authority Health Profiles: http://www.hmrc.gov.uk/stats/personal-tax-credits/child_poverty.htm http://www.healthprofiles.info

1.2 School readiness	
Rationale	This is a key measure of early years development across a wide range of developmental areas. Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life.
Baseline period	2012/13
Indicator definition	**1.2i The percentage of children achieving a good level of development at the end of reception** This rating is drawn from the Early Years Foundation Stage Profile (EYFSP). The EYFSP is the assessment carried out by teachers at the end of Reception and is used to inform plans for child development, informing Key Stage 1 teachers and parents about each child's development and needs. It can thus be seen as a measure of 'school readiness'. The EYFSP requires teachers to assess whether children are 'emerging, expected or exceeding' against 17 early learning goals in the EYFS. From 2013, children will be defined as having reached a good level of development at the end of the EYFS if they achieve at least the expected level in: • the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and; • the early learning goals in the specific areas of mathematics and literacy. **1.2ii The percentage of Year 1 pupils achieving the expected level in the phonics screening check** Data from the phonics screening check is designed to show parents and Year 1 teachers whether pupils at the end of Year 1 have grasped the ability to decode words using phonics to an agreed standard or whether further intervention is required to meet this standard. Pupils are deemed to have met the required standard of phonic decoding if they scored 32 or more out of a possible 40 in the test. The indicators will be presented for pupils eligible for free school meals compared to all other pupils.

1.2 School readiness	
Data source	1.2i: Early Years Foundation Stage Profile 1.2ii: Teacher Assessments Future development of this indicator may make use of the data generated through the Healthy Child Programme developmental review that takes place with all children at age 2 – 2½ years.
Publication of source data	Early Years Foundation Stage Profile attainment data is published by the Department for Education annually. Phonics screening check data, at national and local level, is also published by the Department for Education annually. **Early Years Foundation Stage Profile statistical series**: https://www.gov.uk/government/organisations/department-for-education/series/statistics-early-years-foundation-stage-profile **Phonics screening check statistical series**: https://www.gov.uk/government/organisations/department-for-education/series/statistics-phonics-check

1.3 Pupil absence	
Rationale	Improving attendance (i.e. tackling absenteeism) in schools is a crucial part of the Government's commitment to increasing social mobility and to ensuring every child can meet their potential. If we are to improve school attendance (reduce absence), then it is important that all services that work with young people talk to one another and agree local priorities. This indicator should help to achieve this.
Baseline period	2010/11 (school year)
Indicator definition	**1.3 Percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence)** Numerator: The number of sessions missed due to overall absence Denominator: The total number of possible sessions

1.3 Pupil absence	
	Based on state-funded primary and secondary schools (including maintained primary and secondary schools, city technology colleges and academies) and special schools.
Data source	The School Census
Publication of source data	Published by the Department for Education (DfE) at national and local authority level on a termly basis and at school level for the combined Autumn and Spring terms (4 half terms) and the End Year (5 half terms). Information on absence in special schools is published only annually. **Pupil absence statistical series:** https://www.gov.uk/government/organisations/department-for-education/series/statistics-pupil-absence

1.4 First time entrants to the youth justice system	
Rationale	Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children. This indicator is included to ensure that vulnerable children and young people (aged 10-17) at risk of offending, are included in mainstream planning and commissioning. Mapping relevant risk factors associated with youth crime, for example school absence and low educational attainment, can help inform local authority and NHS commissioning of evidence-based early intervention, therefore maximising the life chances of vulnerable children and improving outcomes for them. A lack of focus in this area could result in greater unmet health needs, increased health inequalities and potentially an increase in offending and re-offending rates, including new entrants to the system. The impact of incorporating these vulnerable children into mainstream commissioning also has the potential benefit of impacting on a young person's wider family now and in the

1.4 First time entrants to the youth justice system	
	future, particularly when they themselves may already be parents.
Baseline period	2010
Indicator definition	**1.4 Rate of 10-17 year olds receiving their first reprimand, warning, youth caution[1] or conviction per 100,000 population** Numerator: Number of 10-17 year olds receiving their first reprimand, warning, youth caution or conviction Denominator: ONS mid-year population estimates, ages 10-17 As part of the National Diversion Programme, DH are testing a data collection system to measure the rate of 10-17 year olds diverted away from the youth justice system and into health interventions. The feasibility of making data available on diversion from 2014 is being explored with cross government partners. If deemed appropriate, a second sub-indicator based on this data collection may be added to this indicator.
Data source	Ministry of Justice (MoJ) criminal justice statistics dataset (based on data submitted by individual police forces, and extracts from court database administrative systems and from the Police National Computer) Figures for local authorities are estimates. Children are mapped to their local authority of residence using their home address or postcode recorded by the police on the Police National Computer. For those with no address recorded, a small proportion has been assumed to foreign postcodes. For the rest,

[1] Since 8th April 2013 there have been a number of changes in out of court disposals. The previously known reprimand and warning disposal categories for juveniles have been replaced with a new out of court disposal: The Youth Caution for young offenders. The guidance is published at the link http://www.justice gov.uk/out-of-court-disposals.

1.4 First time entrants to the youth justice system	
	a model based on the patterns of offenders dealt with by police stations will be used to allocate offenders to local authorities.
Publication of source data	MoJ publish national (England and Wales) data and local authority data quarterly, in the Offending Histories tables of Criminal Justice Statistics in England and Wales: **Latest data**: https://www.gov.uk/government/collections/criminal-justice-statistics-quarterly

1.5 16-18 year olds not in education, employment or training	
Rationale	Young people who are not engaged in education, employment or training (NEET) are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. This indicator is included to encourage services to work together to support young people, particularly the most vulnerable, to engage in education, training and work. To support more young people to study and gain the skills and qualifications that lead to sustainable jobs and reduce the risk of young people becoming NEET, legislation was included in 2013 to raise the participation age as contained within the Education and Skills Act 2008. This required that from 2013 all young people remain in some form of education or training until the end of the academic year in which they turn 17. From 2015, this will rise to their 18th birthday. This means that pupils who left year 11 in summer 2013 need to continue in education or training for at least a further year until 27 June 2014 and pupils who started year 11 or below in September 2013 will need to continue until at least their 18th birthday. Statutory guidance: https://www.gov.uk/government/publications/participation-of-young-people-education-employment-and-training

1.5 16-18 year olds not in education, employment or training	
Baseline period	End 2011
Indicator definition	**1.5 Percentage of 16-18 year olds not in education, employment or training (NEET)** Numerator: Number of 16-18 year olds who are NEET Denominator: Total number of 16-18 year olds known to the local authority whose activity is either NEET or EET. The NEET and EET figures above are adjusted to take account of those whose current activity is not known using an established adjustment factor. This indicator will use the average proportion of 16-18 year olds NEET between November and January each year.
Data source	Data are drawn from the Client Caseload Information System (CCIS) databases maintained by each local authority. These draw together information provided by schools, colleges, partner agencies and young people themselves and is made available on the Department for Education (DfE) website. *Notes:* 1. *National data on the proportion of 16-18 year olds NEET are published annually by DfE but these cannot be broken down to local authority level. DfE/BIS also publish a quarterly estimate of 16-24 year olds NEET drawn from the Labour Force Survey.* 2. *The data from the client management systems maintained by local authorities made available by DfE are not directly comparable with the national figures published by DfE due to differences in definitions used, specifically:* • *age is based on actual age rather than academic age* • *the numerator excludes young people taking a formal gap year or in custody (these may be recorded as NEET in the national data)* • *the data relate to those young people known to the local authority and whose current activity is known*

1.5 16-18 year olds not in education, employment or training	
Publication of source data	National level data on 16-18 year olds NEET are published by DfE but these data are not directly comparable with the data to be used for this indicator – see note in data source section.

1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation	
Rationale	The indicator is intended to improve outcomes for adults with mental health problems in stable and appropriate accommodation by improving their safety and reducing their risk of social exclusion. Maintaining stable and appropriate accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care. Moreover, this indicator is intended to improve outcomes for adults with a learning disability through improving accommodation. The nature of accommodation for adults with a learning disability has a strong impact on their safety and overall quality of life and reducing social exclusion.
Baseline period	2011/12
Indicator definition	**1.6i Percentage of all adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family** *This sub- indicator is shared with indicator 1G in the Adult Social Care Outcomes Framework.* Numerator: Number of working age (aged 18-64) learning disabled clients known to councils with adult social service responsibilities (CASSRs), as described in the denominator, who are living in their own home or with their family during the financial year. The numerator should include those living in their own home or

1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation	
	with their family irrespective of whether they have had a review during the year, but the information would have to be captured within the current financial year. Denominator: Number of working-age (aged 18-64) learning disabled clients known to CASSRs during the financial year. This includes: • those who are assessed or reviewed in the financial year and have received a service • those who are assessed or reviewed in the financial year and have not received a service, and; • those who should have been reviewed in the financial year but were not. The definition of individuals 'known' to a council is currently restricted to those adults with a learning disability (with a primary client group of LD) who have been assessed or reviewed by the council during the year (irrespective of whether or not they receive a service) or who should have been reviewed but were not. 'Living on their own or with their family' is intended to describe arrangements where the individual has security of tenure in their usual accommodation, for instance because they own the residence or are part of a household whose head holds such security. This has the same definition as 'Living independently, with or without support' in sub-indicator 1.6ii (see below), however different wording is used to capture the emphasis on avoiding residential care homes. Situations included within the scope of 'living on their own or with their family': • Owner occupier or shared ownership scheme; • Tenant (including local authority, arm's-length management organisation, registered social landlord, housing association); • Tenant – private landlord; • Settled mainstream housing with family/friends (including flat-sharing); • Supported accommodation/supported lodgings/supported group home (i.e. accommodation supported by staff or resident caretaker); • Adult Placement Scheme; • Approved premises for offenders released from prison or

1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation	
	under probation supervision (e.g. probation hostel); • Sheltered housing/extra care housing/other sheltered housing; and, • Mobile accommodation for Gypsy/Roma and Traveller communities. The following circumstances are not included within the scope of 'living on their own or with their family': • Rough sleeper/squatting; • Night shelter/emergency hostel/direct access hostel (temporary accommodation accepting self-referrals); • Refuge; • Placed in temporary accommodation by council (including homelessness resettlement); • Staying with family/friends as a short-term guest; • Acute/long-stay healthcare residential facility or hospital (e.g. NHS independent general hospital/clinic, long-stay hospital, specialist rehabilitation/recovery hospital); • Registered care home • Registered nursing home; • Prison/Young Offenders Institution/detention centre; and, • Other temporary accommodation. **1.6ii Percentage of adults receiving secondary mental health services living independently at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting** *This sub- indicator is shared with indicator 1H in the Adult Social Care Outcomes Framework* Numerator: Number of adults aged 18-69 who are receiving secondary mental health services on the Care Programme Approach recorded as living independently (with or without support). The most recent record of whether or not the person is in settled accommodation during the financial year is used. Denominator: Number of adults aged 18-69 who have received secondary mental health services and who were on the Care Programme Approach at any point during the financial year. Adults 'in contact with secondary mental health services' is

1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation	
	defined as those aged 18 to 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA). 'Living independently, with or without support' refers to accommodation arrangements where the occupier has security of tenure or appropriate stability of residence in their usual accommodation in the medium- to long-term, or is part of a household whose head holds such security of tenure/residence. These accommodation arrangements are recorded as settled accommodation in the Mental Health Minimum Data Set (MHMDS). This has the same definition as 'Living on their own or with their family' in measure 1.6i (see above), however different wording is used to capture the emphasis on general independence. Accommodation arrangements that are precarious, or where the person has no or low security of tenure/residence in their usual accommodation and so may be required to leave at very short notice, are excluded from the definition of 'living independently, with or without support'. These accommodation arrangements are recorded as non-settled accommodation in the MHMDS.
Data source	1.6i: Adult Social Care Combined Activity Return (ASC-CAR), the Health and Social Care Information Centre 1.6ii: Mental Health Minimum Dataset (MHMDS), the Health and Social Care Information Centre
Publication of source data	ASC-CAR data is reported annually by the Health and Social Care Information Centre. **2010/11 data** http://www.hscic.gov.uk/social-care MHMDS data is reported annually by the Health and Social Care Information Centre: http://www.mhmdsonline.ic.nhs.uk/

1.7 People in prison who have a mental illness or a significant mental illness	
Rationale	A reduction in the proportion of people in prison with a mental illness or a significant mental illness can reflect success in one or more of a number of interventions: • People may be receiving effective or earlier community mental health treatment which keeps them well and therefore they do not offend as a consequence of their illness, including early interventions for young people with psychosis • Successful Care Programme Approach/supervision/ continuity of care in the community with appropriate monitoring of their mental state, keeping them well, or intervening when necessary. As a result, they do not offend as a consequence of their illness. • More people with mental illness may be assessed at the time of an offence and diverted into more appropriate services • Successful mental health assessment and treatment in prison and continuity of mental health care on return to the community keeping them well • Continuity of health care arrangements successfully implemented on return to the community, especially engagement or re engagement with community mental health services.
Baseline period	2010/11
Indicator definition	**1.7 Proportion of all people in prison aged 18 or over who have a mental illness or a significant mental illness** The proposed definition for this indicator is outlined below. Numerator: Number of people in prison aged 18 or over who are on the Care Programme Approach as collected through the Trust Development Agency (TDA) via the Prison Health Performance and Quality Indicators (PHPQI) Mental Health Questionnaire. This definition of "mental illness and serious mental illness" complements that used by the NHS Outcomes Framework. Denominator: Total number of prisoners aged 18 or over in

1.7 People in prison who have a mental illness or a significant mental illness	
	prison
Data source	PHPQI Mental Health Questionnaire collected via TDA. This is a temporary measure until the Prison IT project is in place. Currently, the information is held locally and collected through PHPQI quarterly returns to the TDA. This can provide baseline data for 2010-2011and can be on-going until the new Prison IT system is operational. The new Prison IT system will come into effect in 2016/17, after which more detailed information would be collected through a unified national system through the Health and Social Care Information Centre.
Publication of source data	Data on the number of people in prison aged 18 or over who are on the Care Programme Approach are collected annually through the NHS Trust Development Agency (TDA). Prison population figures are published annually by Ministry of Justice: https://www.gov.uk/government/collections/prison-population-statistics

1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	
Rationale	The 2005 evidence review “Is work good for your health and well-being” concluded that work was generally good for both physical and mental health and well-being. The strategy for public health takes a life course approach and this indicator provides a good indication of the impact of long-term illness on employment among those in the 'working well' life stage. It also provides a link to indicators in the NHS and Adult Social Care Outcomes Frameworks.

1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	
Baseline period	1.8i 2012 1.8ii/1.8iii 2011/12
Indicator definition	**1.8i Percentage of respondents in the Labour Force Survey (LFS) who have a long-term condition who are classed as employed using the International Labour Organisation (ILO) definition of employment, compared to the percentage of all respondents classed as employed** *This indicator is shared with indicator 2.2 in the NHS Outcomes Framework.* In the Labour Force Survey (LFS), a long-term condition is defined as a health problem or disability that is expected to last more than a year. The survey asks: *Q1 "Do you have any health problems or disabilities that you expect will last for more than a year?"* The indicator is constructed as outlined below: Numerator for employment rate of people with a long-term condition: Number of people with a health problem or disabilities that they expect will last for more than a year (based on response to Q1 of LFS) **and** who are in employment (either as an employee, self-employed, in government employment and training programmes or an unpaid family worker – ILO definition of basic economic activity) **and** are of working age (aged 16-64) Numerator for employment rate of population as a whole: Number of people who are in employment (either as an employee, self-employed, in government employment and training programmes or an unpaid family worker – ILO definition of basic economic activity) **and** are of working age (aged 16-64) Denominator for employment rate of people with a long-term condition: Number of people with a health problem or disabilities that they expect will last for more than a year (based on response to Q1 in LFS) **and** are of working age (aged 16-64) Denominator for employment rate of population as a whole: Number of people who are of working age (aged 16-64)

1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	
	The indicator is constructed by calculating the percentage points gap between the employment rate for those with a long-term condition and the population as a whole. **1.8ii Percentage of adults with a learning disability in paid employment, compared to the percentage of all respondents to the Labour Force Survey classed as employed** *This indicator is complementary to indicator 1E in the Adult Social Care Outcomes Framework, which measures the proportion of adults with a learning disability in paid employment.* The indicator is constructed as outlined below: Numerator for employment rate of adults with a learning disability: Number of working age (aged 18-64) learning disabled clients known to CASSRs who are in paid employment within the financial year. This includes: • those who are assessed or reviewed in the financial year and have received a service • those who are assessed or reviewed in the financial year and have not received a service, and; • those who should have been reviewed in the financial year but were not. Numerator for employment rate of population as a whole: Number of people responding to LFS who are in employment (either as an employee, self-employed, in government employment and training programmes or an unpaid family worker – ILO definition of basic economic activity) **and** are of working age (aged 16-64) Denominator for employment rate of adults with a learning disability: Number of working-age (aged 18-64) learning disabled clients known to councils with adult social service responsibilities (CASSRs) during the financial year. This includes: • those who are assessed or reviewed in the financial year and have received a service • those who are assessed or reviewed in the financial year and have not received a service, and; • those who should have been reviewed in the financial year but were not.

1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	
	Denominator for employment rate of population as a whole: Number of people responding to LFS who are of working age (aged 16-64) The indicator is constructed by calculating the percentage points gap between the employment rate for adults with a learning disability and the population as a whole. Notes on the employment rate of adults with a learning disability: • The definition of individuals 'known to the council' is restricted to those adults with a learning disability (with a primary client group of LD) who have been assessed or reviewed by the council during the year (irrespective of whether or not they receive a service) or who should have been reviewed but were not. • The rate is focused on 'paid' employment, to be clear that voluntary work is to be excluded for the purposes of this measure. Paid employment includes working as a paid employee or self-employed (16 or more hours per week) or working as a paid employee or self-employed (up to 16 hours per week) • Working age is defined as ages 18-64 because the data are collected through adult social care services, who are not responsible for the care of those aged 16 and 17 (and therefore individuals aged 16-17 are not captured in this measure). **1.8iii Percentage of adults in contact with secondary mental health services in paid employment, compared to the percentage of all respondents to the Labour Force Survey classed as employed** *This indicator is complementary to:* • *Indicator 1F in the Adult Social Care Outcomes Framework, which measures the proportion of adults in contact with secondary mental health services in paid employment* • *Indicator 2.5 in the NHS Outcomes Framework, which measures the percentage of respondents in the Labour Force Survey (LFS) who have a mental illness who are*

1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	
	classed as employed compared to the percentage of all respondents classed as employed. [Note: this measure is not used in the PHOF as the sample size for LFS does not allow the calculation of robust local authority level figures for the employment rate of adults who have a mental illness] The indicator is constructed as outlined below: Numerator for employment rate of adults in contact with secondary mental health services: Number of working age adults (aged 18-69) who are receiving secondary mental health services and who are on the Care Programme Approach recorded as being in employment during the financial year. The most recent record of employment status for the person during the financial year is used. Numerator for employment rate of population as a whole: Number of people responding to LFS who are in employment (either as an employee, self-employed, in government employment and training programmes or an unpaid family worker – ILO definition of basic economic activity) **and** are of working age (aged 16-64) Denominator for employment rate of adults in contact with secondary mental health services: Number of working age adults (aged 18-69) who have received secondary mental health services and who were on the Care Programme Approach at any point during the financial year. Denominator for employment rate of population as a whole: Number of people responding to LFS who are of working age (aged 16-64) The indicator is constructed by calculating the percentage points gap between the employment rate for adults in contact with secondary mental health services and the population as a whole. Notes on the employment rate of adults in contact with secondary mental health services: • Adults 'in contact with secondary mental health services' is defined as those aged 18 to 69 who are receiving secondary mental health services and who are on the Care Programme Approach (CPA). • The measure is focused on 'paid' employment, to be clear

1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	
	that voluntary work is to be excluded for the purposes of this measure. • Working age is defined as ages 18-69. This matches the age range for a measure that has been used historically and therefore maintains a time series.
Data source	1.8i: Annual Population Survey (APS), Office for National Statistics 1.8ii: Adult Social Care Combined Activity Return (ASC-CAR), the Health and Social Care Information Centre **and** Annual Population Survey (APS), Office for National Statistics 1.8iii: Mental Health Minimum Dataset (MHMDS), the Health and Social Care Information Centre **and** Annual Population Survey (APS), Office for National Statistics Note: The Annual Population Survey (APS) combines results from the Labour Force Survey (LFS) and the English, Welsh and Scottish LFS boosts. The increased sample size of the survey provides enhanced local authority and national estimates on key social and socio-economic variables.
Publication of source data	APS data is reported by the Office for National Statistics (ONS) on a quarterly basis http://www.nomisweb.co.uk/ ASC-CAR data is reported annually by the Health and Social Care Information Centre. http://www.hscic.gov.uk/catalogue/PUB13187 MHMDS data is reported annually by the Health and Social Care Information Centre: http://www.mhmdsonline.ic.nhs.uk/

1.9 Sickness absence rate	
Rationale	The independent review of sickness absence (published December 2011) was commissioned by government to help combat the 140 million days lost to sickness absence every year. The review provided an important analysis of the sickness absence system in the UK; of the impact of sickness absence on employers, the State and individuals; and of the factors which cause and prolong sickness. This is in line with the Government's strategy for public health, which adopts a life-course approach and includes a focus on the working-age population in the 'working well' stage to help people with health conditions to stay in or return to work.
Baseline period	2009-11
Indicator definition	*Sub-indicator 1.9iii needs further development* **1.9i Percentage of employees who had at least one day off sick in the previous week** Numerator: Number of employees aged 16 and over who had at least one period of sickness absence in the previous week Denominator: Employees aged 16 and over A period of sickness absence is at least one day off work because of sickness or injury during an interviewee's reference week. The distribution of reference weeks across any particular month is random. **1.9ii Percentage of working days lost due to sickness absence** Numerator: Number of working days lost due to sickness absence Denominator: Number of working days Further work is required to determine the frequency of updates to these indicators. **1.9iii Rate of Fit Notes issued per quarter (TBC)** Numerator: Number of Electronic Fit Notes issued per quarter to those who are economically active Denominator: The economically active population

1.9 Sickness absence rate	
	Definition of 1.9iii TBC - DH are working with DWP to explore whether the Electronic Fit Note data can be used to provide a useful measure
Data source	*The data source needs further development for 1.9iii* Data source for 1.9i and 1.9ii: Labour Force Survey (ONS) Data source for 1.9iii: Electronic Fit Note (E-med) data from HSCIC (TBC)
Publication of source data	1.9i and 1.9ii: ONS publish sickness absence data at a national level; breakdowns by age and gender are also available. The latest figures can be found at: http://www.ons.gov.uk/ons/rel/lmac/sickness-absence-in-the-labour-market/february-2011/index.html 1.9iii: Publication of Electronic Fit Note (E-med) data from HSCIC – data not yet available

1.10 Killed and seriously injured casualties on England's roads	
Rationale	The indicator is an established measure used to monitor and assess improvements in road safety. Road safety has implications for the safety of communities and the long-term costs to the health and social care systems, as well as to the wider economy.
Baseline period	2009-11
Indicator definition	**1.10 Number of people reported killed or seriously injured on the roads, all ages, per 100,000 resident population** Numerator: The number of people (all ages) reported killed or seriously injured on the roads Denominator: ONS mid-year population estimate

1.10 Killed and seriously injured casualties on England's roads	
	Based on casualties who incur an injury on the public highway (including footways) in which at least one road vehicle or a vehicle in collision with a pedestrian is involved and which becomes known to the police within 30 days of its occurrence. The vehicle need not be moving; accidents involving stationary vehicles and pedestrians or other road users are included. One accident may give rise to more than one casualty. This indicator includes only casualties who are fatally or seriously injured and these categories are defined as follows: • Fatal casualties are those who sustained injuries which caused death less than 30 days after the accident; confirmed suicides are excluded. • Seriously injured casualties are those who sustained an injury for which they are detained in hospital as an in-patient, or any of the following injuries, whether or not they are admitted to hospital: fractures, concussion, internal injuries, crushings, burns (excluding friction burns), severe cuts and lacerations, severe general shock requiring medical treatment and injuries causing death 30 or more days after the accident. A casualty is recorded as seriously or slightly injured by the police on the basis of information available within a short time of the accident. This generally will not reflect the results of a medical examination, but may be influenced according to whether the casualty is hospitalised or not. Hospitalisation procedures will vary regionally. This indicator will use a 3 year average figure.
Data source	STATS 19 - collected by the police and published by the Department for Transport (DfT) Note: Police data are not a complete record of all injury accidents; it is known that a significant proportion of non-fatal accidents are not reported. Further information can be found at: https://www.gov.uk/government/collections/road-accidents-and-safety-statistics
Publication of source data	Figures for single years at national and local authority level are published annually by DfT: https://www.gov.uk/government/collections/road-accidents-and-

1.10 Killed and seriously injured casualties on England's roads	
	safety-statistics Rates at local authority level are included in the annual Local Authority Health Profiles: http://www.healthprofiles.info

1.11 Domestic abuse	
Rationale	Tackling domestic abuse as a public health issue is vital for ensuring that some of the most vulnerable people in our society receive the support, understanding and treatment they deserve. The more we can focus in on interventions that are effective, the more we can treat victims and prevent future re-victimisation. It is also the government's strategic ambition, as set out in *Call to end violence against women and girls 2010* and successive action plans to do what it can to contribute to a cohesive and comprehensive response.
Baseline period	2010/11
Indicator definition	**1.11 Rate of domestic abuse incidents reported to the police, per 1,000 population** Numerator: the number of domestic abuse incidents reported to the police Denominator: ONS mid-year populations estimates, all ages
Data source	Police Recorded Crime data – Office for National Statistics This data source is only available at police force area level and will serve as guidance for local authorities within a police force area. Discussions are on-going regarding the longer term refinement of this indicator. It is difficult to obtain reliable information on the extent of domestic abuse as there is a degree of under-reporting of these incidents. Changes in the level of domestic abuse incidents reported to the police are particularly likely to be affected by changes in recording practices. These kinds of changes may in part be due to greater encouragement by the police to victims to come forward and improvements in police recording, rather than an increase in the level of victimisation.

1.11 Domestic abuse	
Publication of source data	Domestic abuse incidents reported by the police are collected by the Home Office and published by the Office for National Statistics at police force area level. **2010/11, 2011/12** http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/focus-on-violent-crime/stb-focus-on--violent-crime-and-sexual-offences-2011-12.html

1.12 Violent crime (including sexual violence)	
Rationale	The inclusion of this indicator enables a focus on the interventions that are effective and evidence-based including a greater focus on prevention and treatment, which need to be considered alongside criminal justice measures for a balanced response to the issue. The NHS contribution to sexual assault services are a public health function. It is also the government's strategic ambition, as set out in *Call to end violence against women and girls 2010* and successive action plans to do what it can to contribute to a cohesive and comprehensive response.
Baseline period	1.12i: 2009/10-2011/12 1.12ii: 2010/11 1.12iii: 2010/11 Expected publication date of PHOF baseline for 1.12iii: Early 2014
Indicator definition	**1.12i Age-standardised rate of emergency hospital admissions for violence per 100,000 population** Numerator: Emergency hospital admissions for violence defined by external cause codes for the resident population (ICD10 codes X85 to Y09) Denominator: ONS mid-year population estimates Note: this indicator may be replaced or complemented by an indicator based on A&E attendances once the data source is available for general use.

1.12 Violent crime (including sexual violence)	
	1.12ii Rate of violence against the person offences based on police recorded crime data, per 1,000 population Numerator: Number of violence against the person offences Denominator: ONS mid-year population estimates Note: Indicator 1.12i is based on emergency hospital admissions for a local area's resident population irrespective of the location of the incident whilst Indicator 1.12ii is based on police recorded crime data for a local area irrespective of the home address of those involved in the violent offence. **1.12iii Rate of sexual offences based on police recorded crime data, per 1,000 population** Numerator: Number of sexual offences excluding code 88E(Exposure and Voyeurism) Denominator: ONS mid-year population estimates
Data source	1.12i: Hospital Episode Statistics (HES) 1.12ii: Police recorded crime - Office for National Statistics (ONS) 1.12iii: Police recorded crime – Office for National Statistics (ONS) It is difficult to obtain reliable information on the extent of sexual offences as there is a degree of under-reporting of these incidents. Changes in the level of police recorded sexual offences over time are particularly likely to be affected by changes in recording practices. These kinds of changes may in part be due to greater encouragement by the police to victims to come forward and improvements in police recording, rather than an increase in the level of victimisation.
Publication of source data	ONS publish police recorded crime annually at local authority and Basic Command Unit and Community Safety Partnership level: **2010/11 and 2011/12 data**: http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/period-ending-march-2012/rft-recorded-crime-tables-2011-12.xls

1.13 Re-offending levels	
Rationale	Tackling a person's offending behaviour is often intrinsically linked to their physical and mental health, and in particular any substance misuse issues. This outcome therefore cannot be addressed in isolation. Offenders often also experience significant health inequalities that will need to be identified, examined and addressed locally in partnership with organisations across the criminal justice system. Furthermore, a large proportion of families with multiple needs are managed through the criminal justice system, and their issues are inter-generational. Re-offending therefore has a wide impact on the health and well-being of individuals, their children and families, and the communities they live in. The consequences of tackling offending and reoffending will therefore benefit a wide range of services and agencies and enhance their outcomes. Public health is a crucial part of a multi-agency approach to reducing re-offending, which includes police, courts, prisons, probation, community safety partners, social services, housing and education at a local level.
Baseline period	2010
Indicator definition	**1.13i The percentage of offenders who re-offend from a rolling 12 month cohort** Numerator: The number of offenders who reoffend Denominator: The number of offenders in the cohort **1.13ii The average number of re-offences committed per offender from a rolling 12 month cohort** Numerator: The number of re-offences committed Denominator: The number of offenders in the cohort Cohort: All offenders in any one year who received a caution (for adults), a final warning or reprimand (for juveniles), a non-custodial conviction or were discharged from custody. A proven re-offence is defined as any offence committed in a

1.13 Re-offending levels	
	one year follow-up period and receiving a court conviction, caution, reprimand or warning in the one year follow up or a further six months waiting period. Waiting period: This is the additional time beyond the follow up period to allow for offences committed towards the end of the follow up period to be proved by a court conviction, caution, reprimand or final warning.
Data source	Ministry of Justice (MoJ) dataset (cohort of offenders identified from police, probation and prison records; offending assessed via Police National Computer)
Publication of source data	Published by MoJ at national and local authority level every quarter, beginning with data for the 12 month cohort to Dec 2009, which was published in October 2011. https://www.gov.uk/government/publications/proven-re-offending--2

1.14 The percentage of the population affected by noise	
Rationale	There are a number of direct and indirect links between exposure to noise and health outcomes such as stress, heart attacks and other health issues. Furthermore, there is clear evidence that exposure to noise is a key determinant of quality of life and well-being. Complaints about noise are the largest single cause of complaint to most local authorities. The Government's policy on noise is set out in the Noise Policy Statement for England [1] (NPSE). The policy's long term vision is to promote good health and a good quality of life (well-being) through the effective management of noise in the context of Government policy on sustainable development. Within this context and through the effective management and control of environmental, neighbour and neighbourhood noise, the policy aims to: • avoid significant adverse impacts on health and quality of life; • mitigate and minimise adverse impacts on health and quality

1.14 The percentage of the population affected by noise	
	of life; and • where possible, contribute to the improvement of health and quality of life. [1] DEFRA, Noise Policy Statement for England (NPSE) [online]. March 2010. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/69533/pb13750-noise-policy.pdf
Baseline period	1.14i: 2010/11 1.14ii: 2011 1.14iii: 2011
Indicator definition	**1.14i Number of complaints per year per local authority about noise per thousand population (according to statistics collected by CIEH)** Data presented are a combination of actual values and extrapolated data. The data collected by the Chartered Institute of Environmental Health (CIEH) are currently the result of voluntary submissions from local authorities. However, for those local authorities not supplying data an estimate has been made based on their submissions in previous years, the type of authority (i.e. rural / semi-rural or urban) and the trend in complaint numbers for authorities of the same type for which complete data are available. Not all complaints about noise are made to the local authority so this may be an underestimate of the actual number of complaints made about noise. Some complaints are made directly to the perceived source of the noise e g Network Rail, Airports and Highways Authorities and to other regulators, e.g. the Environment Agency. **1.14ii The proportion of the population exposed to road and rail transport noise of 65 dB(A) or more, LAeq,16h per local authority (16h is the period 0700 – 2300)** Noise exposure determined by strategic noise mapping using national calculation methods and input data supplied from the relevant authorities. The results are overlaid on a residential population dataset to determine number of people exposed per authority. **1.14iii The proportion of the population exposed to road and**

1.14 The percentage of the population affected by noise	
	rail transport noise of 55 dB(A) or more, Lnight (LAeq,8h) per local authority (8h is the period 2300 – 0700) Noise exposure determined by strategic noise mapping using national calculation methods and input data supplied from the relevant authorities. The results are overlaid on a residential population dataset to determine number of people exposed per authority.
Data source	1.14i: Data collated by CIEH on number of noise complaints. Extrapolation determined by DEFRA in association with CIEH. 1.14ii and 1.14iii: Data generated by DEFRA on exposure to road and rail transport noise Note: Data for 1.14ii and 1.14iii are currently comprehensively generated only every 5 years.
Publication of source data	Information on complaints made about noise is available at national level on the CIEH website: http://noisestats.cieh.org/About/ Data on exposure to road and rail traffic noise at agglomeration level for 2006 is available at: http://services.defra.gov.uk/wps/portal/noise

1.15 Statutory homelessness	
Rationale	Part of this indicator (number of households in temporary accommodation per thousand households) is a Department for Communities and Local Government (DCLG) departmental impact indicator. These data demonstrate the number of homeless households in temporary accommodation awaiting a settled home. The other part of the indicator (number of homelessness acceptances per thousand households) demonstrates the number of households that are accepted as being owed a duty by their local authority under homelessness legislation as a result of being eligible for assistance, unintentionally homeless and in priority need. Households that are accepted as being homeless or are in temporary accommodation can have greater public health needs than the

1.15 Statutory homelessness	
	population as a whole. Both parts of this indicator are used by ministers and officials in the DCLG in the formulation and monitoring of policy, the allocation of resources, performance monitoring and to support bids for funding from the Treasury.
Baseline period	2010/11
Indicator definition	**1.15i Homelessness acceptances (per thousand households)** Numerator: Number of households who are eligible, unintentionally homeless and in priority need, for which the local authority accepts responsibility for securing accommodation under part VII of the Housing Act 1996 or part III of the Housing Act 1985 Denominator: Total number of households (thousands), mid-year projection **1.15ii Households in temporary accommodation (per thousand households)** Numerator: Number of households in "temporary accommodation" as arranged by local housing authorities Denominator: Total number of households (thousands), mid-year projection
Data source	P1E-Local Authority returns, DCLG Mid-year projection of the number of households, DCLG
Publication of source data	Homelessness statistics are published by DCLG quarterly at England, region, and local authority level: **Live tables:** https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

1.16 Utilisation of outdoor space for exercise / health reasons

1.16 Utilisation of outdoor space for exercise / health reasons	
Rationale	Inclusion of this indicator is recognition of the significance of accessible outdoor space as a wider determinant of public health. There is strong evidence to suggest that outdoor spaces have a beneficial impact on physical and mental well-being and cognitive function through both physical access and use.
Baseline period	March 2009 - February 2012
Indicator definition	**1.16 Percentage of people using outdoor space for exercise / health reasons** Numerator: Number of people reporting that they have taken a visit to the natural environment for health or exercise over the previous seven days Time spent "out of doors" is e.g. in open spaces in and around towns and cities, including parks, canals and nature areas; the coast and beaches; and the countryside including farmland, woodland, hills and rivers. This could be anything from a few minutes to all day. It may include time spent close to home or workplace, further afield or while on holiday in England. However this does not include: • routine shopping trips or; • time spent in own garden Denominator: Weighted number of respondents to survey
Data source	Monitor of Engagement with the Natural Environment (MENE) survey Data is fully available at England and regional level. Upper tier local authority level data have been generated by modifying the survey weighting.
Publication of source data	Results from the MENE survey (annual report and monthly updates) are published by Natural England: http://www.naturalengland.org.uk/ourwork/research/mene.aspx#phof

1.17 Fuel poverty	
Rationale	There is compelling evidence that the drivers of fuel poverty (low income, poor energy efficiency and energy prices) are strongly linked to living at low temperatures (Wilkinson et al 2001) and the recent Marmot Review Team report showed that low temperatures are strongly linked to a range of negative health outcomes. Media coverage of independent Fuel Poverty Review interim report suggested that a conservative estimate of the number of excess winter deaths caused by fuel poverty would be 1 in 10; this equates to 2,700 people per year, more than die on the roads each year.
Baseline period	2011
Indicator definition	**1.17 The percentage of households estimated to be fuel poor** At the spending review in October 2010, the Government announced that it would commission an independent review to consider the current fuel poverty target and definition. In March 2012, Professor Hills published the final report of his independent review of fuel poverty, making several recommendations for how fuel poverty should be measured. Professor Hills proposed a new measure: the Low Income High Cost (LIHC) indicator. Under the "Low Income, High Cost" measure, households are considered to be fuel poor where: 1 - They have required fuel costs that are above average (the national median level) 2 - Were they to spend that amount, they would be left with a residual income below the official fuel poverty line.
Data source	Data for a measure based on the “Low Income, High Cost” definition of fuel poverty is available from the Department for Energy and Climate Change (DECC). Data is available at national and regional level, as well as a number of sub-regional geographies including LSOA, Local Authority and parliamentary constituency level.
Publication of source	Figures on number of households in fuel poverty are published annually by DECC.

1.17 Fuel poverty	
data	**2011 Fuel Poverty Statistics:** https://www.gov.uk/government/organisations/department-of-energy-climate-change/series/fuel-poverty-statistics **2011 Sub-regional Fuel Poverty Statistics:** https://www.gov.uk/government/organisations/department-of-energy-climate-change/series/fuel-poverty-sub-regional-statistics

1.18 Social isolation	
Rationale	There is a clear link between loneliness and poor mental and physical health. A key element of the Government's vision for social care, set out in the Care and Support White Paper, is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to friends and family. The White Paper sets out steps to support these aims, and makes a commitment to develop, with local government, suitable measures of loneliness and isolation for inclusion in the Adult Social Care Outcomes Framework (ASCOF) and the Public Health Outcomes Framework (PHOF). This indicator will focus on social care users and carers, rather than the broader population. However, the problems of loneliness and social isolation are not limited to these groups, and all parts of the health and care system have a role to play in preventing and reducing social isolation and loneliness in the broader population. Whilst the Department understands the importance of addressing loneliness to improve public health, it will not be feasible to develop a robust local level measure of loneliness in the lifetime of the current PHOF. However, tackling loneliness and social isolation remains a priority for the Department and we remain interested in exploring more widely how the issue can be measured in the general population in a way that will support local authorities. We will also pursue more direct approaches, such as promotion of the loneliness toolkit and making funding available to local organisations that are tackling loneliness in our communities. In addition, the existing indicator will be used by local authorities to ensure they are addressing this issue at a local level and targeting interventions and services to those who are most in need.

1.18 Social isolation	
	Note: In January 2012 this indicator 1.18 was a placeholder measure entitled "Social Connectedness". It has since been refined to be focused specifically on levels of social isolation (using levels of social contact as a proxy), in particular to align with the Adult Social Care Outcomes Framework, with which the indicator is shared. The refined indicator will assist local authorities in focusing on some of the most vulnerable people in their communities.
Baseline period	2010/11
Indicator definition	This indicator covers users of social care and carers based on a question in the Adult Social Care Survey and the Carers Survey. **1.18i Percentage of adults social care users who have as much social contact as they would like** This indicator is presented as the percentage of respondents who answered A) to question 8a from the Adult Social Care Survey: "Thinking about how much contact you've had with people you like, which of the following statements best describes your situation? • A) I have as much social contact as I want with people I like • B) I have adequate social contact with people • C) I have some social contact with people, but not enough • D) I have little social contact with people and feel socially isolated" **1.18i Percentage of carers who have as much social contact as they would like (TBC)** This second indicator is presented as the percentage of respondents who answered A) to question 11 from the Carer's survey: "By thinking about social contact you've had with people you like, which statement best describes your present social situation? • A) I have as much social contact as I want with people I like • B) I have some social contact with people but not enough • C) I have little social contact and I feel socially isolated"

1.18 Social isolation	
	This indicator is shared with indicator 1I in the Adult Social Care Outcomes Framework
Data source	Adult Social Care Survey (annually) and Carers Survey (biennially from 2012/13 onwards)
Publication of source data	The current indicator is based on data from the Adult Social Care Survey. Final data for 2010/11- 2012/13 have already been published: http://data.gov.uk/dataset/personal-social-services-adult-social-care-survey-england-final-2010-2011 http://data.gov.uk/dataset/adult-social-care-survey-england-2011-12-final http://www.hscic.gov.uk/catalogue/PUB13182

1.19 Older people's perception of community safety	
Rationale	Perception of safety is an important factor in helping older people to maintain their independence and activity and to avoid social isolation. This indicator will encourage good links between public health and other parts of local government (e.g. the police) to encourage health and well-being boards and public health professionals to consider perceptions of safety as key to improving health and well-being.
Baseline period	2010/11
Indicator definition	This indicator measures the number of respondents who answered that they feel 'fairly safe' or 'very safe' against three questions from the Crime Survey for England and Wales (formerly the British Crime Survey) that are considered to comprise a perception of community safety:

1.19 Older people's perception of community safety	
	1.19i Percentage of older people (65yrs+) who feel very safe or fairly safe walking alone in their area during the day Numerator: Number of respondents aged 65+ who answered "Fairly Safe" or "Very Safe" to the question "How safe do you feel walking alone in this area during the day?" Denominator: Number of respondents aged 65+ who answered the question "How safe do you feel walking alone in this area during the day?" **1.19ii Percentage of older people (65yrs+) who feel very safe or fairly safe walking alone in their area after dark** Numerator: Number of respondents aged 65+ who answered "Fairly Safe" or "Very Safe" to the question "How safe do you feel walking alone in this area after dark?" Denominator: Number of respondents aged 65+ who answered the question "How safe do you feel walking alone in this area after dark?" **1.19iii Percentage of older people (65yrs+) who feel very safe or fairly safe in their own home at night** Numerator: Number of respondents aged 65+ who answered "Fairly Safe" or "Very Safe" to the question "How safe do you feel when you are alone in your own home at night?" Denominator: Number of respondents aged 65+ who answered the question "How safe do you feel when you are alone in your own home at night?"
Data source	The Crime Survey for England and Wales
Publication of source data	Crime statistics are published on ONS website: http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/index.html The Crime survey results for 2010/11 are published in the following report: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116417/hosb1011.pdf

Domain 2: Health improvement

2.1 Low birth weight of term babies	
Rationale	This indicator is in line with the Government's direction for public health on starting well through early intervention and prevention. It has also been included in the DH Business Plan within the context of addressing issues of premature mortality, avoidable ill health, and inequalities in health, particularly in relation to child poverty (see indicator 1.1).
Baseline period	2010
Indicator definition	**2.1 Percentage of all live births at term with low birth weight** Numerator: Number of live births at term (>= 37 gestation weeks) with low birth weight (<2500g) Denominator: Number of live births at term (>= 37 gestation weeks)
Data source	Office for National Statistics (ONS)
Publication of source data	ONS publish data at national level, but there is currently a reporting time lag of 21 months. **2010 data**: http://www.ons.gov.uk/ons/rel/child-health/gestation-specific-infant-mortality-in-england-and-wales/2010/index.html

2.2 Breastfeeding	
Rationale	Inclusion of this indicator will encourage the continued prioritisation of breastfeeding support locally. Increases in breastfeeding initiation and prevalence are expected to reduce illness in young children, which will in turn reduce hospital admissions of the under 1s (and the costs to the

2.2 Breastfeeding	
	NHS that are associated with this). In the longer term, infants who are not breastfed are more likely to become obese in later childhood, develop type 2 diabetes and tend to have slightly higher levels of blood pressure and blood cholesterol in adulthood.
Baseline period	2010/11
Indicator definition	**2.2i Breastfeeding initiation** Numerator: Number of women who initiate breastfeeding in the first 48 hours after delivery Denominator: Number of total maternities **2.2ii Breastfeeding prevalence at 6-8 weeks after birth** Numerator: Number of infants who are totally or partially breastfed at 6-8 week check Denominator: Total number of infants due a 6-8 week check Note: Quarterly breastfeeding data are published by NHS England but individual quarters should not be added together to form the annual figures for this indicator.
Data source	*The data source needs further development* Data will be collected quarterly by NHS England via UNIFY2 at GP practice level from 2013/14 Q1. The Maternity and Children's Services Secondary Uses Data Set will become the data source for this indicator in due course. The data set has received full approval from the Information Standards Board (ISB) for health and social care. The Information Standards Notice (ISN) to mandate local implementation of the standard was published in May 2012.
Publication of source data	Last published by DH at national and PCT level on a quarterly basis: https://www.gov.uk/government/organisations/department-of-health/series/breastfeeding-quarterly-statistics-england See note in definition section – adding together quarterly data as published will not create the annual data used for this indicator.

2.2 Breastfeeding	
	Following implementation of the Maternity and Children's data set in 2014, the Health and Social Care Information Centre will begin publishing reports.

2.3 Smoking status at time of delivery	
Rationale	Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy. The Tobacco Control Plan contains a national ambition to reduce the rate of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth). The inclusion of this indicator will ensure that local tobacco control activity is appropriately focused on pregnant women, in order to try to achieve this national ambition.
Baseline period	2010/11
Indicator definition	**2.3 Rate of smoking at time of delivery per 100 maternities** Numerator: Number of women who currently smoke at time of delivery Denominator: Number of total maternities Note: Quarterly data are published by the Health and Social Care Information Centre (HSCIC), but individual quarters should not be added together to form the annual figures for this indicator.
Data source	*The data source needs further development* Data will be collected quarterly via the HSCIC Omnibus at CCG level from 2013/14 Q1 The Maternity and Children's Services Secondary Uses Dataset will become the data source for this indicator in due course. The

2.3 Smoking status at time of delivery	
	dataset has received full approval from the Information Standards Board (ISB) for health and social care. The Information Standards Notice (ISN) to mandate local implementation of the standard was published in May 2012.
Publication of source data	Last published by the HSCIC at national and PCT level on a quarterly basis: The annual data collected at quarter 4 is used to assess year on year performance. http://www.hscic.gov.uk/datacollections/ssatod See note in definition section – adding together quarterly data as published by the HSCIC will not create the annual data used for this indicator

2.4 Under 18 conceptions	
Rationale	Inclusion of this indicator signals the continuing importance of teenage pregnancy as a key measure of health inequalities and child poverty. Reducing under 18 conceptions has important benefits for short and long term health outcomes. Teenage parents are at increased risk of postnatal depression and poor mental health in the 3 years following birth. They are more likely than older mothers to have low educational attainment, experience adult unemployment and be living in poverty at age 30. Their children experience higher rates of infant mortality and low birth weight, A&E admissions for accidents and have a much higher risk of being born into poverty.
Baseline period	2010
Indicator definition	**2.4 Under 18 conception rate per 1,000 population** Numerator: Total conceptions to all women aged under 18 Denominator: Total female population aged 15-17 Office for National Statistics (ONS) conception statistics are

2.4 Under 18 conceptions	
	compiled by combining information from birth registrations and abortion notifications. Conception statistics include pregnancies that result in: • One or more live or still births; or • A legal abortion under the Abortion Act 1967 Miscarriages and illegal abortions are not included. The date of conception is estimated using recorded gestation for abortions and stillbirths, and assuming 38 weeks gestation for live births. A woman's age at conception is calculated as the number of complete years between her date of birth and the date she conceived. The postcode of the woman's address at time of birth or abortion is used to determine local authority/ward of residence at time of conception. Only about 5% of under 18 conceptions are to girls aged 14 or under and to include younger age groups in the base population would produce misleading results. The 15-17 age group is effectively treated as the "population at risk".
Data source	ONS
Publication of source data	ONS publish annual conception statistics at upper and lower tier local authority level: http://www.ons.gov.uk/ons/publications/all-releases.html?definition=tcm%3A77-27824 At present lower tier local authority figures are 3 year aggregates. Following a recent review ONS will be publishing slightly different tables from next year. This will include single year annual data for both upper and lower tier local authorities. In addition, ONS publish quarterly conception statistics at upper tier local authority level. http://www.ons.gov.uk/ons/rel/vsob1/quart-conc-to-women-und-18/index.html

2.5 Child development at 2 – 2½ years	
Rationale	The Government's Early Years Policy Statement 'Supporting Families in the Foundation Years' (published July 2011) sets out the Government's recognition of the importance of pregnancy and the first years of life and its strong commitment to ensuring all children get the best possible start in life. It also included a commitment to developing an outcome measure of child development at 2-2½ years. This is linked to the Government commitment to increase the number of health visitors, which in turn will help to ensure that more children are offered the Healthy Child Programme review at age 2-2½ years. The indicator will show how many children are receiving this review, as well as provide information on children's development. Children's early life development is strongly related to an individual's life long healthy development. Many factors associated with poor health and well-being in later life have been shown to have their origins in pregnancy and early childhood.
Baseline period	TBC 2.5i/2.5ii: Preliminary baseline data will be collected during 2014/15 and published in 2015/16. This may require an ad-hoc collection from local areas. It is hoped that full baseline data may be collected for all sub-indicators in 2015/16 and published in 2016/17 so that this meets PHOF requirements. This is still to be confirmed.
Indicator definition	*The indicator definition requires further development* The child development indicator will be based upon the 'Ages and Stages Questionnaire' (ASQ-3). This tool is commonly used in the US and its use is becoming increasingly common in the UK as part of the Healthy Child Programme. It is intended that data for this measure will be collected during the integrated review for children at age 2 – 2 ½ (which will come into being in 2015, and will bring together the current Healthy Child Programme review at the same age with the Early Years Progress Check at age 2). Where an integrated review is not yet in place, the data for this measure will be collected via the Healthy Child Programme review at age 2-2½. Implementation piloting will take place during 2014/15 ready for implementation in 2015 alongside the integrated review.

2.4 Under 18 conceptions	
	2.5i Proportion of children aged 2-2½yrs who received an assessment as part of the Healthy Child Programme or an integrated review (using any tool) The number of children aged 2-2½yrs that complete any Healthy Child Programme or integrated review as a proportion of total number of children within this age group. **2.5ii Proportion of children aged 2-2½yrs offered ASQ-3 as part of the Healthy Child Programme or integrated review** The number of children aged 2-2½yrs for whom ASQ-3 is completed as part of the HCP or integrated review as a proportion of total number of children within this age group. The remaining sub-indicator(s) will use the ASQ-3 tool. The tool produces a score for five separate areas of development: • Communication • Gross Motor • Fine Motor • Problem solving • Personal-social The score a child receives can be compared to an expected range of scores for a child of that age, indicating whether further consultation may be required. The 'expected' range of scores for each domain based upon research findings in the US where this tool originates will be used for the implementation piloting in 2014/15. Whether these domain ranges are applicable to children in England will be determined and may be modified accordingly. Example indicator title: **2.5 iii Proportion of children aged 2-2½yrs who receive an ASQ-3 score within the expected range for this age group (TBC)** This would be the number of children who complete the ASQ assessment and receive a score (or scores if applied to all ASQ-3 domains) that is within the 'expected' range, as a proportion of all children who complete the assessment. The exact form this indicator will take is subject to further analysis.

2.4 Under 18 conceptions	
Data source	*The data source needs further development* It is hoped that data from either the Healthy Child Programme review or the Integrated review at 2-2½yrs will be collated from local child health information systems via the Maternity and Children's dataset, which is owned by the Health and Social Care Information Centre (HSCIC). Work is on-going to explore the feasibility of this data collection route. Once established the maternity and children's dataset will be modified in order to provide the mainstream vehicle for data collection. The data collection will comply with the governance arrangements for similar data collections managed by the Health and Social Care Information Centre. Full data for this indicator is not likely to be available before 2016 based on 2015/16 data.
Publication of source data	TBC

2.6 Excess weight in 4-5 and 10-11 year olds	
Rationale	Obesity is a priority area for Government. The Government's "Call to Action" on obesity (published Oct 2011) included national ambitions relating to excess weight in children. Excess weight (overweight and obesity) in children often leads to excess weight in adults, and this is recognised as a major determinant of premature mortality and avoidable ill health.
Baseline period	2010/11 (school year)
Indicator definition	**2.6i Percentage of children aged 4-5 classified as overweight or obese** Numerator: The number of primary school age children in Reception (aged 4-5 years) with valid height and weight recorded (in a particular school year) who are classified as overweight or obese

2.6 Excess weight in 4-5 and 10-11 year olds	
	Denominator: The total number of primary school age children in Reception (aged 4-5 years) with valid height and weight recorded in a particular school year **2.6ii Percentage of children aged 10-11 classified as overweight or obese** Numerator: The number of primary school age children in Year 6 (aged 10-11 years) with valid height and weight recorded (in a particular school year) who are classified as overweight or obese Denominator: The total number of primary school age children in Year 6 (aged 10-11 years) with valid height and weight recorded in a particular school year The published figures define a child as overweight (including obese) if their BMI is greater than or equal to the 85th centile of the British 1990 (UK90) growth reference.
Data source	National Child Measurement Programme (NCMP)
Publication of source data	Data on the National Child Measurement Programme (NCMP) are published annually by the Health and Social Care Information Centre: http://www.ic.nhs.uk/ncmp Information on children who are “overweight” or “obese” is published as separate items within the NCMP publication.

2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years	
Rationale	Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. They are also a source of long-term health issues, including mental health problems related to experience(s) of injury. The inclusion of this indicator is key for cross-sectoral and partnership working to reduce injuries, including child

2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years	
	safeguarding.
Baseline period	2010/11
Indicator definition	**2.7i Crude rate of hospital emergency admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 years, per 10,000 resident population** Numerator: The number of finished in-year emergency admissions of children and young people aged 0-14 years to hospital as a result of unintentional and deliberate injuries (ICD10 codes S00-T79 or V01-Y36 in any of the diagnostic fields). Denominator: ONS mid-year population estimate for age 0-14 years. **2.7ii Crude rate of hospital emergency admissions caused by unintentional and deliberate injuries in children and young people aged 15-24 years, per 10,000 resident population** Numerator: The number of finished in-year emergency admissions of children and young people aged 15-24 years to hospital as a result of unintentional and deliberate injuries (ICD10 codes S00-T79 or V01-Y36 in any of the diagnostic fields). Denominator: ONS mid-year population estimate for age 15-24 years.
Data source	Hospital Episode Statistics (HES), Health and Social Care Information Centre
Publication of source data	Public Health England's 'Injury Profiles' tool contains national and local authority level 2010/11 figures based on underlying cause codes ICD10: V01-Y98 excluding X33-X39 & X52 (forces of nature) for age groups 0-4, 5-17 and 0-17 years. This was the historical 'National Indicator 70' definition. Future updates will match the Public Health Outcomes Framework definition.

2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years	
	See: http://www.apho.org.uk/default.aspx?QN=INJURY_DEFAULT

2.8 Emotional well-being of looked after children	
Rationale	The mental health of all children is important. With half of adult mental health problems starting before the age of 14, early intervention to support children and young people with mental health and emotional well-being issues is very important. Under Section 10 of the Children Act 2004, local authorities have a duty to co-operate to promote well-being among children and young people. The cross Government Mental Health Strategy, 'No Health without Mental Health', identifies looked after children as one of the particularly vulnerable groups at risk of developing mental health problems. Inclusion of this indicator for looked after children will send out a message that this group of young people are a priority for the NHS and local authorities in their new public health role. Without an indicator covering this group, there would be a risk of an even greater increase in rates of undiagnosed mental health problems, placement breakdown, alcohol and substance misuse, convictions and care leavers not in education, employment or training.
Baseline period	2010/11
Indicator definition	**2.8 Average total difficulties score for all looked after children aged between 4 and 16 (inclusive) at the date of their latest assessment, who have been in care for at least 12 months on 31 March** Data is collected by local authorities through a strengths and difficulties questionnaire (SDQ) and a single summary figure for each child (the total difficulties score), ranging from 0 to 40, is submitted to the Department for Education (DfE) through the SSDA903 data return.
Data source	Children Looked After by Local Authorities in England in the year

2.8 Emotional well-being of looked after children	
	ending 31 March based on the SSDA903 data collection on looked after children.
Publication of source data	Data on looked after children (though not specifically this indicator) are published annually by DfE **Latest data (At 31 March 2012):** https://www.gov.uk/government/publications/children-looked-after-by-local-authorities-in-england-including-adoption

2.9 Smoking prevalence – 15 year olds	
Rationale	Smoking is a major cause of preventable morbidity and premature death. There is a large body of evidence showing that smoking behaviour in early adulthood affects health behaviours later in life. The Tobacco Control Plan sets out the Government's aim to reduce the prevalence of smoking among both adults and children and includes a national ambition to reduce rates of regular smoking among 15 year olds in England to 12 per cent or less by the end of 2015. This indicator will ensure that as well as focusing on reducing the prevalence of smoking among adults (primarily through quitting) local authorities will also address the issue of reducing the uptake of smoking among children.
Baseline period	2010
Indicator definition	**2.9i Prevalence of smoking among 15 years olds** Numerator: The number of persons aged 15 who are self-reported smokers Denominator: Total number of respondents (with valid recorded smoking status) aged 15 **2.9ii Prevalence of smoking among 15 year olds – regular smokers** Numerator: The number of persons aged 15 who are regular smokers (at least one cigarette per week)

2.9 Smoking prevalence – 15 year olds	
	Denominator: Total number of respondents (with valid recorded smoking status) aged 15 **2.9iii Prevalence of smoking among 15 year olds – occasional smokers** Numerator: The number of persons aged 15 who are occasional smokers (usually smoking less than one cigarette per week) Denominator: Total number of respondents (with valid recorded smoking status) aged 15
Data source	2.9i Local level data is not available on smoking prevalence among 15 year olds using existing data sources. On behalf of the Department of Health, the Health and Social Care Information Centre has commissioned Ipsos Mori, with the National Child Bureau, to carry out a survey of 15 year olds. The survey is based on a 20 minute postal questionnaire covering a range of topics, including self-reported smoking. The results from this survey will be published in Autumn 2015. 2.9ii, 2.9iii Smoking, Drinking and Drug Use Among Young People in England survey. Information on smoking for 11-15 year olds is collected in the Survey of Smoking, Drinking and Drug Use Among Young People, the sample size for 15 year olds is sufficient to obtain robust estimates only at national level, hence the need for a new survey to provide local authority level data. National data have been included for subindicators 2.9ii and 2.9iii.
Publication of source data	Smoking prevalence for 15 year olds is currently reported by the Health and Social Care Information Centre at national and regional level, based on the Survey of Smoking, Drinking and Drug Use Among Young People: http://www.hscic.gov.uk/catalogue/PUB14579

2.10 Self-harm	
Rationale	Self-harm is a sign of serious emotional distress. There are an estimated 300,000 attendances at A&E for self-harm each year, and we know that this represents only a small proportion of self-harming in the community and the related health and well-being burden of self-harm.

2.10 Self-harm	
	Significant local authority and NHS resources are required for mental health promotion, prevention, early intervention and to deal with the assessment and management of self-harm. People who self-harm describe contact with health services as often difficult, characterised by ignorance, negative attitudes and, sometimes, punitive behaviour by professionals towards people who self-harm. With the risk of death by suicide being considerably higher among people who have self-harmed and with their high rates of mental health problems, and alcohol and substance misuse, it is essential that services address the experience of care by people who self-harm. Those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year. NICE Quality Standards and clinical guidelines on self-harm emphasise the importance that people who have self-harmed are offered a comprehensive psychosocial assessment. Carrying out these assessments on all people who present at A&E with self-harm is associated with a reduction in repeat attendances at A&E.
Baseline period	TBC
Indicator definition	The indicator will have two elements: **2.10i Attendances at A&E for self-harm per 100,000 population** **2.10ii Percentage of attendances at A&E for self-harm that received a psychosocial assessment**
Data source	*The data source needs further development* Initially, the indicator will be estimated using national monitoring data from the Multicentre Study on Self-harm (Universities of Oxford and Manchester and Derbyshire Healthcare NHS Foundation Trust), using detailed data gathered from 6 general hospitals. Expert input from HSCIC analysts is required in relation to the data improvements that would be needed to the HES A&E experimental data collection (for 2.10.1) and the Mental Health Minimum Dataset (for 2.10.2) in order to support calculation of this indicator at local authority level.

2.10 Self-harm	
Publication of source data	*TBC*

2.11 Diet	
Rationale	The importance of diet as a major contributor to chronic disease and premature death in England is recognised in the White Paper 'Healthy Lives, Healthy People'. Poor diet is a public health issue as it increases the risk of some cancers and cardiovascular disease (CVD), both of which are major causes of premature death. These diseases, and type II diabetes (which increases CVD risk) are associated with obesity, which has a very high prevalence in England. The costs of diet related chronic diseases to the NHS and more broadly to society are considerable. Poor diet is estimated to account for about one third of all deaths from cancer and CVD. A quarter of adults in England are obese. Average intakes of saturated fat, sugar, and salt are above recommendations while intakes of fruit and vegetables, fibre and some vitamins and minerals are below recommendations. Average intake of artificial trans fatty acids are within recommendations. Calorie intake is difficult to measure but evidence shows that intake exceeds recommendations.
Baseline period	2013/14
Indicator definition	The diet indicators will use information taken from the Active People Survey. The Active People Survey will ask the following questions: • How many portions of fruit did you eat yesterday? Please include all fruit, including fresh, frozen dried or tinned fruit, stewed fruit or fruit juices and smoothies. • How many portions of vegetables did you eat yesterday? Please include fresh, frozen, raw or tinned vegetables, but do not include any potatoes you ate. **2.11i Proportion of the population meeting the recommended '5-A-Day'**

2.11 Diet	
	The proportion of the population meeting the recommended '5-A-Day' will be used as a proxy for the proportion consuming a balanced diet – this is one which is lower in saturated fat, trans fats, sugar, salt and calories and higher in fruit and vegetables. Activities to improve consumers' diets should span these nutrients and foods. Numerator: Number of adults reporting that 'yesterday' they consumed a total of five or more portions of fruit and/or vegetables Denominator: Total number of adults in sample. **2.11ii Average number of portions of fruit consumed daily** Mean number of portions of fruit reported by sample to have been consumed 'yesterday'. Numerator: Total number of portions of fruit reported by sample to have been consumed 'yesterday'. Denominator: Total number of adults in sample. **2.11iii Average number of portions of vegetables consumed daily** Mean number of portions of vegetables reported by sample to have been consumed ' yesterday'. Numerator: Total number of portions of vegetables reported by sample to have been consumed 'yesterday'. Denominator: Total number of adults in sample
Data source	Active People Survey (APS) Sport England commissions the APS. The survey has a large sample size which enables measurement of local area estimates and analysis by a broad range of demographic information, such as gender, social class, ethnicity, household structure, age and disability.
Publication of source data	Sport England publishes results from the APS every six months on a rolling basis. The latest results are from the sixth wave of the study http://www.sportengland.org/research/active_people_survey/active_people_survey_6.aspx Dietary questions will be included in the questionnaire from

2.11 Diet	
	October 2013. The first wave results to include the dietary questions will be published in Summer 2014.

2.12 Excess weight in adults	
Rationale	Obesity is a priority area for Government. The Government's "Call to Action" on obesity (published Oct 2011) included national ambitions relating to excess weight in adults, which is recognised as a major determinant of premature mortality and avoidable ill health.
Baseline period	National level: 2010 Local authority level: mid-Jan 2012 to mid-Jan 2013
Indicator definition	**2.12 Proportion of adults classified as overweight or obese** Numerator: Number of adults who are classified as overweight or obese Denominator: Number of adults with valid height and weight recorded Adults are defined as overweight (including obese) if their BMI is greater than or equal to 25kg/m^2
Data source	National level: Health Survey for England (measured height and weight) Local authority level: Sport England's Active People Survey (self-reported height and weight adjusted to account for reporting bias to obtain an estimate of the true height and weight of each individual).
Publication of source data	The Health Survey for England is published annually. http://www.hscic.gov.uk/Article/1685 Active People Survey data is published for national and local levels at six monthly intervals. However the experimental data

2.12 Excess weight in adults	
	on self-reported height and weight is not currently published.

2.13 Proportion of physically active and inactive adults	
Rationale	Lack of sufficient physical activity costs the NHS over £1bn/yr - £6.5bn/yr to the wider economy – and is one of the top few risk factors for premature mortality. The need for physical activity has become particularly high profile since the publication of the UK CMO guidelines and in the context of the 2012 legacy. Physical activity provides important health benefits across the life-course. Participation in sport and active recreation during youth and early adulthood can lay the foundation for life-long participation in health-enhancing sport and wider physical activity.
Baseline period	2012
Indicator definition	**2.13i Proportion of adults achieving at least 150 minutes of physical activity per week in accordance with UK CMO recommended guidelines on physical activity** Numerator: Number of adults (16+) doing at least 150 "equivalent" minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more* Denominator: Population of adults (aged 16+) **2.13ii Proportion of adults classified as 'inactive'** Numerator: Number of adults (16+) who do less than 30 "equivalent" minutes of moderate intensity physical activity per week in bouts of 10 minutes or more* Denominator: Population of adults (aged 16+) "Equivalent" minutes of moderate intensity activity would be calculated as the sum of all minutes of moderate intensity activity and 2x all minutes of vigorous intensity activity, accumulated across a week. This is based on the recognition

2.13 Proportion of physically active and inactive adults	
	that one minute of vigorous intensity activity can be counted as two minutes of moderate intensity activities (e.g. 15 minutes of vigorous activities would be counted as equivalent to 30 minutes of moderate activities). * Based on 2011 CMO report 'Start active, stay active'
Data source	Sport England's Active People Survey (APS)
Publication of source data	APS data is published for national and local levels at six monthly intervals. APS data to support this indicator is not published yet. However, APS data on physical activity have been collected since 2005. The most recent are linked to below: http://www.sportengland.org/research/about-our-research/active-people-survey/

2.14 Smoking prevalence – adults (over 18s)	
Rationale	Smoking is a major cause of preventable morbidity and premature death, accounting for 79,100 deaths in England in 2011, some 18 per cent of all deaths of adults aged 35 and over. The Tobacco Control Plan includes a national ambition to reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015.
Baseline period	2010/11
Indicator definition	**2.14 Prevalence of smoking among persons aged 18 years and over** Numerator: The number of persons aged 18+ who are self-reported smokers in the Integrated Household Survey Denominator: Total number of respondents (with valid recorded smoking status) aged 18+ in the Integrated Household Survey*

2.14 Smoking prevalence – adults (over 18s)	
	Smokers are defined as those responding yes to the question "Do you smoke at all nowadays?" *The number of respondents is weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.
Data source	Integrated Household Survey, Office for National Statistics
Publication of source data	National and local authority level figures are published for a rolling twelve month period quarterly: http://www.lho.org.uk/viewResource.aspx?id=16678 Local authority level data on this indicator are also included in the annual Local Authority Health Profiles and the Local Tobacco Control Profiles. Both sets of profiles provide overall smoking prevalence but the latter also includes data for the routine and manual group. http://www.healthprofiles.info http://www.tobaccoprofiles.info/

2.15 Successful completion of drug treatment	
Rationale	Individuals achieving this outcome demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health. It aligns with the ambition of both public health and the Government's drug strategy of increasing the number of individuals recovering from addiction. It also aligns well with the reducing re-offending outcome [Indicator 1.13] as offending behaviour is closely linked to substance use and it is well demonstrated that cessation of drug use reduces re-offending significantly. This in turn will have benefits to a range of wider services and will address those who cause the most harm in local communities.

2.15 Successful completion of drug treatment	
Baseline period	2010
Indicator definition	**2.15 Number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number in treatment** Numerator: The number of adults that successfully complete treatment in a year and who do not re-present to treatment within 6 months Denominator: The total number of adults in treatment in a year
Data source	National Drug Treatment Monitoring System (NDTMS)
Publication of source data	The National Treatment Agency (NTA) publish monthly data for Drug (and Alcohol) Action Teams (DAATs): https://www.ndtms.net/Reports.aspx DAATS are partnerships made up of local organisations - such as PCTs, local authorities, Police, Probation Service etc and can be hosted by any organisation in the partnership. The majority are hosted by local authorities or PCTs.

2.16 People entering prison with substance dependence issues who are previously not known to community treatment	
Rationale	Ensuring that individuals with substance misuse problems receive appropriate and effective early interventions will significantly reduce harms to health and will improve well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health. There is also considerable evidence that treatment interventions for the management of substance misuse can help to reduce offending. It will also serve as a measure of prevention work on substance

2.16 People entering prison with substance dependence issues who are previously not known to community treatment	
	dependence among vulnerable groups.
Baseline period	2012/13
Indicator definition	**2.16 Proportion of people assessed for substance dependence issues when entering prison who then required structured treatment and have not already received it in the community** Numerator: Number of individuals entering prison who are provided with a substance misuse triage assessment to determine dependence on drugs or alcohol, who then require structured treatment and who have not already received it in the community Denominator: Number of individuals entering prison who are provided with a substance misuse triage assessment to determine dependence on drugs or alcohol, who then require structured treatment
Data source	Calculated by Public Health England: Evidence Application Team using data from National Drug Treatment Monitoring System (NDTMS)
Publication of source data	Public Health England (PHE) will publish annual data

2.17 Recorded diabetes	
Rationale	This indicator will raise awareness of trends in diabetes among public health professionals and local authorities. Diabetic

2.17 Recorded diabetes	
	complications (including cardiovascular, kidney, foot and eye diseases) result in considerable morbidity and have a detrimental impact on quality of life. Type 2 diabetes (approximately 90% of diagnosed cases) is partially preventable – it can be prevented or delayed by lifestyle changes (exercise, weight loss, health eating). Earlier detection of Type 2 diabetes followed by effective treatment reduces the risk of developing diabetic complications. The 13 quality statements of the 'Diabetes in adults quality standard' (2011) were informed by a range of NICE clinical guidelines and the 'National Service Framework for Diabetes' that covered all aspects of diabetes care and prevention. Specifically, it is expected that achieving the high quality care set out in this quality standard will reduce the complications associated with diabetes. NICE guidelines for diabetes include those for children and young people, pregnancy, type 1 diabetes, prevention of type 2 diabetes, risk identification and interventions for individuals at high risk. All aim to improve the prevention, identification and management of those people at risk of developing diabetes and those with the condition. http://guidance.nice.org.uk/index.jsp?action=find
Baseline period	At 31 March 2010
Indicator definition	**2.17 Number of QOF-recorded cases of diabetes per 100 patients registered with GP practices (17 years and over)** Numerator: Patients registered with GP practices, aged 17 and over at midnight on the 31st March (in a particular year), with a coded diagnosis of diabetes on the 31st March (in a particular year). (QOF DM19) Denominator: Patients registered with GP practices, aged 17 and over at midnight on the 31st March (in a particular year) This definition is based on Quality and Outcomes Framework (QOF) data and will give a comprehensive measure at national level for those aged 17 and over. As it does not contain patient level data, it is not possible to map patients to local authority boundaries according to their home postcode.

2.17 Recorded diabetes	
	As a result, for this indicator, counts of patients with recorded diabetes are allocated to local authorities based on the postcode of the GP practice with which the patient is registered, using NHS Postcode Directory November 2010.
Data source	QOF, Health and Social Care Information Centre. QOF information is derived from the Quality Management Analysis System (QMAS), a national system developed by NHS Connecting for Health.
Publication of source data	QOF information is published online annually by the Health and Social Care Information Centre (HSCIC) at GP practice level: http://www.qof.ic.nhs.uk/ Local authority data is published in the annual Local Authority Health Profiles: www.healthprofiles.info

2.18 Alcohol-related admissions to hospital	
Rationale	Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually. The Government has said that everyone has a role to play in reducing the harmful use of alcohol – this indicator is one of the key contributions by the Government (and the Department of Health) to promote measurable, evidence based prevention activities at a local level, and supports the national ambitions to reduce harm set out in the Government's Alcohol Strategy. This ambition is part of the monitoring arrangements for the

2.18 Alcohol-related admissions to hospital	
	Responsibility Deal Alcohol Network. Alcohol-related admissions can be reduced through local interventions to reduce alcohol misuse and harm.
Baseline period	2010/11
Indicator definition	*The indicator definition below is in draft but will be confirmed prior to baseline publication* **2.18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 population (age standardised)** The number is estimated by assigning an attributable fraction to each relevant admission, based on the diagnosis codes and age and sex of the patient. The attributable fractions represent the proportion of cases of conditions that can be attributed to alcohol and are based on the latest review of research undertaken by Public Health England.
Data source	Hospital Episode Statistics, Health and Social Care Information Centre.
Publication of source data	National and local authority figures will be made available on the Local Alcohol Profiles for England national indicator web site: http://www.lape.org.uk/natind.html

2.19 Cancer diagnosed at stage 1 and 2	
Rationale	Cancer is a major cause of death, accounting for around a quarter of deaths in England. More than 1 in 3 people will develop cancer at some point in their life. In January 2011 the Government published Improving Outcomes – a Strategy for Cancer. This document sets out how the Government plans to improve cancer outcomes, including improving survival rates through tackling late diagnosis of

2.19 Cancer diagnosed at stage 1 and 2	
	cancer. Diagnosis at an early stage of the cancer's development leads to dramatically improved survival chances. Specific public health interventions, such as screening programmes and information/education campaigns aim to improve rates of early diagnosis. An indicator on the proportion of cancers diagnosed at an early stage is therefore a useful proxy for assessing improvements in cancer survival rates.
Baseline period	2012 (Experimental Statistics)
Indicator definition	**2.19 Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed** This indicator measures new cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed (for specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin). Numerator: Cases of cancer diagnosed at stage 1 or 2, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin. Denominator: All new cases of cancer diagnosed at any stage or unknown stage, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin.
Data source	National Cancer Registry - Data from this source will continue to evolve to improve quality – the data for calendar year 2012 will act as a useful proxy to help establish the baseline.
Publication of source data	Public Health England

2.20 Cancer screening coverage	
Rationale	Breast cancer screening supports the early detection of breast cancer and cervical screening supports the detection of abnormalities of the cervix that if left undetected and untreated may become cancer. Cervical screening is estimated to save 4,500 lives in England each year, while breast screening is estimated to save 1,400 lives. Inclusion of this indicator will provide an opportunity to incentivise screening promotion and other local initiatives to help women make the important choice to take part in screening, and increase coverage of cancer screening. Improvements in coverage would mean more cervical cancers are prevented and more breast cancers are detected at earlier, more treatable stages.
Baseline period	2010
Indicator definition	**2.20i The percentage of women in a population eligible for breast screening at a given point in time who were screened adequately within a specified period** Numerator: Number of women aged 53–70 resident in the area (determined by postcode of residence) with a screening test result in the previous three years Denominator: Number of women aged 53–70 who are eligible for breast screening at a given point in time **2.20ii The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period** Numerator: Number of women aged 25–49 resident in the area (determined by postcode of residence) with an adequate screening test in the previous 3½ years plus the number of women aged 50-64 resident in the area with an adequate screening test in the previous 5½ years Denominator: Number of women aged 25–64 who are eligible for cervical screening at a given point in time A further sub-indicator for bowel cancer screening is under development.
Data source	Indicator calculated using data from NHS Connecting for Health

2.20 Cancer screening coverage	
	'Open Exeter' system
Publication of source data	Detailed reporting on screening programme coverage is available monthly via the NHS Connecting for Health 'Open Exeter' system (accessible by registered users only): https://nww.openexeter.nhs.uk/nhsia/index.jsp Annual data on screening coverage at national and PCT level is published by the Health and Social Care Information Centre Breast screening data: http://www.hscic.gov.uk/catalogue/PUB10339 Cervical screening data: http://www.hscic.gov.uk/catalogue/PUB07990

2.21 Access to non-cancer screening programmes	
Rationale	This indicator will provide an opportunity to track and monitor uptake levels of a variety of screening programmes that have a significant impact on the health and well-being of the population. For example: • diabetic retinopathy is the leading cause of preventable sight loss in working age people in the UK and early detection through screening halves the risk of blindness; • infectious disease screening in pregnancy has almost eliminated HIV positive babies; and • screening for metabolic disease in the newborn period prevents major disability and death. Monitoring uptake levels will highlight whether enough is being done to raise uptake levels and whether or not remedial action is required in areas where uptake is low. The benefits of screening will increase as the uptake levels increase.
Baseline period	2.21i – 2.21vi: 2013/14 (subject to dataset being complete and available) 2.21vii: 2010/11

2.21 Access to non-cancer screening programmes	
Indicator definition	Sub-indicators 2.21i and 2.21ii cover screening coverage or uptake for infectious diseases in pregnancy (which includes screening for HIV, hepatitis B, syphilis and rubella susceptibility) **2.21i HIV coverage: The percentage of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result** Numerator: Total number of *eligible* women for whom a conclusive screening result was available for HIV at the day of report, including women who were known to be HIV positive at booking and were therefore not retested and women who transfer in for care during the reporting period with documented evidence of a screening test result during the pregnancy (and therefore not retested) Denominator: Total number of pregnant women booked[2] for antenatal care during the reporting period, or presenting in labour without previously having booked for antenatal care, excluding: women who miscarry, opt for termination or transfer out between booking and testing (i.e. prior to testing) **2.21ii Syphilis, hepatitis B and susceptibility to rubella uptake: The percentage of women booked for antenatal care, as reported by maternity services, who have a screening test for syphilis, hepatitis B and susceptibility to rubella leading to a conclusive result** Numerator: Number of women tested for each infection for whom a conclusive screening result was available for each of the screening tests on the day of the report, including women who were known to be hepatitis B positive at booking and therefore not retested and women who transfer in for care during the reporting period with documented evidence of a screening test result during the pregnancy (and therefore not retested) Denominator: Number of women booked[2] for antenatal care during the reporting period Coverage is calculated for each maternity unit or trust by quarter

[2] 'Booking' is the point at which the woman first sees a midwife for an antenatal booking history, when details of the current pregnancy are documented in a maternity record (which may be an information system or a paper-based record). The maternity unit where a woman is *booked to deliver* is responsible for capturing and reporting these data.

2.21 Access to non-cancer screening programmes	
	and infection. Percent coverage is calculated as the number of women tested divided by the number of women booked, multiplied by 100. **2.21iii The percentage of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report** Numerator: Total number of eligible women for whom a conclusive antenatal sickle cell and thalassaemia screening result was available at the day of report. Including women for whom a previous result is known (and therefore not retested) and women who transfer in for care during the reporting period with documented evidence of a screening test result during pregnancy (and therefore not retested) In areas with low prevalence of sickle cell disease, this may include women at low risk of sickle cell disease for whom haemoglobinopathy analysis (e.g. HPLC) has not been indicated by Family Origin Questionnaire (FOQ). Denominator: Total number of pregnant women booked[2] for antenatal care during the reporting period, or presenting in labour without previously having booked for antenatal care, excluding women who miscarry, opt for termination or transfer out between booking and testing, or known carriers who had direct access to pre-natal diagnosis. **2.21iv The percentage of babies registered within the local authority area both at birth and at the time of report who are eligible for newborn blood spot screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe.** For this indicator phenylketonuria (PKU) is used as a proxy for all tests. Numerator: Total number of eligible babies for whom a conclusive screening result for PKU was available within an effective timeframe Denominator: Total number of babies born within the reporting period, excluding any baby who died before the age of 8 days For the purposes of this indicator, the cohort includes only babies for whom the local authority area were responsible at birth and are still responsible on the day of report The ‘effective timeframe’ is that a conclusive result for

2.21 Access to non-cancer screening programmes	
	phenylketonuria (PKU) is recorded within the appropriate Child Health Information System by 17 days of age A conclusive result for PKU is one of the following newborn screening status codes: 04 (not suspected), 07 (not suspected - other disorders follow up); 08 (suspected) **2.21v The percentage of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks corrected age (hospital programmes – well babies, all programmes – NICU babies) or 5 weeks corrected age (community programmes – well babies)** Numerator: Total number of eligible babies for whom a decision about referral or discharge from the screening programme has been made within an effective timeframe This includes: • babies for whom a conclusive screening result was available by 4 weeks corrected age (for hospital screening programmes - well babies and all programmes - NICU babies); or • babies for whom a conclusive screening result was available by 5 weeks corrected age (for community screening programmes – well babies); or • babies referred to an audiology department because a newborn hearing screening encounter was inconclusive by the above timescales. The 'screening outcomes' relating to a complete screen within the national software solution for Hearing Screening are: • Clear response – no follow up required • Clear response – targeted follow up required • No clear response – bilateral referral • No clear response – unilateral referral • Incomplete – baby/equipment reason • Incomplete - equipment malfunction • Incomplete – equipment not available • Incomplete – screening contraindicated • Incomplete – baby unsettled Denominator: Total number of babies born within the reporting period whose mother was registered with a GP practice within the area, or (if not registered with any practice) resident within the area, excluding any baby who died before an offer of screening could be made **2.21vi The percentage of babies eligible for the newborn**

2.21 Access to non-cancer screening programmes	
	physical examination who were tested within 72 hours of birth Numerator: Total number of eligible babies for whom a decision about referral (including a decision that no referral is necessary as a result of the newborn examination) for each of the conditions tested has been made within an effective timeframe Denominator: Total number of babies born within the reporting period whose mother was registered with a GP practice within the local authority area or (if not registered with any practice) resident within the local authority area, excluding any baby who died before an offer of screening could be made The 'effective timeframe' for the newborn physical examination is that a conclusive screening result should be available within 72 hours of birth **2.21vii The percentage of those offered screening for diabetic eye screening who attend a digital screening event** Numerator: The number of *subjects offered screening* who attended a digital screening encounter during the reporting period Denominator: The number of eligible people with diabetes offered a screening encounter which was due to take place within the reporting period Where no specific screening encounter date was proposed, the date at which the invitation was sent should be used, and where a range of dates were proposed, the first date in the range should apply A digital screening result relates to screening by digital photography, resulting in either a diabetic retinopathy grade and a diabetic maculopathy grade (meeting national retinopathy grading standards) or an unobtainable/raw ungradeable or unassessable outcome for each eye being entered in to the screening management software. An up to date list of indicator definitions is available at: www.screening.nhs.uk/kpi Note that Abdominal Aortic Aneurysm (AAA) Key Performance Indicators are being introduced in 2013/14. Therefore, in due course an additional sub-indicator on the AAA Screening Programme will be included in the PHOF definition, with a likely

2.21 Access to non-cancer screening programmes	
	baseline period of 2014/15.
Data source	*The data source needs further development* Further development is required for many of the sources to provide local authority level data. Source for 2.21i: Maternity Service currently and Maternity and Child Data Set (MCDS) from 2013/14 Source for 2.21ii: Health Protection Agency (National Infections Screening Monitoring Programme (NAISM)) and MCDS from 2013/14 Source for 2.21iii: Maternity Service and MCDS from 2013/14 Source for 2.21iv: Child Health Information System and MCDS from 2013/14 Source for 2.21v: National Newborn Hearing Screening Programme Office Source for 2.21vi: National Newborn and Infant Physical Examination Programme Office Source for 2.21vii: Local Diabetic Retinopathy Screening Programme The Maternity and Children's Secondary Uses Data Set has received full approval from the Information Standards Board for Health and Social Care (ISB) as an information standard for the NHS in England. The Information Standards Notice (ISN) to mandate local implementation of the standard was published in May 2012. Therefore, subject to the dataset being complete and available, data for indicators 2.21i-2.21iv will be extracted from the maternity and children data sets (MCDS) by local authority area from 2013/14 onwards. Note: For 2.21vi we are currently awaiting the approval for the roll out of a national database
Publication of source data	Data relating to the screening programmes covered by this indicator is currently available to UK National Screening Committee non-cancer screening programmes personnel via a link from the following website: http://www.screening.nhs.uk/kpi

2.22 Take up of the NHS Health Check programme	
Rationale	Local authorities in England have a legal duty to deliver the NHS Health Check programme to 100% of the eligible population over a five year period and to achieve continuous improvement in uptake. Data collected for this indicator provides information on the NHS Health Checks offered and those taken up, providing an indication of reach and accessibility. Further information on the NHS Health Check programme can be found at: www.healthcheck.nhs.uk/ Offering the NHS Health Check programme to around 20% of the eligible population each year so that delivery to 100% of the eligible population can be achieved over five years, and securing high uptake is important to prevent people developing vascular disease and to identify early signs of poor health leading in turn to opportunities for early intervention and for driving down health inequalities.
Baseline period	2.22i & 2.22ii - 2011/12 2.22iii, 2.22iv, 2.22v – 2013/14
Indicator definition	Indicators 2.22i and 2.22ii have been discontinued and replaced by indicators 2iii and 2.22iv, respectively. **2.22i Percentage of eligible population aged 40-74 offered an NHS Health Check in the financial year (this has been discontinued and replaced with 2.22iii)** Numerator: Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check in the financial year Denominator: Number of people aged 40-74 eligible for an NHS Health Check in the financial year **2.22ii Percentage of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check in the financial year (this has been discontinued and replaced with 2.22iv)** Numerator: Number of people aged 40-74 eligible for an NHS Health Check who have received an NHS Health Check in the financial year Denominator: Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check in the

2.22 Take up of the NHS Health Check programme	
	financial year **2.22iii Cumulative percentage of eligible population aged 40-74 offered an NHS Health Check in the five year period 2013/14 - 2017/18 (Replaces indicator 2.22i)** Numerator: Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check in the five year period Denominator: Number of people aged 40-74 eligible for an NHS Health Check in the five year period **2.22iv Cumulative percentage of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check in the five year period 2013/14 - 2017/18. (Replaces indicator 2.22ii)** Numerator: Number of people aged 40-74 eligible for an NHS Health Check who have received an NHS Health Check in the five year period Denominator: Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check in the five year period **2.22v Cumulative percentage of eligible population aged 40-74 who received an NHS Health Check in the five year period 2013/14 – 2017/18.** Numerator: Number of people aged 40-74 eligible for an NHS Health Check who received an NHS Health Check in the five year period Denominator: Number of people aged 40-74 eligible for an NHS Health Check in the five year period
Data source	2013/14 onwards: Responsibility for commissioning the NHS Health Check programme and reporting data on the programme transferred to local authorities in April 2013. Public Health England (PHE) publish these data quarterly on the NHS Health Check website.
Publication of source data	2013/14 onwards: Data are published by PHE on the NHS Health Check website: http://www.healthcheck.nhs.uk/public/interactive_map/

2.23 Self-reported well-being	
Rationale	Well-being is a key issue for the Government and ONS are leading a programme of work to develop new measures of national well-being. People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health. Local data on well-being is likely to be a key component of local Joint Strategic Needs Assessments and form an important part of the work of local Health and Well-being Boards.
Baseline period	2.23i to 2.23iv: 2011/12 2.23v: 2010 at national level, TBC at sub-national level
Indicator definition	The definitions for sub-indicators 2.23i to 2.23iv (see below) are in line with ONS's Measuring National Well-being Programme. ONS are currently measuring individual/subjective well-being for adults (aged 16 and over) based on four questions included on the Annual Population Survey: 1. Overall, how satisfied are you with your life nowadays? 2. Overall, how happy did you feel yesterday? 3. Overall, how anxious did you feel yesterday? 4. Overall, to what extent do you feel the things you do in your life are worthwhile? Responses are given on a scale of 0-10 (where 0 is "not at all satisfied/happy/anxious/worthwhile" and 10 is "completely satisfied/happy/anxious/worthwhile") The first full year of data from these questions was published by ONS in July 2012 and are being treated as experimental statistics. Therefore, some minor changes to the wording of the four questions may arise. N.B. The data is only available at Unitary Authority/Metropolitan County level. For local authorities where scores are not available, the same value as the County/Metropolitan County to which they belong will be presented.

2.23 Self-reported well-being

2.23i The percentage of respondents scoring 0-4 to the question “Overall, how satisfied are you with your life nowadays?”

2.23ii The percentage of respondents scoring 0-4 to the question "Overall, to what extent do you feel the things you do in your life are worthwhile?"

2.23iii The percentage of respondents who answered 0-4 to the question "Overall, how happy did you feel yesterday?"

2.23iv The percentage of respondents scoring 6-10 to the question "Overall, how anxious did you feel yesterday?"

The following supporting sub-indicator will complement the ONS data, using WEMWBS data collected via the Health Survey for England (HSE):

2.23v Average Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) score for adults (16+)

WEMWBS measures social, emotional and psychological well-being using responses to 14 positively worded items:

1. I’ve been feeling optimistic about the future	8. I’ve been feeling good about myself
2. I’ve been feeling useful	9. I’ve been feeling close to other people
3. I’ve been feeling relaxed	10. I’ve been feeling confident
4. I’ve been feeling interested in other people	11. I’ve been able to make up my own mind about things
5. I’ve had energy to spare	12. I’ve been feeling loved
6. I’ve been dealing with problems well	13. I’ve been interested in new things
7. I’ve been thinking clearly	14. I’ve been feeling cheerful

2.23 Self-reported well-being	
	14 responses are given on a scale of 1-5 (where 1 is “none of the time” and 5 is “all of the time”). Responses to the 14 items are summed to give a score in the range 14 to 70 where a higher score corresponds to a higher level of well- being. For a given population the average can then be calculated. Further development work is required to establish the sub-national breakdowns that are feasible for sub-indicator 2.23v.
Data source	2.23i to 2.23iv: Annual Population Survey – Office for National Statistics 2.23v: Health Survey for England (HSE)
Publication of source data	ONS published the first full year of data from the four individual / subjective well-being questions included in the Annual Population Survey in July 2012 (note these are being treated as experimental statistics): http://www.ons.gov.uk/ons/rel/wellbeing/measuring-subjective-wellbeing-in-the-uk/first-annual-ons-experimental-subjective-well-being-results/first-ons-annual-experimental-subjective-well-being-results.html National level WEMWBS data from the Health Survey for England was published for the first time in December 2011: http://www.hscic.gov.uk/Article/1685

2.24 Injuries due to falls in people aged 65 and over	
Rationale	Falls are the largest cause of emergency hospital admissions for older people, and have a significant impact on long term outcomes, e.g. being a major cause of people moving from their own home to long term nursing or residential care. Interventions for recently retired and active older people are likely to be different in provision and uptake for frailer older people. A measure which reflects the success of services in preventing

2.24 Injuries due to falls in people aged 65 and over	
	falls will give an indication of how the NHS, public health and social care are working together to tackle issues locally.
Baseline period	2010/11
Indicator definition	**2.24i Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population** Numerator: Number of hospital admissions for falls classified by first diagnosis code (ICD10 primary diagnosis in the range S00 through T98X) and external cause (ICD10 code W00-W19) and with an emergency admission code in people aged 65 and over. Counted by first finished episode in the respective financial year Denominator: Number of people aged 65 and over based on ONS mid-year population estimates This indicator will have 2 further sub-indicators covering two different age splits (with numerators and denominators as for 2.24i but restricted to the age ranges specified): **2.24ii Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 to 79 per 100,000 population** **2.24iii Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 80 and over per 100,000 population**
Data source	Hospital Episode Statistics (HES), Health and Social Care Information Centre
Publication of source data	The Health and Social Care Information Centre have published limited analysis (counts) of falls hospital admissions on their HES online website, using the external cause codes defined as ICD10 W00-W19, at national and SHA level. However, these data do not match the definition for this indicator. The Older Peoples Health Atlas produced by Public Health England (PHE) publishes falls admission rates for local authorities:

2.24 Injuries due to falls in people aged 65 and over	
	http://www.wmpho.org.uk/olderpeopleatlas/atlas/atlas.html In addition, the Injury Profiles produced by PHE publish falls and falls injuries emergency admission rates for ages 65 and over by local authorities: http://www.apho.org.uk/default.aspx?QN=INJURY_DEFAULT

Domain 3: Health protection

3.1 Fraction of mortality attributable to particulate air pollution	
Rationale	Poor air quality is a significant public health issue. The burden of particulate air pollution in the UK was estimated to be equivalent to nearly 29,000 deaths in 2008 at typical ages and an associated loss of population life of 340,000 life years lost. Inclusion of this indicator in the Public Health Outcomes Framework will enable Directors of Public Health to prioritise action on air quality in their local area to help reduce the health burden from air pollution.
Baseline period	2010
Indicator definition	**3.1 Fraction of annual all-cause adult mortality attributable to long-term exposure to current levels of anthropogenic particulate air pollution (measured as fine particulate matter, $PM_{2.5}$*)** Mortality burden associated with long-term exposure to anthropogenic particulate air pollution at current levels, expressed as the percentage of annual deaths from all causes in those aged 30+. * $PM_{2.5}$ means the mass (in micrograms) per cubic metre of air of particles with an aerodynamic diameter generally less than 2.5 micrometers. $PM_{2.5}$ is also known as fine particulate matter. An increase of 10 µg/m^3 in population-weighted annual average background concentration of $PM_{2.5}$ is assumed to increase all-cause mortality rates by a unit relative risk (RR) factor of 1.06. For a population-weighted modelled annual average anthropogenic background $PM_{2.5}$ concentration x, RR is calculated as $(1.06)^{(x/10)}$ (Committee on the Medical Effects of Air Pollutants [COMEAP], 2010). The fraction of deaths attributable to $PM_{2.5}$ is expressed as a percentage, calculated as 100×(RR-1)/RR. Population-weighted annual average concentrations of anthropogenic $PM_{2.5}$ are provided by AEA for all lower tier and

3.1 Fraction of mortality attributable to particulate air pollution	
	unitary local authorities within England. These are combined to produce figures at upper tier, regional and national level so that attributable fractions can be calculated at those scales also. Concentrations of anthropogenic, rather than total, $PM_{2.5}$ are used as the basis for this indicator, as burden estimates based on total $PM_{2.5}$ might give a misleading impression of the scale of the potential influence of policy interventions (COMEAP, 2012). Note: this definition is different from that published in January 2012. Attributable fraction has several benefits as the metric of an indicator of the mortality effect associated with long-term exposure to current levels of air pollution: it is independent of the age-structure of the local population, is easy to interpret, is useful for prioritisation and comparison and is easy to calculate.
Data source	This indicator is calculated using population-weighted annual average background concentrations of anthropogenic $PM_{2.5}$. These were calculated for 2010 by AEA (details below); The Department for the Environment and Rural Affairs (DEFRA) intends to make these figures available on its website in future years. Background annual average $PM_{2.5}$ concentrations for the year of interest are modelled on a 1km x 1km grid using an air dispersion model, and calibrated using measured concentrations taken from background sites in DEFRA's Automatic Urban and Rural Network (http://uk-air.defra.gov.uk/interactive-map). Data on primary emissions from different sources from the National Atmospheric Emissions Inventory and a combination of measurement data for secondary inorganic aerosol and models for sources not included in the emission inventory (including re-suspension of dusts) are used to estimate the anthropogenic (human-made) component of these concentrations. By approximating local authority boundaries to the 1km by 1km grid, and using ONS census population data, population weighted background $PM_{2.5}$ concentrations for each lower tier local authority are calculated. This work is completed under contract to DEFRA, as a small extension of its obligations under the Ambient Air Quality Directive (2008/50/EC). The current contractor for this work is AEA.

3.1 Fraction of mortality attributable to particulate air pollution	
Publication of source data	Methods for calculation of mortality effects, together with national estimates of the mortality burden of anthropogenic $PM_{2.5}$ in 2008 (and the predicted impact of reductions in $PM_{2.5}$) are published in: COMEAP (2010) The Mortality Effects of Long-Term Exposure to Particulate Air Pollution in the United Kingdom. Available at : http://www.comeap.org.uk/subgroups/51-the-mortality-effects-of-long-term-exposure-to-particulate-air-pollution-in-the-united-kingdom COMEAP's views on estimating the mortality burden attributable to $PM_{2.5}$ at a local (e.g. local authority) level, and simplified methods for doing so, are published in: COMEAP (2012) Statement on Estimating the Mortality Burden of Particulate Air Pollution at the Local Level: http://www.comeap.org.uk/documents/statements/39-page/linking/46-mortality-burden-of-particulate-air-pollution Modelled background $PM_{2.5}$ data are published on a 1km x 1km grid square basis by DEFRA: http://uk-air.defra.gov.uk/data/pcm-data

3.2 Chlamydia detection rate (15-24 year olds)	
Rationale	Chlamydia is the most commonly diagnosed sexually transmitted infection. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. The chlamydia detection rate amongst under 25 year olds is a measure of chlamydia control activities. It represents infections identified (reducing risk of sequelae in those patients and interrupting transmission on to others). Increasing diagnostic rates indicates increased control activity: it is not a measure of morbidity. Inclusion of this indicator in the Public Health Outcomes Framework allows monitoring of progress to control chlamydia.
Baseline period	2010 (3.2i) 2012 (3.2ii)
Indicator	Indicator 3.2i has been replaced by indicator 3.2ii due to

3.2 Chlamydia detection rate (15-24 year olds)	
definition	changes in the data source. Existing PHOF data for 3.2i will remain in the PHOF but will have no further data added after the period 2011. **3.2i Crude rate of chlamydia diagnoses screening detection per 100,000 young adults aged 15-24 using old National Chlamydia Screening Programme (NCSP) data** Numerator: Number of adults aged 15-24 who are diagnosed with chlamydia through screening Denominator: Office for National Statistics mid-year resident population estimate for age 15-24 years **3.2ii Crude rate of chlamydia diagnoses detection per 100,000 young adults aged 15-24 using Chlamydia Testing Activity Dataset (CTAD)** Numerator: Number of positive chlamydia tests in people aged 15-24 Denominator: Office for National Statistics mid-year resident population estimate for age 15-24 years PHE recommends that local authorities should be working towards achieving a diagnosis rate of at least 2,300 per 100,000 population. Achieving a high diagnostic rate indicates success in diagnosing, and treating infections that may otherwise have gone undetected.
Data source	Public Health England (PHE)
Publication of source data	Annual and quarterly data on chlamydia testing among 15-24 year olds are published on the National Chlamydia Screening Programme (NCSP) website. Data are published by lower tier local authority, upper tier local authority, PHE Centres and PHE Regions. http://www.chlamydiascreening.nhs.uk/ps/data.asp Data on chlamydia diagnoses in all age groups are published on the PHE website.

3.3 Population vaccination coverage	
Rationale	Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely related to levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise. This indicator will cover all vaccination programmes across the life course as previous evidence shows that highlighting vaccination programmes encourages improvements in uptake levels.
Baseline period	3.3i: 2010/11 3.3ii:TBC - possibly 2014/15 3.3iii to 3.3x inclusive: 2010/11 (except for the 5 year old figures for 3.3iii and 3.3vi as data only began to be collected part way through 2010/11 so the first full year of data available will be 2011/12) 3.3xi: 2013/14 3.3xii to 3.3xv inclusive: 2010/11
Indicator definition	*The indicator definition needs further development (for sub-indicators 3.3ii and 3.3xi)* This indicator provides a proxy for the level of protection a population will have against vaccine preventable communicable diseases and covers: • Targeted vaccination for neonates, infants and young children - Hepatitis B and BCG • Childhood immunisation programme - Diphtheria (D/d), tetanus (T), pertussis (aP), polio (IPV), *Haemophilus influenzae* type b (Hib), meningococcal serogroup C (MenC), pneumococcal (PCV), measles, mumps and rubella (MMR) • Adolescent immunisation programme - Diphtheria (D/d), tetanus (T), and polio (IPV), Human papillomavirus (HPV) [girls only] • Adults aged 65+ years and 'at risk' programmes - seasonal influenza (Flu) and pneumococcal polysaccharide vaccine (PPV)

3.3 Population vaccination coverage	
	3.3i Hepatitis B vaccination coverage (1 and 2 year olds) Numerator: Number of children at age 1 and 2 years who have received the complete course of hepatitis B vaccine within each reporting area [at present PCT responsible population] Denominator: Eligible population as defined in the hepatitis B chapter of the immunisation against infectious diseases 'Green Book' resident within each reporting area [at present PCT responsible population] **3.3ii BCG vaccination coverage (aged under 1 year)** *Note: Since the definition published in January 2012, the age range for this indicator has been amended from 1-16 year olds to those aged under 1 year as most vaccinations are given opportunistically above this age* Numerator: Number of children aged under 1 year who have received the BCG vaccine within each reporting area [at present PCT responsible population] Denominator: Eligible population aged under 1 year as defined in the tuberculosis chapter of the immunisation against infectious diseases 'Green Book' resident within each reporting area [at present PCT responsible population] As the denominator for this indicator is not yet available, further development is required **3.3iii DTaP / IPV / Hib vaccination coverage (1, 2 and 5 year olds)** Numerator: Number of children at age 1, 2, and 5 years who have received the complete course of DTaP / IPV / Hib vaccine within each reporting area [at present PCT responsible population] Denominator: Number of children at age 1, 2 and 5 years resident within each reporting area [at present PCT responsible population] **3.3iv MenC vaccination coverage (1 year olds)** *Note: Since the definition published in January 2012, the age range for this indicator has been amended from 1, 2 and 5 year olds to just 1 year olds as after a child's first birthday, MenC is monitored with Hib coverage (covered by sub-indicator 3.3vi)*

3.3 Population vaccination coverage	
	Numerator: Number of children at age 1 year who have received the completed course of MenC vaccine within each reporting area [at present PCT responsible population] Denominator: Number of children at age 1 year resident within each reporting area [at present PCT responsible population] **3.3v PCV vaccination coverage (1 year olds)** *Note: Since the definition published in January 2012, the age range for this indicator has been amended from 1, 2 and 5 year olds to just 1 year olds as a PCV booster is offered at age 2 years (covered by sub-indicator 3.3vii) and PCV vaccination is not offered beyond this age* Numerator: Number of children at age 1 year who have received the completed primary course of PCV vaccine within each reporting area [at present PCT responsible population] Denominator: Number of children at age 1 year resident within each reporting area [at present PCT responsible population] **3.3vi Hib / MenC booster vaccination coverage (2 and 5 year olds)** Numerator: Number of children at age 2 and 5 years who have received one booster dose of Hib/MenC vaccine within each reporting area [at present PCT responsible population] Denominator: Number of children at age 2 and 5 years resident within each reporting area [at present PCT responsible population] **3.3vii PCV booster vaccination coverage (2 year olds)** *Note: Since the definition published in January 2012, the age range for this indicator has been amended from 2 and 5 year olds to just 2 year olds as a PCV booster is not offered beyond the age of 2 years* Numerator: Number of children at age 2 years who have received one booster dose of PCV vaccine within each reporting area [at present PCT responsible population] Denominator: Number of children at age 2 years resident within each reporting area [at present PCT responsible population] **3.3viii MMR vaccination coverage for one dose (2 year olds)** Numerator: Number of children at age 2 years who have

3.3 Population vaccination coverage	
	received one dose of MMR vaccine within each reporting area [at present PCT responsible population] Denominator: Number of children at age 2 years resident within each reporting area [at present PCT responsible population] **3.3ix MMR vaccination coverage for one dose (5 year olds)** Numerator: Number of children at age 5 years who have received one dose of MMR vaccine within each reporting area [at present PCT responsible population] Denominator: Number of children at age 5 years resident within each reporting area [at present PCT responsible population] **3.3x MMR vaccination coverage for two doses (5 year olds)** Numerator: Number of children at age 5 years who have received two doses of MMR vaccine within each reporting area [at present PCT responsible population] Denominator: Number of children at age 5 years resident within each reporting area [at present PCT responsible population] **3.3xi Td / IPV booster vaccination coverage (13-18 year olds)** *Note: Since the definition published in January 2012, the schedule for this vaccination is planned to change. A new sub-indicator definition will be developed accordingly.* **3.3xii HPV vaccination coverage (females 12-13 year olds)** *Note: Since the definition published in January 2012, the age range for this indicator has been amended from 12-17 year olds to just 12-13 year olds as this is the age when the vaccination is routinely offered.* Numerator: Number of females in year 8 (aged 12-13) who have received the full course of HPV vaccinations within each reporting area [at present PCT responsible population] Denominator: Number of females in year 8 (aged 12-13) resident within each reporting area [at present PCT responsible population]

3.3 Population vaccination coverage	
	3.3xiii PPV vaccination coverage (aged 65 and over) Numerator: Number of adults aged 65 years and over who have received one dose of PPV within each reporting area [at present PCT responsible population] Denominator: Number of adults aged 65 years and over resident within each reporting area [at present PCT responsible population] **3.3xiv Flu vaccination coverage (aged 65 and over)** Numerator: Number of adults aged 65 years and over who have received Flu vaccine in each reporting period within each reporting area [at present PCT responsible population] Denominator: Number of adults aged 65 years and over resident within each reporting area [at present PCT responsible population] **3.3xv Flu vaccination coverage (at risk individuals from age six months to under 65 years, excluding pregnant women)** *Note: Since the definition published in January 2012, the age range for this indicator has been clarified – it was previously presented as "at risk individuals aged over six months"* Numerator: Number of individuals aged 6 months to under 65 who are in a clinical risk group [as defined in the immunisation against infectious diseases 'Green Book' and detailed in a READ-code specification currently produced by PRIMIS+] who have received Flu vaccine within each reporting area [at present PCT responsible population] Denominator: Number of individuals aged 6 months to under 65 who are in a clinical risk group [as defined in the immunisation against infectious diseases 'Green Book' and detailed in a READ-code specification currently produced by PRIMIS+] within each reporting area [at present PCT responsible population].
Data source	*The data source needs further development (to produce local authority data)* **COVER** – data for the majority of childhood vaccinations including Hepatitis B, DTaP / IPV / Hib, MenC, PCV and MMR **ImmForm system** – data for HPV, PPV and flu vaccinations **KC50** – data for Td / IPV and BCG Data are currently collected at PCT level rather than local

3.3 Population vaccination coverage	
	authority level. It is planned to report data aggregated by Local Area Team, clinical commissioning group and at local authority level in the future. Although no data is currently routinely produced at local authority level, the Child Health Information Systems (which supply data for COVER and KC50) will with modification be able to extract data at local authority level and changes can be made to the ImmForm system to aggregate data to local authority level. As local authority data is not yet available for the autumn release of baseline data it has been decided to estimate local authority figures from the available PCT data. Note that this indicator is primarily based on data at general practice level, and hence the local authority values that have been calculated are for NHS patients registered with the practices that make up the PCT or PCTs that cover the local authority area. Data has been weighted using mid-year Lower Super Output Area (LSOA) Single Year of Age population estimates 2010 (using the appropriate ages for each sub-indicator) as supplied by ONS.
Publication of source data	Immunisation coverage data on the childhood immunisation programme for DTaP / IPV / Hib, MenC, PCV, Hib / MenC, PCV booster, MMR, and hepatitis B 'at risk' are published quarterly by Public Health England: http://www.hpa.org.uk/HPA/Topics/InfectiousDiseases/ InfectionsAZ/1204031507699/ HPV vaccine uptake data are published as provisional data for each of the ten months of each academic year (October to July) and then later as final data for the complete academic year. PPV vaccine uptake data are published for each financial year. Influenza vaccine uptake data are published as provisional data for each of the four months of the influenza season (Nov to Dec) and then later as final data. Data and guidance for each of these are produced by Public Health England: https://www.gov.uk/government/collections/vaccine-uptake Immunisation coverage data are published as National Statistics annually by the Health and Social Care Information Centre and include all data collected through COVER in addition to the

3.3 Population vaccination coverage	
	KC50 collection: **2010/11 data** http://www.hscic.gov.uk/catalogue/PUB00244

3.4 People presenting with HIV at a late stage of infection	
Rationale	The late HIV diagnosis indicator is essential to evaluate and promote public health and prevention efforts to tackle the impact of HIV infection. Over half of patients newly diagnosed in the UK are diagnosed late and 90% of deaths among HIV positive individuals within 1 year of diagnosis are among those diagnosed late. Inclusion of this indicator in the Public Health Outcomes Framework will focus efforts to expand HIV testing and to reduce late HIV diagnoses in the UK. Without a reduction in late HIV diagnosis, consequences may include: continued high levels of short-term mortality in those diagnosed late, poor prognosis for individuals diagnosed late, onward transmission of HIV and higher healthcare costs.
Baseline period	2009-11
Indicator definition	**3.4 Proportion of persons presenting with HIV at a late stage of infection** Numerator: For a given period of time, the number of people aged 15 years or more who had a CD4 count <350 cells per mm^3 within 91 days of their HIV diagnosis, and who have residence information available* Denominator: For a given period of time, the number of people aged 15 years or more newly diagnosed with HIV who had a CD4 count within 91 days of diagnosis and who have residence information available The indicator will be presented as a three year aggregate figure *Since January 2012, the definition has been updated from a

3.4 People presenting with HIV at a late stage of infection	
	CD4 count <200 cells/mm³ within 91 days of diagnosis to <350 cells/mm³. This reflects the 2008 BHIVA treatment guidelines which recommend patients should begin anti-retroviral therapy when CD4 cells counts drop <350 cells/mm³.
Data source	Public Health England (PHE)
Publication of source data	Currently published annually at local authority level by PHE and as part of the Sexual Health Balanced Scorecard. http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SexualHealthProfilesAndIndex/SexualHealthProfilesPerformance/ http://www.apho.org.uk/resource/view.aspx?RID=83256

3.5 Treatment completion for Tuberculosis (TB)	
Rationale	TB re-emerged as a serious public health problem in the UK over the last two decades, with TB incidence rising above the European average. Timely treatment for TB is key to saving lives and preventing long-term ill health, as well as reducing the number of new infections and development of drug resistance. Preventing the development of drug resistant TB is particularly important as it has more severe health consequences and is considerably more expensive to treat.
Baseline period	3.5i: 2011 3.5ii: 2009-11
Indicator definition	**3.5i The percentage of people completing treatment for tuberculosis within 12 months prior to 31st December, of all those whose case was notified the previous year** Numerator: The number of people completing treatment for TB within 12 months of case notification

3.5 Treatment completion for Tuberculosis (TB)	
	Denominator: The number of people with TB whose case was notified the previous year Due to data suppression, some local authorities will not have data presented for TB treatment completion. A decision was taken to suppress treatment completion for upper level local authorities if their three year average incidence was under 20 cases per year. This is because random variation would render the point estimate for treatment completion unreliable for local authorities with small numbers. The following supporting indicator is provided relating to the TB incidence rate to help local authorities understand why treatment completion data may not be published for their area due to low incidence, and to provide local authorities with information about levels of TB in their area and surrounding areas: **3.5ii TB incidence per 100,000 population** Numerator: Number of new cases of TB - three-year rolling average Denominator: Office for National Statistics mid-year population estimate for the middle year of the three-year period Note: Some other public health statistics calculate multi-year averages by summing the figures to obtain the numerator, and summing the population from all years to obtain the denominator. This method usually produces slightly different results from the method used for this indicator.
Data source	A national enhanced web-based TB surveillance system run by the Health Protection Agency (HPA) collects the outcome of treatment for each TB case. The data are collected annually.
Publication of source data	Data are published nationally on an annual basis by the HPA: **HPA annual TB report (2011 data):** http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317134916916

3.6 Public sector organisations with a board approved sustainable development management plan	
Rationale	The Climate Change Act (2008) identifies an 80% reduction in carbon emissions by 2050 to reduce the UK contribution to climate change and requires regular assessment and adaptation to reduce the impacts of a changing climate. The Stern Review (http:/www.hm-treasury.gov.uk/sternreview_index.htm) outlines the impacts of climate change as a cause of premature mortality and avoidable ill health. Sustainable development provides a framework for balancing economic, social and environmental considerations, including climate change – this supports public health through strengthening community resilience and reducing health inequalities in addition to adapting for the years ahead. Achievement of a sustainable, low carbon, public sector will not be possible without monitoring and measuring progress. The first step to monitoring sustainability is a process measure for board approved sustainable development management plans for public sector organisations.
Baseline period	At March 2011
Indicator definition	**3.6 Percentage of NHS organisations with a board approved sustainable development management plan** Numerator: For a given date, the number of NHS organisations assigned to a local authority where the board approved a sustainable development management plan in the preceding 12 months Denominator: For a given date, the total number of NHS organisations assigned to that local authority A sustainable development management plan is a board approved document that assists organisations to clarify their objectives on sustainable development (including mitigation and adaptation to climate change) and sets out a plan of action. Experience and empirical evidence from working with NHS boards suggests that organisations who have not considered the legal, policy and reputational drivers for sustainability will not have a sound operational approach to sustainable development.

3.6 Public sector organisations with a board approved sustainable development management plan	
	Note: the definition for this indicator is restricted to NHS organisations only. The intention is that in future further indicators should be developed to cover all public sector organisations that have an influence on the public health of the population. Services provided on behalf of the public sector could also be included in this study.
Data source	Based on responses to the question: "Has your board approved a sustainable development management plan in the last 12 months?" asked in the NHS Sustainability reporting template – this has been mandatory since 2011.
Publication of source data	The data are currently published annually at national level: http://www.erpho.org.uk/viewResource.aspx?id=21255

3.7 Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies	
Rationale	This indicator will provide an indication of the preparedness for organisations to respond to health protection incidents and emergencies. Legislation requires emergency planning resilience and response to be in place for the NHS, NHS Commissioning Board Authority, NHS –funded providers, Public Health England as well as other organisations. Providers of regulated activities are required by law to demonstrate compliance with criterion 9 of the *Code of Practice for the prevention and control of infection and related guidance* and have systems in place to report significant outbreaks of infection to their local health protection unit. Whilst this indicator reflects a process rather than an outcome, it is an important quality-focused proxy measure for assessing the preparedness of local authorities and relevant organisations operating in their areas to respond to incidents, which threaten the health of the public in a locality.
Baseline period	TBC

3.7 Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies	
Indicator definition	**3.7 Comprehensive, agreed inter-agency plans for responding to public health incidents** (1) Inter agency describes those organisations categorised as responders under the CCA (2005) as well as other NHS-funded and public health organisations. (2) Plans to be fit for purpose, tested and of appropriate quality in line with the requirements for plans of Category 1 Responders described in the Civil Contingency Act 2004 (Contingency Planning) Regulations 2005. (3) Incidents as defined by the Health Protection Agency Incident and Emergency Response Plan: "An event or a situation which threatens or causes damage to the health of the public and that requires urgent action from the agency at whatever level." (4) Emergencies as defined by the Civil Contingencies Act 2004 Cabinet Office Short Guidance – as an event or situation which threatens serious damage to human welfare; an event or situation which threatens serious damage to the environment; or war, or terrorism, which threatens serious damage to security. Local authorities have a process in place which gives them assurance that comprehensive inter-agency plans for responding to public health incidents are in place across the system. This will be based on Health and Wellbeing Peer Review improvement process. The Department of Health (DH) worked closely with the Local Government Association (LGA) and others to define the parameters for this indicator.
Data source	The DCLG/LGA Single Data List Gateway Group will provide a data source for this indicator. This will be based on responses to the following questions: • Are there clear and appropriate health protection arrangements in place? • Is there clarity over relative roles, responsibilities, and leadership arrangements in the context of a health protection incident or outbreak of communicable disease? • Are the emergency preparedness, resilience and response

3.7 Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies	
	relationships effective? • Are there strong connections to wider emergency planning and resilience arrangements through the Local Health Resilience Partnerships?
Publication of data source	No current reporting on this indicator

Domain 4: Healthcare public health and preventing premature mortality

4.1 Infant mortality	
Rationale	This indicator is in line with the Government's direction for public health on starting well through early intervention and prevention. Reducing the risk of infant mortality will improve the life chances, health and well-being of both the mother and the baby. This is a shared indicator with the NHS Outcomes Framework, addressing issues of premature mortality, which are influenced by both the NHS and public health interventions.
Baseline period	2009-11
Indicator definition	**4.1 Crude rate of infant deaths (persons aged less than 1 year) per 1,000 live births** *This indicator is shared with indicator 1.6i in the NHS Outcomes Framework.* Rates are based on pooled data for three year periods. Numerator: The number of infant deaths (aged under 1 year) in the respective calendar years Denominator: The number of live births in the respective calendar years
Data source	Office for National Statistics (ONS) births and deaths data
Publication of source data	Data on infant mortality is published annually by ONS: Summary data based on death registrations http://www.ons.gov.uk/ons/rel/vsob1/death-reg-sum-tables/index.html More detailed data for England and Wales based on death occurrences

4.1 Infant mortality	
	http://www.ons.gov.uk/ons/rel/vsob1/child-mortality-statistics--childhood--infant-and-perinatal/index.html Breakdown by social and biological factors for England and Wales based on death occurrences http://www.ons.gov.uk/ons/rel/child-health/infant-and-perinatal-mortality-in-england-and-wales-by-social-and-biological-factors/index.html Local authority level figures are published annually in the Local Authority Health Profiles and on the Health and Social Care Information Centre (HSCIC) Indicator Portal: http://www.healthprofiles.info https://indicators.ic.nhs.uk/webview/

4.2 Tooth decay in children aged 5	
Rationale	Tooth decay is a predominantly preventable disease. Significant levels remain (31% of 12 –year old children have observable decay), resulting in pain, sleep loss, time off school and in a few cases treatment under general anaesthetic. Inclusion of this indicator in the Public Health Outcomes Framework will encourage local authorities to focus on and prioritise oral health and oral health improvement initiatives to reduce tooth decay.
Baseline period	2011/12
Indicator definition	**4.2 Rate of tooth decay in children aged 5 years based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted – decayed/missing/filled teeth (dmft)** Numerator: Number of dmft in the survey sample of 5-year-old children Denominator: Number of 5-year-old children in the survey sample
Data source	NHS dental epidemiological survey programme currently undertaken by PCTs led by Public Health England (PHE). From

4.2 Tooth decay in children aged 5	
	April 2013 the funding for all dental epidemiological survey programmes will be held by the local authorities who will commission dentists to undertake the inspections from service providers, from NHS Trusts, Community Trusts and Social Enterprise organisations Data are currently only collected every 4 years, however from 2014/15 there is a possibility that data could be collected at more frequent intervals. This would be based on a new data source and would need to be assessed to confirm whether it is a reliable replacement.
Publication of source data	Currently data are published every 4 years at national, regional, PCT and local authority level. Main page of the publication: http://www.nwph.net/dentalhealth/ 2007/08 data: http://www.nwph.net/dentalhealth/survey-results.aspx?id=1

4.3 Mortality rate from causes considered preventable	
Rationale	Preventable mortality can be defined in terms of causes that are considered to be preventable through individual behaviour or public health measures limiting individual exposure to harmful substances or conditions. Examples include lung cancer, illicit drug use disorders, land transport accidents and certain infectious diseases. The inclusion of this indicator in the Public Health Outcomes Framework (alongside an indicator on mortality from causes amenable to healthcare in the NHS Outcomes Framework) sends out a clear signal of the importance of prevention as well as treatment in reducing avoidable deaths.
Baseline period	2009-11
Indicator definition	The indicator is based on the preventable mortality component of avoidable mortality as defined by the Office for National

4.3 Mortality rate from causes considered preventable

Statistics (ONS) in April 2012. A death is considered preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense.

4.3 Age-standardised rate of mortality from causes considered preventable per 100,000 population

This indicator is complementary to indicator 1a in the NHS Outcomes Framework, which measures Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare.

Rates are based on pooled data for three year periods.

Numerator: Number of deaths that are considered preventable (classified by underlying cause of death recorded as ICD10 codes set out in the table below, and for the age groups shown) registered in the respective calendar years

ICD10 codes	Condition group and cause	Ages included
Infections		
A15-A19, B90	Tuberculosis	0-74
B17.1, B18.2	Hepatitis C	0-74
B20-B24	HIV/AIDS	All
Neoplasms		
C00-C14	Malignant neoplasm of lip, oral cavity and pharynx	0-74
C15	Malignant neoplasm of oesophagus	0-74
C16	Malignant neoplasm of stomach	0-74
C18-C21	Malignant neoplasm of colon and rectum	0-74
C22	Malignant neoplasm of liver	0-74
C33-C34	Malignant neoplasm of trachea, bronchus and lung	0-74
C43	Malignant melanoma of skin	0-74

4.3 Mortality rate from causes considered preventable			
	C45	Mesothelioma	0-74
	C50	Malignant neoplasm of breast	0-74
	C53	Malignant neoplasm of cervix uteri	0-74
	Nutritional, endocrine and metabolic		
	E10-E14	Diabetes mellitus	0-49
	Drug use disorders		
	F10, G31.2, G62.1, I42.6, K29.2, K70, K73, K74 (excl. K74.3-K74.5), K86.0	Alcohol related diseases, excluding external causes	0-74
	F11-F16, F18-F19	Illicit drug use disorders	0-74
	Cardiovascular diseases		
	I20-I25	Ischaemic heart disease	0-74
	I26, I80.1-I80.3, I80.9, I82.9	DVT with pulmonary embolism	0-74
	I71	Aortic aneurysm and dissection	0-74
	Respiratory diseases		
	J09-J11	Influenza (including swine flu)	0-74
	J40-J44	Chronic obstructive pulmonary disorder	0-74
	Unintentional injuries		
	V01-V99	Transport Accidents	All
	W00-X59	Accidental Injury	All
	Intentional injuries		
	X60-X84, Y10-Y34	Suicide and self-inflicted injuries	All
	X85-Y09, U50.9	Homicide/Assault	All
	Y60-Y69, Y83-Y84	Misadventures to patients during surgical and medical care	All
	Denominator: ONS mid-year population estimates aggregated across three years		

4.3 Mortality rate from causes considered preventable	
Data source	Office for National Statistics (ONS) death registrations and mid-year population estimates
Publication of source data	ONS publish annual data on avoidable mortality, including preventable mortality, at national level: http://www.ons.gov.uk/ons/rel/subnational-health4/avoidable-mortality-in-england-and-wales/index.html

4.4 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)	
Rationale	Cardiovascular disease (CVD) is one of the major causes of death in under 75s in England. There have been huge gains over the past decades in terms of better treatment for CVD and improvements in lifestyle, but to ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment. The inclusion of this as a shared indicator in the Public Health Outcomes Framework and NHS Outcomes Framework sends out a clear signal of the importance of prevention as well as treatment of CVD.
Baseline period	2009-11
Indicator definition	**4.4i Age-standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years of age per 100,000 population** *This indicator is shared with indicator 1.1 in the NHS Outcomes Framework.* Rates are based on pooled data for three year periods. Numerator: Number of deaths from all cardiovascular diseases (classified by underlying cause of death recorded as ICD10 codes I00-I99) registered in the respective calendar years, in

4.4 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)

people aged under 75

Denominator: Office for National Statistics (ONS) mid-year population estimates aggregated across three years, for people aged under 75

4.4ii Age-standardised rate of mortality that is considered preventable from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years of age per 100,000 population

This indicator is based on the preventable mortality component of avoidable mortality as defined by ONS in April 2012.

Rates are based on pooled data for three year periods.

Numerator: Number of deaths that are considered preventable from all cardiovascular diseases (classified by underlying cause of death recorded as ICD10 codes set out in the table below) registered in the respective calendar years, in people aged under 75

ICD10 codes	Condition group and cause	Ages included
I20-I25	Ischaemic heart disease	0-74
I26, I80.1-I80.3, I80.9, I82.9	DVT with pulmonary embolism	0-74
I71	Aortic aneurysm and dissection	0-74
I42.6	Alcoholic cardiomyopathy	0-74

Denominator: ONS mid-year population estimates aggregated across three years, for people aged under 75

Data source	ONS death registrations and mid-year population estimates
Publication of source data	The Health and Social Care Information Centre (HSCIC) publish annual data on mortality rates from all cardiovascular diseases at national and local authority level on the HSCIC Indicator

4.4 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)	
	Portal: https://indicators.ic.nhs.uk/webview/

4.5 Under 75 mortality rate from cancer	
Rationale	Cancer is the highest cause of death in England in under 75s. To ensure that there continues to be a reduction in the rate of premature mortality from cancer, there needs to be concerted action in both prevention and treatment. The inclusion of this as a shared indicator in the Public Health Outcomes Framework and NHS Outcomes Framework sends out a clear signal of the importance of prevention as well as treatment of cancer.
Baseline period	2009-11
Indicator definition	**4.5i Age-standardised rate of mortality from all cancers in persons less than 75 years of age per 100,000 population** *This indicator is shared with indicator 1.4.vii in the NHS Outcomes Framework.* Rates are based on pooled data for three year periods. Numerator: Number of deaths from all cancers (classified by underlying cause of death recorded as ICD10 codes C00-C97) registered in the respective calendar years, in people aged under 75 Denominator: Office for National Statistics (ONS) mid-year population estimates aggregated across three years, for people aged under 75 **4.5ii Age-standardised rate of mortality that is considered preventable from all cancers in persons less than 75 years of age per 100,000 population** This indicator is based on the preventable mortality component

4.5 Under 75 mortality rate from cancer

	of avoidable mortality as defined by ONS in April 2012. Rates are based on pooled data for three year periods. Numerator: Number of deaths that are considered preventable from all cancers (classified by underlying cause of death recorded as ICD10 codes set out in the table below) registered in the respective calendar years, in people aged under 75

ICD10 codes	Condition group and cause	Ages included
C00-C14	Malignant neoplasm of lip, oral cavity and pharynx	0-74
C15	Malignant neoplasm of oesophagus	0-74
C16	Malignant neoplasm of stomach	0-74
C18-C21	Malignant neoplasm of colon and rectum	0-74
C22	Malignant neoplasm of liver	0-74
C33-C34	Malignant neoplasm of trachea, bronchus and lung	0-74
C43	Malignant melanoma of skin	0-74
C45	Mesothelioma	0-74
C50	Malignant neoplasm of breast	0-74
C53	Malignant neoplasm of cervix uteri	0-74

	Denominator: ONS mid-year population estimates aggregated across three years, for people aged under 75.
Data source	ONS death registrations and mid-year population estimates.
Publication of source data	The Health and Social Care Information Centre (HSCIC) publish annual data on mortality rates from all cancers at national and local authority level on the HSCIC Indicator Portal:

4.5 Under 75 mortality rate from cancer	
	https://indicators.ic.nhs.uk/webview/

4.6 Under 75 mortality rate from liver disease	
Rationale	Liver disease is one of the top causes of death in England and people are dying from it at younger ages. Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence, which are both amenable to public health interventions. The inclusion of this as a shared indicator in the Public Health Outcomes Framework and NHS Outcomes Framework sends out a clear signal of the importance of prevention as well as treatment of liver disease, and will provide an impetus for local authorities to prioritise action on the drivers of liver disease.
Baseline period	2009-11
Indicator definition	**4.6i Age-standardised rate of mortality from liver disease in persons less than 75 years of age per 100,000 population** *This indicator is shared with indicator 1.3 in the NHS Outcomes Framework.* Rates are based on pooled data for three year periods. Numerator: Number of deaths from liver disease (classified by underlying cause of death recorded as ICD10 codes set out in the table below) registered in the respective calendar years, in people aged under 75 **ICD10 codes** — **Condition group and cause** K70 — Alcoholic liver disease K71 — Toxic liver disease K72 — Hepatic failure, not elsewhere classified K73 — Chronic hepatitis, not elsewhere classified

4.6 Under 75 mortality rate from liver disease	

K74	Fibrosis and cirrhosis of liver
K75	Other inflammatory liver diseases
K76	Other diseases of liver
K77	Liver disorders in diseases classified elsewhere
B15	Acute hepatitis A
B16	Acute hepatitis B
B17	Other acute viral hepatitis
B18	Chronic viral hepatitis
B19	Unspecified viral hepatitis
C22	Malignant neoplasm of liver
I81	Portal vein thrombosis
I85	Oesophageal varices
T86.4	Liver transplant failure and rejection

Denominator: Office for National Statistics (ONS) mid-year population estimates aggregated across three years, for people aged under 75

4.6ii Age-standardised rate of mortality that is considered preventable from liver disease in persons less than 75 years of age per 100,000 population

This indicator is based on the preventable mortality component of avoidable mortality as defined by ONS in April 2012.

Rates are based on pooled data for three year periods.

Numerator: Number of deaths that are considered preventable from liver disease (classified by underlying cause of death recorded as ICD10 codes set out in the table below) registered in the respective calendar years, in people aged under 75

ICD10 codes	Condition group and cause	Ages included
K70, K73, K74 (excl. K74.3-K74.5)	Alcohol related diseases, excluding external causes	0-74
B17.1, B18.2	Hepatitis C	0-74
C22	Malignant neoplasm of liver	0-74

4.6 Under 75 mortality rate from liver disease	
	Denominator: ONS mid-year population estimates aggregated across three years, for people aged under 75.
Data source	ONS death registrations and mid-year population estimates
Publication of source data	The Health and Social Care Information Centre (HSCIC) publish annual data on mortality rates from all liver disease at national and local authority level as part of the NHS Outcomes Framework indicator data on the HSCIC Indicator Portal: https://indicators.ic.nhs.uk/webview/

4.7 Under 75 mortality rate from respiratory diseases	
Rationale	Respiratory disease is one of the top causes of death in England in under 75s and smoking is the major cause of chronic obstructive pulmonary disease (COPD), one of the major respiratory diseases. This indicator will focus public health attention on the prevention of smoking and other environmental factors that contribute to people getting respiratory disease. The inclusion of this as a shared indicator in the Public Health Outcomes Framework and NHS Outcomes Framework sends out a clear signal of the importance of prevention as well as treatment of respiratory diseases.
Baseline period	2009-11
Indicator definition	**4.7i Age-standardised rate of mortality from respiratory diseases in persons less than 75 years of age per 100,000 population** *This indicator is shared with indicator 1.2 in the NHS Outcomes Framework.*

<table>
<tr><th colspan="2">4.7 Under 75 mortality rate from respiratory diseases</th></tr>
<tr><td></td><td>
Rates are based on pooled data for three year periods.

Numerator: Number of deaths from respiratory diseases (classified by underlying cause of death recorded as ICD10 codes J00-J99) registered in the respective calendar years, in people aged under 75

Denominator: Office for National Statistics (ONS) mid-year population estimates aggregated across three years, for people aged under 75

4.7ii Age-standardised rate of mortality that is considered preventable from respiratory diseases in persons less than 75 years of age per 100,000 population

This indicator is based on the preventable mortality component of avoidable mortality as defined by ONS in April 2012.

Rates are based on pooled data for three year periods.

Numerator: Number of deaths that are considered preventable from respiratory disease (classified by underlying cause of death recorded as ICD10 codes set out in the table below) registered in the respective calendar years, in people aged under 75

<table>
<tr><th>ICD10 codes</th><th>Condition group and cause</th><th>Ages included</th></tr>
<tr><td>J09-J11</td><td>Influenza (including swine flu)</td><td>0-74</td></tr>
<tr><td>J40-J44</td><td>Chronic obstructive pulmonary disorder</td><td>0-74</td></tr>
</table>

Denominator: ONS mid-year population estimates aggregated across three years, for people aged under 75
</td></tr>
<tr><td>Data source</td><td>ONS death registrations and mid-year population estimates</td></tr>
<tr><td>Publication of source data</td><td>The Health and Social Care Information Centre (HSCIC) publish annual data on mortality rates from all respiratory diseases at national and local authority level as part of the NHS Outcomes Framework indicator data on the HSCIC Indicator Portal:</td></tr>
</table>

4.7 Under 75 mortality rate from respiratory diseases	
	https://indicators.ic.nhs.uk/webview/

4.8 Mortality rate from communicable diseases	
Rationale	Inclusion of this indicator in the Public Health Outcomes Framework reinforces how seriously the Government takes the control of communicable diseases and prevention of avoidable deaths. Prevention of spread of communicable diseases is an important issue for Public Health. There is evidence that rapid identification, treatment and prevention of spread can reduce mortality
Baseline period	2009-11
Indicator definition	**4.8 Age-standardised mortality rate from communicable diseases per 100,000 population** Rates are based on pooled data for three-year periods. Numerator: Number of deaths from certain infectious and parasitic diseases (classified by underlying cause of death recorded as ICD10 codes A00-B99, J09-J18) registered in the respective calendar years Denominator: Office for National Statistics (ONS) mid-year population estimates aggregated across three years
Data source	ONS death registrations and mid-year population estimates
Publication of source data	The Health and Social Care Information Centre (HSCIC) publish annual data on mortality rates from infectious and parasitic diseases (based on ICD10 codes A00-B99) and from pneumonia (ICD10 J12-J18) – i.e. not for the exact indicator defined above - at national and local authority level on the HSCIC Indicator Portal: https://indicators.ic.nhs.uk/webview/

4.9 Excess under 75 mortality rate in adults with serious mental illness	
Rationale	The Disability Rights Commission has reported on the serious inequalities experienced (in terms of reduced life expectancy) by those with severe mental illness. For example, people with serious mental illness are estimated to be twice as likely to die from coronary heart disease and four times as likely to die from respiratory disease as the general population. This is a shared indicator with the NHS Outcomes Framework – its inclusion in this and the Public Health Outcomes Framework reflects the importance of such high-level priorities being joined up between the public health and NHS / health service agendas.
Baseline period	2010/11
Indicator definition	**4.9 Excess mortality rate in adults with serious mental illness, ages under 75, per 100,000 population** *This indicator is shared with indicator 1.5 in the NHS Outcomes Framework.* Premature mortality in adults with serious mental illness (SMI) is compared to premature mortality in adults in the general population. 'Adults with serious mental illness' are defined as anyone aged 18 or over who has been in contact with the secondary mental care services in the current financial year or in either of the two previous financial years who is alive at the beginning of the current financial year. Those aged 75 and over are excluded to align this indicator with the other premature mortality indicators in Domain 4, and those aged under 18 are excluded because children under 18 are not covered by the main data source (MHMDS). There is no evidence that children with SMI are at particularly high risk of death by disease. The mortality rate for adults with serious mental illness is directly standardised by age and sex to the general population of the relevant geographical area (i.e. England or individual local authority as appropriate). The general population mortality rate is the crude rate for people aged 18 to 74.

4.9 Excess under 75 mortality rate in adults with serious mental illness	
Data source	Mental Health Minimum Dataset (MHMDS) data linked to mortality data in the Primary Care Mortality Database (PCMD), The Health and Social Care Information Centre. Office for National Statistics (ONS) death registrations and mid-year population estimates.
Publication of source data	Annual data on excess under 75 mortality in adults with serious mental illness at national and local authority level is published by The Health and Social Care Information Centre (HSCIC) as part of the NHS Outcomes Framework indicator data on the IC Indicator Portal: https://indicators.ic.nhs.uk/webview/

4.10 Suicide rate	
Rationale	*Preventing suicide in England: A cross-government outcomes strategy to save lives* (published September 2012) has the overall aim of reducing the suicide rate in the general population in England. The inclusion of this indicator in the Public Health Outcomes Framework reflects the importance of sustained efforts to keep the suicide rate at or below current levels.
Baseline period	2009-11
Indicator definition	**4.10 Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population** Rates are based on pooled data for three year periods. Numerator: Number of deaths from suicide and injury of undetermined intent (classified by underlying cause of death recorded as ICD10 codes X60-X84 (all ages) and Y10-Y34 (for ages 15 and over)) registered in the respective calendar years. Denominator: Office for National Statistics (ONS) mid-year population estimates aggregated across three years

4.10 Suicide rate	
Data source	ONS death registrations and mid-year population estimates.
Publication of source data	The Health and Social Care Information Centre (HSCIC) publish annual data on rates of mortality from suicide and injury of undetermined intent at national and local authority level on the HSCIC Indicator Portal (based on ICD10 codes X60-X84, Y10-Y34 (all ages) excluding Y33.9) – note this is not directly comparable to this indicator: https://indicators.ic.nhs.uk/webview/

4.11 Emergency readmissions within 30 days of discharge from hospital	
Rationale	This indicator follows individuals discharged from hospital to monitor success in avoiding emergency readmissions. Health interventions and social care can play roles in putting in place the right re-ablement, rehabilitation and intermediate care services to support individuals to return home or regain their independence, so avoiding crisis in the short-term. This indicator is also included within the NHS Outcomes Framework under the domain 'Helping people to recover from episodes of ill health or following injury'.
Baseline period	2010/11
Indicator definition	**4.11 Indirectly standardised percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission** *This indicator is shared with indicator 3b in the NHS Outcomes Framework.* Readmissions for cancer and obstetrics are excluded. Numerator: The number of finished and unfinished continuous

4.11 Emergency readmissions within 30 days of discharge from hospital	
	inpatient (CIP) spells that are emergency admissions within 0-29 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main specialty upon readmission coded under obstetric; and those where the readmitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy for cancer coded anywhere in the spell Denominator: The number of finished CIP spells within selected medical and surgical specialties, with a discharge date up to March 31st within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days prior to admission are excluded.
Data source	Hospital Episode Statistics (HES), Health and Social Care Information Centre
Publication of source data	The Health and Social Care Information Centre (HSCIC) publish annual readmissions data at national and local authority level on the HSCIC Indicator Portal: https://indicators.ic.nhs.uk/webview/

4.12 Preventable sight loss	
Rationale	Prevention of avoidable sight loss is recognised as a key priority for the WHO's global initiative for the elimination of avoidable blindness by 2020 – Vision 2020 – The Right To Sight to which the UK is a signatory and which is also a key priority for Vision 2020UK and the UK Vision Strategy. It is a particularly important issue in the context of an aging population. Inclusion of this indicator will ensure that avoidable sight loss is recognised as a critical and modifiable public health issue. Research by the Royal National Institute of Blind People (RNIB) suggests that 50% of cases of blindness and serious sight loss could be prevented if detected and treated in time. Prevention of sight loss will help people maintain independent lives as far as

4.12 Preventable sight loss	
	possible and reduce needs for social care support, which would be necessary if sight was lost permanently.
Baseline period	2010/11
Indicator definition	**4.12i Crude rate of sight loss due to Age Related Macular Degeneration (AMD) in persons aged 65 and over per 100,000 population** This indicator relates to AMD, the most prevalent of the three main eye diseases, which can result in blindness or partial sight if not diagnosed and treated in time. Numerator: Count of new certifications of visual impairment (CVI) with a main cause of sight loss of AMD or where no main cause is attributed where AMD is a contributory cause, for people aged 65 and over Denominator: Office for National Statistics (ONS) mid-year population estimate, for people aged 65 and over **4.12ii Crude rate of sight loss due to glaucoma in persons aged 40 and over per 100,000 population** This indicator relates to glaucoma, one of the three main eye diseases, which can result in blindness or partial sight if not diagnosed and treated in time. The advice given for early detection of glaucoma, particularly if an individual is at high risk, is that they should be regularly reviewed by their optometrist from around age 40 years as this is when it may be clinically detectable or glaucomatous damage may develop. Numerator: Count of new CVIs with a main cause of sight loss of glaucoma or where no main cause is attributed where glaucoma is a contributory cause, for people aged 40 and over Denominator: ONS mid-year population estimate, for people aged 40 and over **4.12iii Crude rate of sight loss due to Diabetic Eye Disease in persons aged 12 and over per 100,000 population** This indicator relates to Diabetic Eye Disease, one of the three main eye diseases, which can result in blindness or partial sight if not diagnosed and treated in time. Diabetic retinopathy is the leading cause of preventable sight loss in working age people in

4.12 Preventable sight loss	
	the UK and early detection through screening halves the risk of blindness. By providing data on blindness due to diabetic retinopathy the indicator will also provide valuable information for the national diabetic retinopathy screening programme. Numerator: Count of new CVIs with a main cause of sight loss of Diabetic Eye Disease or where no main cause is attributed where Diabetic Eye Disease is a contributory cause, for people aged 12 and over Denominator: ONS mid-year population estimate, for people aged 12 and over **4.12iv Crude rate of sight loss certifications per 100,000 population** This indicator relates to completions of CVI (all causes both preventable and non-preventable) by a consultant ophthalmologist - this initiates the process of registration with a local authority and leads to access to services Numerator: New CVIs in the respective financial year Denominator: ONS mid-year population estimate For further information on the methodology used for this indicator please see the descriptive metadata which accompanies the data.
Data source	Numerator: The Database for Epidemiological data on Visual Impairment Certificates (DEVICE), the Certifications Office, the Royal College of Ophthalmologists, at Moorfields Eye Hospital NHS Foundation Trust, supported by a grant from RNIB. The Department of Health and the Royal College of Ophthalmologists have jointly contracted Moorfields to be responsible for the data. Completion of a CVI (certificate of visual impairment) by a consultant ophthalmologist initiates the process of registration with a local authority and leads to access to services. Certification (CVI) and registration are voluntary. For information on caveats to the data please see the descriptive metadata which accompanies the data. Denominator: ONS mid-year population estimates
Publication	These indicators have been defined for the Public Health

4.12 Preventable sight loss	
of source data	Outcomes Framework and have not been previously published. However, Moorfields Eye Hospital NHS Foundation Trust do publish CVI data specifically for diabetic eye disease annually by PCT – these data can be accessed by registered users only. Data for 2008/9 and 2009/10 are in the public domain - hosted on Moorfields website with access by request: http://ecvi.moorfields.nhs.uk/Default.aspx The Health and Social Care Information Centre publish data on people registered Blind and Partially Sighted every three years at council level. http://www.hscic.gov.uk/social-care

4.13 Health-related quality of life for older people	
Rationale	1 in 5 people are over 65 and this is set to rise to 1 in 3 by 2033. The number of "oldest old" (over 85) has doubled in the past decade and the percentage of people dying before 65 has remained constant for the past 20 years. Older people are the biggest and costliest users of health and social care – those with complex needs, long-term conditions, functional, sensory or cognitive impairment are the highest cost and volume group of service users. Dementia alone accounts for more expenditure than heart disease and cancer combined. This indicator will provide a greater focus on preventing ill health, preserving independence and promoting well-being in older people – this is key to keep systems functioning and to ensure that the needs of this large group of users are addressed.
Baseline period	2011/12
Indicator definition	**4.13 Average health status score for adults aged 65 and over** Health status is derived from responses to Q34 on the GP Patient Survey, which asks respondents to describe their health status using the five dimensions of the EuroQuol 5D (EQ-5D) survey instrument:

4.13 Health-related quality of life for older people	
	• Mobility • Self-care • Usual activities • Pain/discomfort • Anxiety/depression This indicator assesses whether health-related quality of life is changing over time, while controlling for potential measurable confounders (age, sex, long-term conditions, caring responsibility, etc.). The definition and the methodology for producing this indicator aligns as far as possible with the similar indicator on "Health-related quality of life for people with long-term conditions" in the NHS Outcomes Framework (https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014) EQ-5D™ is a registered trademark of EuroQol. Further details are available from http://www.euroqol.org.
Data source	GP Patient Survey (GPPS)
Publication of source data	The most recent GP Patient Survey data covering 2012/13, is available at http://www.gp-patient.co.uk/results/

4.14 Hip fractures in people aged 65 and over	
Rationale	Hip fracture is a debilitating condition - only 1 in 3 sufferers return to their former levels of independence and 1 in 3 end up leaving their own home and moving to long term care (resulting in social care costs). Hip fractures are almost as common and costly as strokes and the incidence is rising. There is evidence of interventions to treat osteoporosis, to prevent falls and to prevent fractures in people who have already suffered one fragility fracture. Interventions for recently retired and active older people are likely to be different in provision and uptake for frailer older people. Inclusion of this

4.14 Hip fractures in people aged 65 and over	
	indicator in the Public Health Outcomes Framework will encourage prioritisation of such interventions.
Baseline period	2010/11
Indicator definition	**4.14i Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 65 and over per 100,000 population** Numerator: Number of emergency hospital admissions classified by first diagnosis code (ICD10 primary diagnosis of S72.0, S72.1, S72.2) and with an emergency admission code in people aged 65 and over. Counted by first finished episode in the respective financial year. Denominator: Number of people aged 65 and over based on Office for National Statistics mid-year population estimates ICD10 codes for fractured proximal femur refer to the following primary diagnoses: • S72.0 Fracture of neck of femur • S72.1 Pertrochanteric fracture • S72.2 Subtrochanteric fracture This indicator will have two further sub-indicators covering two different age splits (with numerators and denominators as for 4.14i but restricted to the age ranges specified): **4.14ii Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 65 to 79 per 100,000 population** **4.14iii Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 80 and over per 100,000 population** Further work is needed to investigate the effect of transfers between hospitals on admission rates.

4.14 Hip fractures in people aged 65 and over	
Data source	Hospital Episode Statistics (HES), Health and Social Care Information Centre Figures can be corroborated with the National Hip Fracture Database
Publication of source data	Limited headline data on numbers of hospital episodes for hip fractures are published in HES tables by the Health and Social Care Information Centre: http://www.hscic.gov.uk/hes Local authority data for this indicator is published annually in the Local Authority Health Profiles http://www.healthprofiles.info

4.15 Excess winter deaths	
Rationale	There are significantly more deaths in winter than in the rest of the year, particularly amongst older people and those on low incomes. Cold weather exacerbates minor and pre-existing medical conditions, and mental health is negatively affected by fuel poverty and cold housing. Excess winter deaths were identified as a public health challenge in Healthy Lives, Healthy People, the Marmot Review and the CMO annual report 2009. The Excess Winter Deaths Index is a key measure for the Cold Weather Plan for England.
Baseline period	2010/11 for Single year data and 2009/12 for 3 years aggregated data
Indicator definition	**4.15i Excess Winter Deaths Index (single year, 01/08/YYYY to 31/07/YYYY+1): The ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths.** Numerator: Number of excess winter deaths, i.e. number of deaths occurring in December in year YYYY and January to March in year YYYY+1 minus half the number of deaths in the

4.15 Excess winter deaths	
	non-winter months (preceding August to November in year YYYY and following April to July in year YYYY+1). Denominator: The average number of deaths per quarter occurring in the non-winter months, i.e. half the number of deaths occurring in the preceding August to November in year YYYY and the following April to July in year YYYY+1. **4.15ii Excess Winter Deaths Index (single year, ages 85+): The ratio of extra deaths from all causes that occur in all those aged 85 and over in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths in those aged 85 and over.** Numerator: Number of excess winter deaths in those aged 85 and over, i.e. number of deaths occurring in December in year YYYY and January to March in year YYYY+1 minus half the number of deaths in the non-winter months (preceding August to November in year YYYY and following April to July in year YYYY+1). Denominator: The average number of deaths in those aged 85 and over per quarter occurring in the non-winter months, i.e. half the number of deaths occurring in the preceding August to November in year YYYY and the following April to July in year YYYY+1. **4.15iii Excess Winter Deaths Index (three years aggregated, 01/08/YYYY to 31/07/YYYY+3): The ratio of extra deaths from all causes that occur in the aggregated winter months compared with the expected number of deaths, based on the average of the number of aggregated non-winter deaths.** Numerator: Number of excess winter deaths, i.e. number of deaths occurring in December in years (YYYY, YYYY+1, YYYY+2) and January to March in years (YYYY+1, YYYY+2 YYYY+3) minus half the number of deaths in the non-winter months (August to November in years (YYYY, YYYY+1, YYYY+2) and from April to July in years (YYYY+1, YYYY+2 YYYY+3). Denominator: The average number of deaths per quarter occurring in the non-winter months, i.e. Half the number of deaths occurring in the non-winter months (August to November in years (YYYY, YYYY+1, YYYY+2) and in April to July in years (YYYY+1, YYYY+2 YYYY+3).

4.15 Excess winter deaths	
	4.15iv Excess Winter Deaths Index (three years aggregated, ages 85+): The ratio of extra deaths from all causes that occur in all those aged 85 and over in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths in those aged 85 and over. Numerator: Number of excess winter deaths in those aged 85 and over, i.e. number of deaths occurring in December in years (YYYY, YYYY+1, YYYY+2) and January to March in years (YYYY+1, YYYY+2 YYYY+3) minus half the number of deaths in the non-winter months (August to November in years (YYYY, YYYY+1, YYYY+2) and from April to July in years (YYYY+1, YYYY+2 YYYY+3). Denominator: The average number of deaths in those aged 85 and over per quarter occurring in the non-winter months, i.e. Half the number of deaths occurring in the non-winter months (August to November in years (YYYY, YYYY+1, YYYY+2) and in April to July in years (YYYY+1, YYYY+2 YYYY+3).
Data source	Office for National Statistics (ONS) death registrations
Publication of source data	ONS publish data on excess winter deaths annually at national and regional level by age group: http://www.ons.gov.uk/ons/rel/subnational-health2/excess-winter-mortality-in-england-and-wales/index.html Local authority level data are published by Public Health England in the annual Local Authority Health Profiles (three year pooled) and the Excess Winter Deaths in England Atlas (three year pooled and single year) http://www.healthprofiles.info http://www.wmpho.org.uk/excesswinterdeathsinEnglandatlas/

4.16 Estimated diagnosis rate for people with dementia	
Rationale	There are an estimated 670,000 people in England with dementia, a number expected to double in the next 30 years. Dementia accounts for more expenditure than heart disease and cancer combined and costs society around £20bn a year. The inclusion of this indicator will help public health practitioners to recognise the contribution they can make to minimising the effects of dementia or preventing it through promoting better lifestyle and exercise as up to half of dementias have a vascular component.
Baseline period	2010/11
Indicator definition	*The indicator definition needs further development* **4.16 Estimated diagnosis rate for people with dementia: number of people diagnosed with dementia as a percentage of estimated dementia prevalence** Numerator: Number of people on the dementia register for England in the Quality and Outcomes Framework (QOF) Denominator: Estimated prevalence of dementia The Dementia UK 2007 report contains estimates of late onset dementia prevalence rates (i.e. how many people have dementia as a proportion of the population in that age band) by five year age bands from age 30 to 95+. These rates are available by gender and as a weighted average for all persons. For estimated prevalence at national level, the prevalence rates by age band and sex are multiplied by the national population for each group. The results are summed to give a total figure for the estimated prevalence for England. Further work is required to develop a method for estimating dementia prevalence at local authority level.
Data source	Numerator: Quality and Outcomes Framework (QOF), The Health and Social Care Information Centre (HSCIC) Denominator: The Dementia UK report (2007); Office for

4.16 Estimated diagnosis rate for people with dementia	
	National Statistics (ONS) population projections
Publication of source data	Data at England level has been published as part of the NHS Outcomes Framework on the Health and Social Care Information Centre's Indicator Portal: https://indicators.ic.nhs.uk/webview/