Department of Health

Improving outcomes and supporting transparency

Part 2: Summary technical specifications of public health indicators, January 2012

DH INFORMATION READER

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Description	This update sets out a new Public Health Outcomes Framework. In three parts, Part 1 - this document - introduces the overarching vision for public health, the outcomes we want to achieve and the indicators that will help us understand how well we are improving and protecting health. Part 2 specifies all the technical details we can currently supply for each public health indicator and indicates where we will conduct further work to fully specify all indicators, and Part 3 consists of the Impact Assessment and Equalities Impact Assessment.
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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.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. Exact definition TBC. This will be either healthy life expectancy or disability-free life expectancy. Healthy life expectancy is an estimate of expected years of life spent in self-reported good health; disability-free life expectancy is an estimate of expected years of life spent without a self-reported limiting long-standing illness or disability.
Data source	The data source is ready. Office for National Statistics (ONS) (health expectancy data based on life expectancy, derived from death registrations and mid-year population estimates, and survey data on self-reported health status – details of specific survey TBC).
Reporting	National level data on healthy life expectancy and disability-free life expectancy is published by ONS. Latest update: http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-and-age-65-in-the-united-kingdom/2007-09/index.html

0.2 Differences in life expectancy and healthy life expectancy between communities	
Rationale	This is a key high-level outcome and core to the aims of the Department of Health. This is the only indicator in the set which is explicitly an inequalities indicator and it will enable a national and local look at inequalities. It 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 inequalities. This will set the context within which local areas can assess the other indicators and identify the drivers of life expectancy and health expectancy, especially in areas where these are low.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. Exact definition TBC. The detailed definition is still to be specified. The indicator will measure inequalities in life expectancy and health expectancy (healthy life expectancy or disability-free life expectancy) by area deprivation. The indicator will cover both between-local authority and within-local authority inequalities, where feasible, subject to data availability.
Data source	The data source is ready. ONS (life expectancy data based on death registrations and mid-year population estimates; health expectancy data based on life expectancy and survey data on self-reported health status – details of specific survey TBC).
Reporting	TBC

Indicators corresponding to the public health domains

While we will be able to provide information on the performance against the 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 will be 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 intend to improve this range of information over the coming year and we have set out in this document how we intend to do that, with the continued engagement and involvement of our partners at the local and national levels.

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.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **1.1 Percentage of children in relative poverty (living in households where income is less than 60% of median household income before housing costs).** National level definition Numerator: Number of children living in households where income is less than 60% of median household income before housing costs. Denominator: 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 16-19 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 level definition For local authority level data, the definition is slightly different, providing an approximation of the relative child poverty measure: the percentage of children living in families in receipt of out of work benefits or tax credits where their reported 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 the local authority area. The definition of 'child' is the same as for the national data set.
Data source	The data source is ready. National level: Households Below Average Income data (Department of Work and Pensions (DWP)), based on the Family Resources Survey and the British Household Panel Survey. Local authority level: Data derived from a combination of population data from ONS, tax credit data from HMRC and benefit data from DWP.

1.1 Children in poverty (continued)	
Reporting	National level data is published annually by DWP in the Households Below Average Income series. 2009/10 data: http://statistics.dwp.gov.uk/asd/hbai/hbai2010/pdf_files/full_hbai11.pdf Local authority level data is published 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 (Placeholder)	
Rationale	This is a key measure of early years development across a wide range of developmental areas. The data from the Early Years Foundation Stage Profile is used each year to inform plans for child development, informing Key Stage 1 teachers about each child's development and needs.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. Exact definition TBC – a new Early Years Foundation Stage Profile (EYFSP) is being developed for the 2012-13 academic year on which this indicator will be based. Using the existing EYFS Profile, such an indicator would need to be based on the "good level of development" measure, defined as a child achieving six or more points across the seven scales of PSE and CLL and who also achieves 78 or more points across all 13 scales. The new EYFS Profile being introduced in 2012-13 will measure seven areas of learning and development, including "physical development"(including moving and handling and also health and self care),"Personal, social and emotional development" and also "Communication and Language". All three provide a snapshot of children's health and all round wellbeing at five.
Data source	The data source needs further development. DfE has a statutory local and national data collecting system for an annual profile on all children in the school year in which they turn five. A new simpler profile is being designed for 2012-13 (subject to consultation).
Reporting	Early Years Foundation Stage Profile Attainment data is published by DfE annually. Latest data: http://www.education.gov.uk/rsgateway/DB/SFR/s000979/index.shtml

1.3 Pupil absence	
Rationale	Improving attendance (ie 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.
Final indicator available from	TBC
Indicator definition	The indicator definition is ready. **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. 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 data source is ready. The School Census.
Reporting	Published by DfE at national and local authority level on a termly basis and at school level for the combined autumn and spring terms (four half terms) and the end year (five half terms). Information on absence in special schools is only published annually. Spring/autumn data: http://www.education.gov.uk/rsgateway/DB/SFR/s001020/index.shtml Annual data: http://www.education.gov.uk/rsgateway/DB/SFR/s000994/index.shtml

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 (10-18) 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 future, particularly when they may already be parents themselves.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **1.4 Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population.** Numerator: Number of 10-17 year olds receiving their first reprimand, warning or conviction. Denominator: ONS mid-year population estimates, ages 10-17. As part of the National Diversion Programme, the Department of Health is 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	The data source needs further development. MoJ criminal justices 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 model based on the patterns of offenders dealt with by police stations has been used to allocate offenders to local authorities.
Reporting	MoJ publishes national (England and Wales) data quarterly, and local authority data annually, in the Offending Histories tables of Criminal Justice Statistics in England and Wales: http://www.justice.gov.uk/publications/statistics-and-data/criminal-justice/criminal-justice-statistics.htm

1.5 16-18 year olds not in education, employment or training	
Rationale	Young people who are not engaged in education, employment or training 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.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **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 who are EET (in education, employment or training) and NEET. Both EET and NEET figures are adjusted to take account of those whose current activity is not known. This indicator will use the average proportion of 16-18 year olds NEET between November and January each year.
Data source	The data source is ready. 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. Note that national data on the proportion of 16-18 year olds NEET is published annually by DfE but cannot be broken down to local authority level. Instead this indicator will use data drawn from the client management systems maintained by local authorities. Note that data from the client management systems maintained by local authorities are not directly comparable with the national figures published by DfE due to differences in definitions used: > 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.
Reporting	National level data on 16-18 year olds NEET are published annually by DfE but this data is not directly comparable with the data to be used for this indicator – see note in data source section.

1.6 People with mental illness and or disability in settled accommodation	
Rationale	The indicator is intended to improve outcomes for adults with mental health problems in settled accommodation by improving their safety and reducing their risk of social exclusion. Maintaining settled accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital of more costly residential care and ensures a positive experience of social care. Moreover, this indicator is intended to improve outcomes for adults with learning disabilities through improving accommodation. The nature of accommodation for people with learning disabilities has a strong impact on their safety and overall quality of life and reducing social exclusion.
Final indicator available from	Now
Indicator definition	The indicator definition is ready **1.6i Percentage of adults with learning disabilities known to social services who are assessed or reviewed during the year and were in settled accommodation at the time of their latest assessment.** Numerator: Number of working age learning disabled clients known to councils with adult social service responsibilities (CASSRs) who are in settled accommodation at the time of assessment. Denominator: Number of working age learning disabled clients known to councils with adult social service responsibilities (CASSRs). **1.6ii Percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi disciplinary care planning meeting.** Numerator: Number of adults receiving secondary mental health services and who are on the Care Programme Approach known to be in settled accommodation. Denominator: Number of adults receiving secondary mental health services and who are on the Care Programme Approach.
Data source	The data source is ready. Adults with learning disabilities: Adult Social Care Combined Activity Return (ASC-CAR), the NHS Information Centre. Adults receiving mental health services: Mental Health Minimum Dataset (MHMDS), the NHS Information Centre.
Reporting	Data from the Mental Health Minimum Dataset is published quarterly by the NHS Information Centre: http://www.ic.nhs.uk/services/mhmds/quarterly

1.7 People in prison who have a mental illness or a significant mental illness (Placeholder)	
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 that 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.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. **1.7 Proportion of all people in prison who have a mental illness or a significant mental illness.** Exact definition TBC. Proposed definition is outlined below (though subject to confirmation that Read Code can be used from System1 data collection). Numerator: Number of people in prison with significant mental illness by Read Code. Denominator: Total number of prisoners in the prison.
Data source	The data source needs further development. Data source TBC. Possible data source is the System1 prison IT system.
Reporting	TBC

1.8 Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness	
Rationale	The recent review "Is work good for your health and wellbeing" concluded that work was generally good for both physical and mental health and wellbeing. The strategy for public health takes a life course approach and this indicator provides a good indication of the impact limiting long-term illness has on employment among those in the "working well" life stage. It also provides a link to indicators in the NHS Outcomes Framework.
Final indicator available from	TBC
Indicator definition	The indicator definition needs development (conditions included have been defined but methodology to be confirmed). **1.8i Gap between the employment rate for those with a long-term health condition and the overall employment rate.** 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?" Anyone with a long-term health condition is asked which of the following conditions they have (respondents are able to select as many conditions as apply): Q3 "Do you have… 1. problems or disabilities (including arthritis or rheumatism) connected with arms or hands, legs or feet, back or neck 2. difficulty in seeing (while wearing spectacles or contact lenses) 3. difficulty in hearing 4. a speech impediment 5. severe disfigurement, skin conditions, allergies 6. chest or breathing problems, asthma, bronchitis 7. heart, blood pressure or blood circulation problems 8. stomach, liver, kidney or digestive problems 9. diabetes 10. depression, bad nerves or anxiety 11. epilepsy 12. severe or specific learning difficulties (mental handicap) 13. mental illness or suffer from phobias, panics or other nervous disorders 14. progressive illness not included elsewhere (eg cancer not included elsewhere, multiple sclerosis, symptomatic HIV, Parkinson's disease, muscular dystrophy) 15. other health problems or disabilities".

1.8 Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness (continued)	
Indicator definition (continued)	Someone is defined as being in employment if they answer "yes", rather than "no", to the following question: Q4 "Did you do any paid work in the seven days ending Sunday either as an employee or as self-employed?" Numerator: All people who report having a long-term condition (codes 1 to 18 in Q3) who are in employment. Denominator: All people who report having a long-term condition. This indicator reflects indicator 2.2 in the NHS Outcomes Framework. **1.8ii Gap between the employment rate for those with a learning difficulty/ disability and the overall employment rate.** Numerator: All people who report having severe or specific learning difficulties (code 15 in Q3) who are in employment. Denominator: All people who report having severe or specific learning difficulties. **1.8iii Gap between the employment rate for those with a mental illness and the overall employment rate.** Numerator: All people who report having "depression, bad nerves or anxiety" (code 13 in Q3) or "mental illness or suffer from phobias, panics or other nervous disorders" (code 16 in Q3) who are in employment. Denominator: All people who report having "depression, bad nerves or anxiety" or "mental illness or suffer from phobias, panics or other nervous disorders". A similar indicator is included in the NHS Outcomes Framework (indicator 2.2 – "Employment of people with mental illness"). Both indicators are based on LFS data but the NHS Outcomes Framework indicator defines mental illness as having one (or more) of the following conditions (ie codes 13, 15 and 16 in Q3): 13. depression, bad nerves or anxiety 15. severe or specific learning difficulties (mental handicap) 16. mental illness or suffer from phobias, panics or other nervous disorders. As there is a separate indicator in the Public Health Outcomes Framework on learning difficulties/disabilities, the Public Health Outcomes Framework indicator on mental illness does not include learning difficulties/disabilities.

1.8 Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness (continued)	
Indicator definition (continued)	Mapping to employment rate of general population The employment rate for those people with a long-term health condition (measure 1.8i)/learning difficulty/disability (1.8ii)/mental illness (1.8iii) will be mapped to the general employment rate. The difference in the two rates will be assessed. This method needs to be developed. This is a similar approach to that being used for the relevant NHS Outcomes Framework indicators and we will mirror this where appropriate. Limiting long-term health conditions The LFS also includes a question to ascertain whether a long-term health condition limits the kind of paid work that a person can do. Evidence shows that it is the "limiting" aspect of a health condition has the greatest affect on a person's ability to work (Understanding Society, 2011). Further analysis is planned to look at the impact of including only limiting health conditions in the indicator definition.
Data source	The data source is ready. Secondary analysis of the LFS data would be required to calculate the measure and to provide breakdowns by health conditions. The LFS allows for analysis down to the local authority level. We need to explore whether the sample size is sufficient to provide robust breakdowns by health condition at the local authority level.
Reporting	LFS data is reported on a quarterly basis: http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/october-2011/statistical-bulletin.html

1.9 Sickness absence rate	
Rationale	The independent review of sickness absence (published December 2011) was commissioned by the 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 that 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. As part of this stage, the Government aims to help people with health conditions to stay in or return to work.
Final indicator available from	1.9i available now. 1.9ii available now. 1.9iii TBC.
Indicator definition	The indicator definition 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 Number of working days lost due to sickness absence.** Numerator: Number of working days lost due to sickness absence. Denominator: Number of working days. **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. Definition of 1.9iii TBC, the Department of Health is 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. Data source for 1.9i and 1.9ii: Labour Force Survey (ONS). Data source for 1.9iii: Electronic Fit Note (E-med) data from DWP (TBC) – does not yet exist.
Reporting	1.9i and 1.9ii: ONS publishes sickness absence rates 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: TBC.

1.10 Killed and seriously injured casualties on England's roads	
Rationale	The indicator is an established measure used to assess improvements in road safety. Road safety has implications for the safety of communities, on the long-term costs to the health and social care systems, and to the wider economy.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **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. Based on casualties who incur 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 and 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.
Data source	The data source is ready. STATS 19 – collected by the police and published by 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: http://www.dft.gov.uk/statistics/series/road-accidents-and-safety
Reporting	Numbers for single years at national and Local Authority level are published annually by DfT: 2010 DfE publication – http://assets.dft.gov.uk/statistics/tables/ras30031.xls Rates at local authority level are included in the annual Local Authority Health Profiles: 2011 Local Authority Health Profiles – http://www.healthprofiles.info

1.11 Domestic abuse (Placeholder)	
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.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. TBC Discussions are ongoing with the Home Office to establish the most appropriate definition for this indicator.
Data source	The data source needs further development. TBC Discussions are ongoing with the Home Office to establish the most appropriate data source for this indicator, which will allow robust upper tier local authority level estimates to be produced.
Reporting	TBC

1.12 Violent crime (including sexual violence) (Placeholder)	
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.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. TBC Discussions are ongoing with the Home Office to establish the most appropriate definition for this indicator.
Data source	The data source needs further development. TBC Discussions are ongoing with the Home Office to establish the most appropriate data source for this indicator, which will allow robust upper tier local authority level estimates to be produced.
Reporting	TBC

1.13 Re-offending	
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 wellbeing 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 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.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **1.13i The proportion 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 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	The data source is ready. MoJ dataset (cohort of offenders identified from police, probation and prison records; offending assessed via Police National Computer).
Reporting	Reported by MoJ at national and local authority level every quarter, beginning with data for the 12 month cohort to Dec 2009. This was published in October 2011.

1.14 The percentage of the population affected by noise (Placeholder)	
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. Complaints about noise are the largest single cause of complaint to most local authorities, and furthermore there is evidence that exposure to noise is a key determinant of health and wellbeing.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. The current proposed definition is outlined below – please note this is TBC. **1.14i Number of complaints per year per local authority about noise per thousand population (according to statistics collected by CIEH).** **1.14ii The proportion of the population exposed to transport noise (primarily road) of more than x dB(A) per local authority.** The exposure level would need to be decided based on when health effects can occur, eg using WHO data (and could be based on daytime or night-time exposure or both). Note that 1.14ii is only fully calculated every five years but it is possible to estimate changes on an annual basis. There is some supplementary information which could potentially also be included in or alongside this composite indicator: > complaints to local highways authorities (this will capture some data about environmental noise complaints) > how well local authorities and others are implementing the noise action plans (eg proportion of Important Areas in the local authority area that have been investigated). An Important Area or hotspot is where exposure to transport noise is highest as identified in the noise action plans. This will enable us to monitor what the progress being made on implementing the action plans. An alternative option is using the indicator "percentage of the population for whom noise spoils their home life". This is a question in the National Noise Attitude Survey and is currently available nationally and once every 10 years. There is a possibility of obtaining this data more regularly and at the local authority level.
Data source	The data source is ready. Based on the proposed definition, the data sources would be data collated by CIEH on number of noise complaints and statistics collected by DEFRA on exposure to transport noise. Note that if the alternative definition on noise spoiling home life were used then the data source would need to be developed in order to obtain the information more frequently and down to local authority level. Currently, the data comes from the National Noise Attitude Survey that is carried out every 10 years and provides national level data only.

1.14 The percentage of the population affected by noise (Placeholder) (continued)	
Reporting	Information on complaints made about noise is available at national level on the CIEH website: http://noisestats.cieh.org/About/.aspx Data on exposure to traffic noise at agglomeration level is available at: http://services.defra.gov.uk/wps/portal/noise Data on the alternative option at national level can be found at: www.bre.co.uk/pdf/NAS.pdf

1.15 Statutory homelessness	
Rationale	Part of this indicator (number of households in temporary accommodation per thousand households) is a 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 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.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **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 estimate. **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 estimate.
Data source	The data source is ready. P1E-Local Authority returns, DCLG. Mid-year estimated number of households, DCLG.
Reporting	Homelessness statistics are published by DCLG quarterly at England, region, and local authority level: Live tables – http://www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/homelessnessstatistics/livetables

1.16 Utilisation of green space for exercise/health reasons	
Rationale	Inclusion of this indicator is recognition of the significance of accessible green space as a wider determinant of public health. There is strong evidence to suggest that green spaces have a beneficial impact on physical and mental wellbeing and cognitive function through both physical access and usage.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **1.16 Percentage of people using green space for exercise/health reasons.** Numerator: Number of people reporting that they have taken a visit to green space for health or exercise over the previous seven days. Denominator: Total number of respondents to survey.
Data source	The data source is ready. Monitor of Engagement with the Natural Environment (MENE) survey. Data is fully available at England and regional level. It will be possible to produce upper tier local authority level data from this source.
Reporting	Results from the MENE survey (annual report and monthly updates) are published by Natural England: http://www.naturalengland.org.uk/ourwork/enjoying/research/monitor/#statistics

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. Recent 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. Children living in cold homes are twice as likely to suffer from chest problems, asthma and bronchitis (Barnes et al 2008).
Final indicator available from	Now
Indicator definition	The indicator definition is ready. A household is classified as fuel poor when it would need to spend more than 10% of its income on energy in order to maintain an adequate level of warmth. The Fuel Poverty Ratio is defined as: Required fuel costs (ie required usage x price)/Income. If this ratio is greater than 0.1 then the household is fuel poor. In calculating the fuel poverty ratio, the fuel costs are modelled dependent on the following factors: the type of people that live in the home; the fuels used; and the dwelling characteristics. It should be noted that measurement of fuel poverty is currently the subject of an independent review by Professor John Hills. The review is due to report to the Government in early 2012.
Data source	The data source is ready. English Housing Survey (DCLG). Domestic Fuels Inquiry (DECC). Prices sourced for consumer price indices (ONS). Data available at local authority and parliamentary constituency level – these data are estimates based on national and local area data.
Reporting	Figures on number of households in fuel poverty are published annually by DECC. The indicator is well established and the figures are classified as a National Statistic. 2009 national level figures: http://www.decc.gov.uk/en/content/cms/statistics/fuelpov_stats/fuelpov_stats.aspx

1.18 Social connectedness (Placeholder)	
Rationale	TBC
Final indicator available from	TBC
Indicator definition	New definition required. Definition TBC
Data source	The data source needs further development. TBC – a possibility is that existing questions in the DCLG citizenship survey could be adapted locally for measures at local authority level.
Reporting	TBC

1.19 Older people's perception of community safety (Placeholder)	
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 (eg the police) to encourage health and wellbeing boards and public health professionals to consider perceptions of safety as key to improving health and wellbeing.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. Definition TBC. The British Crime Survey has related indicators on perceptions of antisocial behaviour and crime.
Data source	The data source needs further development. TBC A possible source for this measure is the British Crime Survey.
Reporting	TBC

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 Department of Health 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).
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **2.1 Low-birth weight of term live births.** Calculated as 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 weeks). Indicator = (Num/Den) x 100.
Data source	The data source is ready. ONS.
Reporting	ONS publishes data at national level, but there is currently a reporting time lag of 21 months. ONS does not publish data at local authority level but this should be available on request. Data for 2009 is available from: http://www.ons.gov.uk/ons/rel/child-health/gestation-specific-infant-mortality-in-england-and-wales/2009/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 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.
Final indicator available from	Now at national (and primary care trust (PCT)) level. Expected to be available at local authority level in due course.
Indicator definition	The indicator definition is ready. **2.2i Breastfeeding initiation.** Numerator: Number of women who initiate breastfeeding in the first 48 hours after delivery. Denominator: Number of 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: Number of infants due a 6-8 week check where breastfeeding status is known.
Data source	The data source needs further development. Data is currently collected by Department of Health via UNIFY2 at PCT level. It is expected that data will be collected from local authorities in due course.
Reporting	Published by the Department of Health at national (and PCT) level on a quarterly basis: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/DH_124185

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% 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.
Final indicator available from	Now at national (and PCT) level. Expected to be available at local authority level in due course.
Indicator definition	The indicator definition is ready. **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 maternities. Rate = (Num/Den) x 100.
Data source	The data source needs further development. Data is currently collected by the IC via NHS IC Omnibus at PCT level. It is expected that data will be collected from local authorities in due course.
Reporting	Published by the Department of Health at national (and PCT) level on a quarterly basis: Data for Q2 2011/12 available via – http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_130858

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 three 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.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **2.4 Under 18 conception rate.** Numerator: Total conceptions to all women aged under 18. Denominator: Total female population aged 15-17. Rate = (Num/Den) x 1,000. ONS conception statistics are 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	The data source is ready. ONS. Three-year aggregate data at census ward level is currently available to individual local authorities. ONS is considering a move towards publishing three-year aggregate data for Middle Layer Super Output Areas (MSOAs) from 2012.

2.4 Under 18 conceptions (continued)	
Reporting	ONS publishes 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 three-year aggregates. Following a recent review ONS will be publishing slightly different tables from next year. This will include single-year annual statistics for both upper and lower tier local authorities. In addition, ONS publishes quarterly conception statistics at upper tier local authority level: http://www.ons.gov.uk/ons/rel/vsob1/quart-conc-to-women-und-18/q2-2010/index.html

2.5 Child development at 2-2.5 years (Placeholder)	
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 outcomes measure at 2-2.5 years. Children's early life development is strongly related to an individual's lifelong healthy development. Many factors associated with poor health and wellbeing in later life have been shown to have their origins in pregnancy and early childhood.
Final indicator available from	2014-15
Indicator definition	A new definition is required. It is intended that this indicator is based on an existing validated measure of an aspect of child development at this age. Which aspect of child development is most meaningful and can be efficiently measured for this purpose is being considered.
Data source	The data source needs further development. A study is under way to explore whether data to measure a relevant aspect of child development can be collected via the Healthy Child Programme review that takes place with families when their child is between age 2 and 2.5 years and aggregated to produce national and local level population measures. .
Reporting	TBC

2.6 Excess weight in 4-5 and 10-11 year olds	
Rationale	Obesity is a priority area for the Government. The "Healthy Lives, Healthy People: A call to action on obesity in England" document includes 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.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **2.6i Proportion 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. 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 Proportion 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	The data source is ready. National Child Measurement Programme (NCMP).
Reporting	Data on the National Child Measurement Programme are published annually by the NHS Information Centre: http://www.ic.nhs.uk/ncmp Information on children who are "overweight" and "obese" is published separately

2.7 Hospital admissions caused by unintentional and deliberate injuries in under 18s	
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 related to experience(s). This inclusion of this indicator is key for cross-sectoral and partnership working to reduce injuries, including child safeguarding.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **2.7 Crude rate of hospital emergency admissions caused by unintentional and deliberate injuries in age 0-17 years, per 10,000 resident population.** Numerator: The number of finished in-year emergency admissions of children and young people aged 0-17 years to hospital as a result of unintentional and deliberate injuries (ICD 10 codes V01-Y98 excluding X33-X39 and X52 which refer to forces of nature). Denominator: ONS mid-year population estimate for age 0-17 years. Rate = (Num/Den) x 10,000. Breakdowns will be explicitly published in the Public Health Outcomes Framework for two age breakdowns: > 0-4 year olds > 5-17 year olds.
Data source	The data source is ready. Hospital Episode Statistics.
Reporting	National and local authority level figures for 0-17 year olds are published annually on the South West Public Health Observatory website: 2003/04 – 2009/10 figures – http://www.swpho.nhs.uk/resource/browse.aspx?RID=41062

2.8 Emotional wellbeing of looked after children (Placeholder)	
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 wellbeing issues is very important. Under Section 10 of the Children Act 2004, local authorities have a duty to co-operate to promote wellbeing 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 is 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.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. Exact definition TBC. There are several potential options using the current SSDA903 data collection on looked after children, for example looking at: > Strengths and Difficulties Questionnaire (SDQ) score > substance misuse > stability of placements > not in education, employment or training at 19 years old.
Data source	The data source is ready. Children Looked After by Local Authorities in England in the year ending 31 March based on the SSDA903 data collection on looked after children.
Reporting	Data on looked after children are published annually by DfE. Latest statistics are included in the 2010-11 SFR "Children Looked After by Local Authorities in England (including adoption and care leavers) – year ending 31 March 2011" and the 2009/10 SFR "Outcomes for Children Looked After by Local Authorities in England, as at 31 March 2010": http://www.education.gov.uk/rsgateway/DB/SFR/s001026/index.shtml http://www.education.gov.uk/rsgateway/DB/SFR/s000978/index.shtml

2.9 Smoking prevalence – 15 year olds (Placeholder)	
Rationale	Smoking is the primary 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% 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.
Final indicator available from	TBC
Indicator definition	The indicator definition is ready. **2.9 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.
Data source	The data source needs further development. TBC* * Information on smoking for 11-15 year-olds is collected in the Survey of Smoking, Drinking and Drug Use Among Young People but the sample size for 15 year olds is only sufficient to obtain robust estimates at national and regional level. Therefore, it will be necessary to set up a new data collection in order to collect robust local authority level data for this indicator. The Department of Health is currently assessing feasibility.
Reporting	Smoking prevalence for 15 year olds is currently reported at national and regional level. 2010 report: http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/smoking-drinking-and-drug-use-among-young-people-in-england/smoking-drinking-and-drug-use-among-young-people-in-england-in-2010

2.10 Hospital admissions as a result of self-harm	
Rationale	Self-harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year. 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 healthcare professionals address the experience of care by people who self-harm.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **2.10 Age-sex standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population.** Numerator: Number of emergency hospital admissions for intentional self-harm defined by external cause codes (ICD10 X60-X84). Denominator: ONS mid-year population estimates for males and females. Self-harm is defined by external cause codes (ICD10 X60-X84), which include: > intentional self-poisoning (X60 to X69 inclusive) > intentional self-harm by hanging, drowning or jumping (X70, X71 and X80) > intentional self-harm by firearm/explosive (X72 to X75 inclusive) > intentional self-harm using other implement (X78 and X79) > intentional self-harm other (X76, X77 and X81 to X84).
Data source	The data source is ready. Hospital Episode Statistics.
Reporting	Local authority level figures are published annually in the Local Authority Health Profiles, produced by the Public Health Observatories working in partnership: http://www.healthprofiles.info

2.11 Diet (Placeholder)	
Rationale	Diet and nutrition is a fundamental contributor to public health. Diet makes an important contribution to health outcomes such as the prevalence of obesity, stroke and cardiovascular disease and some cancers. The importance of including an indicator focusing on dietary indicators was noted in responses to the consultation to "Healthy Lives, Healthy People".
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. **2.11 Diet: comparison with national dietary targets and guidelines.** Exact definition TBC. National dietary recommendations and targets for a number of dietary components including the proportion of energy from fat, saturated fat, NMES or the amount of salt, or fruit and vegetables are set out by government advisory groups and in national strategy documents. A multi-component indicator will be defined that describes differences between the measured values of these dietary components in the population and population dietary goals. This will allow monitoring of dietary change over time.
Data source	The data source needs further development. National level: National Diet and Nutrition Survey (NDNS). Local authority level: TBC.
Reporting	Headline data from NDNS compared to key population dietary goals is reported on an annual basis by the Department of Health. 2008/09-2009/10 figures: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_128166

2.12 Excess weight in adults	
Rationale	Obesity is a priority area for Government. The forthcoming obesity "Call to Action" document will include national ambitions relating to excess weight in adults, which is recognised as a major determinant of premature mortality and avoidable ill health.
Final indicator available from	Now at national level. Probably January 2012 at local authority level.
Indicator definition	The indicator definition is ready. **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. Adults are defined as obese if their BMI is greater than or equal to 30kg/m^2.
Data source	The data source needs further development. National level: Health Survey for England. Local authority level: TBC – development work is underway to produce this data from existing surveys – it is likely that Sport England's Active People Survey will be used.
Reporting	Reporting frequency to be decided – it is likely that information would be reported on a six-monthly basis.

2.13 Proportion of physically active and inactive adults	
Rationale	Lack of sufficient physical activity costs the NHS over £1bn per year – £6.5bn per year 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 lifelong participation in health-enhancing sport and wider physical activity.
Final indicator available from	January 2012.
Indicator definition	The indicator definition is ready. **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 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 minutes of moderate intensity physical activity per week in bouts of 10 minutes or more*. Denominator: Population of adults (aged 16+). * Based on 2011 CMO report "Start active, stay active".
Data source	The data source is ready. Sport England's Active People Survey. Work is under way to align questions with the new physical activity guidelines – data collection to commence in January 2012.
Reporting	Active People Survey data relating to sport and wider physical activity (the data source for this indicator) will be published for national and local levels at six monthly intervals.

2.14 Smoking prevalence – adults (over 18s)	
Rationale	Smoking is the primary cause of preventable morbidity and premature death, accounting for 81,400 deaths in England in 2009, some 18% 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% or less by the end of 2015.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **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*. 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	The data source is ready. Integrated Household Survey.
Reporting	National and local authority level data are published for a rolling 12-month period quarterly: http://www.lho.org.uk/viewResource.aspx?id=16678 Local authority level data on this indicator is 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.lho.org.uk/LHO_TOPICS/ANALYTIC_TOOLS/TOBACCOCONTROLPROFILES

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.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **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 six 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 six months. Denominator: The total number of adults in treatment in a year.
Data source	The data source is ready. National Drug Treatment Monitoring System.
Reporting	Published monthly by the National Treatment Agency for Substance Misuse (NTA) by 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 and probation service, 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	There is significant evidence that treatment interventions for the management of substance misuse can help to reduce re-offending. This indicator will be a measure of successful outcome of treatment interventions in the community. It will also serve as a measure of primary and secondary prevention work on the development of problematic substance misuse among vulnerable groups.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. **2.16 Proportion of people assessed for substance dependence issues when entering prison.** 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 people entering prison. The indicator looks at individuals provided with a triage assessment to determine dependence on drugs or alcohol. This intervention is provided in cases of suspected dependence. It further breaks this group down into those with no previous history of engaging with community based treatment. This will allow Public Health England nationally and locally to assess whether initiatives like DIP are effectively identifying and engaging substance misusing offenders at an earlier stage in the criminal justice process thus diverting them from custody. It will be possible to identify those who are treatment naive using NDTMS data. Work is ongoing with colleagues at the Ministry of Justice and National Offender Management Service to develop this indicator.
Data source	The data source needs further development. Prison data will be captured through System1 and reported monthly to the NTA. The data source is being installed this year (2011-12) and will be fully in place for 2013-14. First data expected to be available from June 2012.
Reporting	It is believed that data for this indicator will be reported on a monthly basis by prison.

2.17 Recorded diabetes	
Rationale	This indicator will raise awareness of trends in diabetes among public health professionals and local authorities. Diabetic 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, healthy eating). Earlier detection of type 2 diabetes followed by effective treatment reduces the risk of developing diabetic complications.
Final indicator available from	Now
Indicator definition	The indicator definition needs further development (to consider the most appropriate way to produce local authority level data). **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 31 March (in a particular year), with a coded diagnosis of diabetes on 31 March (in a particular year). (QOF DM19). Denominator: Patients registered with GP practices, aged 17 and over at midnight on 31 March (in a particular year). This definition is based on 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. However, it would be possible to group the data based on the local authority of the patient's registered GP practice. Consideration will be given as to whether it would be beneficial to extend the definition for local authority level data to include data from the National Diabetes Audit, which contains patient level data, including home postcode.
Data source	The data source is ready. QOF information is derived from the Quality Management Analysis System (QMAS), a national system developed by NHS Connecting for Health. As mentioned above, consideration will be given to whether to extend the definition at local authority level to include data for the National Diabetes Audit, which covers people with diagnosed diabetes from primary and secondary care.
Reporting	QOF information is published online annually by the Information Centre at GP Practice level: http://www.qof.ic.nhs.uk National Diabetes Audit data is published annually by the Information Centre at GP practice and PCT level: 2009-10 data – http://www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/national-diabetes-audit/analysis/2009-2010-analysis

2.18 Alcohol-related admissions to hospital	
Rationale	Alcohol misuse is the third-greatest overall contributor to ill health, after smoking and raised blood pressure. Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Over 1 million hospital admissions related to alcohol in 2009/10. 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, together with a national ambition to reduce alcohol-related hospital admission. This ambition is part of the monitoring arrangements for the Responsibility Deal Alcohol Network.
Final indicator available from	Now (subject to outcome of separate consultation on measurement of alcohol-related admissions to hospitals).
Indicator definition	The indicator definition needs further development. Following the previous consultation, the preferred option is for an indicator based on just alcohol-related primary diagnoses, to minimise the risk of perverse consequences from any changes in coding practice so the indicator rewards local areas for good performance. The North West Public Health Observatory will be consulting on the methods used to measure alcohol-related admissions in due course. The definition adopted for the Public Health Outcomes Framework will be informed by the results of that consultation.
Data source	The data source is ready. Hospital Episode Statistics.
Reporting	National and local authority figures are published on the NWPHO website quarterly within the "Local Alcohol Profiles for England": http://www.lape.org.uk/natind.html In addition, this indicator is published at local authority level in the Local Authority Health Profiles: http://www.healthprofiles.info

2.19 Cancer diagnosed at stage 1 and 2 (Placeholder)	
Rationale	Stage of cancer at diagnosis is an excellent proxy for changes in cancer survival rates – there is a direct link between stage at diagnosis and survival outcome. Catching cancer earlier makes it easier to treat and reduces the level and nature of long-term effects of treatment. This indicator will enable us to determine the success of the Government's policies to improve survival rates quickly enough to assess what more needs to be done, where – and so to speed up action to bring about change.
Final indicator available from	Should be available from October 2013.
Indicator definition	The indicator definition requires further development. **2.19 Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed.** Exact definition TBC – work is ongoing to develop this.
Data source	A new data source is required. Indicator to be based on data collected by cancer registries, the collection of which is already planned. Registries are required to have recorded stage (to agreed standards) for at least 70% of 2011 registrations by 31 December 2012.
Reporting	No data reported yet for this indicator as the definition has not been finalised and data collected are not yet of sufficient quality/completeness.

2.20 Cancer screening coverage	
Rationale	Breast screening supports early detection of cancer and cervical screening supports detection of symptoms that 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 increase coverage of cancer screening. Improvements in coverage would mean more cervical cancer is prevented and more breast cancers are detected at earlier, more treatable stages.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **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 50-70 with a screening test result in the previous three years. Denominator: Number of women aged 50-70 who are eligible for breast screening. **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 25-64 who have had an adequate screening test within the last five years. Denominator: Number of women aged 25-64 who are eligible for cervical screening. Women ineligible for screening, and thus not included in the numerator or denominator of the coverage calculation, are those whose recall has been ceased for clinical reasons (most commonly due to hysterectomy).
Data source	The data source is ready. The NHS Information Centre collects PCT level data from PCTs (KC63 return for breast, KC53 for cervical). The KC data come to the NHS Information Centre from PCOs via the NHS Connecting for Health NHAIS "Exeter" system. It is not yet clear whether this data collection will move over to being on a clinical commissioning group or local authority basis. Although data is not currently routinely produced at local authority level, individual level data that is collected includes postcodes so it would be possible to aggregate the existing data to local authority level.
Reporting	Detailed reporting on screening programme coverage is produced annually by the NHS Information Centre at national and PCO level. 2009/10 breast screening data: http://www.ic.nhs.uk/webfiles/publications/008_Screening/Breastscrn0910/Breast_Screening_Publication_2010_Report.pdf 2009/10 cervical screening data: http://www.ic.nhs.uk/webfiles/publications/008_Screening/cervscreen0910/2009_10_Cervical_Bulletin_Final_Report_AI_v1F.pdf

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, which have a significant impact on the health and wellbeing 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.
Final indicator available from	Now at national level. TBC at local authority level.
Indicator definition	The indicator definition is ready. Sub-indicators 2.21i and 2.21ii cover screening coverage/uptake for infectious diseases in pregnancy (which includes screening for HIV, hepatitis B, syphilis and rubella susceptibility). **2.21i HIV coverage: The proportion 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 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 (ie prior to testing). "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 (continued)	
Indicator definition (continued)	**2.21ii Syphilis, hepatitis B and susceptibility to rubella uptake: The proportion of women booked for antenatal care, as reported by maternity services, who have a screening test for syphilis, hepatitis B and susceptibility to rubella.** Numerator: Number of women tested for each infection. Denominator: Number of women booked (booking is defined as the point at which a pregnant woman first sees a midwife for an antenatal booking history, when details of the current pregnancy are documented in maternity records (which should be an auditable information system but may be a paper-based record where appropriate information systems have not been implemented). Uptake is calculated for each maternity unit/trust by quarter and infection. Percent uptake is calculated as the number of women tested divided by the number of women booked, multiplied by 100. **2.21iii The proportion 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 (eg HPLC) has not been indicated by Family Origin Questionnaire (FOQ). Denominator: Total number of pregnant women booked 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 prenatal diagnosis. **2.21iv The proportion of babies registered within the area (currently PCT) 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 eight days.

2.21 Access to non-cancer screening programmes (continued)	
Indicator definition (continued)	For the purposes of this indicator, the cohort includes only babies for whom the area (currently PCT) were responsible at birth and are still responsible on the day of report. The "effective timeframe" is that a conclusive result for 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 proportion of babies eligible for newborn hearing screening for whom the screening process is complete within four weeks corrected age (hospital programmes-well babies, all programmes NICU babies) or five 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 four 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 five weeks corrected age (for community screening programmes); 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.

2.21 Access to non-cancer screening programmes (continued)	
Indicator definition (continued)	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 proportion of babies eligible for the newborn 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 PCT, or (if not registered with any practice) resident within the PCT 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 proportion of those offered screening for diabetic retinopathy 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), 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

2.21 Access to non-cancer screening programmes (continued)	
Data source	The data source needs further development (to produce data at local authority level). Source for 2.21i: Health Protection Agency (via a quarterly return by maternity units to the UK National Screening Unit). Source for 2.21ii: Health Protection Agency (National Infections Screening Monitoring Programme (NAISM)). Source for 2.21iii: Maternity service IT systems. Source for 2.21iv: Child Health Information System. 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. In the medium term the Maternity and Children's Data Set (MCDS) (developed by the NHS Information Centre, approved by ISB and awaiting Cabinet approval for implementation) will further facilitate collection of the ante natal and newborn access data. It is important to note that data collected using MCDS will be pseudonymised patient level data but fields "GMP practice code of mother" and "postcode of usual address (mother)" could be used to provide local authority level data. Currently data for the non-cancer screening programmes is produced and reported at a variety of levels – therefore, work will be required to determine how best to produce data from the sources listed above at local authority level.
Reporting	Data relating to the screening programmes covered by this indicator is currently available to UK National Screening Committee (UKNSC) non-cancer screening programmes personnel via a link from: http://www.screening.nhs.uk/kpi

2.22 Take up of the NHS Health Check programme – by those eligible	
Rationale	NHS Health Checks will be a mandated service for local authorities to provide. Data collected for this indicator will provide information on the number of NHS Health Checks that are conducted so will provide an indication of how well the programme is taken up and how accessible it is. An increased uptake is important to identify early signs of poor health leading to opportunities for early interventions.
Final indicator available from	Now at national level. TBC at local authority level.
Indicator definition	The indicator definition is ready. **2.22 Percentage of eligible people who receive an NHS Health Check.** Numerator: Number of eligible people who received an NHS Health Check. Denominator: Number of people eligible for an NHS Health Check.
Data source	The data source is ready. Data is collected by the Department of Health via Unify2 data collection IPMR_1 at national, strategic health authority and PCT level. Data is not currently available for local authorities unless they are co-terminous with PCTs. However, responsibility for commissioning the NHS Health Check programme and reporting data on the programme will transfer to local authorities in 2013 so it is expected that data will then be collected at local authority level. Note: Numerators and denominators exist via this existing data source. A simple calculation is required to calculate the indicator as per the definition.
Reporting	Data is reported at national, strategic health authority and PCT level quarterly by the Department of Health on: > number of people eligible for an NHS Health Check > number of people offered an NHS Health Check > number of people who received an NHS Health Check > percentage of eligible people who were offered an NHS Health Check. Data is not currently reported specifically on the percentage of eligible people who received at NHS Health Check although this may be included in publications after this financial year.

2.23 Self-reported wellbeing	
Rationale	Wellbeing is a key issue for the Government, and the ONS is leading a programme of work to develop new measures of national wellbeing. People with higher wellbeing have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health. Local data on wellbeing 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 Wellbeing Boards.
Final indicator available from	Usable indicator available now. The final indicator will be developed in line with ONS's Measuring National Wellbeing Programme and is expected to be ready in 2013.
Indicator definition	The indicator definition is ready (for the current definition). The final indicator will be developed in line with ONS's Measuring National Wellbeing Programme and is TBC. **2.23 Self-reported wellbeing.** Current measure to be used until 2013 is the the average Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) score for adults (16+). WEMWBS measures social, emotional and psychological wellbeing using responses to 14 positively worded items: 1. I've been feeling optimistic about the future* 2. I've been feeling useful* 3. I've been feeling relaxed* 4. I've been feeling interested in other people 5. I've had energy to spare 6. I've been dealing with problems well* 7. I've been thinking clearly* 8. I've been feeling good about myself 9. I've been feeling close to other people* 10. I've been feeling confident 11. I've been able to make up my own mind about things* 12. I've been feeling loved 13. I've been interested in new things 14. I've been feeling cheerful. 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 wellbeing. For a given population the average can then be calculated.

2.23 Self-reported wellbeing (continued)	
Indicator definition (continued)	A shortened seven-item version of the WEMWBS is also available – the Short Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS). Items included in the short version are indicated with a "*" in the above list. Both versions of the WEMWBS are validated for use with adults in the UK. From 2013 this definition will be enhanced by the wellbeing measure currently being developed by ONS in its Measuring National Wellbeing programme of work. ONS is currently measuring individual/subjective wellbeing based on four questions included on the Integrated Household 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 data from these questions will be published in July 2012 and will be treated as experimental statistics.
Data source	The data source is ready (for the WEMWBS measure). The data source(s) for the measure based on the ONS programme is under development. National level (measure until 2013 based on 14-item WEMWBS): Health Survey for England – baseline data available December 2011. Understanding Society (seven-item WEMWBS) – baseline data available now. Local authority level (measure until 2013 based on seven-item WEMWBS): Understanding Society (longitudinal study co-funded by the Department of Health) – only available every two years. Source from 2013: ONS (possibly Integrated Household Survey) – TBC.
Reporting	Understanding Society reported national level data on the SWEMWBS in 2011. See: http://research.understandingsociety.org.uk/files/research/findings/early-findings/9%20Early%20findings%20Chapter%209.pdf Local authority level data from Understanding Society has not yet been published and would require additional analysis. National level data from the Health Survey for England was published for the first time in December 2011: http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england/health-survey-for-england--2010-respiratory-health ONS will be publishing the first full year of data from the four individual/subjective wellbeing questions included on the Integrated Household Survey in July 2012.

2.24 Falls and fall injuries in the over 65s	
Rationale	Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, eg being a major precipitant of people moving from own home to long-term nursing or residential care. A measure that reflects the success of services in preventing falls will give an indication of how the NHS, public health and social care are working together to tackle issues locally.
Final indicator available from	TBC
Indicator definition	The indicator definition requires further development. **2.24: Age-sex standardised rate of emergency hospital admissions for falls or falls injuries in persons aged 65 and over.** Numerator: Number of hospital admissions in age 65 and over for falls classified by first diagnosis code (ICD-10 primary diagnosis in the range S00 through T98X) and external cause (ICD10 code W00-W19) and an emergency admission code admitted in the respective financial year. Denominator: ONS Census based mid-year population estimate. Further work needs to be done to investigate some detailed definitional issues and the impact of factors such as seasonality.
Data source	The data source is ready. Hospital Episode Statistics (HES).
Reporting	The NHS 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 strategic health authority level. However, this data does not match the suggested definition for the Public Health Outcomes Framework indicator. The Older People's Health Atlas produced by WMPHO has published falls admission rates for local authorities: http://www.wmpho.org.uk/olderpeopleatlas/atlas/atlas.html

Domain 3: Health protection

3.1 Air pollution	
Rationale	Poor air quality is a significant public health issue. The current burden of particulate air pollution in the UK is 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.
Final indicator available from	Now at national level. Not yet calculated at local authority level.
Indicator definition	The indicator definition is ready. **3.1 The mortality effect of anthropogenic particulate air pollution (measured as fine particulate matter, $PM_{2.5}$*) per 100,000 population.** Mortality Burden: To be expressed as attributable deaths and associated years of life lost. (a) Attributable deaths are obtained by multiplying local $PM_{2.5}$ data (population-weighted modelled background anthropogenic $PM_{2.5}$ concentrations, to be supplied by Defra – see below) by annual deaths (age 30+)** and the Committee on the Medical Effects of Air Pollutants (COMEAP)-recommended relative risk of 6% increase in mortality per 10 $\mu g/m^3$ $PM_{2.5}$. (b) Years of life lost associated with these attributable deaths are then calculated (eg by summing age-specific life expectancies for each attributable death). Data on the resident population can be used to express the burden per 100,000 people. * $PM_{2.5}$ means the mass (in micrograms) per cubic metre of air of individual particles with an aerodynamic diameter generally less than 2.5 micrometers. $PM_{2.5}$ is also known as fine particulate matter. ** The national estimates (COMEAP, 2010) have been calculated using data on deaths at ages 30+, as this reflects the study in which the relative risk was reported. COMEAP considers that it might be appropriate to calculate local estimates using data on total deaths.
Data source	The data source is ready. The data for population-weighted anthropogenic $PM_{2.5}$ will come from the annual assessment of air quality in the UK, already undertaken by Defra as part of its obligations under the Ambient Air Quality Directive (2008/50/EC). This produces a modelled estimate of population exposure to $PM_{2.5}$ across the UK, calibrated using measured concentrations taken from Defra's Automatic Urban and Rural Network (http://uk-air.defra.gov.uk/interactive-map).

3.1 Air pollution (continued)	
Data source (continued)	COMEAP has recently considered methods for estimating the mortality burden associated with $PM_{2.5}$ at a local level and concluded that it is feasible to make assessments at the local authority level. Mortality data are available from ONS.
Reporting	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/documents/reports.html Modelled background $PM_{2.5}$ data are published nationally by Defra (http://laqm.defra.gov.uk/maps/maps2008.html#anch5). A small extension to this, to include population-weighting, would be required. Mortality data are published by and available from ONS.

3.2 Chlamydia diagnoses (15-24 year olds)	
Rationale	Chlamydia causes avoidable sexual and reproductive ill-health, including sympotomatic acute infection and complications such as pelvic inflamatory disease (PID), ectopic pregnancy and tubal-factor infertility. The chlamydia diagnosis rate among under 25 year olds is a measure of chlamydia control activities that can be correlated to changes in chlamydia prevalence (and thereby to changes in ill-health due to chlamydia). Increasing the diagnostic rate will reduce the prevalence of asymptomatic infections. Inclusion of this indicator in the Public Health Outcomes Framework will allow progress that has already been made towards establishing widely available access to chlamydia screening though a range of health services to be built upon over the coming years.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **3.2 Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24.** Numerator: Number of adults aged 15-24 who are diagnosed with chlamydia. Denominator: ONS mid-year resident population estimate for age 15-24 years. Rate = (Num/Den) x 100,000. The Health Protection Agency recommends that local authorities should be working towards achieving a diagnosis rate of 2,400 per 100,000 population to 3,000 or higher (provisional).
Data source	The data source is ready. Health Protection Agency.
Reporting	Annual local authority and PCT data are published on the Health Protection Agency website. Health Protection Agency website for annual strategic health authority data: http://www.hpa.org.uk/stiannualdatatables Health Protection Agency website for annual PCT and local authority data: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SexualHealthProfilesAndIndex/SexualHealthProfilesPerformance Currently, annual PCT data is also included in SWPHO's Sexual Health Balanced Scorecard and the local authority version of the Scorecard will be released end March 2012. Sexual Health Balanced Scorecard data: http://www.apho.org.uk/resource/view.aspx?RID=83256

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 correlated with 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.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. This indicator will provide a proxy for the level of protection a population will have against vaccine preventable communicable diseases and will cover: > 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) [all], human papillomavirus (HPV) [girls only] > adult and "at risk" programmes – seasonal influenza (Flu) and pneumococcal polysaccharide vaccine (PPV). **3.3i Hepatitis B vaccination coverage (one and two year olds).** Numerator: Number of children at age one and two 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" within each reporting area (at present PCT responsible population). **3.3ii BCG vaccination coverage (1-16 year olds)** Numerator: Number of children at each age one year up to 16 years who have received the BCG vaccine within each reporting area (at present PCT responsible population). Denominator: Eligible population as defined in the tuberculosis chapter of the immunisation against infectious diseases "Green Book" within each reporting area (at present PCT responsible population).

3.3 Population vaccination coverage (continued)	
Indicator definition (continued)	**3.3iii DTaP/IPV/Hib vaccination coverage (one, two and five year olds).** Numerator: Number of children at age one, two and five 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 one, two and five years resident within each reporting area (at present PCT responsible population). **3.3iv MenC vaccination coverage (one, two and five year olds).** Numerator: Number of children at age one, two and five years who have received the completed course of MenC vaccine within each reporting area (at present PCT responsible population). Denominator: Number of children at age one, two and five years resident within each reporting area (at present PCT responsible population). **3.3v PCV vaccination coverage (one, two and five year olds).** Numerator: Number of children at age one, two and five years who have received the completed course of PCV vaccine within each reporting area (at present PCT responsible population). Denominator: Number of children at age one, two and five years resident within each reporting area (at present PCT responsible population). **3.3vi Hib/MenC booster vaccination coverage (two and five year olds)** Numerator: Number of children at age two and five 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 two and five years resident within each reporting area (at present PCT responsible population). **3.3vii PCV booster vaccination coverage (two and five year olds).** Numerator: Number of children at age two and five 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 two and five years resident within each reporting area (at present PCT responsible population). **3.3viii MMR vaccination coverage for one dose (two year olds).** Numerator: Number of children at age two years who have received one dose of MMR vaccine within each reporting area (at present PCT responsible population). Denominator: Number of children at age two years resident within each reporting area (at present PCT responsible population).

3.3 Population vaccination coverage (continued)	
Indicator definition (continued)	**3.3ix MMR vaccination coverage for one dose (five year olds).** Numerator: Number of children at age five years who have received one dose of MMR vaccine within each reporting area (at present PCT responsible population). Denominator: Number of children at age five years resident within each reporting area (at present PCT responsible population). **3.3x MMR vaccination coverage for two doses (five year olds).** Numerator: Number of children at age five years who have received two doses of MMR vaccine within each reporting area (at present PCT responsible population). Denominator: Number of children at age five years resident within each reporting area (at present PCT responsible population). **3.3xi Td/IPV booster vaccination coverage (13-18 year olds).** Numerator: Number of children at each age 13 years up to 18 years who have received the Td/IPV vaccine within each reporting area (at present PCT responsible population). Denominator: Number of children at each age 13 years up to 18 years resident within each reporting area (at present PCT responsible population). **3.3xii HPV vaccination coverage (females 12-17 year olds).** Numerator: Number of females in each school year (years 8 to 13) who have received the HPV vaccine within each reporting area (at present PCT responsible population). Denominator: Number of females in each school year (years 8 to 13) resident within each reporting area (at present PCT responsible population). **3.3xiii PPV vaccination coverage (over 65s).** 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 (over 65s).** 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).

3.3 Population vaccination coverage (continued)	
Indicator definition (continued)	**3.3xv Flu vaccination coverage (at risk individuals aged over six months).** Numerator: Number of individuals aged six months and older who are in a clinical risk group (as defined in the immunisation against infectious diseases and detailed in the read-code specification produced by PRIMIS+) who have received flu vaccine within each reporting area (at present PCT responsible population). Denominator: Number of individuals aged six months and older who are in a clinical risk group (as defined in the immunisation against infectious diseases and detailed in the read-code specification produced by PRIMIS+) within each reporting area (at present PCT responsible population).
Data source	The data source is ready (although it will need to be developed further to take into account the restructuring of primary care). 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 authority level – it has yet to be determined whether this will transfer over to being collected at clinical commissioning group or local authority level or both 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 be able to extract data at local authority level and changes can be made to the ImmForm system to aggregate data up to local authority level.
Reporting	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 the Health Protection Agency: http://www.hpa.org.uk/HPA/Topics/InfectiousDiseases/InfectionsAZ/1204031507699 HPV vaccine uptake data are published as provisional data by the Department of Health/Health Protection Agency for each of the ten months of each academic year (October to July) and then later as final data for the complete academic year at: http://www.dh.gov.uk/en/Publichealth/Immunisation/Keyvaccineinformation/DH_103944 PPV vaccine uptake data are published for each financial year at: http://www.dh.gov.uk/en/Publichealth/Immunisation/Keyvaccineinformation/DH_103944 Influenza vaccine uptake are published as provisional data by the Department of Health/Health Protection Agency for each of the four months of the influenza season (November to December) and then later as final data at: http://www.dh.gov.uk/en/Publichealth/Immunisation/Keyvaccineinformation/DH_104070 Immunisation coverage data are published as national statistics annually by the NHS Information Centre and include all data collected through COVER in addition to the KC50 collection: 2010/11 data: http://www.ic.nhs.uk/pubs/immstats1011

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.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **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 or an AIDS diagnosis 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 have a CD4 count within 91 days of diagnosis and who have residence information available. If single year numbers are found to be too small, then it may be necessary to combine several years of data. The definition is being updated to include AIDS diagnoses within 91 days. It has also been recently updated from a CD4 count <200 cells/mm^3 within 91 days of diagnosis to <350 cells/mm^3. This reflects the 2008 BHIVA treatment guidelines, which recommend patients should begin anti-retroviral therapy when CD4 cells counts drop <350 cells/mm^3.
Data source	The data source is ready. Health Protection Agency.
Reporting	Currently published annually at PCT level on the Health Protection Agency website and as part of the SWPHO Sexual Health Balanced Scorecard. Health Protection Agency website for annual PCT data: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SexualHealthProfilesAndIndex/SexualHealthProfilesPerformance Sexual Health Balanced Scorecard data: http://www.apho.org.uk/resource/view.aspx?RID=83256 There are existing plans to publish this by local authority on both websites.

3.5 Treatment completion for tuberculosis	
Rationale	Tuberculosis re-emerged as a serious public health problem in the UK over the last two decades, with tuberculosis incidence rising above the European average. Timely treatment for tuberculosis 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 tuberculosis is particularly important as it has more severe health consequences and is considerably more expensive to treat.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **3.5 Proportion of patients who successfully complete treatment for tuberculosis.** Numerator: Number of cases who successfully completed treatment for tuberculosis. Denominator: Number of cases of tuberculosis in the population.
Data source	The data source is ready. A national enhanced web-based tuberculosis surveillance system run by the Health Protection Agency collects the outcome of treatment for each tuberculosis case. The data are collected annually.
Reporting	Data are published nationally on an annual basis by the Health Protection Agency. November 2010 annual report: http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1287143581697 It should be possible to publish data at local authority level but would require consideration of deductive disclosure issues for many parts of the country.

3.6 Public sector organisations with board-approved sustainable development management plan	
Rationale	The Climate Change Act identifies an 80% reduction in carbon emissions by 2050 to reduce the UK impact on climate change. 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 as a cause of avoidable ill health. Sustainable development provides a framework for balancing economic, social and environmental considerations, including climate change – this supports public health through strengthening communities and reducing inequalities now in addition to adaptation and resilience for the years ahead. Achievement of 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 (SDMPs) for public sector organisations.
Final indicator available from	Now at national level for NHS organisations. TBC at local authority level and for non-NHS organisations.
Indicator definition	The indicator definition needs further development, eg to define what public sector organisations will be included. **3. 6 Percentage of NHS organisations with board-approved sustainable development management plan.** Numerator: For a given date, the number of NHS organisations where the board approved a Sustainable Development Management Plan in the preceding 12 months. Denominator: For a given date, the number of NHS organisations. The intention is that the indicator should be developed in future to cover all public sector organisations that have an influence on the public health of the population. A study project would be required to identify the organisations to include in this indicator, eg police, social care services and local authorities. Services provided on behalf of the public sector would also be included in this study, eg any qualified provider for NHS services. Further work is required on the definition at local authority level to determine whether data for an organisation should be attributed to the local authority where it is based or the local authority it provides services for.
Data source	The data source exists but requires further development. This indicator is 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 will be mandatory from 2011. Information is available now at national level for NHS organisations, collected by 10 regional leads. The NHS Sustainable Development Unit (SDU) is working with partners to ensure the data is collected in a streamlined manner.

3.6 Public sector organisations with board-approved sustainable development management plan (continued)	
Data source (continued)	It will be possible to produce local authority level data using this source though (as outlined above) further work is needed to determine which local authority organisations' data should be attributed to. As above, we propose that work is undertaken to identify data sources for public sector organisations as identified.
Reporting	The data is currently published annually at national level for NHS organisations: http://www.erpho.org.uk/viewResource.aspx?id=21255 Data is not currently published at local authority level.

3.7 Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)	
Rationale	This indicator will provide an indication of the preparedness for organisations to respond to emergencies and outbreaks of infection. Legislation requires emergency planning resilience and response to be in place for NHS, Public Health England and local authorities. Providers of regulated activities should be able 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. While this indicator reflects a process rather than an outcome, it is an important quality focused proxy measure for assessing the probability that our response to public health incidents and outbreaks of infection will achieve the best possible outcome.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. **3.7 Comprehensive, agreed inter-agency plans for responding to public health incidents.** 1. Emergency preparedness and response plans assured by both Public Health England and Directors of Public Health, demonstrating a clear strategy for interagency working to ensure the safety of the public at all times. 2. Policies for outbreaks of communicable infection should include initial assessment, communication, management and organisation, plus investigation and control.
Data source	A new data source is required. 1. TBC – Public Health England and Directors of Public Health are possible sources for this indicator. 2. Public Health England possible source of data.
Reporting	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 wellbeing of both the mother and the baby. The infant mortality indicator is a shared improvement area with the NHS Outcomes Framework, addressing issues of premature mortality, which are influenced by both the NHS and public health interventions.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **4.1 Crude rate of infant deaths (persons aged less than one year) per 1,000 live births.** Numerator: The number of registered infant deaths aged under one year Denominator: The number of live births registered. Rate = (Num/Den) x 1,000.
Data source	The data source is ready. ONS death occurrence and registration records along with linked birth and death occurrence and registration records.
Reporting	Data is published annually by ONS: 2010 death registrations data published by ONS (England and Wales): http://www.ons.gov.uk/ons/rel/vsob1/death-reg-sum-tables/2010/index.html 2009 ONS data on infant mortality by social and biological factors (England and Wales): http://www.ons.gov.uk/ons/rel/child-health/infant-and-perinatal-mortality-in-england-and-wales-by-social-and-biological-factors/2009/statistical-bulletin.html Local authority level figures published annually in the Local Authority Health Profiles and in the compendium of population health indicators: http://www.healthprofiles.info https://indicators.ic.nhs.uk/webview

4.2 Tooth decay in children aged five	
Rationale	Tooth decay is a predominantly preventable disease. Significant levels remain (31% of children), resulting in treatment need, pain, and in some cases treatment required under general anaesthetic. Inclusion of this indicator in the Public Health Outcomes Framework will encourage local areas to focus on and prioritise oral health and oral health improvement initiatives (which can be very effective in preventing tooth decay).
Final indicator available from	Now at national and local authority level (on a four-yearly basis). From 2014/15, there is a possibility that data could be published annually. It would be based on a new data source and therefore needs to be assessed, to confirm whether it would be a reliable replacement (see below).
Indicator definition	The indicator definition is ready. **4.2 Rate of tooth decay in children aged five years (based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted – dmft).** Numerator: Number of decayed/missing/filled teeth in the survey sample of five-year-old children. Denominator: Number of five-year-old children in the survey sample. Rate = (Num/Den).
Data source	The data source needs further development (to produce annual data). NHS dental epidemiological survey programme undertaken by PCTs lead by the Dental Observatory of North West Public Health Observatory (NWPHO). Data is currently only collected every four years, however from 2014/15 there is a possibility of collecting this information annually, from a different source (although this needs to be assessed, to confirm it is an acceptable replacement). In early 2013 data will be available for the year 2011/12.
Reporting	Data is published every four years by the NWPHO and The Dental Observatory at national, regional, PCT and local authority level. Main page of the publication: http://www.nwph.net/dentalhealth The most recently published data (2007/08): http://www.nwph.net/dentalhealth/survey-results.aspx?id=1

4.3 Mortality 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. ONS is working on a definition of preventable mortality, following a public consultation earlier in 2011 and are expecting to report on this soon. There will be a clear role for public health to play in reducing preventable mortality in the general population. We suggest that this indicator could incorporate mortality associated with healthcare-associated infections in the community and that associated with food-borne illnesses. Both of these are reported to the Health Protection Agency and are therefore measurable.
Final indicator available from	TBC
Indicator definition	The indicator definition requires further development. **4.3 Age-standardised rate of mortality from causes considered preventable per 100,000 population.** Numerator: Number of deaths from causes considered preventable. Denominator: Total population based on ONS mid-year population estimates. Exact definition TBC – ONS is currently developing a definition of preventable mortality and the definition of this indicator will align with this. Mortality due to organisms resistant to key life-saving antibiotics could be a potential indicator in the future.
Data source	The data source is ready. ONS death registrations data and population estimates.
Reporting	ONS will publish data on preventable mortality once the definition is finalised.

4.4 Mortality from all 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 indicator in the Public Health Outcomes Framework (alongside an equivalent indicator in the NHS Outcomes Framework) sends out a clear signal that prevention of CVD is just as important as treatment.
Final indicator available from	4.4i available now. 4.4ii TBC.
Indicator definition	The indicator definition needs further development. **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.** Numerator: Number of deaths from all cardiovascular diseases (including heart disease and stroke) classified by underlying cause of death recorded as ICD10 codes I00-I99 registered in the respective calendar years, in people aged under 75. Denominator: Number of people aged under 75 based on ONS mid-year population estimates. This is a shared sub-indicator with the NHS Outcomes Framework. **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.** Numerator: Number of deaths that are considered preventable from all cardiovascular diseases (including heart disease and stroke) classified by underlying cause of death recorded as ICD10 codes I00-I99 registered in the respective calendar years, in people aged under 75. Denominator: Number of people aged under 75 based on ONS mid-year population estimates. Exact definition TBC – ONS is currently developing a definition of preventable mortality and the definition of this sub-indicator will align with this.
Data source	The data source is ready. ONS death registrations data and population estimates.
Reporting	Standardised mortality rates at national and local authority level are published in the compendium of population health indicators: https://indicators.ic.nhs.uk/webview

4.5 Mortality 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 indicator in the Public Health Outcomes Framework (alongside several indicators in the NHS Outcomes Framework relating to cancer survival rates) sends out a clear signal that prevention of cancer is just as important as treatment.
Final indicator available from	4.5i available now. 4.5ii TBC.
Indicator definition	The indicator definition needs further development. **4.5i Age-standardised mortality rate from all cancers for persons aged under 75 per 100,000 population.** 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: Number of people aged under 75 based on ONS mid-year population estimates. This is a shared sub-indicator with the NHS Outcomes Framework. **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.** Numerator: Number of deaths that are considered preventable 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: Number of people aged under 75 based on ONS mid-year population estimates. Exact definition TBC – ONS is currently developing a definition of preventable mortality and the definition of this sub-indicator will align with this.
Data source	The data source is ready. ONS death registrations data and population estimates.
Reporting	Standardised mortality rates are published at national and local authority level in the compendium of population health indicators: https://indicators.ic.nhs.uk/webview

4.6 Mortality 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. Inclusion of this indicator in the Public Health Outcomes Framework will provide an impetus for local authorities to prioritise action on the drivers of liver disease. The inclusion of this indicator in the Public Health Outcomes Framework (alongside an equivalent indicator in the NHS Outcomes Framework) sends out a clear signal that prevention of liver disease is just as important as treatment.
Final indicator available from	4.6i available now. 4.6ii TBC.
Indicator definition	The indicator definition needs further development. **4.6i Age-standardised mortality rate from liver disease for persons aged under 75 per 100,000 population.** Numerator: Number of deaths from liver disease classified by underlying cause of death recorded as as ICD10 codes K70-K77, B15-B19, C22, I81, I85 and T86.4 registered in the respective calendar years, in people aged under 75. K70 Alcoholic liver disease K71 Toxic liver disease K72 Hepatic failure, not elsewhere classified K73 Chronic hepatitis, not elsewhere classified 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 and intrahepatic bile ducts I81 Portal vein thrombosis I85 Oesophageal varices T86.4 Liver transplant failure and rejection.

4.6 Mortality from liver disease (continued)	
Indicator definition (continued)	Denominator: Number of people aged under 75 based on ONS mid-year population estimates. **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.** Numerator: Number of deaths that are considered preventable from liver disease classified by underlying cause of death recorded as as ICD10 codes K70-K77, B15-B19, C22, I81, I85 and T86.4 registered in the respective calendar years, in people aged under 75. Denominator: Number of people aged under 75 based on ONS mid-year population estimates. Exact definition TBC – ONS is currently developing a definition of preventable mortality and the definition of this sub-indicator will align with this.
Data source	The data source is ready. ONS death registrations data and population estimates.
Reporting	Data for this indicator not currently published

4.7 Mortality 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 indicator in the Public Health Outcomes Framework (alongside an equivalent indicator in the NHS Outcomes Framework) sends out a clear signal that prevention of respiratory disease is just as important as treatment.
Final indicator available from	4.7i available now. 4.7ii TBC.
Indicator definition	The indicator definition needs further development. **4.7i Age-standardised mortality rate from respiratory diseases for persons aged under 75 per 100,000 population.** 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: Number of people aged under 75 based on ONS mid-year population estimates. **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.** Numerator: Number of deaths that are considered preventable 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: Number of people aged under 75 based on ONS mid-year population estimates. Exact definition TBC – ONS is currently developing a definition of preventable mortality and the definition of this sub-indicator will align with this.
Data source	The data source is ready. ONS death registrations data and population estimates.
Reporting	Data for this indicator not currently published.

4.8 Mortality from communicable diseases (Placeholder)	
Rationale	Inclusion of this indicator in the Public Health Outcomes Framework will reinforce 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. A key area of prevention is healthcare-associated infections (HCAI). Inclusion of this indicator would reinforce how seriously the Government takes the control of HCAI and prevention of avoidable deaths.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. Exact definition TBC – need to work to decide the full range of specific diseases that will be included and the most appropriate method of estimation. The specific diseases that can be measured are mortality due to MRSA, MSSA, *Escherichia coli* bacteraemia and *Clostridium difficile* infection. ONS already publishes this data and the Health Protection Agency also collects data on bacteraemia.
Data source	The data source is ready. ONS death registrations data and population estimates in combination (as appropriate) with infectious disease surveillance data.
Reporting	TBC – pending agreement of final definition.

4.9 Excess under 75 mortality in adults with serious mental illness (Placeholder)	
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 joint indicator with the NHS Outcomes Framework – its inclusion in this and the Public Health Outcomes Framework will reflect the importance of such high-level priorities being joined up between the public health and NHS/ health service agendas.
Final indicator available from	April 2012
Indicator definition	The indicator definition needs further development. Exact definition TBC. The intention is that this will align with the definition used in the NHS Outcomes Framework. Premature mortality in people with serious mental illness (SMI) will be compared to premature mortality in the general population. "People with serious mental illness" are defined as those listed in the Mental Health Minimum Dataset (MHMDS) for the current and previous two years. The MHMDS covers those adults receiving secondary healthcare for a mental illness. It is proposed to exclude those aged 75 and over to align with the other premature mortality indicators in domain 4, and those aged under 18 as children under 18 are treated by CAMHS as opposed to adult services. The exact method of calculating the indicator is still to be finalised by the Department of Health in consultation with experts in ONS and the Information Centre for Health and Social Care (IC).
Data source	The data source needs further development. Mental Health Minimum Data Set linked with ONS death registrations data. The Information Centre is carrying out a development project to set up routine production of this indicator. The first data from this is likely to be available in April 2012.
Reporting	This data is likely to be published by the NHS Information Centre but it is currently unclear when this is likely to begin.

4.10 Suicide	
Rationale	The draft suicide prevention outcomes strategy 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 will be the primary lever for making progress on this cross-Government strategy. Without the indicator, the strategy is likely to have minimal impact, and the suicide rate is very likely to rise above current levels.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **4.10 Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population.** Numerator: Number of deaths from suicide and injury of undetermined intent classified by underlying cause of death recorded as ICD10 codes X60-X84, Y10-Y34 registered in the respective calendar years. Denominator: ONS mid-year population estimates.
Data source	The data source is ready. ONS death registrations data and population estimates.
Reporting	Data published at national and local authority level in the compendium of population health indicators: https://indicators.ic.nhs.uk/webview

4.11 Emergency readmissions within 30 days of discharge from hospital (Placeholder)	
Rationale	This indicator will follow individuals discharged from hospital to monitor success in avoiding emergency readmissions. Health interventions and social care will play significant 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 as a placeholder within the NHS Outcomes Framework.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. Exact definition TBC. The intention is that this will align with the definition used in the NHS Outcomes Framework – currently under development.
Data source	The data source is ready. Hospital Episode Statistics.
Reporting	Readmissions data published at England and local authority level are currently published in the compendium of population health indicators: 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 ageing 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 for 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 possible and reduce needs for social care support, which would be necessary if sight was lost permanently.
Final indicator available from	TBC
Indicator definition	The indicator definition needs further development. **4.12 Proportion of Certificate of Visual Impairment (CVI) registrations that are due to age related macular degeneration (AMD), glaucoma and diabetic retinopathy.** The indicator relates to three of the main eye diseases, which can result in blindness or partial sight if not diagnosed and treated in time. These are AMD, glaucoma and diabetic retinopathy. Therefore "Preventable Sight Loss", as a new indicator definition, would be those who are classified as blind or partially sighted, due to one of these three eye conditions. This would be measured by taking the proportion of partially sighted/blind registration for these preventable eye diseases, against the total number of registrations. Numerator: The number of CVI registrations that are due to AMD, glaucoma and diabetic retinopathy. Denominator: Total number of CVI registrations. The CVI form includes date of birth so it is possible to separate or combine age groups. This would be particularly important as AMD and glaucoma are age prevalent. The form would also distinguish between blind or partially sighted registrations, so this also can be reported and/or assessed separately. By providing data on blindness due to diabetic retinopathy the indicator would also provide valuable information for the national diabetic retinopathy screening programme.

4.12 Preventable sight loss (continued)	
Data source	The data source is ready. The data source is the CVI registrations, which are available at national and local level. Data is analysed by a team based at Moorfields Eye Hospital and currently funded by the RNIB. The Department of Health and the Royal College of Ophthalmologists have jointly contracted with Moorfields to be responsible for the data. The team at Moorfields uses the Blind/Partially Sighted registered (published by the IC every two years) as a means of quality assuring the CVI data (to identify gaps etc). Caveats to these data sources: Neither (CVI or Register) are a complete count of all people who are blind but instead are the by-products of administrative systems. Registering is voluntary (although it does provide some financial benefits) and Moorfield does not receive all CVIs. However, this was recently assessed and it was found that just over 92% of CVIs were received by Moorfields. We would recommend this to be monitored regularly.
Reporting	The data for this new indicator definition, "Preventable Sight Loss", is not currently published but it is held centrally (by Moorfield Eye Hospital). However, Moorfields does 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/latest_news.aspx The NHS Information Centre publishes data on people registered Blind and Partially Sighted every two years at council level: http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/registered-blind-and-partially-sighted-people--year-ending-31-march-2011-in-england

4.13 Health-related quality of life for older people (Placeholder)	
Rationale	One in five people are over 65 and this is set to rise to one in three 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 wellbeing in older people – this is key to keep systems functioning and to ensure that the needs of this large group of users are addressed.
Final indicator available from	TBC
Indicator definition	A new definition is required. Exact definition TBC. The intention is that this definition will align 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.
Data source	The data source needs further development. Exact data source TBC – likely to use EQ-5D data currently collected in the Health Survey for England (HSE) or English Longitudinal Survey of Ageing (ELSA).
Reporting	Data not currently published for this indicator.

4.14 Hip fractures in over 65s	
Rationale	Hip fracture is a debilitating condition – only one in three sufferers return to their former levels of independence and one in three 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. Inclusion of this indicator in the Public Health Outcomes Framework will encourage prioritisation of such interventions.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **4.14 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 for primary diagnosis of fractured neck of femur in 65+ age group. Denominator: Number of people aged 65 and over based on ONS mid-year population estimates. This indicator relates to fractured neck of femur classified by primary diagnosis (ICD10 S72.0, S72.1, S72.2) with an emergency admission code admitted in the respective financial year. ICD10 codes for fractured proximal femur refer to the following diagnoses: > S72.0 Fracture of neck of femur > S72.1 Pertrochanteric fracture > S72.2 Subtrochanteric fracture.
Data source	The data source is ready. Hospital Episode Statistics. Figures can be corroborated with the National Hip Fracture Database (NHFD).
Reporting	Data on hip fractures are published in HES tables by the NHS Information Centre. Three-year aggregated 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	Excess winter deaths are a major cause of mortality and ill health, 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 EWD Index is a key measure for the Cold Weather Plan for England.
Final indicator available from	Now
Indicator definition	The indicator definition is ready. **4.15 Excess Winter Deaths Index: The ratio of extra deaths from all causes that occur in the winter months compared to the expected number of deaths, based on the average of the number of non-winter deaths.** Numerator: Number of excess winter deaths, ie number of deaths occurring in the months December to March minus half the number of deaths in the non-winter months (preceding August to November and following April to July). Denominator: The average number of deaths per quarter occurring in the non-winter months, ie number deaths occurring in the preceding August to November and the following April to July, for a single year divided by two.
Data source	The data source is ready. ONS death registrations data.
Reporting	ONS publishes 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/excess-winter-mortality-in-england-and-wales--2009-10--provisional--and-2008-09--final-/excess-winter-mortality-in-england-and-wales.pdf Local authority level data is published by PHOs in the annual Local Authority Health Profiles (three-year pooled) and WMPHO Excess Winter Deaths in England Atlas (three-year pooled and single year): http://www.healthprofiles.info http://www.wmpho.org.uk/excesswinterdeathsinEnglandatlas

4.16 Dementia and its impacts (Placeholder)	
Rationale	There are an estimated 610,000 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 over £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 half of dementias have a vascular component.
Final indicator available from	TBC
Indicator definition	A new definition is required. Exact definition TBC.
Data source	The data source needs further development. There are a number of possible data sources that could be used depending on the exact definition of this indicator including the Quality and Outcomes Framework, PHO estimates of the prevalence of dementia, Hospital Episode Statistics and the Mental Health Minimum Data Set.
Reporting	Data not currently reported on this indicator.

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