Strategic Review of health inequalities post 2010 (Marmot Review)

Framework of indicators to assess performance improvement in delivering Review recommendations

This document presents a selection of indicators against the Framework. These indicators could be used to assess improvement in delivering the Review recommendations. They are examples of possible indicators and for many of them the data to populate the indicator are not currently available. These examples will be further developed, in terms of the breadth of recommendations and details of the measurement of inequality in the coming months.

Go to the indicators

Framework of indicators to assess performance improvement in delivering Review recommendations

Policy Objective A - Give every child the best start in life

Policy recommendation	Delivery mechanisms and interventions	Process indicators	Output indicators	Outcome indicators	Delivery agences
Giving priority to pre and post natal interventions that reduce adverse outcomes of pregnancy	Antenatal care, home visiting	Engagement with women at risk across the social gradient (e.g. ante natal care). More parents in receipt of quality home-visiting support across the support across the gradient e.g. quantity, reach and quality of health visiting in year 1	Risk reduction (e.g. smoking in pregnancy), breastfeeding rates. Parenting skills improved acros the gradient	Improved birth outcomes (e.g. mother's age, gestational age, birthweight and infant death).	DH, DCSF, NHS
Example 1		Percentage of women receiving an initial antenatal assessment within the first 12 weeks of pregnancy.	Percentage of women totally or partially breastfeeding at 6/8 weeks after delivery	Number of infant deaths per 1,000 live births.	
Example 2		Percentage of women receiving an initial antenatal assessment within the first 12 weeks of pregnancy.	Percentage of mothers who are smoking at delivery	Live and stillborn infants with low birth weights (<2500 grams) as a percent of all live and stillborn infants with a stated birth weight.	
Example 3		Number of females aged 15-17 living a distance of < 20 minute's walking time from an EHC provider as a percentage of all females aged 15-17	Mothers aged under 18 not in education, employment or training (NEET) as a percentage of all mothers aged under 18.	The number of conceptions in women aged under 18 per 1,000 resident females aged 15-17.	

Select any yellow cell to go to the specific indicator definition

Policy Object F - Strengthen the role and impact of ill health prevention

Policy recommendation	Delivery mechanisms and interventions	Process indicators	Output indicators	Outcome indicators	Delivery agences
Prioritise investment in ill health prevention and health promotion across government departments to reduce the social gradient	Ensure that effort and resources in lifestyle and behavioural interventions are focused on having and impact on the social gradient	Access to advice on healthy living that is appropriate across the social gradient. Take up of preventive services across the social gradient, including early diagnosis and treatment	Improvement in healthy living indicators across the social gradient. Increased numbers actively involved in specific disease prevention programmes across the social gradient	Improved disease specific outcomes (incidence, prevalence, mortality)	NHS, Social Care, Local Authority planning, CLG, DH, third sector, retailers, food manufacturers, food standards, tobacco, alcohol, pharmaceutical indiustries
Example 4		Percentage of population aged 15-24 screened for Chlamydia.	Chlamydia diagnoses per 100,000 population aged 15-24 years.	Pelvic Inflammatory Disease (PID) diagnoses (or admissions) per 100,000 female population aged 15-30 years	
Example 5		Percentage of children identifying their usual mode of travel to school as being by bicycle or walking	Percentage of children aged 5-14 participating in child pedestrian training schemes and cycle training	i) Percentage change in the number of children aged under 16 years killed or seriously injured (KSI) in road traffic collisions (RTCs) based on a 3 year rolling average compared to the average for 1994 to 1998. ii) Or, age-standardised rate of hospital admissions in children aged under 16 years killed or seriously injured due to RTCs per 100,000 resident population.	
Example 6		Percentage of mothers of infants offered safety awareness training initiatives (and safety guards for the those economically less well off)	Percentage of mothers of infants taking up safety awareness training initiatives (and safety guards for those economically less well off)	Hospital admissions for serious accidental injury in age group 0-4 years, with a length of stay exceeding 3 days, directly age-standardised rate per 100,000 European standard population	

Select any yellow cell to go to the specific indicator definition

Policy recommendation	Delivery mechanisms and interventions	Process indicators	Output indicators	Outcome indicators	Delivery agences
Example 7		Percentage of older people offered fall prevention awareness initiatives (and home safety improvements for those economically less well off).	Percentage of older people taking up fall prevention awareness initiatives (and home safety improvements for those economically less well off).	The number of emergency admissions to hospital of persons with fractured neck of femur followed by relevant surgery within the first two days of admission (expressed as a rate per 100,000 residents for those aged 65 and over.)	
Example 8		Number of women aged 25-64 screened for cervical cancer within the last 3 or 5 years, as a percentage of the total number of women aged 25-64 eligible for screening.		The age standardised incidence cervical cancer in women of all ages.	
Example 9		The percentage of children who have completed all of the recommended vaccination programmes.		Percentage of children with childhood infectious diseases covered by an immunisation programme admitted to hospital with complications	

Select any yellow cell to go to the specific indicator definition

Policy recommendation	Delivery mechanisms and interventions	Process indicators	Output indicators	Outcome indicators	Delivery agences
Implement evidence-based programmes of ill-health preventive interventions that are effective across the social gradient by:	Greater emphasis on evidence based prevention in NICE programme	Increased availability of advice on cost effective preventive interventions. Greater use of cost effective preventive interventions.	Greater effectiveness of preventive programmes.	Reduction in preventable and avoidable death and disability	NICE, NHS
Example 10		Percentage of population aged 15-24 years with adequate knowledge of the need for condoms and how to access and use them (possibly including awareness of various strategies to reduce likelihood of engaging in risky sexual behaviour).	Percentage of sexually active 15-24 year olds engaging in protected sex (condom usage) with new partners.	Chlamydia diagnoses per 100,000 population aged 15-24 years.	
Example 11		Observed percentage of patients on primary care coronary heart disease (CHD) registers compared with the expected percentage from the modelled CHD prevalence estimate by PCT, local authority and GP practice.	Percentage of practices achieving maximum points for coronary heart disease (CHD) management.	Mortality from coronary heart disease in persons aged <75 (directly age-standardised rate per 100,000 population)	
Example 12		Observed percentage of patients on primary care hypertension registers compared with the expected percentage from the modelled hypertension prevalence estimate by PCT and local authority.	The percentage of patients with hypertension in whom the last blood pressure (measured in the last 9 months) is 150/90 or less.	Mortality from stroke in persons aged <75, directly age-standardised rate per 100,000 population.	
Example 13		Observed prevalence of renal replacement therapy (RRT) as a percentage of the expected prevalence, based on national benchmark levels of provision, indirectly standardised for age and sex for the local population.	Patients on chronic kidney disease (CKD) registers in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less as a percentage of all patients on the CKD registers.	The number of people aged 18 and over with stage 3-5 chronic kidney disease (CKD) as a percentage of the resident population aged 18 and over, standardised for age and sex.	

Select any yellow cell to go to the specific indicator definition

Policy recommendation	Delivery mechanisms and interventions	Process indicators	Output indicators	Outcome indicators	Delivery agences
Example 14		The number of people with diabetes having access to structured education to manage their condition	The percentage of patients with diabetes in whom the last HbA1C is 7.5 or less in the previous 15 months	The risk of death for people with diabetes between the age of 20 and 79 years, compared to those without the condition (expressed as relative risk)	

Policy recommendation	Delivery mechanisms and interventions	Process indicators	Output indicators	Outcome indicators	Delivery agences
Increasing and improving the scale and quality of drug treatment programmes, diverting problem drug users from the criminal justice system	Medicalisation of the response to problem drug use	Availability of active recruitment programmes. Diversion from the criminal justice system.	Reduction in the numbers involved in problem drug use and in criminal activity to fund their usage.	Reduction in adverse health outcomes of problem drug use and the social and economic cost of drug-related crime.	NHS, MoJ, HO, ACPO, third sector
Example 15		Percentage of individuals with successful drug treatment outcomes	Prevalence of drug use in the last year and the last month.	Age-standardised mortality rate from causes attributable to drug use (i.e. use of any illicit substance) (age standardised rate per 100,000 population).	

Select any yellow cell to go to the specific indicator definition

Policy recommendation	Delivery mechanisms and interventions	Process indicators	Output indicators	Outcome indicators	Delivery agences
Focusing public health interventions such as smoking cessation programmes and alcohol reduction on reducing the social gradient	Refocusing of needs assessment. Development of evidence based interventions that are effective across the social gradient.	Increase in scale and intensity of evidence based preventive interventions that are effective across the social gradient.	Increase numbers actively involved in specific disease prevention programmes across the social gradient. Reduction in numbers of people across the social gradient involved in behaviours that have adverse health consequences.	Reduction in preventable and avoidable deaths and disability across the social gradient.	SH, NHS, local authorities
Example 16		Price of alcohol across all types of alcohol outlet (£ per unit of alcohol)	Percentage of drinkers aged 18 years and over drinking more than government recommended daily amounts (age standardised rate)	Alcohol attributable morbidity from 1) chronic conditions and 2) acute conditions (directly standardised rate per 100,000 population), presented in terms of persons admitted based on the greatest harm record from multiple (in year) admissions if applicable.	
Example 17		Percentage of alcohol outlets selling alcohol to persons aged under 18 years	Percentage of persons aged under 18 years following Chief Medical Officer's advice* on consumption during childhood (age standardised rate)	Alcohol attributable morbidity from acute conditions in persons aged under 18 years (crude rate per 100,000 population), presented in terms of persons admitted based on the greatest harm record from multiple (in year) admissions if applicable.	
Example 18		The number of smokers that had set a quit date and had successfully quit smoking at the 4 week and 52 week follow up expressed as a rate per 1,000 resident smokers.	The percentage of the adult population that are current, former (ex) and never smokers.	Smoking attributed mortality among people aged over 35 (Directly age standardised mortality rate per 100,000 population)	

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Policy recommendation	Delivery mechanisms and interventions	Process indicators	Output indicators	Outcome indicators	Delivery agences
Improving programmes to address the causes of obesity across the social gradient	Refocusing of needs assessment. Development of evidence based interventions that are effective across the social gradient	Increase in scale and intensity of evidence based preventive and health promotion interventions that are effective across the social gradient	Reduction in the obesogenic environment and behaviours leading to obesity. Increase in aspects of healthy living that reduce obesity	Reduction in levels of obesity and disease associated with obesity across the social gradient.	DH, NHS, local authorities
Example 19		Percentage of children identifying their usual mode of travel to school as being by bicycle or walking	Percentage of children aged 2-15 meeting the recommended levels of physical activity (60 minutes or more of moderate intensity physical activity per day including walking, housework, gardening, sport or exercise, excluding things done as part of school lessons).	Percentage of school children Year 6 (ages 10-11), with valid height and weight recorded, who are obese.	
Example 20		Percentage of eligible adult practice population taking up a physical activity opportunities (counselling; walking; cycling; exercise referral programme) after referral from a primary care professional.	Percentage of adults meeting recommended levels of physical activity (30 minutes or more of moderate intensity physical activity on five or more days per week)	Percentage of adults who are obese. Obesity is defined as a Body Mass Index (BMI) >30 kg/m2	
Focus core efforts of public health departments on interventions related to the social determinants of health proportionately across the social gradient	Refocusing of needs assessment	Increase in plans, guidance and advice on preventive interventions across the social gradient. Increased scale and intensity of interventions focused on the social gradient	Increased numbers of people across the social gradient benefiting from interventions	Reduction in preventable and avoidable deaths and disability across the social gradient	DH, NHS, local authorities

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Category	Definition
Framework category	Process
Indicator definition	Percentage of women receiving an initial antenatal assessment within the first 12 weeks of pregnancy.
Numerator definition	Total number of maternities where the woman received an antenatal assessment within the first 12 weeks
Denominator definition	Total number of maternities
Current policy justification	Early access to and engagement with maternity services enables a plan of care to be established. The plan is tailored to suit the individual health and social care needs of the woman and her partner throughout pregnancy and the transition to parenthood. Late access is associated with poorer birth outcomes and inequalities in outcomes, particularly by ethnic group.
Current provision of this indicator	This indicator is currently produced by the Information Centre https://mqi.ic.nhs.uk/IndicatorDefaultView.aspx?ref=1.06.01at PCT level.
Current data availability	PCTs are required to submit aggregate data on this indicator as part of the Local Delivery Plans, however, individual level data are collected in Hospital Episode Statistics (HES), but the quality is currently poor.
Potential for future development	The possibility of routinely reporting on these data through maternity datasets and HES is being explored.
Limitations of the indicator	Maternity data in HES is currently very poorly coded for many Trusts.

Category	Definition
Framework category	Output
Indicator definition	Percentage of women totally or partially breastfeeding at 6/8 weeks after delivery
Numerator definition	Number of women totally or partially breastfeeding at 6/8 weeks after delivery
Denominator definition	Number of infants due for 6-8 week checks
Current policy justification	Breastfeeding is associated with both short and long term health benefits amoung infants and children. There are inequalities in breastfeeding initiation and duration as mothers in higher socio-economic groups are more likely to breastfeed than mothers in lower socio-economic groups.
Current provision of this indicator	This indicator is routinely published at PCT level on the Department of Health website. http://www.dh.gov.uk/en/Healthcare/Children/Maternity/Maternalandinfantnutrition/Breastfeedinginfantfeeding/DH_085657
Current data availability	PCTs are required to submit aggregate data on this indicator as part of the Local Delivery Plans, however, individual level data are not centrally collected.
Potential for future development	The potential to include this indicator in the Quality and Outcomes Framework (QOF) could be considered. Additional information on the mother's such as age, ethnicity and postcode would provide important information in inequalities on breastfeeding levels.
Limitations of the indicator	There are some data quality issues with this indicator. The evidence base suggests that data on breastfeeding at 6 months would be a more useful indicator, but is not currently collected.

Category	Definition
Framework category	Outcome
Indicator definition	Number of infant deaths per 1,000 live births.
Numerator definition	Number of deaths in the first year of live.
Denominator definition	Number of live births.
Current policy justification	Infant mortality is commonly used indicator of the general health of the population. There are large inequalities in infant mortality rates between areas and between other population groups. One of the existing health inequalities targets aims to reduce the gap in infant mortality between births born to fathers in the 'routine and manual' group and the population as a whole.
Current provision of this indicator	This indicator is produced annually by the Office for National Statistics at national level by various dimensions of inequalities including ethnicity, National Statistics Socio-economic Classification and mother's country of birth. This indicator is produced at national, regional, local authority and PCT level in the Compendium of Clinical and Health Indicators.
Current data availability	Country of birth, parents' National Statistics Socio-economic Classification, infant's gender, infant's age are all recorded at death registration. Parent's country of birth, parent's National Statistics Socio-economic Classification, gender, multiple birth type, registration status (inside marriage, jointly registered outside marriage, sole registered) are all recorded at birth registration. Postcode of residence is recorded at birth and death registration and therefore data can be presented for small areas and by deprivation if numbers allow.
Potential for future development	ONS links all infant deaths to the corresponding birth record, therefore it is possible to calculate mortality rates by parent's country of birth, parent's National Statistics Socio-economic Classification, gender, age and registration type. In addition to this ONS is now linking deaths to the information available through the NHS numbers for babies programme. From this it is possible to estimate the ethnic group for all live births and infant deaths and therefore infant mortality rates by ethnicity are also possible to produce.
Limitations of the indicator	Although many dimensions of inequality are recorded, the small number of infant deaths in any given year means that the calculation of infant death rates by local authority for these dimensions is impractical.

Category	Definition
Framework category	Process
Indicator definition	Percentage of women receiving an initial antenatal assessment within the first 12 weeks of pregnancy.
Numerator definition	Total number of maternities where the woman received an antenatal assessment within the first 12 weeks
Denominator definition	Total number of maternities
Current policy justification	Early access to and engagement with maternity services enables a plan of care to be established. The plan is tailored to suit the individual health and social care needs of the woman and her partner throughout pregnancy and the transition to parenthood. Late access is associated with poorer birth outcomes and inequalities in outcomes, particularly by ethnic group.
Current provision of this indicator	This indicator is currently produced by the Information Centre https://mqi.ic.nhs.uk/IndicatorDefaultView.aspx?ref=1.06.01 at PCT level.
Current data availability	PCTs are required to submit aggregate data on this indicator as part of the Local Delivery Plans, however, individual level data are collected in Hospital Episode Statistics (HES), but the quality is currently poor.
Potential for future development	The possibility of routinely reporting on these data through maternity datasets and HES is being explored.
Limitations of the indicator	Maternity data in HES is currently very poorly coded for many Trusts.

Category	Definition
Framework category	Output
Indicator definition	Percentage of mothers smoking at delivery.
Numerator definition	Number of women smoking at delivery.
Denominator definition	Total number of maternities.
Current policy justification	Smoking during pregnancy harms both the mother and the unborn child. The Scientific committee on Tobacco on Health (SCOTH), which advises Government on smoking and health and tobacco control issues, said in its 1998 Report: 'Smoking in pregnancy causes adverse outcomes, notably an increased risk of miscarriage, reduced birth weight and perinatal death'.
Current provision of this indicator	The indicator is published by the Department of Health at PCT level http://www.dh.gov.uk/en/publichealth/healthimprovement/tobacco/tobaccogeneralinformation/dh_4139682. This indicator is not routinely produced for any dimensions of inequality at present.
Current data availability	PCTs are required to submit aggregate data on this indicator as part of the Local Delivery Plans. However, individual level data on further dimensions of inequality are not centrally collected
Potential for future development	If this data was collected directly from individual health records rather than as a collated return more detailed inequality data could be identified. More detail on pregnant women attending smoking cessation services and outcomes is available at PCT level from the Information Centre website.
Limitations of the indicator	There are some data quality issues with this indicator. In some PCTs the percentage of maternities without smoking status recorded is very high.

Category	Definition
Framework category	Outcome
Indicator definition	Live and stillborn infants with low birth weights (under 2500 grams) as a percentage of all live and stillborn infants with a stated birth weight.
Numerator definition	Number of live and still births occurring in the respective calendar year with birth weights under 2500 grams from birth registrations.
Denominator definition	All live and still births occurring with a stated birth weight in the respective calendar year. From birth registrations.
Current policy justification	Low birth weight is an enduring aspect of childhood morbidity, a major factor in infant mortality and has serious consequences for health in later life. There are wide inequalities in low birth weight in England which are likely to affect childhood and adult health.
Current provision of this indicator	Publically available in the Compendium of Clinical and Health Indicators at national, regional and local authority level. PCT level data published in NHS version only.This indicator is not routinely produced for any dimensions of inequality at present.
Current data availability	Data on all live and stillbirths in England and Wales are collected by the Office for National Statistics. Data on National Statistics Socio-economic Classification of mother and father, country of birth of mother and father, registration type (e.g. whether in marriage, jointly registered, or sole registered), multiple birth type are all collected. Postcode of residence is recorded at birth registration and therefore data can be presented for small areas and by deprivation if numbers allow.
Potential for future development	Health outcomes following low birth weight have been shown to vary according to different ethnic groups. Ethnicity is not routinely collected at birth registration, however, ONS links birth registrations to the NHS numbers for babies programme where ethnicity is recorded.
Limitations of the indicator	The use of low birth weight as an indicator is potentially problematic for a number of reasons including: differences in health outcomes according to different ethnic groups at the same weight, increased survival of premature babies means that the prevalence of low birth weights is likely to increase, multiple births are likely to be smaller than average and are increasing due to developments in assisted fertility.

Category	Definition
Framework category	Process
Indicator definition	Number of females aged 15-17 living a distance of less than 20 minutes walking time from an EHC provider as a percentage of all females aged 15-17
Numerator definition	Not routinely available. Number of females aged 15-17 living a distance of < 20 minutes walking time from an EHC provider.
Denominator definition	ONS population estimates (females aged 15-17). For more precise small area population data the national patient register could be used.
Current policy justification	Although clearly not an ideal method of preventing unwanted pregnancies, emergency contraception is a valid last opportunity. Services provided locally to the communities at greatest risk, at appropriate times (e.g. Sat and Sun mornings) can be expected to be more effective.
Current provision of this indicator	Not routinely available.
Current data availability	It may be possible to use the national "Sexwise" database, used as part of the "r u thinking" website to determine the location of providers of this service, depending on how complete, accurate and up to date this database is. The local patient registers could be used with a geographic information system to determine the number of females living within 20 minutes walk from each provider.The dimensions of inequality at which that indicator could be provided would depend only on the data available on the patient register. Ethnicity is poorly coded, but deprivation could be attributed ecologically at small area level, to enable approximate deprivation-related inequalities in access to be calculated.
Potential for future development	A national database of EHC providers would need to be maintained centrally. The national patient register could be used to analyse the walking distances from each 15-17 year-old female resident to their nearest EHC provider. This would provide a comparative indicator on provision of EHC in each PCT.
Limitations of the indicator	The primary limitations would be on the coding of personal data on the patient register, but it would also depend on the accuracy of the provider database. The GIS analysis could be compromised by factors affecting distances as well, e.g. a route which is shorter, may not be acceptable to young women as a route to walk alone, for safety reasons.

Category	Definition
Framework category	Output
Indicator definition	Mothers aged under 18 not in education, employment or training (NEET) as a percentage of all mothers aged under 18.
Numerator definition	Females under 18 with dependent children that are NEET
Denominator definition	Females under 18 with dependent children
Current policy justification	Teenage motherhood has a strong tendency to replicate from generation to generation. Young mothers often fail to continue in education. Persevering with education is likely to improve the prospects for mother and child/children, and may reduce the likelihood of those children becoming teenage mothers themselves.
Current provision of this indicator	Not currently available.
Current data availability	Data on young people NEET in general are published by Department for Children, Schools and Families at local authority level, and are derived from a number of national administrative datasets and surveys. However, the number of females under 18 with dependent children that are NEET is not currently collected.
Potential for future development	
Limitations of the indicator	

Category	Definition
Framework category	Outcome
Indicator definition	The number of conceptions in women aged under 18 expressed as a rate per 1,000 resident females aged 15-17.
Numerator definition	The number of conceptions in women aged under 18 (abortions and total births)
Denominator definition	ONS population estimates (females aged 15-17).
Current policy justification	UK has one of the highest under-18 conception rates in the world. Health outcomes for teenage mothers and their babies tend to be poorer than average. A reduction in the rates is widely accepted as a desirable.
Current provision of this indicator	This indicator is published annually at top tier local authority level. Three year aggregated data are published for lower tier local authorities and wards. Data are not routinely produced at any other geographic levels or for any dimensions of inequality at present.
Current data availability	Data on conceptions are collected, collated and published by ONS in aggregated form. It is produced by combining birth registrations and legal abortion notifications. Postcode of residence is collected on both data sources and therefore it would be possible to provide data on the number of conceptions for small areas and by deprivation. Data are not published for any other dimensions of inequality. Marital status is collected for abortion notifications, and ethnicity has been added recently. Data on National Statistics Socio-economic Classification of mother and father, country of birth of mother and father, registration type (e.g. whether in marriage, jointly registered, or sole registered), multiple birth type are all collected at birth registration. Ethnicity at birth can be obtained through linkage to the NHS number for babies programme data.
Potential for future development	It is unlikely that individual level data would be considered appropriate for release to local organisations by ONS - the cases are sensitive. However, the possibility of producing this indicator at LSOA/MSOA level, and by ethnicity at higher geographies could be explored.
Limitations of the indicator	Illegal abortions are excluded from this indicator, but the numbers are thought to be small. The data will also exclude early miscarriages.

Category	Definition
Framework category	Process
Indicator definition	Percentage of population aged 15-24 screened for Chlamydia.
Numerator definition	Number of people aged 15-24 screened for Chlamydia.
Denominator definition	Number of people aged 15-24 from ONS population estimates.
Current policy justification	Sexually transmitted infections particularly affect young people, deprived populations, those who engage in male to male sexual activity and those in certain minority ethnic groups. If presented for these different dimensions of inequaliy, this indicator could assess whether interventions and campaigns are tackling groups with the highest rates of infections. Chlamydia is the most commonly diagnosed sexually transmitted infection, and thus could be a good marker for sexual health. Untreated infection can lead to serious health problems, particularly for women such as pelvic inflammatory disease, ectopic pregnancy and infertility. In men, it can cause urethritis, epididymitis and Reiter's Syndrome (arthritis). An extension of chlamydia screening coverage sufficient to impact on population prevalence of the disease is a key action identified by the Sexual Health Strategy Review.
Current provision of this indicator	A comprehensive indicator of chlamydia screening across all care settings is not yet available, but a PCT level indicator is being developed and will be available soon through the Health Protection Agency (HPA) and the Association of Public Health Observatories (APHO) Sexual Health Balanced Scorecard.
Current data availability	The new PCT level indicator will be based on Chlamydia screening from: 1. The National Chlamydia Screening Programme (NCSP) - available now by PCT/LA. Postcode of residence is recorded along with age, gender, ethnicity and number of sexual partners. 2. Genitourinary medicine (GUM) clinic testing, based on new Genitourinary medicine clinic activity data set (GUMCAD) collection system - PCT data to be released shortly. Postcode of residence is recorded, currently only collated at Strategic Health Authority (SHA) level. GUMCAD data collects information on age, gender and ethnicity. 3. Laboratory results for GP practice and other settings - currently just PCT total provided. Laboratories do record postcode, but not comprehensively. Laboratories record age and gender. Where postcode of residence is recorded, data could be presented by small areas or by deprivation levels.
Potential for future development	Work on the data listed above will enable more comprehensive coverage of this indicator. Existing collected data could be used to report by age group, gender and ethnic group across settings. The Information Centre General Practice Extraction Service initiative is looking into the potential for extracting information on chlamydia screening from GP practice IT systems so this could potentially enhance the quality of information collected for that setting.
Limitations of the indicator	Collection of ethnic group information could be improved as the quality is currently poor. The population aged 15-24 is used as the denominator but not all 15-24 year olds will be sexually active. However, this population could be estimated.

Category	Definition
Framework category	Output
Indicator definition	Chlamydia diagnoses per 100,000 population aged 15-24 years.
Numerator definition	Number of people aged 15-24 diagnoses with Chlamydia.
Denominator definition	Number of people aged 15-24 from ONS population estimates.
Current policy justification	Sexually transmitted infections particularly affect young people, deprived populations, those who engage in male to male sexual activity and those in certain minority ethnic groups. If presented for these different dimensions of inequaliy, this indicator could assess whether interventions and campaigns are tackling groups with the highest rates of infections. Chlamydia is the most commonly diagnosed sexually transmitted infection, and thus could be a good marker for sexual health. Untreated infection can lead to serious health problems, particularly for women such as pelvic inflammatory disease, ectopic pregnancy and infertility. In men, it can cause urethritis, epididymitis and Reiter's Syndrome (arthritis). An extension of chlamydia screening coverage sufficient to impact on population prevalence of the disease is a key action identified by the Sexual Health Strategy Review.
Current provision of this indicator	A comprehensive indicator of chlamydia diagnoses across all care settings is not yet available, but a PCT level indicator is being developed and will be available soon through the Health Protection Agency (HPA) and the Association of Public Health Observatories (APHO) Sexual Health Balanced Scorecard.
Current data availability	The new PCT level indicator will be based on Chlamydia diagnoses from: 1. The National Chlamydia Screening Programme (NCSP) - available now by PCT/LA. Postcode of residence is recorded along with age, gender, ethnicity and number of sexual partners. 2. Genitourinary medicine (GUM) clinic testing, based on new Genitourinary medicine clinic activity data set (GUMCAD) collection system - PCT data to be released shortly. Postcode of residence is recorded, currently only collated at Strategic Health Authority (SHA) level. GUMCAD data collects information on age, gender and ethnicity. 3. Laboratory results for GP practice and other settings - currently just PCT total provided. Laboratories do record postcode, but not comprehensively. Laboratories record age and gender. Where postcode of residence is recorded, data could be presented by small areas or by deprivation levels.
Potential for future development	Work on the data listed above will enable more comprehensive coverage of this indicator. Existing collected data could be used to report by age group, gender and ethnic group across settings. The Information Centre General Practice Extraction Service initiative is looking into the potential for extracting information on chlamydia diagnoses from GP practice IT systems so this could potentially enhance the quality of information collected for that setting.
Limitations of the indicator	Collection of ethnic group information could be improved as the quality is currently poor. The population aged 15-24 is used as the denominator but not all 15-24 year olds will be sexually active. However, this population could be estimated. As the condition is often asymptomatic, quality will depend on how comprehensive and robust the screening coverage and data are.

Category	
Framework category	Outcome
Indicator definition	Pelvic Inflammatory Disease (PID) diagnoses (or admissions) per 100,000 female population aged 15-30 years
Numerator definition	Number of PID diagnoses (or admissions) in females aged 15-30 years.
Denominator definition	Female population aged 15-30 from ONS population estimates.
Current policy justification	PID is a clinical syndrome referring to infection and inflammation of the upper female genital tract. Many people with PID may not be aware that they have it, however it can lead to serious complications such as ectopic pregnancy, infertility and chronic pelvic pain. Chlamydial infection is a common cause of PID, however, other micro-organisms such as Neisseria gonorrhoeae, genital microplasms, endogenous vaginal flora and aerobic streptococci are also implicated. It can be treated in both primary care and outpatient settings, but may lead to the need for hospital admission. This indicator could help inform targeting of chlamydia screening.
Current provision of this indicator	A comprehensive view of pelvic inflammatory diagnoses across all care settings is not yet available. Pelvic Inflammatory Disease hospital admissions per 100,000 population aged 15-30 years will be made available through the forthcoming Association of Public Health Observatories (APHO) - Health Protection Agency (HPA) Sexual Health Balanced Scorecard at PCT level.
Current data availability	This indicator could be developed from the following sources: 1. Hospital Episode Statistics (HES) inpatient data records information on admissions for PID. 2. Genitourinary medicine clinic activity data set (GUMCAD) - Diagnoses of 'complicated Chlamydia' and 'complicated gonorrhoea' are also recorded in GUM clinics and thus could potentially be made available through the new GUMCAD system. 3. HES outpatient data could also potentially be utilised to determine attendances for PID. 4. The Information Centre General Practice Extraction Service initiative is looking into the potential for extracting information on chlamydia diagnosis from GP practice IT systems so this could potentially be developed in future to capture complications of the diagnosis. Postcode of residence is recorded on all these datasets, therefore data could be presented by small areas or by deprivation level. Age group, gender and ethnic group are also recorded.
Potential for future development	This indicator is not currently available, however, comprehensive information on hospital admissions is available. Combined recording from the sources listed above would produce a comprehensive indicator at PCT level, with the potential to breakdown by further dimensions of inequality.
Limitations of the indicator	Admissions data provides an incomplete view of PID. As outlined above, chlamydia, although a common cause, is not the only cause of PID. Admission levels may be influenced by changes in diagnostic methods, increases in outpatient treatment and better management of PID in primary care.

Category	Definition
Framework category	Process
Indicator definition	Percentage of children identifying their usual mode of travel to school as being by bicycle or walking
Numerator definition	Number of children identifying their usual mode of travel to school as being by bicycle or walking
Denominator definition	Number of school children.
Current policy justification	Children who cycle and walk to school have higher levels of total physical activity. School travel interventions have been found to be effective. Rates of cycling and walking to school may be lower in deprived areas due to poor infrastructure and high levels of traffic (although this relationship may not be found in urban areas where children may live close to school and so walk).
Current provision of this indicator	Data on school travel are collected through the Annual School Census, which is a statutory requirement. Department for Transport oversee the school travel element, which focuses on usual mode of travel.
Current data availability	Data are available at school level and collected at pupil level so they could be related to aspects of inequality, for example using other information from the school census, such as ethnicity, eligibility for free school meals, special educational needs, educational attainment and by linking on postcode to other area measures such as deprivation.
Potential for future development	This could be supplemented with data from specific schools that have active travel interventions e.g. schools classed as 'Bike It' schools (a Sustrans initiative) collect more detailed travel data.
Limitations of the indicator	Some concern has been expressed over the accuracy of the Annual School Census data. Currently only required to be collected for schools with an approved Travel Plan. Teachers may provide data based on their assessment of the pupils' travel modes; may guess; or may apply one mode to the whole class. Data limited to maintained schools only.

Category	Definition
Framework category	Output
Indicator definition	Percentage of children aged 5-14 participating in child pedestrian training schemes and cycle training.
Numerator definition	Number of children aged 5-14 participating in child pedestrian training schemes and cycle training.
Denominator definition	Number of children aged 5-14 (ONS population estimates).
Current policy justification	Road Traffic Collisions are large in number and often result in serious trauma or death. They also result in large numbers of years of life lost. A quarter of child deaths are due to pedestrian injuries. There is a significant social gradient, with higher levels of deprivation associated with higher levels of road traffic collisions.
Current provision of this indicator	This indicator is not currently collected and requires new data collection.
Current data availability	Data for this indicator are not currently collected.
Potential for future development	Schools based monitoring of interventions and tests of understanding could be collected. They could measure inequalities by age group, gender, deprivation (using postcode), income-expenditure (using e.g. school meals uptake) and rural/urban classifications.
Limitations of the indicator	This represents only one approach, although an important one, to tackling road traffic collision levels in children. Other methods would include speed restrictions/traffic calming measures; safe travel to school initiatives; transport planning; improved driver training; clamp down and campaigns to reduce alcohol/drug use in drivers; use of improved car design features.

Category	Definition
Framework category	Outcome
Indicator definition	i) Percentage change in the number of children aged under 16 years killed or seriously injured (KSI) in road traffic collisions (RTCs) based on a 3 year rolling average compared to the average for 1994 to 1998. ii) Or, age-standardised rate of hospital admissions in children aged under 16 years killed or seriously injured due to RTCs per 100,000 resident population.
Numerator definition	i) Number of children KSI in RTCs. ii) Number of hospital admissions for children under 16 KSI in RTCs.
Denominator definition	i) Number of children KSI in RTcs in 1994 to 1998 ii) Population aged under 16 years (ONS population estimates)
Current policy justification	Road Traffic Collisions are large in number and often result in serious trauma or death. They also result in large numbers of years of life lost. A quarter of child deaths are due to pedestrian injuries. There is a significant social gradient, with higher levels of deprivation associated with higher levels of road traffic collisions.
Current provision of this indicator	i) Local authority figures based on collisions occurring on roads within the local authority area using police Stats19 data. This is routinely reported by the Department for Transport. ii) Not routinely reported, but data are available from Hospital Episode Statistics (HES) to calculate this indicator.
Current data availability	i) Provided through Stats19 data. Area of collision is recorded as is postcode of residence of casualties therefore it is possible to calculate this indicator for small areas or by deprivation. Stats 19 data record age, sex and ethnicity. ii) HES data. Postcode of residence is recorded therefore it is possible to calculate this indicator for small areas or by deprivation. HES data available by age group, gender, and ethnic group.
Potential for future development	Indicator (i) is readily available by local authority. Local authority is based on the area that the collision occurred. It is therefore difficult to determine the population at risk to calculate a rate. Options for estimating the population at risk of collision could be explored. This indicator (i) could then be expressed as a rate by 1000 population instead of the percentage change in the number of KSI.
Limitations of the indicator	Doubts have been raised about the quality of Stats19 data due to differences in levels of children KSI compared to HES data. An alternative age-standardised rate (ii) based on residence information would provide a useful way of comparing areas on a like-for-like basis. Postcode of residence is poorly recorded on Stats19 data.

Category	Definition
Framework category	Process
Indicator definition	Percentage of mothers of infants offered safety awareness training through local injury prevention programmes.
Numerator definition	Number of mothers with infants under the age of 1 offered safety awareness training.
Denominator definition	Number of women with dependent children under the age of 1.
Current policy justification	Unintentional injury is a leading cause of death and illness among children and causes more children to be admitted to hospital each year than any other reason. Levels vary according to factors such as age, gender, social class, environment and behaviour. But, crucially, many of these injuries are preventable. It is a major concern for all those seeking to improve health and reduce inequalities.
Current provision of this indicator	Not currently available
Current data availability	Not currently comprehensively collected
Potential for future development	
Limitations of the indicator	Data for this indicator does not currently exist. Methods of collecting data for and reporting on this indicator could be explored.

Category	Definition
Framework category	Output
Indicator definition	Percentage of mothers of infants taking up safety awareness training through local injury prevention programmes.
Numerator definition	Number of mothers with infants under 1 taking up safety awareness training.
Denominator definition	Number of mothers with infants under 1 offered safety awareness training.
Current policy justification	Unintentional injury is a leading cause of death and illness among children and causes more children to be admitted to hospital each year than any other reason. Levels vary according to factors such as age, gender, social class, environment and behaviour. But, crucially, many of these injuries are preventable. It is a major concern for all those seeking to improve health and reduce inequalities.
Current provision of this indicator	Not currently available
Current data availability	Not currently comprehensively collected
Potential for future development	
Limitations of the indicator	Data for this indicator does not currently exist. Methods of collecting data for and reporting on this indicator could be explored.

Category	Definition
Framework category	Outcome
Indicator definition	Hospital admissions for serious accidental injury in age group 0-4 years, with a length of stay exceeding 3 days, directly age-standardised rate per 100,000 European standard population
Numerator definition	Number of hospital admission for serious accidental injury in children aged 0-4 days with a length of stay exceeding 3 days from Hospital Episode Statistics (HES).
Denominator definition	Number of children aged 0-4 years (ONS population estimates)
Current policy justification	Unintentional injury is a leading cause of death and illness among children and causes more children to be admitted to hospital each year than any other reason. Levels vary according to factors such as age, gender, social class, environment and behaviour. But, crucially, many of these injuries are preventable. It is a major concern for all those seeking to improve health and reduce inequalities.
Current provision of this indicator	This indicator is available via the Compendium of Clinical and Health Indicators. Data provided by PCT/LA and gender (but this is suppressed in the public access version due to small numbers) and for higher geographies.
Current data availability	HES inpatient data available by postcode and therefore this indicator could be produced for small areas and by deprivation.Age group, gender, and ethnic group are recorded.
Potential for future development	This indicator is routinely available at national, regional, PCT and LA level. It is possible to calculate it for small areas if numbers are large enough. Data are available by gender and ethnicity, but due to small numbers it is unlikely to be possible to disaggregate by these factors below regional level.
Limitations of the indicator	Figures are estimates (i.e. adjusted to include estimates of how many injury admissions without a valid cause code relate to unintentional injury, and how many multi-episode spells exceed 3 days).

Category	Definition
Framework category	Process
Indicator definition	Percentage of older people offered falls prevention advice through local falls prevention programmes.
Numerator definition	Number of older people offered falls prevention advice.
Denominator definition	Number of older people (aged 65 and over) (ONS population estimates).
Current policy justification	Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK, with large implications for the quality of life of older people who survive a fall. There are also considerable inequalities, both in terms of risk and longer term implications. Falls prevention programmes aim to reduce the incidence of falls and fractured neck of femur (hip) in the community.
	Hip fracture is the most common injury related to falls in older people. More than 95% of hip fractures in adults ages 65 and older are caused by a fall. Hip fractures in the elderly and frail can lead to loss of mobility and loss of independence. For many older people it is the event that forces them to leave their homes and move into residential care. Mortality after hip fracture is high: around 30% for one year.
Current provision of this indicator	Not currently available
Current data availability	Not currently available
Potential for future development	This information is not currently collected, but could be collected in primary and community care settings.
Limitations of the indicator	These initiatives are unlikely to be applied consistently across the country and could be occasional rather than ongoing interventions.

Category	Definition
Framework category	Output
Indicator definition	Percentage of older people offered and taking up falls prevention advice through local falls prevention programmes.
Numerator definition	Number of older people taking up falls prevention advice.
Denominator definition	Number of older people offered falls prevention advice.
Current policy justification	Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK, with large implications for the quality of life of older people who survive a fall. There are also considerable inequalities, both in terms of risk and longer term implications. Falls prevention programmes aim to reduce the incidence of falls and fractured neck of femur (hip) in the community. Hip fracture is the most common injury related to falls in older people. More than 95% of hip fractures in adults ages 65 and older are caused by a fall. Hip fractures in the elderly and frail can lead to loss of mobility and loss of independence. For many older people it is the event that forces them to leave their homes and move into residential care. Mortality after hip fracture is high: around 30% for one year.
Current provision of this indicator	Not currently available
Current data availability	Not currently available
Potential for future development	This information is not currently collected, but could be collected in primary and community care settings.
Limitations of the indicator	These initiatives are unlikely to be applied consistently across the country and could be occasional rather than ongoing interventions.

Category	Definition
Framework category	Outcome
Indicator definition	The number of emergency admissions to hospital of persons with fractured neck of femur followed by relevant surgery within the first two days of admission (expressed as a rate per 100,000 residents for those aged 65 and over).
Numerator definition	The number of emergency admission for patients aged 65 and over with a primary diagnosis of fractured neck of femur who had relevant surgery between 0-1 days (inclusive) of the date of admission. The data can be obtained from Hospital Episode Statistics (HES).
Denominator definition	Population aged 65 and over (ONS population estimates).
Current policy justification	Hip fracture is a common, serious and costly injury related to falls in older people (95% of cases in adults ages 65 and older). The fracture often results in a reduction in mobility and loss of independence.
	The speed of surgical intervention of hip fracture has been associated with better outcome as the risk of death is increased in the months after suffering a fracture neck of femur. For many older people it is the event that forces them to leave their homes and move into residential care. Mortality after hip fracture is high: around 30% for one year
	The quality of care for hip fracture patients varies considerably across the country. There is therefore a need to set a benchmark and promote continuing improvement in the quality and cost effectiveness of care for hip fracture patients.
Current provision of this indicator	This is currently being reported for all ages in the Compendium of Clinical and Health Indicators for England, regions, PCTs and local authorities. It is not currently published for those aged 65 and over as per indicator definition above.
Current data availability	Postcode pf residence is recorded in HES and therefore this indicator can be produced for small areas and by deprivation. HES contains information on age, sex, deprivation and ethnic origin. The coverage of ethnic origin is sparse but has been improving.
Potential for future development	The data in the indicator would be useful if supplemented with data on levels of function, disability, handicap etc. This would enable levels of mobility after fracture neck of femur to be assessed and adjusted for case mix.
Limitations of the indicator	The data may include transfers to and from other hospitals and may be influenced by variation in the pattern of care between providers. Data do not allow assignment of severity of illness nor do they allow adjustment for this.

Category	Definition
Framework category	Process
Indicator definition	Number of women aged 25-64 screened for cervical cancer within the last 3/5* years, as a percentage of the total number of women aged 25-64 eligible for screening. (* 3 years for women aged 25-49, 5 years for women aged 50-64)
Numerator definition	Number of women aged 25-64 screened for cervical cancer within the last 3/5* years (* 3 years for women aged 25-49, 5 years for women aged 50-64)
Denominator definition	Number of women aged 25-64 eligible for screening.
Current policy justification	Screened women are less likely to die from cervical cancer as any cancer should be identified at an earlier or pre-cancerous stage. Treatment is far more likely to be successful if cancers are detected at earlier stages.
Current provision of this indicator	The indicator is currently published by the NHS Information Centre (IC) at PCT (responsible population) level, and, nationally by age of women. It is not published for any other dimensions of inequality. Responsible population is all patients registered with general practices accountable to the PCT, plus any patients not registered with a GP, living within the PCT's boundary.
Current data availability	Numerator: Numbers of women screened are reported routinely by PCTs to the IC, on KC53 ('Körner') returns in the case of cervical screening. These are aggregated counts at PCT level. Screening services hold data at individual level. Denominator: Numbers of eligible women are reported on the same returns to the NHS Information Centre. Eligible women is, derived from female population, less those not recalled for clinical reasons (most commonly because of previous hysterectomy). Numerator and denominator data are published for different ages of women at national level, but not at PCT level. Only aggregate counts by PCT are centrally collated. Screening services hold data at individual level. Locally, individual level data are held, in order to manage the call-recall programme. These data could be linked with population registers, and hence can be analysed in various dimensions of inequality, e.g. ethnicity, geography-based deprivation indicators, depending on the extent of coding in general practice information systems.
Potential for future development	The indicator could potentially be calculated for different dimensions of inequality (e.g. ethnicity, small area and geographically based measures of deprivation) from the General Practice Extraction Service (GPES) as it develops. This would involve linking the screening service data with any such primary care database.
Limitations of the indicator	Analysis of dimensions of inequality would be limited by the extent of coding within general practice data. Analysing deprivation based on ecological assignment of population characteristics is subject to usual ecological issues.

Category	Definition
Framework category	Outcome
Indicator definition	Age-standardised incidence of cervical cancer.
Numerator definition	Number of registrations for cervical cancer in women of all ages.
Denominator definition	Total population (ONS population estimates.
Current policy justification	There are wide inequalities in the incidence of cancer, including cervical cancer. People from deprived and less affluent backgrounds are more likely to get some types of cancer and overall are more likely to die from it once they have been diagnosed. There are a number of reasons for these inequalities in cancer. Different levels of exposure to key risk factors for cancer are very important. Lower awareness of the symptoms of cancer in some social groups, later presentation to GPs, lower uptake of screening services and unequal access to high quality services also play a role.
Current provision of this indicator	This indicator is routinely provided at local authority district level, Primary Care Trust, SHA, ONS cluster in the Compendium of Clinical and Health Indicators, however, numbers are small for many areas. Further information is available through the National Cancer Intelligence Network (www.ncin.org.uk)
Current data availability	Data on age, gender, ethnicity are routinely collected at cancer registration. Postcode of residence is collected and therefore data can be produced at small area level and by deprivation.
Potential for future development	
Limitations of the indicator	The number of registrations in small areas and by dimensions of inequality is likely to be very small.

Category	Definition
Framework category	Process
Indicator definition	The percentage of children who have completed all of the recommended vaccination programmes.
Numerator definition	The number of children who have completed all of the recommended vaccination programmes.
Denominator definition	The total number of children aged 2 or 5 (PCT responsible population)
Current policy justification	Data for this indicates whether immunisations are up to date or not for specific diseases. There are inequalities in immunisation uptake, deprived groups tend to have a relatively low immunisation coverage, partly because of barriers to accessing services. In line with current World Health Organisation (WHO) immunisation recommendations, at least 95% of children should complete vaccination programmes to maximise their impact.
Current provision of this indicator	This indicator is routinely produced for looked after children only and is available at top local authority level only and are published by Department for Children, Schools and Families (DCSF). It is not routinely produced for all children. Other immunisation statistics are published by the Information Centre http://www.ic.nhs.
Current data availability	Numbers and percentages of uptake are published for individual immunisation programmes at PCT level. However, the numerator for this indicator would combine all immunisation programmes. This is not centrally collected, but might be available through local child health systems. Responsible population is all patients registered with general practices accountable to the PCT, plus any patients not registered with a GP, living within the PCT's boundary. Child health systems collect a wide variety of information on children and therefore further stratification by dimensions of inequality is possible locally, but not centrally collected.
Potential for future development	If these data were collected directly from individual health records rather than as a collated return this indicator could be produced, and could possible be produced for further dimensions of inequality.
Limitations of the indicator	There are some data quality issues with Child Health Systems, particularly in London. In addition, there are some problems with establishing the PCT responsible populations aged 2 or 5.

Category	Definition
Framework category	Outcome
Indicator definition	Percentage of children with childhood infectious diseases covered by an immunisation programme admitted to hospital with complications
Numerator definition	Number of children admitted to hospital with complications of childhood infectious diseases
Denominator definition	Total number of children with childhood infectious diseases covered by an immunisation programme.
Current policy justification	Complications occur in approximately 30% of reported cases of measles, including otitis media, bronchitis, pneumonia, convulsions, blindness and encephalitis. The incidence of encephalitis is around 1 in 1000 cases, and it has a mortality of around 15%. Similar patterns of complications occur with other preventable childhood diseases. There are inequalities in immunisation uptake, deprived groups tend to have a relatively low immunisation coverage, partly because of barriers to accessing services. In line with current World Health Organisation (WHO) immunisation recommendations, at least 95% of children should complete vaccination programmes to maximise their impact.
Current provision of this indicator	This indicator is not routinely produced at any geographic levels or for any dimensions of inequality at present.
Current data availability	The Health Protection Agency collects information on the number of notifiable childhood infectious diseases. These are published at local authority level http://www.hpa.org.uk/HPA/Topics/InfectiousDiseases/InfectionsAZ/1191942172956/. Although not presently centrally collated the number of admissions is available through Hospital Episode Statistics (HES). Postcode of residence is recorded on HES and therefore this indicator could be presented for small areas or by deprivation if numbers allow. Ethnicity, age and sex are recorded in HES data.
Potential for future development	
Limitations of the indicator	Doctors in England and Wales have a statutory duty to notify a 'Proper Officer' of the local authority, often the CCDC (Consultant in Communicable Disease Control), of suspected cases of certain infectious diseases, however, notification is not complete for all diseases.

Category	Definition
Framework category	Process
Indicator definition	Percentage of population aged 15-24 years with adequate knowledge of the need for condoms and how to access and use them (possibly including awareness of various strategies to reduce likelihood of engaging in risky sexual behaviour).
Numerator definition	Number of people aged 15-24 years with adequate knowledge of the need for condoms and how to access and use them.
Denominator definition	Population aged 15-24 (ONS population estimates)
Current policy justification	The indicator is a measure of the success of both sex and relationship education in schools and sexual health/condom awareness/distribution campaigns. Sexually transmitted infections particularly affect young people, deprived populations, those who engage in male to male sexual activity and those in certain minority ethnic groups. If presented for these different dimensions, the measure could assess whether interventions and campaigns are tackling groups with the highest rates of infections.
Current provision of this indicator	This is not currently available on a national routine basis.
Current data availability	The annual Tellus survey in schools (reported at Local Authority level) simply asks whether the sexual health education received is perceived as adequate - this could be used as a proxy in the short-term. Schools and students health education unit (SHEU) surveys in schools ask more detailed questions regarding knowledge of contraception by gender. However, these are only undertaken on request by individual Local Authorities, so the annual national report only reflects patchy geographic coverage. SHEU surveys collect information on ethnicity, sexual orientation and education levels. The annual ONS Omnibus survey of Contraception and Sexual Health (adults, reported at national level only), Gay Men's Sex Survey (adults, reported at PCT level), an update of the 'BASS Line' African Health and Sex Survey (adults, reported at SHA level in 2007) and the National Survey of Sexual Attitudes and Lifestyles (adults by gender, carried out every 10 years - due 2010, could be region level) could be used to contribute to this indicator.
Potential for future development	Existing surveys could improve collection of information on contraception knowledge/awareness and collect postcode of residence, gender, ethnic group and sexual orientation. Also as Personal Social and Health Education (PSHE) will become statutory there may be opportunities through monitoring of provision.http://www.teachernet.gov.uk/wholeschool/healthyliving/sre/
Limitations of the indicator	The degree to which the indicator will be able to judge 'adequate knowledge' will be limited, and there is the danger that the definition of this could be vague. The relevance of this indicator to individuals may vary according to age, sexual orientation, sexual experience and the nature of any current sexual relationship.

Category	Definition
Framework category	Output
Indicator definition	Percentage of sexually active 15-24 year olds engaging in protected sex (condom usage) with new partners
Numerator definition	The number of sexually active 15-24 year olds engaging in unprotected sex with new partners.
Denominator definition	The number of sexually active 15-24 year olds.
Current policy justification	The indicator is a measure of the success of both sex and relationship education in schools and sexual health/condom awareness/distribution campaigns. Sexually transmitted infections particularly affect young people, deprived populations, those who engage in male to male sexual activity and those in certain minority ethnic groups. If presented for these different dimensions, the measure could assess whether interventions and campaigns are tackling groups with the highest rates of infections.
Current provision of this indicator	This is not currently available on a national routine basis.
Current data availability	The annual Tellus survey in schools (reported at Local Authority level) simply asks whether the sexual health education received is perceived as adequate - this could be used as a proxy in the short-term. Schools and students health education unit (SHEU) surveys in schools ask more detailed questions regarding knowledge of contraception by gender. However, these are only undertaken on request by individual Local Authorities, so the annual national report only reflects patchy geographic coverage. SHEU surveys collect information on ethnicity, sexual orientation and education levels. The annual ONS Omnibus survey of Contraception and Sexual Health (adults, reported at national level only), Gay Men's Sex Survey (adults, reported at PCT level), an update of the 'BASS Line' African Health and Sex Survey (adults, reported at SHA level in 2007) and the National Survey of Sexual Attitudes and Lifestyles (adults by gender, carried out every 10 years - due 2010, could be region level) could be used to contribute to this indicator. The National Survey of Sexual Attitudes and Lifestyles (NATSSAL) includes a question on first sexual experience and whether condom was used - but this is addressed to all age groups.
Potential for future development	Existing surveys could improve collection of information on contraception knowledge/awareness and collect postcode of residence, gender, ethnic group and sexual orientation. Also as Personal Social and Health Education (PSHE) will become statutory there may be opportunities through monitoring of provision. http://www.teachernet.gov.uk/wholeschool/healthyliving/sre/
Limitations of the indicator	The degree to which the indicator will be able to judge 'adequate knowledge' will be limited, and there is the danger that the definition of this could be vague. The relevance of this indicator to individuals may vary according to age, sexual orientation, sexual experience and the nature of any current sexual relationship.

Category	Definition
Framework category	Outcome
Indicator definition	Chlamydia diagnoses per 100,000 population aged 15-24 years.
Numerator definition	Number of people aged 15-24 diagnoses with Chlamydia.
Denominator definition	Number of people aged 15-24 from ONS population estimates.
Current policy justification	Sexually transmitted infections particularly affect young people, deprived populations, those who engage in male to male sexual activity and those in certain minority ethnic groups. If presented for these different dimensions of inequaliy, this indicator could assess whether interventions and campaigns are tackling groups with the highest rates of infections. Chlamydia is the most commonly diagnosed sexually transmitted infection, and thus could be a good marker for sexual health. Untreated infection can lead to serious health problems, particularly for women such as pelvic inflammatory disease, ectopic pregnancy and infertility. In men, it can cause urethritis, epididymitis and Reiter's Syndrome (arthritis). An extension of chlamydia screening coverage sufficient to impact on population prevalence of the disease is a key action identified by the Sexual Health Strategy Review.
Current provision of this indicator	A comprehensive indicator of chlamydia diagnoses across all care settings is not yet available, but a PCT level indicator is being developed and will be available soon through the Health Protection Agency (HPA) and the Association of Public Health Observatories (APHO) Sexual Health Balanced Scorecard.
Current data availability	The new PCT level indicator will be based on Chlamydia diagnoses from: 1. The National Chlamydia Screening Programme (NCSP) - available now by PCT/LA. Postcode of residence is recorded along with age, gender, ethnicity and number of sexual partners. 2. Genitourinary medicine (GUM) clinic testing, based on new Genitourinary medicine clinic activity data set (GUMCAD) collection system - PCT data to be released shortly. Postcode of residence is recorded, currently only collated at Strategic Health Authority (SHA) level. GUMCAD data collects information on age, gender and ethnicity. 3. Laboratory results for GP practice and other settings - currently just PCT total provided. Laboratories do record postcode, but not comprehensively. Laboratories record age and gender. Where postcode of residence is recorded, data could be presented by small areas or by deprivation levels.
Potential for future development	Work on the data listed above will enable more comprehensive coverage of this indicator. Existing collected data could be used to report by age group, gender and ethnic group across settings. The Information Centre General Practice Extraction Service initiative is looking into the potential for extracting information on chlamydia diagnoses from GP practice IT systems so this could potentially enhance the quality of information collected for that setting.
Limitations of the indicator	Collection of ethnic group information could be improved as the quality is currently poor. The population aged 15-24 is used as the denominator but not all 15-24 year olds will be sexually active. However, this population could be estimated. As the condition is often asymptomatic, quality will depend on how comprehensive and robust the screening coverage and data are.

Category	Definition
Framework category	Process
Indicator definition	Observed percentage of patients on primary care coronary heart disease (CHD) registers compared with the expected percentage from the modelled CHD prevalence estimate by PCT, local authority and GP practice.
Numerator definition	The observed percentage of patients on primary care coronary heart disease (CHD) registers
Denominator definition	The expected percentage on the register obtained from the modelled CHD prevalence estimate by PCT, local authority and GP practice.
Current policy justification	Identifying patients with CHD and entering them onto a CHD register is a critical part of the CHD care pathway - without identification control and management of risk factors cannot be instituted. By comparing the percentage of patients on CHD registers with the expected numbers provides an estimate of the comprehensiveness of identification in general practice. Patients are at increased risk if they are not identified. Patients from areas of deprivation are at higher risk of CHD, but are less likely to present with symptoms. By comparing the gap between actual and expected percentages this will identify where more active identification of patients is required.
Current provision of this indicator	This indicator is not routinely calculated nationally but has been used in the South East clinical quality reports at PCT level. The indicator can be updated annually so will show change over time. It should be possible to calculate this indicator at PCT, local authority and GP practice level.
Current data availability	Numerator: The proportion of patients on CHD registers is available through Quality and Outcome Framework (QOF) at practice and PCT level. Practices can be amalgamated to local authorities. Denominator: Modelled CHD prevalence estimates are available for PCT, local authority and GP practices through the Association of Public Health Observatories (APHO). The GP practices, PCTs and local authorities can be allocated deprivation scores which would give an indication of inequalities in identifying CHD by deprivation.
Potential for future development	The introduction of the NHS Health Check Programme will include a new group of patients identified as being at high risk of cardiovascular disease (CVD). People at high risk of CHD will be included on a register and the information will be available at practice and PCT level. Guidance on what will be available by practice through the NHS Health Check will be published in the future.
Limitations of the indicator	It depends on a modelled prevalence estimate for comparison. Accuracy of modelled estimates will depend on the assumptions made in modelling methodology.

Category	Definition
Framework category	Output
Indicator definition	Percentage of practices achieving maximum points for coronary heart disease (CHD) management
Numerator definition	Number of practices achieving maximum points for coronary heart disease (CHD) management
Denominator definition	Number of practices
Current policy justification	The purpose of managing people with CHD is to effectively intervene to prevent progression of disease and complications. There is a likelihood that risk factors in patients in more deprived areas of England will be more poorly controlled. The indicator will identify areas where patients on CHD registers are receiving suboptimal management and control of risk factors.
Current provision of this indicator	This indicator is not routinely calculated nationally but has been used in the South East clinical quality reports. It is derived from information within GP records that measure the control of risk factors, and management for patients with CHD. It is a composite indicator combining all the Quality and Outcomes Framework (QOF) CHD management indicators (CHD 2, CHD 6, CHD 8, CHD 9,CHD 10, CHD 11, CHD 12). It is calculated as the percentage of practices which achieve the target score for all measures (the threshold for achieving maximum points for a GP practice).The indicators are updated annually so will show change over time.
Current data availability	The information is derived from the CHD management indicators in QOF which are available at practice level. This indicator will only be available at PCT and local authority level (practices can be allocated to the local authority in which they are situated). The PCTs and LAs can be allocated deprivation scores which would give an indication of inequalities in management of CHD by deprivation.
Potential for future development	The introduction of the NHS Health Check Programme will include a new group of patients identified as being at high risk of cardiovascular disease (CVD). People at high risk of CHD will require management and control of the risk factors. Guidance on what will be available by practice through the NHS Health Check will be published in the future.
Limitations of the indicator	The indicator depends on the target system within QOF. The targets may change, but as QOF is derived from individual patient records it can be back calculated.

Category	Definition
Framework category	Outcome
Indicator definition	Mortality from coronary heart disease in persons aged <75, directly age-standardised rate per 100,000 population.
Numerator definition	Number of deaths from coronary heart disease in persons aged under 75.
Denominator definition	Population aged under 75 (ONS population estimates)
Current policy justification	CHD is one of the most common causes of premature death in the UK. Around 1 in 5 men and 1 in 7 women die from CHD from the disease and there are marked inequalities between socio-economic and ethnic groups. Rates are higher in areas of deprivation.
Current provision of this indicator	This indicator is routinely provided at local authority district level, Primary Care Trust, SHA, ONS cluster in the Compendium of Clinical and Health Indicators by age and gender.
Current data availability	Data on age, gender, Standard Occupation Classification (which can be linked to National Statistics Socio-economic Classification category) and country of birth are routinely collected in mortality records. Postcode of residence is collected and therefore data can be produced at small area level and by deprivation.
Potential for future development	Currently only country of birth is collected in the mortality record which can only be used as proxy for ethnic group. Methods for estimating ethnicity at death should be explored.
Limitations of the indicator	This indicator is based on underlying cause of death and there is potential for this to be incorrectly attributed on the death certificate and, therefore, cause of death misclassified.

Category	Definition
Framework category	Process
Indicator definition	Observed percentage of patients on primary care hypertension registers compared with the expected percentage from the modelled hypertension prevalence estimate by PCT, local authority and GP practice.
Numerator definition	The observed percentage of patients on primary care hypertension registers
Denominator definition	The expected percentage on the register obtained from the modelled hypertension prevalence estimate by PCT, local authority and GP practice.
Current policy justification	Identifying patients with hypertension and entering them onto a hypertension register is a critical part of the stroke care pathway - without identification, control and management of hypertension and other risk factors cannot be instituted. By comparing the percentage of patients on hypertension registers with the expected numbers provides an estimate of the comprehensiveness of identification in general practice. Patients are at increased risk if they are not identified. Patients from areas of deprivation are at higher risk of cardiovascular disease. By comparing the gap between actual and expected percentages this will identify where more active identification of patients with hypertension is required.
Current provision of this indicator	This indicator is not routinely calculated nationally.
Current data availability	Numerator: the Quality and Outcomes Framework (QOF) indicator BP 1: The practice can produce a register of patients with established hypertension which can be analysed at the levels of practice, local authority and PCT; Denominator: The modelled prevalence estimates for hypertension which are at GP practice, PCT and local authority level (available from the Association of Public Health Observatories (APHO)). The GP practices, PCTs and LAs can be allocated deprivation scores which would give an indication of inequalities in identifying hypertension by deprivation.
Potential for future development	The introduction of the NHS Health Check Programme will include a new group of patients identified as being at high risk of cardiovascular disease (CVD) due to raise blood pressure. Guidance on what will be available by practice through the NHS Health Check will be published in the future.
Limitations of the indicator	This indicator depends on a modelled prevalence estimate for comparison. Accuracy of modelled estimates will depend on the assumptions made in modelling methodology.

Category	Definition
Framework category	Output
Indicator definition	The percentage of patients with hypertension in whom the last blood pressure (measured in the last 9 months) is 150/90 or less.
Numerator definition	The number of patients with hypertension in whom the last blood pressure (measured in the last 9 months) is 150/90 or less.
Denominator definition	The number of patients with hypertension
Current policy justification	This indicator measures the level of control of hypertension at a population level. Hypertension is a major risk factor for stroke, coronary heart disease and other illnesses such as kidney disease and aortic aneurysm. Incidence and prevalence of hypertension is greater in areas of higher deprivation and in certain ethnic groups.
Current provision of this indicator	This indicator is based on the Quality and Outcomes Framework (QOF) indicator BP 5: The percentage of patients with hypertension in whom the last blood pressure (measured in the last 9 months) is 150/90 or less. The indicator is currently published at GP practice and PCT level.
Current data availability	The percentage of patients with hypertension in whom the last blood pressure (measured in the previous nine months) is 150/90 or less is currently collected as part of QOF. It is available at GP practice, PCT and local authority level. This indicator can be provided at practice, PCT and local authority level. It is possible to allocate an deprivation score to practices and to local authorities, so a measure of inequality by deprivation can be derived.
Potential for future development	In future, blood pressure will be measured every five years in all patients aged 40 to 74 as part of the NHS Health Check Programme which will increase ascertainment. Future data collection should consider individual level collections from general practice to enable analysis by further dimensions of inequality
Limitations of the indicator	This is no record level data so this indicator is not age standardised.

Category	Definition
Framework category	Outcome
Indicator definition	Mortality from stroke in persons aged <75, directly age-standardised rate per 100,000 population.
Numerator definition	Number of deaths from stroke in persons aged under 75.
Denominator definition	Population aged under 75 (ONS population estimates)
Current policy justification	Stroke is a major cause of premature mortality in the UK. There are inequalities across the social gradient and between ethnic groups.
Current provision of this indicator	This indicator is routinely provided at local authority district level, Primary Care Trust, SHA, ONS cluster in the Compendium of Clinical and Health Indicators by age and gender.
Current data availability	Data on age, gender, Standard Occupation Classification (which can be linked to National Statistics Socio-economic Classification category) and country of birth are routinely collected in mortality records. Postcode of residence is collected and therefore data can be produced at small area level and by deprivation.
Potential for future development	Currently only country of birth is collected in the mortality record which can only be used as proxy for ethnic group. Methods for estimating ethnicity at death should be explored.
Limitations of the indicator	This indicator is based on underlying cause of death and there is potential for this to be incorrectly attributed on the death certificate and, therefore, cause of death misclassified.

Category	Definition
Framework category	Process
Indicator definition	Observed prevalence of renal replacement therapy (RRT) as a percentage of the expected prevalence (based on national benchmark levels of provision) indirectly standardised for age and sex.
Numerator definition	Number of people on RRT
Denominator definition	Total population by age and sex (ONS population estimates)
Current policy justification	Access to timely high quality renal replacement therapy services is an important factor in determining outcomes for patients with kidney disease. This indicator compares equity of access to these services, identifying variations between areas. Standardising the prevalence allows comparison between the different areas within the UK based on age and sex.
Current provision of this indicator	Provided by the UK Renal Registry at PCT level.
Current data availability	Numerator: Number of people in RRT. Data collected from dialysis centres by UK Renal Registry. Postcode of residence is collected therefore these data can be presented for small areas or by deprivation. Age, gender, marital status and ethnicity information collected by the renal registry. Ethnicity recording is not complete.
Potential for future development	Numbers of patients within small areas, and within different dimensions of inequality, may be too small for meaningful analysis within PCTs, but analysis of various dimensions of inequalities may be possible at national level to inform policy. The usefulness would depend on the extent of coding within the renal registry data and on research to determine the different needs for different ethnic groups, socio-economic groups, etc
Limitations of the indicator	Accuracy of inequalities analysis will depend on coding of patient data and accuracy of population data and research on the needs of different populations.

Category	Definition
Framework category	Output
Indicator definition	Patients on chronic kidney disease (CKD) registers in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less as a percentage of all patients on the CKD registers.
Numerator definition	Patients on chronic kidney disease (CKD) registers in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less
Denominator definition	Patients on chronic kidney disease (CKD) registers
Current policy justification	Diabetes and high blood pressure are amongst the most common underlying causes of renal failure. South Asian, Black African and Black Caribbean populations are more likely to have kidney failure than White populations, largely due to high blood pressure and diabetes. Good blood pressure control in CKD can reduce the rate of progression of the disease.
Current provision of this indicator	Currently provided through the Quality and Outcomes Framework (QOF) at PCT and general practice level. Not provided for any other dimensions of inequality, but could be presented at local authority level.
Current data availability	This data are currently not available for specific dimensions of inequality.
Potential for future development	Analysis for different dimensions of inequality, e.g. age, ethnicity and geographically based measures of deprivation could be provided from patient-level general practice data, e.g. from the General Practice Extraction Service (GPES) as it develops.
Limitations of the indicator	Data can be misleading due to varying proportions of patients excepted from the indicator by the practice, due to non-response to invitations for blood-pressure checks. This can be alleviated by including excepted patients in the denominators.

Category	Definition
Framework category	Outcome
Indicator definition	The number of people aged 18 and over with stage 3-5 chronic kidney disease (CKD) expressed as a percentage of the population aged 18 and over, standardised for age and sex.
Numerator definition	The number of people aged 18 and over with stage 3-5 chronic kidney disease (CKD)
Denominator definition	The number of people aged 18 and over, standardised for age and sex.
Current policy justification	This is an indicator of the burden of CKD within given populations. South Asian, Black African and Black Caribbean populations are more likely to have kidney failure than White populations.
Current provision of this indicator	Not currently provided in this form. The crude prevalence of CKD among those over 18 years is published at practice and PCT level as part of Quality and Outcomes Framework (QOF). It is not provided for any other dimensions of inequality.
Current data availability	Numerator: Number of people with CKD on GP QOF registers in over 18 population. This is currently available by practice and PCT, but is not broken down by age, sex or any other dimensions of inequality. Denominator: Practice list size, by age and sex if required for standardisation. This is available from the national patient register, but not as part of QOF.
Potential for future development	This indicator, including different dimensions of inequality, e.g. age, ethnicity and geographically based measures of deprivation could be provided from patient-level general practice data, e.g. from the General Practice Extraction Service (GPES) as it develops. This would potentially permit crude prevalence rates (the only currently available data) to be replaced by age and sex standardised rates, giving fairer comparability.
Limitations of the indicator	All analyses are subject to variations in case-finding by practices - a low prevalence could be due to a low burden of disease or due to poor case-finding by GPs.

Category	Definition
Framework category	Process
Indicator definition	The percentage of people with diabetes having access to structured education to manage their diabetes.
Numerator definition	The number of people with diabetes having access to structured education to manage their diabetes.
Denominator definition	The number of people with diabetes.
Current policy justification	There are inequalities in the risk of developing diabetes. Those who are overweight, physically inactive or have a family history of diabetes are at increased risk of developing diabetes. People from South Asian, Black African, Black Caribbean groups have a higher than average risk of developing diabetes, as do people in lower socio-economic groups. Structured education provides a framework for people with diabetes to successfully self care and manage their condition. Across England 10.5% of people with diabetes reported that they had attended an education or training event to manage their diabetes. However, considerable variation was recorded across the country with the percentage of people attending courses at PCT level ranging from 1.4% to 52.4%.
Current provision of this indicator	This indicator is taken from a one off survey of adults with diabetes by the Healthcare Commission in 2006 (Single Patient Experience Survey). This indicator is currently available at PCT and SHA level. This indicator is not currently available by any other dimensions of inequality.
Current data availability	As above
Potential for future development	Further similar surveys would be needed for this indicator to be used to measure change over time.
Limitations of the indicator	As this indicator is taken from a one off survey there is no scope to measure change over time.

Category	Definition
Framework category	Output
Indicator definition	The percentage of patients with diabetes in whom the last HbA1C is 7.5* or less in the previous 15 months (Note definition will change to less than 7. 8 or 9 from 2009/10).
Numerator definition	The number of patients with diabetes in whom the last HbA1C is 7.5 or less in the previous 15 months.
Denominator definition	The number of patients with diabetes.
Current policy justification	This indicator provides an overall measure of control and provides a picture of the patients ability to self care. It also provides an early sign of potential longer term complications.
Current provision of this indicator	This indicator is currently available at GP Practice, PCT and SHA level and is published by the Information Centre as part of the Quality and Outcomes Framework (QOF)
Current data availability	As above
Potential for future development	If the QOF data collection process was expanded to include more detailed information about the patients included in the indicators (eg age breakdown, deprivation, ethnicity etc) the indicators could be used to examine patterns of inequality in access to care and outcomes.
Limitations of the indicator	QOF does not currently contain any information on the age, sex and ethnicity of patients.

Category	Definition
Framework category	Outcome
Indicator definition	Relative risk of death for people with diabetes between the aged of 20 and 79 years compared to those without the condition.
Numerator definition	Death rate for people with diabetes between the aged of 20 and 79.
Denominator definition	Death rate in people aged 20 and 79 years.
Current policy justification	People with diabetes have considerably higher mortality rates than those without the disease. The majority of these deaths are associated with long term complications of diabetes such as cardiovascular disease, stroke and renal disease rather than due specifically to blood glucose control. This indicator would give an indicator of the long term health and care of people with diabetes.
Current provision of this indicator	Data for this indicator is not collated at the moment but a linkage of the National Diabetes Audit (NDA) and the ONS mortality files could provide the information required. The NDA collects information on whether everybody recorded on a General practice diabetes register.
Current data availability	See above.
Potential for future development	If the data linkage suggested above was undertaken this indicator could be calculated at PCT and SHA level. It could also be available by age, gender and deprivation.
Limitations of the indicator	Participation in the National Diabetes Audit is not compulsory. It currently covers about two thirds of people diagnosed with diabetes.

Category	Definition
Framework category	Process
Indicator definition	Percentage of individuals with successful drug treatment outcomes.
Numerator definition	Number of individuals with successful drug treatment outcomes.
Denominator definition	Number of individuals discharged from drug treatment.
Current policy justification	Analysis of post-treatment outcomes is important to monitor long-term impact of drug treatment, relapse rates and social/economic/personal changes.
Current provision of this indicator	Outcomes are currently monitored during drug treatment through the Treatment Outcomes Profile (TOP) (at treatment start, review and exit of treatment journey). Currently a post-discharge TOP is not mandatory. The TOP information includes items about the individual's drug use, injecting risk behaviour, criminality and health and social functioning. It can be used as a measure of stability and productive contribution to society amongst drug users and ex-drug users.
Current data availability	Initial treatment outcome data publication began at the end of December 07, although it is important to note that early data was not robust enough to be used for performance management or commissioning purposes. It is expected that the National Treatment Agency will release national TOPs data in 2010. The TOP data links to the National Drug Treatment Monitoring System (NDTMS) and an individual's data can be matched to provide demographic information used for inequality analysis. Data on gender, ethnicity, postcode of residence (which can be linked to deprivation) and accommodation status is provided, amongst others. Full information on the items collected by NDTMS can be found at http://www.nta.nhs.uk/areas/ndtms/default.aspx
Potential for future development	Analysis of post-treatment outcomes is important to monitor long-term impact of drug treatment, relapse rates and social/economic/personal changes. TOP data (NDTMS) could be utilised for this indicator during the treatment journey.
Limitations of the indicator	TOP data are limited because it only includes those in contact with treatment services. It does not give a complete picture of the outcomes of drug treatment. It is currently not mandatory to collect this information.

Category	Definition
Framework category	Output
Indicator definition	Prevalence of drug use in the last year and the last month.
Numerator definition	Number of adults who have used drugs in the last year and the last month.
Denominator definition	Total population of adults.
Current policy justification	This indicator is a measure of the use of illicit drugs. If assessed at different geographical levels or for sub groups of the population, analysis would illustrate the areas/populations where drug use is highest and enhance service planning and delivery to tackle this issue amongst the groups/areas with the greatest need.
Current provision of this indicator	Estimates of last year drug use are currently published annually in the Drug Misuse Declared series of reports. This series of reports is based on data from the British Crime Survey (BCS). The data are published by type of drug used, age group, gender, ethnicity and government office region.
Current data availability	The main survey BCS data, which excludes the drug module, are available from the UK Data Archive. The drugs module is available from the BCS team, with permission (2001/02-2007/08). The data set includes the potentiak to look at gender, age, marital status, ethnicity, lone parenthood, socio-economic classification, employment, education and deprivation indices.
Potential for future development	The BCS is an effective measure of drug use amongst the general population and reaches a wide sample of the population. However, improvements to the BCS would enhance drug use surveillance. Specifically, enhanced surveillance of those in prison, and inclusion of students and booster samples of homeless, sub groups of specific occupations and lifestyles.
Limitations of the indicator	The BCS is based on random representative sampling; however, the numbers are estimates of prevalence of drug use. As a household survey, the methodology is not sensitive enough to reach certain groups where drug use is particularly prevalent, such as those who are homeless, those in prison, students living in halls of residence, those who lead chaotic lives and are rarely at home, and those without a permanent address. The methodological nature of the survey underestimates the use of some drugs, in particular heroin and crack cocaine, as many of the users of these drugs are among the hard to reach populations and may not wish to disclose their true drug use. Therefore, estimates of problematic drug use should be considered from a source other than BCS (Hay et al., 2008). The nature of steroid use regimes (e.g. 10 weeks using the drugs followed by a similar drug-free period) means inevitably individuals will be missed in surveys monitoring current use. Additionally the characteristics and activities of steroid users mean that they are more likely to be excluded from household samples. Only 16 to 59 year olds are eligible to complete the drug module and, considering recent trends in drug use among older populations, potentially some trends in drug use are not captured.

Category	Definition
Framework category	Outcome
Indicator definition	Age-standardised mortality rate from causes attributable to drug use (i.e. use of any illicit substance) (age standardised rate per 100,000 population).
Numerator definition	All deaths that can be attributed to the use of illicit drugs (i.e. not just those from poisonings due to illegal drugs)
Denominator definition	The total population (ONS population estimates)
Current policy justification	This indicator is a measure of mortality attributable to illicit drugs. If assessed at different geographical levels, analysis would illustrate the areas where drug attributed mortality is highest and enhance service planning and delivery to tackle this issue amongst the groups/areas with the greatest need.
Current provision of this indicator	This indicator is not currently provided in this form. In 2001 the Government set a target to reduce drug-related deaths by 20% by 2004. Since 1993, the Office for National Statistics (ONS) has reported the numbers of 'drug-related deaths' in England and Wales. Drug related deaths are defined as deaths from 'drug-related poisonings' due to drug abuse and drug dependence involving illegal drugs. Data on drug-related deaths is provided in the Autumn volume of Health Statistics Quarterly annually. Data is provided by gender, substance mentioned on death certificate and age.
Current data availability	The data foir this indicator are not currently available.
Potential for future development	Drug-related deaths are currently the main measure of mortality amongst drug users. However, a change in focus to all causes of death related to drug use would enhance our understanding of the number of deaths which are attributable to drug use (i.e. with drugs as a primary or secondary cause). To develope this indicators, additional data sources could be used to identify deaths of drug users. These include the National Drug Treatment Monitoring System (NDTMS) and Hospital Episode Statistics (HES) where data on both drug use and death is recorded.
Limitations of the indicator	The main limitation with collecting data on drug attributed mortality and drug attributed illness concerns the consistent identification, diagnosis and reporting of drug attributable deaths and illnesses. There may also be a lack of sensitivity regarding whether something was attributable to or associated with illicit drug use.

Category	Definition
Framework category	Process
Indicator definition	Price of alcohol per unit of alcohol, across all types of alcohol outlet (£ per unit of alcohol)
Numerator definition	N/A
Denominator definition	N/A
Current policy justification	There is overwhelming evidence that the price of alcohol is related to alcohol consumption. The lower the price of alcohol, the higher the consumption rate. UK prices of alcoholic drink as measured by the Alcohol Price Index have increased considerably more than general price increases. However, in real terms, the disposable income of households has increased at a higher rate, making alcohol more affordable. http://www.ias.org.uk/resources/factsheets/price_availability.pdf. An analysis of these data by postcode of outlet will present inequalities in price by small areas and therefore deprivation.
Current provision of this indicator	Not currently available
Current data availability	Not currently available
Potential for future development	Survey of outlets using a mystery shopper technique would gather the necessary information for this indicator. It is possible to develop a 'shopping basket' of alcohol (e.g. most popular products from beer, cider, wine etc.) and measure the price if bought in bulk and individually.
Limitations of the indicator	This measure would measure alcohol availability to local residents. The extent that people travel to individual alcohol outlets would not be known (this is likely to differ by outlet type). Postcodes of people purchasing the alcohol would be unknown.

Category	Definition
Framework category	Output
Indicator definition	Percentage of people aged 18 years and over drinking more than government recommended daily amounts (age standardised rate)
Numerator definition	Number of people aged 18 years and over drinking more than government recommended daily amounts (age standardised rate)
Denominator definition	Number of people aged 18 years and over.
Current policy justification	Analysis of inequalities in alcohol consumption can be used to predict future inequalities in alcohol related harm and enhance commissioners' ability to provide services accordingly. Quantities and patterns of drinking differ across socio-demographic groups, as do harmful outcomes.
Current provision of this indicator	The General Lifestyle Survey (GLS) and Health Survey for England are national surveys that contains measures of the percentage of people drinking more than recommended amounts. This indicator is published at national and regional levels. From 2009/10 the GLS will be a module attached to the Integrated Household Survey (IHS).
Current data availability	Data are available through the General Lifestyle Survey (GLS) (formerly General Household Survey) or the Health Survey for England (HSE) on 16+ year olds. The lowest geographical level available is regional level, therefore estimates for local areas rely on modelled data (synthetic estimates).The GLS and HSE collect data on gender, age, ethnicity, income, employment, lone parenthood, socio-economic classification.
Potential for future development	The survey methodology could be enhanced to more accurately reflect the total alcohol consumed, and reduce the discrepancy between sales' data and survey data. The size of the sample could be increased so that reliable estimates could be generated at a lower geographical level. The dataset could be expanded to cover sexual orientation, transgender status, religion or belief. It could also be expanded to cover those not living in households. If alcohol questions were included as part of the core IHS survey (currently smoking is included but not alcohol) it could be used to generate estimates at the local authority level.
Limitations of the indicator	Obtaining reliable data on drinking behaviour is difficult, and social surveys consistently under-report alcohol consumption. Data on alcohol sales in England suggest that only 55-60% of alcohol consumed in the UK is detected by these surveys. This is partly because people may consciously or unconsciously underestimate how much alcohol they consume. Drinking at home is particularly likely to be underestimated because the quantities consumed are not measured and are likely to be larger than those dispensed in licensed premises. Comparison over time can also be compromised if survey methodology changes. As a household survey, the GHS does not cover homeless people, students in halls, prisons or armed forces barracks. These are some of the groups more at risk of excessive alcohol consumption.

Category	Definition
Framework category	Outcome
Indicator definition	Alcohol attributable morbidity from 1) chronic conditions and 2) acute conditions (directly standardised rate per 100,000 population), presented in terms of persons admitted based on the greatest harm record from multiple (in year) admissions if applicable.
Numerator definition	Alcohol attributable morbidity from 1) chronic conditions and 2) acute conditions, presented in terms of persons admitted based on the greatest harm record from multiple (in year) admissions if applicable.
Denominator definition	Total population (ONS population estimates)
Current policy justification	The indicator is a measure of 1) chronic - long-term and 2) acute - short-term harm from alcohol and can be used to predict future patterns in health outcomes and enhance commissioners' ability to provide services accordingly.
Current provision of this indicator	This indicator is not currently routinely published.The components that make up this indicator are available at postcode and Output Area (OA) and can therefore map to a range of geographies and some dimensions of inequality. The indicator is not expressed/disseminated precisely in this format at present, but could be published for example by type (chronic/acute), age group, gender, ethnicity and government office region.
Current data availability	Information on diagnoses attributable to alcohol are routinely collected by hospital episode statistics (HES) at postcode level. Age, gender and ethnicity are recorded.Many of the conditions are not specific to alcohol, therefore alcohol attributable fractions are applied using a standard methodology. Further information on this methodology is available at: www.nwph.net/alcohol/lape/NI39Technical_Dec2008.pdf
Potential for future development	Capture similar data from other settings. At present, equivalent measures of impact are not readily available for primary care (including general practice and community-based treatment centres), for social care, or for treatment at hospital accident and emergency departments. Existing HES dataset could be improved to increase accuracy and completion rate of ethnicity.
Limitations of the indicator	This indicator does not take into account multiple admissions, and does not attempt to calculate total hospital activity as a result of such hospital admissions. As with all HES data, regional/temporal variations in coding and reporting practices may make comparisons more difficult.

Category	Definition
Framework category	Process
Indicator definition	Percentage of alcohol outlets selling alcohol to persons aged under 18 years
Numerator definition	Number of alcohol outlets selling alcohol to persons aged under 18 years
Denominator definition	Number of alcohol outlets selling alcohol .
Current policy justification	The indicator is a measure of young people's access to alcohol. Restricting young people's access to alcohol is likely to reduce risky drinking patterns.
Current provision of this indicator	This indicaotr is not routinely reported. The Home Office have data on the number of test purchases, http://press.homeoffice.gov.uk/press-releases/alcohol-industry-underage-sales. Local areas hold data on their test purchasing exercises. The test purchasing exercises are targeted rather than random.
Current data availability	Data are not routinely available.
Potential for future development	If data were collected with postcode of outlet, inequalities at a small area based level could be identified. Outlets could be selected randomly rather than using a targeted approach (outlets currently targeted using local data on anti-social behaviour etc. and information received from the public).
Limitations of the indicator	Identification of locations where alcohol is sold to volunteers could be used to imply alcohol availability to underage local residents, but the actual address of young people purchasing the alcohol would be unknown (unless survey data are used). The indicator does not address proxy purchasing (e.g. by older siblings and friends, and adults). Likely to be too resource intensive to generate robust local level data.

Category	Definition
Framework category	Output
Indicator definition	Percentage of persons aged under 18 years following Chief Medical Officer's advice* on consumption during childhood (age standardised rate) *1. an alcohol-free childhood is the healthiest and best option - if children drink alcohol, it shouldn't be before they reach 15 years old; * 2. for those aged 15 - 17 years old all alcohol consumption should always be with the guidance of a parent or carer or in a supervised environment; *3. parents and young people should be aware that drinking, even at age 15 or older, can be hazardous to health and not drinking is the healthiest option for young people. If children aged 15 - 17 consume alcohol they should do so infrequently and certainly on no more than one day a week; * 4. the importance of parental influences on children's alcohol use should be communicated to parents, carers and professionals. Parents and carers need advice on how to respond to alcohol use and misuse by children; * 5. support services must be available for children and young people who have alcohol related problems and their parents.
Numerator definition	Number of persons aged under 18 years following Chief Medical Officer's advice* on consumption during childhood (age standardised rate)
Denominator definition	Total number of persons under 18 years.
Current policy justification	Analysis of inequalities in alcohol consumption can be used to predict future inequalities in alcohol related harm and enhance commissioners' ability to provide services accordingly. Quantities and patterns of drinking differ across socio-demographic groups, as do harmful outcomes.
Current provision of this indicator	This indicator is not currently collected in this form. The 'Smoking, drinking and drug use among young people in England' report (produced by the National Centre for Social Research) contains results from an annual survey of secondary school pupils in years 7 to 11 (mostly aged 11 to 15). It measures the percentage of pupils drinking more than recommended amounts and could be used to measure point 1 (above - percentage who have had at least one alcoholic drink in their lifetime). Data are available through the General Lifestyle Survey (GLS) (formerly General Household Survey) or the Health Survey for England (HSE) on 16+ year olds. The lowest geographical level available is regional level, therefore estimates for local areas rely on modelled data (synthetic estimates).The GLS and HSE collect data on gender, age, ethnicity, income, employment, lone parenthood, socio-economic classification.
Current data availability	Smoking, Drinking and Drug Use among Young People is published at national level by the Information Centre. The GHS is published at regional level by the Office for National Statistics. The Health Survey for England is published at regional level by the Information Centre.
Potential for future development	The young people's survey could be expanded to collect the necessary data. Collection of participants' postcodes would allow mapping to inequalities markers at a small area level (e.g. index of multiple deprivation and socio-geodemographic classifications such as Mosaic groups, People and Places).
Limitations of the indicator	Obtaining reliable data on drinking behaviour is difficult, and social surveys consistently under-report alcohol consumption. This is partly because people may consciously or unconsciously underestimate how much alcohol they consume. Comparison over time can also be compromised if survey methodology changes. Survey only collects data on those who attend school - not on truants, excludees.

Category	Definition
Framework category	Outcome
Indicator definition	Alcohol attributable morbidity from acute conditions in persons aged under 18 years (crude rate per 100,000 population), presented in terms of persons admitted based on the greatest harm record from multiple (in year) admissions if applicable.
Numerator definition	Alcohol attributable morbidity in persons aged under 18 from 1) chronic conditions and 2) acute conditions, presented in terms of persons admitted based on the greatest harm record from multiple (in year) admissions if applicable.
Denominator definition	Total population aged under 18 (ONS population estimates)
Current policy justification	The indicator is a measure of 1) chronic - long-term and 2) acute - short-term harm from alcohol and can be used to predict future patterns in health outcomes and enhance commissioners' ability to provide services accordingly.
Current provision of this indicator	This indicator is not currently routinely published.The components that make up this indicator are available at postcode and Output Area (OA) and can therefore map to a range of geographies and some dimensions of inequality. The indicator is not expressed/disseminated precisely in this format at present, but could be published for example by type (chronic/acute), age group, gender, ethnicity and government office region.
Current data availability	Information on diagnoses attributable to alcohol are routinely collected by hospital episode statistics (HES) at postcode level. Age, gender and ethnicity are recorded.Many of the conditions are not specific to alcohol, therefore alcohol attributable fractions are applied using a standard methodology. Further information on this methodology is available at: www.nwph.net/alcohol/lape/NI39Technical_Dec2008.pdf
Potential for future development	Capture similar data from other settings. At present, equivalent measures of impact are not readily available for primary care (including general practice and community-based treatment centres), for social care, or for treatment at hospital accident and emergency departments. Existing HES dataset could be improved to increase accuracy and completion rate of ethnicity.
Limitations of the indicator	This indicator does not take into account multiple admissions, and does not attempt to calculate total hospital activity as a result of such hospital admissions. As with all HES data, regional/temporal variations in coding and reporting practices may make comparisons more difficult.

Category	Definition
Framework category	Process
Indicator definition	The number of smokers that had set a quit date and had successfully quit smoking at the 4 and 52 week follow up expressed as a rate per 1,000 resident smokers.
Numerator definition	The number of smokers that had set a quit date and had successfully quit smoking at the 4 and 52 week follow up
Denominator definition	Number of smokers
Current policy justification	The indicator is a measure of how many people are stopping smoking as a result of the service in the area. If presented for different dimensions of inequality, it would assess whether services are tackling groups with the highest smoking prevalence and thereby contributing to a reduction in inequalities.
Current provision of this indicator	This indicator is not routinely produced at any geographic levels or for any dimensions of inequality at present.
Current data availability	Numerator: Information on the number of smoking quitters is collected and routinely reported at PCT and SHA level by the Information Centre. Information is presented according to the area of service access, not client residence. However, postcode of residence is collected. Therefore there is the potential to produce numbers by LA or small area of residence, but postcode completion is poor. Information on both 4 week and 52 week quit status is collected, but completion of 52 week status is very incomplete.The age, sex, ethnic origin and National Statistics Socio-economic Classification category of smoking quitters is collected. Information on ethnicity and National Statistics Socio-economic Classification is very incomplete. Denominator: Information on the number of smokers is routinely available through lifestyle surveys at regional and national level. Information on the number of estimated smokers by PCT of residence will be released from the Integrated Household Survey (IHS) and will be available from 2010/11. Currently modelled estimates of the number of smokers by PCT, local authority and small area of residence are available. The IHS will allow direct estimates of smoking prevalence by PCT. It is not yet clear which dimensions of inequality it will be possible to stratify by, but information on gender, age, ethnicity, National Statistics Socio-economic Classification, lone parenthood, employment, income, education, and disability are likely to be collected.
Potential for future development	Improving the quality of the recording of postcode of residence, ethnicity, National Statistics Socio-economic Classification and long term outcome (e.g. quit at 52 weeks) in the smoking quit data could be prioritised.
Limitations of the indicator	The numerator data will only include those that stop smoking through NHS stop smoking services. It is not an indicator of smoking quitting in general.The denominator data will be an estimate and is therefore subject to fluctuations according to the method used.

Category	Definition
Framework category	Output
Indicator definition	The percentage of the adult population that are current, former (ex) and never smokers.
Numerator definition	The number of adults that are current, former (ex) and never smokers.
Denominator definition	The population of adults aged 16 and over (ONS population estimates)
Current policy justification	Smoking is an important cause of preventable ill health and mortality. It is an important contributor to respiratory illness, cancer and coronary heart disease. Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population. The prevalence of smoking varies widely between population groups and there is a national target to reduce the gap in smoking levels between 'routine and manual' groups and the population as a whole.
Current provision of this indicator	Information on the number and percentage of smokers is routinely available through lifestyle surveys at regional and national level.
Current data availability	Estimates of current, ex and never smokers by National Statistics Socio-economic Classification, income, age, sex, ethnicity, marital status, household composition and housing type are currently possible at national level through the Health Survey for England. Information on the number of estimated smokers by PCT of residence will be released from the Integrated Household Survey (IHS) and will be available from 2010/11. Currently modelled estimates of the number of smokers by PCT, local authority and small area of residence are available. The IHS will allow direct estimates of smoking prevalence by PCT. It is not yet clear which dimensions of inequality it will be possible to stratify by, but information on gender, age, ethnicity, National Statistics Socio-economic Classification, lone parenthood, employment, income, education, and disability are likely to be collected. It is not yet clear whether this will also include an estimate of ex-smokers and never smokers.
Potential for future development	Methods of obtaining prevalence data by ethnicity, National Statistics Socio-economic Classification and other dimensions of inequality at local authority/PCT level could be explored.
Limitations of the indicator	The numerator data will be an estimate and is therefore subject to fluctuations according to the method used.

Category	Definition
Framework category	Outcome
Indicator definition	Smoking attributed mortality among people aged over 35 (Directly age standardised mortality rate per 100,000 population)
Numerator definition	Number of deaths from smoking related causes among those aged 35 and over.
Denominator definition	Population aged 35 and over (ONS population estimates).
Current policy justification	Smoking is the single biggest cause of death in England and therefore is a main contributor to inequalities in mortality between areas and different population groups.
Current provision of this indicator	This indicator is published at national, regional and local authority level as part of the Association of Public Health Observatories (APHO) health profiles.
Current data availability	This indicator relies on the availability of a number of different data sources: 1. Estimates of the contribution of smoking to various causes of death - currently for the health profiles this is obtained from the American Cancer Prevention Study II. Produced on the SAMMEC website. 2. Number of deaths by cause - this is available from death registrations at postcode level and can therefore be grouped to higher geographies and deprivation based on this. 3. Smoking and ex-smoking prevalence. Estimates of current, ex and never smokers by National Statistics Socio-economic Classification, income, age, sex, ethnicity, marital status, household composition and housing type are currently possible at national level through the Health Survey for England. Information on the number of estimated smokers by PCT of residence will be released from the Integrated Household Survey (IHS) and will be available from 2010/11. Currently modelled estimates of the number of smokers by PCT, local authority and small area of residence are available. The IHS will allow direct estimates of smoking prevalence by PCT. It is not yet clear which dimensions of inequality it will be possible to stratify by, but information on gender, age, ethnicity, National Statistics Socio-economic Classification, lone parenthood, employment, income, education, and disability are likely to be collected. It is not yet clear whether this will also include an estimate of ex-smokers and never smokers. Ex smoking is currently only available at national level from the Health Survey for England, but can be estimated for smaller geographies. Assuming that the contribution of smoking to various causes of death does not vary it should be possible to produce this indicator for smaller geographies and by National Statistics Socio-economic Classification at national level if numbers allow.
Potential for future development	The collection of ethnicity at death registration would enable this indicator to be calculated by ethnic group as it is collected in the Health Survey for England.
Limitations of the indicator	The indicator relies on applying national prevalence data to local levels and will therefore be an underestimate in high smoking prevalence areas and an overestimate in low prevalence areas. The accuracy of the indicator would be increased if we had direct estimates of smoking and ex-smoking prevalence at local levels. This should be available from the Integrated Household Survey next year.

Category	Definition
Framework category	Process
Indicator definition	Percentage of children identifying their usual mode of travel to school as being by bicycle or walking
Numerator definition	Number of children identifying their usual mode of travel to school as being by bicycle or walking
Denominator definition	Number of school children.
Current policy justification	Children who cycle and walk to school have higher levels of total physical activity. School travel interventions have been found to be effective. Rates of cycling and walking to school may be lower in deprived areas due to poor infrastructure and high levels of traffic (although this relationship may not be found in urban areas where children may live close to school and so walk).
Current provision of this indicator	Data on school travel are collected through the Annual School Census, which is a statutory requirement. Department for Transport oversee the school travel element, which focuses on usual mode of travel.
Current data availability	Data are available at school level and collected at pupil level so they could be related to aspects of inequality, for example using other information from the school census, such as ethnicity, eligibility for free school meals, special educational needs, educational attainment and by linking on postcode to other area measures such as deprivation.
Potential for future development	This could be supplemented with data from specific schools that have active travel interventions e.g. schools classed as 'Bike It' schools (a Sustrans initiative) collect more detailed travel data.
Limitations of the indicator	Some concern has been expressed over the accuracy of the Annual School Census data. Currently only required to be collected for schools with an approved Travel Plan. Teachers may provide data based on their assessment of the pupils' travel modes; may guess; or may apply one mode to the whole class. Data limited to maintained schools only.

Category	Definition
Framework category	Output
Indicator definition	Percentage of children aged 2-15 meeting the recommended levels of physical activity (60 minutes or more of moderate intensity physical activity per day including walking, housework, gardening, sport or exercise, excluding things done as part of school lessons).
Numerator definition	Number of children aged 2-15 meeting the recommended levels of physical activity (60 minutes or more of moderate intensity physical activity per day including walking, housework, gardening, sport or exercise, excluding things done as part of school lessons).
Denominator definition	Number of children aged 2-15 years.
Current policy justification	This level of activity is minimal for protecting against obesity and may help to establish healthy activity patterns for later life. There are inequalities in the levels of physical activity in relation to age, gender, ethnicity and disability.
Current provision of this indicator	Data are collected nationally through the Health Survey for England (HSE), although only on a modular basis (i.e. on specific years when a child physical activity module is specifically funded). Data are collected using questionnaires (although in 2008 the HSE also collected data using accelerometers and measured fitness in a sub-sample of adults and children).
Current data availability	Data are produced at national and regional level. HSE has comprehensive coverage of many demographic and socio-economic indicators.
Potential for future development	The most comprehensive data would be accelerometer data on a sample large enough to provide PCT-level estimates, though this would be prohibitively expensive.
Limitations of the indicator	Physical activity undertaken as part of school lessons is not included in the HSE. Some validation studies have shown self-report in the HSE to over-estimate levels of physical activity. 60 minutes of activity may be insufficient to prevent obesity and/or help weight loss in those already obese.

Category	Definition
Framework category	Outcome
Indicator definition	Percentage of school children Year 6 (ages 10-11), with valid height and weight recorded, who are obese.
Numerator definition	The number of school children Year 6 (ages 10-11), with valid height and weight recorded who are classified as obese.
Denominator definition	Total school children in Year 6 with valid height and weight recorded.
Current policy justification	Childhood obesity is an indicator of poor health and is likely to track into adulthood. It is associated with both current and future health problems and is inversely related to socio-economic status.
Current provision of this indicator	The NHS Information Centre routinely publish the prevalence of obesity based on National Child Measurement Programme (NCMP) data for Regions, Local Authority Districts, SHAs and PCTs.
Current data availability	The height and weight of school children in Year 6 is routinely collected by all PCTs in England on an annual basis as part of the National Child Measurement Programme (NCMP). Information on the age, ethnic group and area of residence of the child are also collected. Information is presented according to the PCT responsible for the school or area of school location rather than by area of residence of the pupils. However, Lower Super Output Area (LSOA) of residence is collected for the majority of pupils. Therefore there is the potential to produce statistics by area of residence even for very small areas. Data can be analysed by sex, age, ethnicity, as well as by a variety of ecologically-assigned indicators based on LSOA of residence, including socio-economic status. It is also possible to assign a variety of indicators based on the school a pupil attends, using information from the school census. This will allow analysis by a number of further dimensions of inequality.
Potential for future development	The NCMP should remain the core method of data collection. The main improvement will be to increase response rate. Development of child health systems across the country, and the integration of NCMP data into these, would enable linking of records over time and analysis using other child health information to be performed. Currently this level of analysis can only be performed by a small number of PCTs.
Limitations of the indicator	NCMP participation rates vary between PCTs. It is possible that lower participation rates may impact on the reliability of the prevalence figures reported. The NCMP does not include children educated in the Independent sector or at schools catering for Special Educational needs and therefore does not provide a complete sample of the population. Body Mass Index (BMI) is a proxy measure for obesity, and may not be equally valid across all population groups (especially ethnic groups).

Category	Definition
Framework category	Process
Indicator definition	Percentage of eligible adult practice population taking up a physical activity intervention (counselling; walking; cycling; exercise referral programme) after referral from a primary care professional.
Numerator definition	Number of eligible adult practice population taking up a physical activity intervention (counselling; walking; cycling; exercise referral programme) after referral from a primary care professional.
Denominator definition	Eligible adult practice population.
Current policy justification	There are inequalities in the levels of physical activity in relation to age, gender, ethnicity, socio-economic status and disability. NICE evidence supports the promotion of physical activity within primary care, based on assessment of activity level and appropriate intervention. Primary care offers the potential to reach high proportions of the adult population each year.
Current provision of this indicator	This indicator is not currently routinely collected and published. Some PCTs have been monitoring this for some time as part of their exercise referral programme, while others are beginning.
Current data availability	Data are not currently routinely collected.
Potential for future development	Collection of these data should be integrated into GP data systems.
Limitations of the indicator	The definition of a successful intervention would need to be defined. This information would only be recorded for those people attending general practice.

Category	Definition
Framework category	Output
Indicator definition	Percentage of adults meeting recommended levels of physical activity (30 minutes or more of moderate intensity physical activity (all forms) on five or more days per week).
Numerator definition	Number of adults meeting recommended levels of physical activity (30 minutes or more of moderate intensity physical activity (all forms) on five or more days per week).
Denominator definition	Total number of adults.
Current policy justification	People who are physically active are 30-50% less likely to be Obese. Obesity has serious health consequences; it is an independent risk factor for heart disease and is associated with all cause mortality and decreased life expectancy. Obesity prevalence is inversely related to socio-economic status.
Current provision of this indicator	This indicator is published by the Information Centre at national and regional level.
Current data availability	Data are collected through the Health Survey for England (HSE), although only on a modular basis (i.e. on specific years when an adult physical activity module is specifically funded.) Data collected through questionnaire (although in 2008 the HSE also collected data using accelerometers and measured fitness in a sub-sample of adults and children). These data are available to SHA level. HSE has comprehensive coverage of many demographic and socio-economic indicators. (Note: Data are also collected and published through the Sport England Active People Survey but the published indicators do not include some activities such as walking and cycling for the purposes of transport. While data on walking and cycling for all purposes are collected as part of the survey, these data are not included in the published estimates. These data are available at local authority level but not for any inequality dimensions).
Potential for future development	The most comprehensive data would be accelerometer data on a sample large enough to provide PCT-level estimates, though this would be prohibitively expensive.
Limitations of the indicator	This indicator currently relies on self-assessment of physical activity levels.

Category	Definition
Framework category	Outcome
Indicator definition	Percentage of adults who are obese. Obesity is defined as a Body Mass Index (BMI) >30 kg/m2
Numerator definition	Number of adults who are obese.
Denominator definition	Total number of adults.
Current policy justification	People who are physically active are 30-50% less likely to be Obese. Obesity has serious health consequences; it is an independent risk factor for heart disease and is associated with all cause mortality and decreased life expectancy. Obesity prevalence is inversely related to socio-economic status.
Current provision of this indicator	The prevalence of obesity is routinely reported at national and regional level by the Information Centre using data from the Health Survey for England. Modelled estimates of the prevalence of adult obesity are available at LA, PCT and small area of residence, however, these are not suitable for monitoring change over time.
Current data availability	Adult height and weight data, from which BMI can be calculated, are routinely collected annually as part of the annual Health Survey for England and available to Regional and SHA level. Dimensions of inequality include age, gender, ethnicity, socio-economic status. HSE is too small to go down to small geographical areas.
Potential for future development	Measured height and weight must remain a core part of the data collection of the HSE. A larger HSE sample would allow estimates to be made at local authority level.
Limitations of the indicator	BMI gives no indication of the distribution of body fat. There is some evidence that central adiposity is more damaging for health.