**Public Health Dashboard Indicators**

**Best Start in Life**

|  |  |
| --- | --- |
| **Indicators** | **Rationale** |
| **Proportion of New Birth Visits (NBVs) completed within 14 days** – % completeness of the second of five mandated health reviews | Local Authorities are mandated to provide 5 health reviews as part of a universal health visiting service. These are scheduled antenatal visit, new birth visit, 6-8-week review, 1 year review and 2-21/2 years review. It is the responsibility of the LA to ensure that the pregnant women, infants and children who are eligible for this service can benefit from it.  This indicator acts as proxy for the delivery of the mandated elements of the service to ensure all families receive support on becoming parents, and families are identified early where extra help is needed. |
| **Proportion of children ready for school (%), aged 5** – Proportion of children achieving a good level of development at the end of reception | Local Authorities are responsible for children’s public health (0–5 years) and for improving the health and wellbeing of this population. School readiness is a key outcome measure for the effectiveness of services responsible for identifying where extra help is needed and ensuring early intervention.  Children from more deprived backgrounds are more at risk of poorer development outcomes and the evidence shows that differences by social background emerge early in life. |
| **Breastfeeding prevalence (%), at 6-8 Weeks** – % of all infants due a 6-8 week health review that are totally or partially breastfed | Local authorities are responsible for delivery of the universal health visiting service. Health visitors and their teams have a key role in promoting the health benefits of breastfeeding and encouraging the continued prioritisation of breastfeeding support locally.  Breastfeeding prevalence is monitored at the 6-8 weeks health review as a key outcome. Evidence shows that increases in breastfeeding rates and duration have health benefits for the infant and the mother. |
| **Proportion of children who received ASQ-3 (%), aged 2-2½** - Proportion of children aged 2-2½yrs who were assessed using ASQ-3 as part of their mandated health review at 2 - 2½yrs or integrated review | Local Authorities are responsible for delivery of the universal health visiting service. A key component of this is the universal review at 2 21/2 years where the development outcomes for all children are assessed using the Ages and Stages Questionnaire.  Dimensions of development include communication, gross motor, fine motor, problem solving and social & emotional skills. A good level of development at this age is critical for health and wellbeing outcomes but also for accessing pre-school and later educational opportunities.  This indicator will help to build a picture of child development at age 2-2½ at national and local level. It will support local areas in assessing the effectiveness and impact of services for 0-2 year olds and with planning services for children age 2 and beyond. |

**Child Obesity**

|  |  |
| --- | --- |
| **Indicators** | **Rationale** |
| **Prevalence of obesity (%), aged 4-5** – Prevalence of obesity in children aged 4-5 years in Reception year as measured by NCMP | This indicator identifies the prevalence of obesity at the start of primary school. The health consequences of childhood obesity include type 2 diabetes, hypertension and psychological problems such as social isolation, low self-esteem, teasing and bullying among other things. There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood.  By taking action to reduce levels of childhood obesity, local authorities can help ensure healthy behaviours persist into adulthood culminating in a healthier population, a reduction in inequalities and reduced demand on social and health care services. |
| **Prevalence of obesity (%), aged 10-11** – Prevalence of obesity in children aged 10-11 years in Year 6 as measured by NCMP | This indicator identifies the prevalence of obesity at the end of primary school. The health consequences of childhood obesity include type 2 diabetes, hypertension and psychological problems such as social isolation, low self-esteem, teasing and bullying among other things. There is concern about the rise of childhood obesity, the more than doubling of child obesity prevalence between Reception and Year 6 and the implications of such obesity persisting into adulthood.  By taking action to reduce levels of childhood obesity, local authorities can help ensure healthy behaviours persist into adulthood culminating in a healthier population, a reduction in inequalities and reduced demand on social and health care services. |

**Drug Treatment**

|  |  |
| --- | --- |
| **Indicators** | **Rationale** |
| **Proportion of opiate and/or crack cocaine users (i.e. OCU) not in treatment (%)** – the % persons not in treatment (based on prevalence estimate) | Services delivering evidence-based and effective structured drug treatment interventions are vital components of a local authority’s response to drug misuse and dependence. Such interventions can improve the lives of individuals, the life chances of their children and family, and community stability. They also have a significant impact on reducing the spread of blood-borne viruses, reducing drug related deaths and reducing crime. The harmful effects of drugs are greater in poorer communities and effective treatment services can play an important role in addressing these inequalities.  This indicator identifies how well need is being met in local areas. |
| **Proportion waiting over three weeks for treatment (%)** – the % waiting over 3 weeks for treatment | This indicator measures the proportion of people waiting beyond a reasonable timescale for treatment. Prompt access to treatment is vital in terms of engaging people in treatment, and long waiting times can be a sign of problems with the availability and/or effectiveness of treatment. |
| **Successful completion of drug treatment, treatment ratio -** people who do not re-present within 6 months of completion, ratio of observed to expected | This indicator allows a comparison of recovery rates and can illustrate the effectiveness of a service in a particular area. Individuals achieving this outcome have overcome their drug dependence, which can lead to improvements in health and well-being, reduced mortality, reduced blood-borne virus transmission risk, improved parenting and improved physical and psychological health.  This indicator aligns with the public health ambition of the Government's drug strategy of increasing the number of individuals recovering from addiction. It also supports reductions in re-offending, as offending behaviour is closely linked to substance use and there is evidence that treatment reduces re-offending significantly. This in turn will have benefits for a wide range of other services. |
| **Deaths in drug treatment, mortality ratio** – ratio of observed to expected deaths | This indicator identifies local authorities where deaths in treatment are higher or lower than expected. This rate is indicative of the safety, effectiveness and protection afforded by drug treatment services. |

**Alcohol Treatment**

|  |  |
| --- | --- |
| **Indicator/s** | **Rationale** |
| **Proportion of dependent drinkers not in treatment (%)** – the % persons not in treatment based on prevalence estimate | Services delivering evidence-based and effective structured substance misuse treatment interventions are vital components of a local authority’s response to substance misuse and dependence Such interventions can improve the lives of individuals, the life chances of their children and family, and community stability. They also have a significant impact in reducing alcohol related deaths and in reducing crime and health costs. The harmful effects of alcohol are greater in poorer communities and effective treatment services can play an important role in addressing these inequalities.  This indicator identifies how well need is being met in local areas. |
| **Proportion waiting over three weeks for treatment (%)** – the % waiting over 3 weeks for treatment | This indicator measures the proportion of people waiting beyond a reasonable timescale for treatment. Prompt access to treatment is vital in terms of engaging people in treatment, and long waiting times can be a sign of problems with the availability and/or effectiveness of treatment. |
| **Successful completion of alcohol treatment, treatment ratio -** people who do not re-present within 6 months of completion (%) | Individuals achieving this outcome demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced alcohol-related illness and hospital admissions, improved parenting skills and improved psychological health. It will also reduce the harms to others caused by dependent drinking.  Alongside this, it aligns with the ambition of both public health and the Government's strategy of increasing the number of individuals recovering from addiction. It also aligns with the PHOF re-offending indicators, as some offending behaviour is closely linked to dependent alcohol use. |
| **Deaths in alcohol treatment, mortality ratio** – ratio of observed to expected deaths | This indicator identifies local authorities where deaths in treatment are higher or lower than expected. This rate is indicative of the safety, effectiveness and protection afforded by alcohol treatment services. |

**NHS Health Checks**

|  |  |
| --- | --- |
| **Indicators** | **Rationale** |
| **Proportion of eligible population having an NHS Health Check (%), aged 40-74** | Local authorities have a legal duty to make arrangements to provide the NHS Health Check programme to 100% of the eligible population over a five-year period and to achieve continuous improvement in uptake. A high take up of NHS Health Check is important to identify early signs of poor health leading to opportunities for early interventions.  This indicator demonstrates the cumulative progress made by local authorities in the proportion of eligible people having an NHS Health Check. |
| **Proportion of eligible population invited for an NHS Health Check (%), aged 40-74** | Local authorities have a legal duty to make arrangements to provide the NHS Health Check programme to 100% of the eligible population over a five-year period and to achieve continuous improvement in eligible people having a check. A high coverage is important to identify early signs of poor health leading to opportunities for early interventions across the population.  This indicator demonstrates the progress made by local authorities in offering NHS Health Checks. |

**Tobacco Control**

|  |  |
| --- | --- |
| **Indicators** | **Rationale** |
| **Adult smoking prevalence (%)** - % persons aged 18 + who are self-reported smokers in the Annual Population Survey | Smoking is the single largest cause of preventable deaths and one of the largest causes of health inequalities in England. As well as dying prematurely, smokers also suffer many years of poor health. As a consequence of taking action to help reduce the prevalence of smoking, local authorities can take significant progress in their duty to improve the health of people who live in their area. |
| **Smoking status at time of delivery (% of mothers)** - % of mothers known to be smokers at the time of delivery as a percentage of all maternities. | Smoking during pregnancy increases the risk of stillbirth, and babies born to mothers are more likely to be born underdeveloped and in poor health. Reducing the levels of smoking in this group will help reduce health inequalities and help give children the best start in life. Local Authorities have responsibilities for commissioning stop smoking services and ensuring that these are available to priority populations and those in most need, which include pregnant women.  This indicator monitors the progress made in reducing smoking at the time of delivery. |

**Sexual and Reproductive Health**

|  |  |
| --- | --- |
| **Indicators** | **Rationale** |
| **Chlamydia detection rate per 100,000, aged 15-24 -** Rate of chlamydia detection per 100,000 young people aged 15 to 24 | Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility.  Chlamydia screening is the responsibility of local authorities and the detection rate in under 25 year olds is sensitive to levels of service delivery.  The chlamydia detection rate amongst under 25 year olds is used as a measure of chlamydia control activity. Thus, unlike the metrics relating to other STIs, a higher detection rate equates to a better outcome as it is a marker of increased control activity. The data are presented and interpreted in this way in the Public Health Outcomes Framework and other profiles. |
| **HIV testing coverage, total (%) -** proportion of ‘eligible new attendees’ in whom a HIV test was accepted | Local authorities are required to provide, or secure the provision of, open access sexual health services in its area including: preventing the spread of sexually transmitted infections (STIs); treating, testing and caring for people with STIs and partner notification.  This measure of coverage relates to tests offered in specialist genitourinary medicine (GUM) sexual health services. The coverage metric examines the proportion of all those who are eligible (recommended) to be tested who receive a test. It takes into account both the proportion offered a test, and those who accepted.  HIV testing in GUM clinics is part of the open access sexual health services commissioned by local authorities. HIV testing is integral to the treatment and management of HIV.  Knowledge of HIV status and access to treatment increases survival rates, improves quality of life and reduces the risk of HIV transmission. |
| **Total prescribed LARC (excluding injections) rate per 1,000, females aged 15-44** - Rate of GP and Sexual and Reproductive Health Services prescribed long acting reversible contraception (LARC), excluding injections | All LARC provision is through local authority commissioning, either through sexual and reproductive health clinics or as an additional service commissioned from General Practice.  An increase in the provision of LARC is a proxy measure for wider access to the range of possible contraceptive methods and should also lead to a reduction in rates of unintended pregnancy.  This measure is includes prescribed LARC for all age groups accessing these services although it is expressed as a rate per 1,000 females aged 15-44. |
| **Under 18s conception rate per 1,000** - conceptions per 1,000 females aged 15-17 | Research evidence shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS.  This is a direct outcome measure of reproductive health advice and services provision to the most vulnerable population, as well as reflecting the contribution of other services provided by local authorities. |
| **STI testing (excl. Chlamydia <25) / 100,000 -** Rate per 100,000 population (aged 15 to 64). | Local authorities are required to provide, or secure the provision of, open access sexual health services in its area including: preventing the spread of sexually transmitted infections (STIs); treating, testing and caring for people with STIs and partner notification.  STI testing is an important aspect of STI prevention activity. This is a measure of tests done for syphilis, gonorrhoea, HIV and, in those aged 25+,  chlamydia  The testing rate is strongly correlated with the STI diagnoses rate. The rate uses the population denominator for 15 to 64 year olds, which includes the majority of those tested and diagnosed.  This metric excludes chlamydia testing in under 25 year olds, which is conducted primarily through the National Chlamydia Screening Programme and is already included within the Chlamydia detection metric. |

**Air Quality**

|  |  |
| --- | --- |
| **Indicators** | **Rationale** |
| **Air quality -** Proportion of the population living within AQMAs (%) | Poor air quality is a significant public health issue. The burden of particulate air pollution in the UK is estimated to be equivalent to nearly 29,000 deaths every year.  Since December 1997 each local authority in the UK has been carrying out a review and assessment of air quality in their area. This involves measuring air pollution and trying to predict how it will change in the next few years. The aim of the review is to make sure that the national air quality objectives will be achieved throughout the UK by the relevant deadlines. These objectives have been put in place to protect people's health and the environment.  If a local authority finds any places where the objectives are not likely to be achieved it must declare an Air Quality Management Area there. This area could be just one or two streets, or it could be much bigger.  The indicator provides an at-a-glance summary of the LA's position relative to other LAs on the proportion of residential population within AQMAs. It is intended that this will raise awareness of Local Air Quality Management (LAQM) and differing approaches to declaring an AQMA (in terms of differences in size and shape). |