NHS PLAN

TECHNICAL SUPPLEMENT ON TARGET SETTING FOR HEALTH IMPROVEMENT

March 2001

STATISTICS DIVISION AND CENTRAL HEALTH MONITORING UNIT, DEPARTMENT OF HEALTH
SUMMARY

This Technical Supplement is intended to provide some background to the setting of health outcome targets including many of those published in the NHS Plan, and to assist at national and local level, the process of setting health targets and assessing progress across the whole range of influences on health.

The publication of this document is the first stage in a process of interactive development of a web site focused on issues surrounding target setting, health monitoring and the development and assessment of health indicators, developed for the Our Healthier Nation website: www.ohn.gov.uk (look under “OHN”, then “Technical Supplement”).

This document aims to draw together information on data sources, to signpost relevant Government initiatives, and to provide reference material which should be helpful to those involved in setting targets and monitoring progress at national or at local level.

It is structured in four main sections:

SECTION 1 - NATIONAL OVERVIEW
This section describes:
- The purpose and scope of the Technical Supplement
- The health outcome targets for health improvement set out in the NHS Plan
- The rationale for setting the national targets for England
- Intermediate “milestones” for assessing progress
- A framework for measuring and assessing progress

SECTION 2 - MEASURES OF PROGRESS
This section suggests possible measures of progress under the headings of
- Lifestyle
- Environment
- Services
- Social and Economic
  for the three health outcome targets specified in the NHS Plan:
- Cancer
- Circulatory Diseases
- Mental Health

SECTION 3 - LOCAL TARGET SETTING AND MONITORING
This section discusses:
- General principles of local target setting
- Approaches to local target setting
- Monitoring progress

SECTION 4 - TECHNICAL APPENDICES
This section presents more detailed information on several key initiatives and provides a summary of data sources. In the penultimate appendix, a number of examples of good practice are presented. The final appendix provides an update on the areas of sexual health and teenage pregnancy where new strategies are evolving.
TECHNICAL SUPPLEMENT TO
THE NHS PLAN
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SECTION 1

NATIONAL OVERVIEW

This section describes:

• The purpose and scope of the Technical Supplement
• A rationale for setting the national targets for England
• Intermediate “milestones” for assessing progress
• A framework for measuring and assessing progress
• How health inequalities will be monitored – nationally and locally
TECHNICAL SUPPLEMENT TO
THE NHS PLAN

Introduction

1.1 The NHS Plan was published in July 2000. Health outcome targets relating to three of the major disease areas focused on - cancer, circulatory diseases (including coronary heart disease & stroke) and mental health - were identified. These targets were those previously presented in the White Paper “Saving Lives: Our Healthier Nation”, published in July 1999. In addition the NHS Plan included a commitment to set national health inequalities targets:

<table>
<thead>
<tr>
<th>Objective 1: improving health outcomes for everyone.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reduce substantially the mortality rates from major killers by 2010: from circulatory disease by at least 40% in people under 75; from cancer by at least 20% in people under 75; and from suicide and undetermined injury by at least 20%. Key to the delivery of this target will be implementing the National Service Frameworks for Coronary Heart Disease and Mental Health and the NHS Cancer Plan.</td>
</tr>
<tr>
<td>2. Narrow the health gap between socio-economic groups and between the most deprived areas and the rest of the country, in childhood and throughout life. Specific national targets are being developed in consultation with external stakeholders and experts and have been published in 2001 in time to become fully operational by the beginning of 2002-03.</td>
</tr>
</tbody>
</table>

1.2 The Department of Health has formed 10 Taskforces to implement the recommendations of the NHS Plan. The Taskforces are responsible for delivering the practical aspects of the NHS Plan - drawing together the resources, planning the work and monitoring progress to ensure that change happens. Several of the Taskforces focus on service delivery:

- Coronary Heart Disease (CHD).
- Cancer.
- Mental health.
- Older people.
- Children.

and a further task force provides support on Inequalities and Public Health.

1.3 This document will help to underpin the process of target setting and monitoring in these and other areas. The document provides specific information on cancer, circulatory diseases and mental health but the general methodology presented is equally relevant to other areas. Accidents, which is an important contributor both to the ill-health of children and older people is also covered in some detail in Appendix 12.
Purpose and scope of this document

1.4 This document is for everyone who has an interest in helping to achieve the Government’s goals and targets, and who needs to make use of information. It should be particularly relevant to colleagues in health authorities, local authorities, public health observatories and their partner organisations. The document suggests some measures of progress to monitor progress, draws together information on data sources, and signposts relevant initiatives and references which may be helpful to those involved in monitoring progress at national or at local level. As a result of consultation with potential users at a workshop in 1999, the printed version will, in due course, be supplemented by more detailed information on the Our Healthier Nation web site, situated at http://www.ohn.gov.uk (look under “OHN”, then “Technical Supplement”), which will be regularly updated and supplemented with additional material as appropriate.

1.5 The document is not intended to be comprehensive, but the web site will offer the opportunity for a more interactive, flexible and evolving process. Comments and suggestions from users will be welcome, and, as appropriate, these can be incorporated in the web site in due course. Comments can be e-mailed via the web site, or direct to Technical-Supplement@doh.gsi.gov.uk

1.6 It is also important to stress that development of measures of progress has been taken forward with the underlying principle that wherever possible, pre-existing indicators / measures of progress / recommendations / targets should be used. This principle means that the substantial majority of measures of progress will already be in the public domain, for example, in National Service Frameworks, various Government White Papers etc. Furthermore, wherever possible, measures of progress have been identified based on currently available data.

1.7 The aim of this document is to provide support to those working locally to set and monitor targets, without being prescriptive. Apart from reflecting national targets, each area has the flexibility to set additional targets which are relevant to the health needs of its own locality. These targets should be discussed and agreed with the relevant Regional Office, but do not have to be “sanctioned” nationally.

1.8 National health inequalities targets have now been set – see Appendix 2 for full details. It will now be necessary to identify a broad “basket” of indicators to monitor progress and focus efforts. These will be the subject of a consultation exercise during 2001. The material in this document should contribute to this process and will form a useful basis for further development.
Goals of the health strategy

1.9 The Government aims to tackle poor health, with the twin goals of:

- improving the health of everyone, and
- improving the health of the worst off in particular – to narrow the health gap.

1.10 In order to achieve the overall goals of the health strategy, we have to tackle the major causes of preventable ill health and premature death including cancer, circulatory diseases (coronary heart disease, stroke and related diseases), mental illness (suicide and undetermined injury) and accidental injury. Together they account for around 75 per cent of all deaths in England before the age of 75 years.

Rationale for setting the national targets for England

1.11 To focus attention on the two overarching goals and to stimulate progress in the priority areas, specific health outcome targets have been set. The number of national targets has been kept small because the intention is to stimulate action, not “number crunching”. Targets are a powerful tool for concentrating attention where it is needed. They are not an end in themselves. On their own, targets do not make a strategy but they can be a way of focusing effort. That is what the national targets set out in the NHS Plan are designed to do.

1.12 The task was to identify targets which are amenable to action, which are scientifically based, which are sufficiently challenging to instil an urgency of action, and which are achievable by the best performing public health programmes.

1.13 The targets, if achieved, should have a major impact on health in this country. For example if all of the proposed mortality target levels are achieved by the year 2010, it has been estimated that a cumulative total of over 300,000 deaths will have been avoided by that date. The range of activities which will help us reach the targets will have a significant impact on illness and injury as well as death, and will contribute to better health for people of all ages.

1.14 Targets have been chosen to be challenging yet realistic. More detail on the setting of the national targets can be found in Appendix 9.

1.15 In addition to the targets set out in Paragraph 1.1, a target focused on accidents was also identified in the Our Healthier Nation White Paper: “To reduce the death rate from accidents among people of all ages by at least one fifth (20%) by the year 2010 and to reduce the rate of hospital admissions for serious injury by at least one tenth (10%) by 2010.” This target is discussed in detail in Appendix 12 of this document.
Assessing Progress: Milestones

Intermediate "milestones" for national targets

1.16 The national mortality targets for cancer, circulatory diseases and suicide are set for the year 2010.

1.17 These are necessarily long term targets because actions to achieve them will take time to be implemented and to show effects. In the meantime, there are a number of possible approaches to tracking progress towards these targets, which will include looking at “faster to move” measures of progress, (covered in the following section), and setting “milestones” along the track to the targets.

1.18 Interim "milestones" have been set for each mortality target for the year 2005. Each “milestone” has been set at a position exactly on a straight line between the baseline and the target points. These are indicative only – we would not say that a target will be missed if its milestone is not achieved, since we would expect progress to be faster in the latter part of the decade, as the effects of improvements in lifestyle, better treatments and a range of other initiatives begin to show results. The milestones, however, do provide a useful insight into progress.

1.19 For each of the mortality targets, the percentage reductions on the 1995/6/7 baseline are:

Circulatory diseases - under 75:
Target for year 2010 = 40% reduction on 1995/6/7 baseline
Milestone for 2005 = 25% reduction on 1995/6/7 baseline

Cancers - under 75; Suicide and undetermined injury – all ages:
Target for year 2010 = 20% reduction on 1995/6/7 baseline
Milestone for 2005 = 12% reduction on 1995/6/7 baseline

Rationale for Intermediate "milestones" for national targets

1.20 The milestones are positioned exactly on a straight line between the baseline and the target points. They are therefore calculated as the 2010 target percentage figure scaled down by a factor of 8 divided by 13 - with 8 being the number of years between baseline and 2005, and 13 being the number of years between baseline and 2010.

1.21 Given that we expect that slower progress will be made in the early years of the strategy, while the effects of activities and interventions take time to show through, these milestones are ambitious. However, we did not think it useful to assume any more sophisticated “path” to the targets, so have used the “straight line” model for simplicity. Evaluation of progress by way of these milestones will therefore require due caution. The milestones will however provide a useful measure of whether we are “on track” to meet the targets.
Assessing Progress: Measures of Progress

Rationale/Framework

1.22 The national targets identified in the NHS Plan – and in the earlier OHN White Paper - and described in the preceding sections, are high level and relatively long-term targets. The targets themselves represent an important measure of progress. Each target however represents the summary of action on the whole range of factors which influence each of the priority areas.

1.23 Progress will, therefore need to be assessed in the shorter term by a broad range of measures. The range is well illustrated by the figure below from Dahlgren and Whitehead. Relevant factors include:

- "upstream" fundamental factors closer to the point of causation (e.g. educational achievement in local schools, access to affordable nutritious foods);
- lifestyle determinants (e.g. smoking prevalence in teenagers and in adults, obesity, hypertension), and
- outcome measures (e.g. mortality rates).

The Main Determinants of Health

1.24 The exact formulation of these intermediate measures of progress will be determined largely by the needs of the user, however earlier work by the Chief Medical Officer's OHN Working Group developed a set of measures which could be used in relation to each priority area. The list of measures was selected by the Working Group as that most likely to be of use to most partners (at both national and, wherever possible, local level) and to meet the following criteria:

- be meaningful and useful
- minimise the burden in collecting the data
- address inequalities
- be locally owned and with accountability at Health Improvement Programme (HImP) level

1.25 The list is by no means exhaustive and the Department will also be monitoring other sources whenever appropriate. The measures identified are therefore subject to further development as efforts to achieve the targets evolve.

1.26 Whenever possible existing targets/indicators that have already been adopted for other purposes should be used.

1.27 The choice of measures of progress (taken together with targets) will shape the direction of public health programmes at national and local level. The balance will ensure that programmes are designed which tackle the fundamental, wider social determinants, the roots of adverse lifestyle and the disease prevention/healthier lifestyle measures which are necessary to produce change.

1.28 Several measures are relevant to more than one priority area and are included in each section. Also included are some more generic indicators which, whilst not all being specifically relevant to a priority area, will reflect changes in the general health of the population and thus reflect progress towards achieving the two overarching goals of the health strategy.

1.29 Measures of progress have been identified in each priority area according to four broad categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIFESTYLE</td>
<td>SOURCE</td>
</tr>
<tr>
<td>ENVIRONMENT</td>
<td>SOURCE</td>
</tr>
<tr>
<td>SERVICES</td>
<td>SOURCE</td>
</tr>
<tr>
<td>SOCIAL &amp; ECONOMIC</td>
<td>SOURCE</td>
</tr>
</tbody>
</table>
The NHS Performance Assessment Framework

1.30 Whilst the measures of progress were developed to help interpret progress towards the OHN targets they are also of great relevance to the Performance Assessment Framework.

The NHS Performance Assessment Framework has six areas:

- **Health Improvement** (to reflect the overarching aims of improving the general health of the population and reducing health inequalities, which are influenced by many factors, reaching well beyond the NHS).
- **Fair Access** to health services
- **Effective Delivery of Appropriate Healthcare**
- **Efficiency**
- **Patient/Carer Experience**
- **Health Outcomes of NHS Care**

1.31 A set of NHS Performance Indicators has been developed to underpin the framework. The indicators look across a wide range of service areas. They allow comparison between health authority areas and in some instances between NHS trusts.

1.32 The measures of progress in this supplement are particularly relevant to the Health Improvement domain referred to above. As the NHS Plan acknowledges the current measures of performance in the Framework are of variable quality and the Department of Health will be working with other bodies to develop proposals for improved measures. Readers of this document may wish to consider the measures of progress listed in Appendix 1 and to suggest which of these might be suitable for inclusion in the Health Improvement domain of the framework. See Appendix 6 for more detail on the PAF, and for the direct web link.
Health Inequalities (see also Appendix 2)

1.33 Attacking health inequalities is at the heart of the NHS Plan. Health Inequalities will be addressed in each of the priority areas identified, and this should make a valuable input to diminishing overall health inequalities. The NHS Plan makes reference to a number of areas central to efforts to improve health and reduce inequalities including:
   - Ensuring a healthy start in life – the health of children
   - Reducing smoking
   - Improving diet and nutrition
   - Tackling drugs and alcohol misuse

1.34 The NHS Plan identifies more specific activities in these areas, including initiatives to:
   - increase and improve primary care in deprived areas
   - introduce screening programmes for women and children
   - step up smoking cessation services
   - improve the diet of young children by making fruit freely available in schools for 4-6 year olds.

1.35 But addressing health inequalities goes much further. Although there is much that can be taken forward by the NHS, it is recognised that the NHS cannot tackle health inequalities alone. Developing new partnerships to tackle inequality is a key strategic role for health authorities. And across Government, measures to address the root determinants of health inequalities - poor housing, unemployment, poor education, poverty etc - are being implemented as a top priority. In terms of assessing progress, initiatives such as Sustainable Development and Opportunity for All will form an integral part of the process.

1.36 The NHS Plan also contains an undertaking to set national health inequalities targets “to narrow the gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country” (paragraph 13.4 of the NHS Plan). Two targets were set in February 2001, one for infant mortality and one for life expectancy. Full details are given in Appendix 2.

1.37 At the local level, local inequalities targets will be set as part of the Health Improvement Programme development process. This also promotes intersectoral action by, for example, announcing incentives for joint working between health and local authorities and announces the formation of local strategic partnerships.

1.38 The OHN White Paper indicated the need for future review of changes at the national level to:
   - expectation of life
   - healthy life expectancy and
   - health inequality (paragraph 11.44 of White Paper).
1.39 But more generally reducing health inequalities - social class, ethnic, gender, geographical - will be an integral part of each and every level of the health priorities. Thus progress in inequalities will be monitored closely in relation to:

- the goals (including various measures of general health)
- the national targets in each area
- a much wider range of indicators of progress

1.40 Targets and indicators associated with the many relevant initiatives being taken forward by Government will underpin this monitoring framework. For example, healthy life expectancy is one of the Government’s 15 key headline indicators of sustainable development (see Appendix 13), and also one of the key indicators for “Opportunity for All”.

1.41 To aid the process of setting targets and monitoring progress in relation to health inequalities, the Technical Supplement:
- Identifies some of the important wider determinants of health in each priority area
- Identifies a framework for the general process of target setting, with addressing of inequalities and improvement of the wider determinants of health being major drivers in the process
- Identifies in information templates the availability of data by area, gender, ethnicity and social class – some example templates are presented in this document, more will be made available on the OHN web site.
- Summarises some of the most important sources of statistical information

1.42 In due course Regional Public Health Observatories (PHOs) should also provide a major focus for development in this area. PHOs are local public health resource/development centres charged with bringing together information in order to strengthen the availability and use of information at local level about health and thus improve health surveillance. As such, they will provide the essential information base for regional and local strategies tackling health inequalities, and through the partnerships forged with Government Offices for the Regions and Regional Development Agencies, contribute to the wider cross-sectoral and multi-agency public health agenda. Their web site is at www.pho.org.uk

1.43 The Health Development Agency (HDA) is a recently established special health authority that aims to improve the health of people in England - in particular, to reduce inequalities in health between those who are well off and those on low incomes or reliant on state benefits. The HDA’s role in achieving this aim is to:
- gather evidence of what works
- advise on good practice
- support all those working to improve the public’s health.
1.44 Much further background information on health inequalities is presented in the Acheson Report on Inequalities in Health (1998) and in *Reducing Health Inequalities: An Action Report*, which summarised activity across Government to tackle inequalities. (See Appendix 10).

1.45 For the full text of the NHS Plan, visit the web site at http://www.nhs.uk/nhsplan.
SECTION 2
MEASURES OF PROGRESS

For each of the areas of Cancer, Circulatory Diseases and Mental Health, this section:

• Identifies the key factors which need to be addressed if the targets are to be achieved
• Refers to a range of complementary initiatives and activities which are being taken forward
• Sets out some of the interlinkages between the work of various Government departments
• Identifies some suggested measures of progress under the headings:
  • lifestyle
  • environment
  • services
  • social and economic

(See also Appendix 1)

[For Accidents see Appendix 12]
MEASURES OF PROGRESS ON CANCER

2.1 The first ever comprehensive NHS Cancer Plan was launched on 27 September 2000. The Plan sets out the future of cancer services, setting waiting time targets for the treatment of cancer patients and unprecedented investment in specialist palliative care and hospices. The many new measures from the NHS Cancer Plan aim to:

- Save lives
- Improve patients' quality of life - through ensuring they get the right professional support and care
- Reduce inequalities
- Build for the future - so that the NHS never falls behind in cancer care again.

2.2 The national target on cancer mortality, already in existence, is to reduce the death rate from cancer in those under 75 by at least a further fifth by 2010.

2.3 An analysis carried out for the Chief Medical Officer’s expert working group on the health strategy estimated that a substantial reduction in mortality could be achieved through primary prevention, with the remainder coming from secondary prevention (screening) and improved treatment.

Potential improvements in total cancer mortality due to specific intervention

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Target Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in tobacco consumption</td>
<td>- 7.3%</td>
</tr>
<tr>
<td>Improvement in provision of treatment services</td>
<td>- 4%</td>
</tr>
<tr>
<td>Increase in fruit and vegetable consumption</td>
<td>- 4%</td>
</tr>
<tr>
<td>Breast screening with incremental improvement</td>
<td>- 2%</td>
</tr>
<tr>
<td>Cervical screening with incremental improvement</td>
<td>- 1%</td>
</tr>
<tr>
<td>Reduction in heavy alcohol consumption</td>
<td>- 1%</td>
</tr>
<tr>
<td>Colorectal screening (# phased introduction of new modalities)</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Source: Prof Nick Day
Institute of Public Health, Cambridge

*estimates produced for the under 65 age group and assumed to apply equally to under 75 age group
2.4 However, these estimates are based on certain assumptions including sufficient success in reducing lifestyle risk factors such as smoking and poor diet, which in many cases are likely to take some time to achieve. In addition it excludes a number of the wider determinants of health such as poverty which may be important but whose effects are difficult to quantify. Furthermore, because the overall target is one based on mortality, progress towards it (or lack of it) cannot be attributed to any of these factors without the aid of supporting “measures” of progress. In some cases, measures already exist and may even be the basis of specific targets.

**Lifestyle**

<table>
<thead>
<tr>
<th>Source of target / indicator</th>
<th>Smoking Kills White</th>
</tr>
</thead>
</table>

**Paper**

The NHS Cancer Plan introduced the first ever smoking inequalities target:

- to reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010, in order to narrow the health gap (to be monitored via the General Household Survey)  
- diet - increase consumption of fruit and vegetables  
- alcohol - reduce excessive consumption  
- sunburn - avoid  
- obesity - reduce % of people who are obese

**Environment**

<table>
<thead>
<tr>
<th>Source of target / indicator</th>
<th>DETR programme</th>
</tr>
</thead>
</table>

**Services**

**Waiting times:**

- % patients seen within one month from urgent GP referral to treatment for children's cancer, testicular cancer and acute leukaemia  
- % patients with breast cancer receiving treatment within one month of diagnosis  
- % patients seen within two months from urgent GP referral to treatment for breast cancer  
- % patients seen within two months from urgent GP referral to treatment for all cancers

- breast screening to be extended to women aged 65-70 years by 2004  
- smoking cessation services [numbers of clinics, clinic users, success rates…]  
- end the postcode lottery for cancer treatment
- expenditure on chemotherapy drugs
- numbers of patients benefiting

increase workforce numbers in cancer specialties in those areas where there are inequalities in service provision NHS Cancer Plan

**Social and economic**
reduce proportion of people in low income households DSS Opportunity for All
increase employment DfEE Sustainable in DETR
improve education DfEE Development indicator set

Many of these measures are not specific to cancer but are relevant to other priority areas also.

2.5 To assist this process the Statistics Division of the Department of Health have prepared a series of “templates” which specify the types of measures that are being proposed and the sources of data at national and local level that are available to support them. These represent a starting point, and will be subject to further development on the web site over time. Examples of these templates can be seen in Appendix 1.
## CANCERS

<table>
<thead>
<tr>
<th>Key Disaggregations</th>
<th>Inequalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>type of cancer</td>
<td>age, gender, socio-economic, geography, ethnicity</td>
</tr>
</tbody>
</table>

### Potential Key Measures

#### Lifestyle
- smoking: reduce prevalence
- diet: increase consumption of fruit and vegetables
- alcohol: reduce excessive consumption
- sunburn: avoid
- obesity: reduce % of people who are obese

#### Environment
- exposure to radon and other environmental carcinogens: reduce / avoid

#### Services
- uptake of breast and cervical screening
- treatment – implement NICE guidance
- smoking cessation services

#### Social and economic
- poverty
- employment
- education

Further indicators to be added, to link directly with actions identified

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**TARGET**

To reduce the death rate from cancer among people aged under 75 by at least 20% by 2010.
MEASURES OF PROGRESS ON CIRCULATORY DISEASES

2.6 The national target is: to reduce the death rate from coronary heart disease, stroke and related diseases among people aged under 75 by at least 40% by 2010. The Chief Medical Officer’s OHN Working Group concluded that the key measures of progress should focus on a range of factors:

- lifestyle,
- environment,
- services, and
- social and economic

2.7 These key factors will reflect the risk factors for coronary heart disease and stroke. For example, the risk of these diseases is substantially increased by a combination of adverse personal behaviour patterns, such as smoking and being physically inactive, and circumstances outside an individual’s control, such as social and economic conditions that offer poor employment prospects.

2.8 Building on each key measure of progress hinges on action at national and local level. At national level, bringing about change in each of these areas is the objective of a range of initiatives undertaken by Government and agencies. For example, the development of smoking cessation services is a key area in the Government’s White Paper “Smoking Kills”. Arrangements are also underway between the Department of Health, Department of the Environment, Transport and the Regions, and the Department for Education and Employment to bring about lifestyle changes by, for instance, improving the rates of cycling and walking and developing healthier modes of transport to schools. In the latter case, the Healthy Schools Programme will play a crucial role in setting healthy habits among young people and thus ensuring that risk factors for heart disease and stroke are not stored up for later life. Primary prevention is reinforced with special service indicators that focus on treatment through, for example, drug therapies.

2.9 To assist in assessing the movement towards or away from the national mortality target, a series of measures of progress are being defined. Where possible, these will already be defined as indicators for an existing strategy or from an available data source. Such measures may include:

**Lifestyle**
- Smoking – reduce prevalence of smoking (Smoking White Paper targets)
- Diet - reduce fat consumption in diet and increase in fruit and veg consumption (NHS Cancer Plan and COMA recommendations)
- Obesity – reduce percentage of people classified as obese (Health Survey for England)
- Physical activity – increase % of people taking regular exercise (Health Survey for England)
- Alcohol – sensible drinking (Sensible Drinking Report)
Environment
Increase in the percentage of journeys made by walking or cycling (National Travel Survey)
Improve housing (DETR data)
Improve “job control” (i.e. how much control people have in their work) (e.g. Whitehall study)
Improve air quality (DETR data)

Services
The following measures are set out as ‘immediate priorities’ in the CHD NSF:

By April 2001, Health Authorities will introduce specialist smoking cessation clinics [helping 150,000 people]
By April 2001, there should be 50 rapid access chest pain clinics…There should be 100 by April 2002 and nationwide rollout [by 2003]
Improving ambulance response times
Provision of thrombolysis in at least 75% of A&E departments
Thrombolysis available for eligible patients within 20 minutes of hospital arrival by April 2003 [interim target of 30 minutes by 2001]
Improving the use of effective medicines [aspirin, beta-blockers etc] after heart attack
Increasing the number of revascularisations (heart operations)
Beginning to modernise heart disease services by delivering the NSF milestones on systematic approaches to delivery of care

Social and economic
Proportion of births of low birthweight (ONS)
Proportion of people in low income households (DSS)
Proportion of people in employment (Labour Force Survey)
Education – improved attainment level (DfEE)
**CIRCULATORY DISEASES**

**TARGET**

To reduce the death rate from heart disease, stroke and related diseases among people aged under 75 by at least 40% by 2010

<table>
<thead>
<tr>
<th>Key Disaggregations</th>
<th>INEQUALITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>cause (e.g. CHD, stroke, peripheral vascular disease)</td>
<td>age, gender, socio-economic, geography, ethnicity</td>
</tr>
</tbody>
</table>

**Potential Key Measures**

**Lifestyle**
- smoking - reduce prevalence
- diet - reduce consumption of fat, increase consumption of fruit and vegetables
- obesity - reduce % of people who are obese
- physical activity - increase % of people taking regular physical exercise

**Environment**
- % of journeys made by walking or cycling
- suitable housing - meeting fitness standards
- job control
- air quality

**Services**
- no and % of GPs with systematic approach to following up CHD patients
- smoking cessation services
- no and % of CHD patients aged 35-74 given advice on aspirin by GP
- rapid response by ambulances
- rehabilitation services

**Social and economic**
- e.g.
  - low birthweight
  - poverty
  - employment
  - education - level of attainment

Further indicators to be added, to link directly with actions identified
MEASURES OF PROGRESS ON MENTAL HEALTH

ADULT MENTAL HEALTH SERVICES

The Mental Health National Service Framework published in September 1999 established a ten year programme to put in place new standards of care. It set national standards and defined service models for promoting mental health and treating mental illness in the areas of mental health promotion; primary care and access to services, effective services for people with severe mental illness, caring about carers and preventing suicide.

The NHS Plan published in July 2000 included extra annual investment of over £300 million by 2003/2004 to fast forward the implementation of the NSF. It set specific objectives and targets for service development in each of these areas:

By April 2001, extra investment will provide

- Almost 500 additional secure beds.
- Over 320 24-hour staffed beds.
- 170 Assertive Outreach Teams.
- A written care plan for all service users on enhanced CPA, which explains how to contact mental health services around the clock.

Additional provision beyond April 2001:

- 1000 new graduate primary care mental health workers to help GPs manage and treat common mental health problems in all age groups, including children.
- 500 more community mental health staff to work with GPs and primary care teams, with NHS Direct and in each accident and emergency department to respond to people who need immediate help.
- By 2004 more than 300,000 people will receive extra help from the new primary care mental health workers and around 500,000 people will benefit from additional mental health staff working in frontline settings.
- Early intervention to reduce the period of untreated psychosis in young people to prevent initial problems and improve long-term outcomes. This will include 50 Early Intervention Teams, established over the next 3 years, to provide treatment and active support in the community to these young people and their families. By 2004 all young people who experience a first episode of psychosis, such as schizophrenia, will receive the early and intensive support they need. This will benefit 7,500 young people each year.
• 335 Crisis Resolution Teams will be established over the next 3 years. By 2004, all people in contact with specialist mental health services will be able to access crisis resolution services at any time.

• A further 50 Assertive Outreach Teams over the next 3 years in addition to the 170 Teams which will be in place by April 2001. By 2003 all 20,000 people estimated to need assertive outreach will be receiving these services.

• 200 long term secure beds with 400 additional community staff to provide intensive support when patients are discharged from high secure hospitals.

• Some 300 additional staff will be employed to improve the health screening of those received into custody and to try to identify and provide treatment for prisoners with mental health problems. By 2004, 5,000 prisoners at any one time should be receiving more comprehensive mental health services in prison. All people with severe mental illness will be in receipt of treatment, and no prisoner with serious mental illness will leave prison without a care plan and a care co-ordinator.

Together the NHS Plan and the Mental Health NSF set out a radical shift towards new service models for mental health. The implementation of the MHNSF and NHS Plan for mental health is under way and overseen by the Mental Health Taskforce Board chaired by the National Director for Mental Health Professor Louis Appleby comprising representatives of statutory and voluntary sector agencies and user groups. There are project managers for each standard, and also for the underpinning programmes of Workforce, Information, and Research and Development. A Mental Health Information Strategy has just been published, and a Mental Health Minimum Data Set is being rolled out.

A range of action has been taken to prevent suicides to meet the target in Our Healthier Nation of reducing suicide by at least one fifth by 2010. These have involved reducing the pack sizes of paracetamol and aspirin, and supporting people who are at high risk of suicide. The Department has continued to develop the CALM helpline to offer advice, guidance, information, referrals and counselling to young men at the onset of depression. The Department is also promoting the implementation of the recommendations of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Services are being required to reduce to zero by the end of March 2002 the number of suicides on acute psychiatric wards by ensuring that immediate action is taken to remove all non-collapsible structures such as bed, shower and curtain rails in all psychiatric in-patient settings. In addition, the Department plans to develop, under the direction of Professor Louis Appleby, a National Suicide Prevention Strategy to ensure a co-ordinated and coherent approach to reducing suicides.

There is also a programme of performance management underway aiming to focus on outcomes for service users. This is supported by a process of service mapping and review, locality self-assessments carried out by Local Implementation Teams, and regional monitoring. There is also a review of data collected centrally by the Department for performance monitoring, and networks of benchmarking groups being established in localities and regions. The Mental Health policy branch is working...
closely with NHS and SCR regional mental health leads on the implementation of the MHNSF and NHS Plan.

The NHS Plan Implementation Plan published in December 2000 sets targets and objectives for 2001/2002. This builds upon the investment of the last two years in secure beds, 24 hour staffed beds, extra assertive outreach teams and improving access to services 24 hours a day, 7 days a week.

To deliver these services local health and social care communities will have to prepare effectively during 2001/2002, and plan for full-scale implementation of the new models in 2002/2003 and 2003/2004, using the increased funding in the 2001-02 Mental Health Grant. Developing a robust plan will require a comprehensive review of community mental health provisions to ensure that new services are delivered in a co-ordinated way. Mental Health Local Implementation Teams (LITs) will take the lead in this process, and the local mental health implementation plan remains the key document for consolidating investment and service development, and for delivering NHS Plan and MHNSF requirements.

However, whilst the planning process is going on, it is important that there is continuing improvement in mental health services during 2001-02. Mental health services should already be working towards delivery of key NSF milestones including the implementation of the MHIS, the MHMDS, clinical decision support systems, and the Workforce Action Team requirements.

**Targets:**

- **By November 2001,** each Local Implementation Team will have signed-off by the relevant NHS and Social Care Regional Office, their Stage 3 plan for implementing the MHNSF, and the mental health targets in the NHS Plan. Each health authority must reflect the LIT plans in their planning for 2002/03 and beyond.

- **By March 2002,** each health authority must have identified all service users who require the assertive outreach approach, and prepared plans for a further 50 assertive outreach teams to ensure that all service users who need this approach will be in receipt of such services by 2003. Also, the national psychiatric re-admission rate must be reduced to 12.3% by end March 2002.

- **By March 2001,** all specialist mental health service users on enhanced CPA should have a written care plan, available to staff providing care and to users at the time and place required to provide appropriate and effective care, which includes: the action to be taken in a crisis by the service user, the carer and the care co-ordinator; advises the GP of the response required if the service user needs additional help; is regularly reviewed by the care co-ordinator; and informs the service user how to access services 24 hours a day, 365 days a year. By March 2002, this should be extended to cover all service users on CPA, and all patients discharged from inpatient care should have a written care plan at the time of discharge. By March 2002, the written care plan for those people on enhanced
CPA must show plans to secure suitable employment or other occupational activity, adequate housing and their appropriate entitlement to welfare benefits, and all regular carers of people on enhanced CPA, including children with caring responsibilities, should have their own written care plan which addresses their caring, physical and own mental health needs.

- By end March 2001, all health authorities should have in place protocols agreed and implemented between primary care and specialist mental health services for the management of: depression and post-natal depression; anxiety disorders; schizophrenia; those requiring psychological therapies; and drug and alcohol dependence. By end March 2002, all health authorities should have reviewed the operation of these protocols to ensure they are being used and operating effectively. In addition, health authorities will need to ensure that information about treatment and services are available for all people (regardless of age) presenting in primary care with mental health problems, including information about access to local self-help groups and support services such as housing and employment.

- To help prevent suicides amongst high risk groups, by March 2002 all patients with a current or recent history of severe mental illness and/or deliberate self-harm, and in particular those who at some time during their admission were detained under the Mental Health Act because of a high risk of suicide, must be followed up by a face to face contact with a mental health professional within 7 days of discharge from inpatient hospital care. Also, every health authority and local council must have multi-agency protocols agreed and operational for the sharing of information relevant to reducing risk of serious harm to self or others.

- By end March 2002, 60 staff will be recruited to provide prison in-reach services at selected prisons and 40 new secure beds will be provided to transfer those people no longer requiring the conditions of high security. These schemes will be discussed and agreed with Regional Offices.
## Mental Health

### Service and Financial Framework (SaFFR) table

<table>
<thead>
<tr>
<th>Target / Milestone</th>
<th>SaFFR line</th>
<th>Org level</th>
<th>Plan Source</th>
<th>Monitor Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental health promotion</strong></td>
<td>Number of patients aged 16-64 under care of or accepted by MH services under enhanced level of CPA.</td>
<td>HA and Trust SaFFR</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td><strong>Mental health promotion</strong></td>
<td>Number of patients aged 16-64 under the enhanced level of CPA with a written care plan which includes plans to secure suitable employment or other occupational activity, adequate housing and their appropriate entitlement to welfare benefits.</td>
<td>HA and Trust SaFFR</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td><strong>Primary care and access</strong></td>
<td>Expenditure on promoting mental health.</td>
<td>HA SaFFR</td>
<td>✗</td>
<td>✅</td>
</tr>
<tr>
<td><strong>Primary care and access</strong></td>
<td>Have protocols between primary and specialist services for the management of: depression and post-natal depression; anxiety disorders; schizophrenia; those requiring psychological therapies; and drug and alcohol dependence, been agreed and implemented?</td>
<td>HA SaFFR</td>
<td>✗</td>
<td>✅</td>
</tr>
<tr>
<td><strong>Primary care and access</strong></td>
<td>Has there been a review of the operation of the protocols between primary and specialist services for the management of: depression and post-natal depression; anxiety disorders; schizophrenia; those requiring psychological therapies; and drug and alcohol dependence, to ensure they are being used and operating effectively?</td>
<td>HA SaFFR</td>
<td>✗</td>
<td>✅</td>
</tr>
<tr>
<td><strong>Primary care and access</strong></td>
<td>Is information about treatment and services available for all people (regardless of age) presenting in primary care with mental health problems, including information about access to local self-help groups and support services such as housing and employment?</td>
<td>HA SaFFR</td>
<td>✗</td>
<td>✅</td>
</tr>
</tbody>
</table>
## Section 2

### Severe Mental Illness

| Target: By the end of March 2002 each health authority must have identified all clients who require the assertive outreach approach, and prepared plans for a further 50 assertive outreach teams to ensure that all clients who need this approach will be in receipt of such services by 2003. | Number of assertive outreach teams. | HA | SaFFR | ✔ | ✔ | CIC |
| Target: By the quarter ending March 2002, reduce the national psychiatric re-admission rate to 12.3%. | Number of assertive outreach staff. | HA | SaFFR | ✔ | ✔ | CIC |
| Target: By end March 2001 all specialist mental health service users on enhanced CPA should have a written care plan, available to staff providing care to users at the time and place required to provide appropriate and effective care, which includes: the action to be taken in a crisis by the service user, the carer and the care co-ordinator; advises the GP of the response required if the service user needs additional help; is regularly reviewed by the care co-ordinator; and informs the service user how to access services 24 hours a day, 365 days a year. | Number of patients aged 16-64 under care of or accepted by specialist MH services under CPA. | HA and Trust | SaFFR | ✔ | ✔ | CIC |
| Milestone: By end March 2002, 60 staff will be recruited to provide prison in-reach services at selected prisons and 40 new secure beds will be provided to transfer those people no longer requiring the conditions of high security. These schemes will be discussed and agreed with regional offices. | Number of patients aged 16-64 under CPA with a written care plan as described in the target. | HA and Trust | SaFFR | ✔ | ✔ | CIC |
| Milestone: By end March 2002, 60 staff will be recruited to provide prison in-reach services at selected prisons and 40 new secure beds will be provided to transfer those people no longer requiring the conditions of high security. These schemes will be discussed and agreed with regional offices. | Number of discharges (from inpatient hospital care under a psychiatric specialist) of patients aged 16-64, where the patient had a written care plan at the time of discharge. | HA and Trust | SaFFR | ✔ | ✔ | CIC |
| Carers: By the quarter ending March 2002, all regular carers of people on enhanced CPA have their own written care plan which addresses their caring, physical and own mental health needs. This includes children with caring responsibilities. | Number of long-term secure beds for people discharged from high secure hospitals. | HA | - | x | ✔ |
| Carers: By the quarter ending March 2002, all regular carers of people on enhanced CPA have their own written care plan which addresses their caring, physical and own mental health needs. This includes children with caring responsibilities. | Number of prison in-reach staff (wte). | HA | - | x | ✔ |

### Preventing suicide

| Target: By March 2002 every health authority and local authority must have multi-agency protocols agreed and operational for the sharing of information relevant to reducing risk of serious harm to self or others. | Number of discharges (from inpatient hospital care under a psychiatric specialist) of patients with a current or recent history of severe mental illness and/or deliberate self-harm, or who at some time during their admission were detained under the Mental Health Act because of a high risk of suicide. | HA and Trust | SaFFR | ✔ | ✔ | CIC |
| Target: By March 2002 every health authority and local authority must have multi-agency protocols agreed and operational for the sharing of information relevant to reducing risk of serious harm to self or others. | Number of discharges (from inpatient hospital care under a psychiatric specialist) of patients with a current or recent history of severe mental illness and/or deliberate self-harm, or who at some time during their admission were detained under the Mental Health Act because of a high risk of suicide. | HA and Trust | SaFFR | ✔ | ✔ | CIC |
| Target: By March 2002 every health authority and local authority must have multi-agency protocols agreed and operational for the sharing of information relevant to reducing risk of serious harm to self or others. | Does the HA have multi-agency protocols, for the sharing of information relevant to reducing risk to others agreed and operationalised? | HA and LA | SaFFR | x | ✔ | CIC |
Underpinning programmes

<table>
<thead>
<tr>
<th>NSF objective: Implementation of Mental Health Information Strategy (MHIS).</th>
<th>Total number of provider trusts based within the health authority's geographical boundaries providing adult or elderly mental health services, for which the authority is the principal commissioner.</th>
<th>LIT</th>
<th>SuFFR x</th>
<th>CIC</th>
<th>HA and Trust</th>
<th>SuFFR x</th>
<th>CIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSF objective: Implementation of Mental Health Minimum Data Set (MHMDS) by March 2003.</td>
<td>Number of provider trusts based within the health authority's geographical boundaries providing adult or elderly mental health services, for which the authority is the principal commissioner, which plan to implement the MHMDS by 31st March 2002.</td>
<td>HA and Trust</td>
<td>SuFFR x</td>
<td>CIC</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The above lines are those for HAs to respond to in their SaFFR, questions will be modified for monitoring NHS Trusts.
SECTION 3
LOCAL TARGET SETTING AND MONITORING

This section is intended to provide practical guidance to those working in health authorities, local authorities and their partners. It discusses:

- General principles of local target setting
- Approaches to local target setting
- Monitoring progress
Local Target Setting and Monitoring

3.1 Paragraph 11.45 of the OHN White Paper ‘Saving Lives’ stated that “much of the action that we are putting in place will be delivered at the level of local communities. We expect health authorities and their partner local authorities as well as other local agencies to set out in their Health Improvement Programmes (HImPs) how they plan to achieve the national priorities through targets at local level. Health Improvement Programmes will be required to include additional local targets to address particular local priorities and to cut out health inequality.” This message is reinforced in the NHS Plan.

3.2 This section aims to help local partners consider these issues by setting out:
   a. **general principles** of local target setting;
   b. **approaches** to local target setting;
   c. **ways of monitoring progress** and dissemination of good practice.

General Principles

3.3 Health Authorities have a key role in improving the health of their population in partnership with other NHS bodies, local authorities and other local agencies. The HImP will be the framework in which targets should be set. (See the HImP guidance in **Appendix 3**). Plans can, where possible, include cash release proposals which allow money to be recycled into priority areas.

3.4 Setting local targets in this context should:
   a. involve all appropriate local agencies;
   b. identify and motivate local action;
   c. reflect local priorities;
   d. be consistent with the overall aims of the NHS Plan (and Our Healthier Nation) of improving overall health and reducing inequalities.

3.5 The OHN White Paper and the HImP Guidance stress that local health improvement targets will address:
   a. the local contribution to the achievement of the national health targets. This should include both local versions of the national targets and local targets relating to the measures of progress set out in the “Measures of Progress” Section 2;
   b. other locally identified priorities;
   c. inequalities.
Every HA in England has already drawn up comprehensive Local Delivery Plans for implementing the CHD NSF, based on local needs assessment etc. These have been drawn up by local CHD Implementation Groups involving all relevant local agencies, and will meet the requirements set out in para 3.4 above.

**Approaches to Local Target Setting**

3.6 To address the three areas in para 3.5 above it is first necessary to consider the areas identified as national priorities. The NHS Plan clearly articulates the Government’s priorities, and the NHS Plan Implementation Programme, issued in December 2000, identifies the priority areas for 2001/02. Local targets should be based on the same definitions as in Appendix 8 of this document and health authorities, in negotiation with their Regional Office, should set targets that reflect the national targets as a minimum. Health Authorities are free to set more challenging targets – offering scope to address geographical inequalities relating to their area. The process should include setting of local targets within each priority area (e.g. other relevant health measures, determinants of health, health services etc). This process of local target setting should take place within the established annual planning round detailed in Planning for Health and Social Care, issued in December 2000. This includes the completion of Service and Financial Frameworks which capture the agreed action and investment to be taken to meet national and local priorities. The setting of local targets for health improvement should be considered as integral to the process of planning services throughout the health community. The measures of progress section of this document, Section 2, and related information in the Appendices, will facilitate this process.

3.7 Specific local priorities should be identified through examination of local and national data sources, sounding out the views of users and local communities, using local intelligence on key problems, and through knowledge of the age and social structure of the population. Local targets could take several forms, and may encompass areas beyond the national priority areas, but it is important that there is a connection between them and the long-term health goals. Examples could include:-

- Changes in health measures: e.g. the number of people quitting smoking, teenage pregnancy, oral health, low or mean birthweight;

- Changes in the possible environmental, social and economic determinants of health. Many of the wider determinants will be outside the direct control of the NHS but the NHS will work with its local partners as part of the HImP process to help achieve them e.g. improve the housing stock, reduce the number of school exclusions, improve the uptake of welfare benefits;
Changes in services and their use e.g. increase the number of smoking cessation services provided / clinics held, support efforts to increase the re-housing of homeless people, or the establishment of good co-ops. These would be tangible markers of local progress.

3.8 Local targets for reducing health inequalities should reflect identified local problems and the intended action to address them. They might cover, for example, planned reductions in teenage pregnancies in particular groups or communities; targets and access to services for ethnic minority groups, or a reduction in differentials in smoking rates between social classes or areas.

3.9 Initial information from the HDA suggests target setting in initial HImPs has been patchy. And targets are often expressed as objectives rather than quantified targets, and may focus on process or activity. Targets and objectives are usually directed at specific population groups, and specific measurable outcome targets are usually geographically based, and may be service related. This illustrates the diversity of targets that may be felt appropriate to meet local needs. Availability of data represents an important constraint on what may be feasible.

**Monitoring Progress**

*Data Sources*

3.10 The Public Health Observatories should be able to provide advice to local organisations. Sources will include:

a. national sources of health data (list of sources is at Appendix 14);

b. sources from Government initiatives (Appendix 13);

c. local data collections.

Functions of the Public Health Observatories will include:

♦ Monitoring disease patterns and trends at local level and drawing together information from different sources and organisations to facilitate local priority-setting and planning.

♦ Analysing existing data and identifying gaps in the information base to give early warning of emerging health problems and changes in health trends to ensure that policy is kept locally relevant and up to date.

♦ Evaluating the impact of local actions and assessing the effectiveness of local agencies in improving health and tackling health inequalities.

The PHOs will add value to the work already being carried out at the local level by bringing together information, analysing and interpreting it and sharing it with relevant partner organisations. By co-ordinating this information, the eight PHOs will enable the NHS and local authorities to be better equipped to implement the recommendations set out in the NHS Plan.
3.11 Where data are not available locally, consideration should be given as to how and whether to obtain them. Where national definitions and surveys exist, collection should ideally be undertaken in a consistent way. Even where national definitions and surveys do not exist there would be advantage in different localities adopting similar methodology to tackle similar problems, and different local organisations should get together to agree these.

**Actions**

3.12 Actions need to be identified locally which will produce the necessary health improvements. Local partners should jointly agree local actions required and draw on experience elsewhere. Identification of actions should be associated with a review of possible targets and likely measures of progress.

**Monitoring**

3.13 Adequate mechanisms need to be set up locally to monitor progress on the actions agreed, the measures of progress and the targets themselves.

**Good Practice**

3.14 Some examples of good practice are given in Appendix 15. Further examples will be presented in due course on the OHN web-site.

**Summary of the process**

3.15 The figure on the following page summarises the process of local target setting.
Local Target Setting

- Identify locality
- Identify local agenda
- Identify local partners
  - Mechanisms for involvement
  - Define targets
  - Set data quality criteria
  - Monitoring arrangements
  - Reporting
  - Review
Identifying the locality

3.16 The locality for which a target is to be set will usually be based on a geographic area, but this may not always be so (a GP list for example could be used).

3.17 The statistical validity of any measure applied to a specific locality will be dependent on the frequency of the event(s) measured and the population of the locality. If a locality is too small it might be necessary to aggregate localities or time periods to obtain statistically valid results. Expert advice on such issues should be obtained from local analysts (who may include health economists, statisticians and information experts).

Identifying the local agenda

3.18 Any targets set in support of the national targets will need to have local relevance in order to gain the support of local partners. Each partner is likely to have different agenda.

3.19 The following characteristics of the locality need to be taken into account before determining targets (the list is not exhaustive):

<table>
<thead>
<tr>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
</tr>
<tr>
<td>Socio-economic characteristics</td>
</tr>
<tr>
<td>Area deprivation indices</td>
</tr>
<tr>
<td>Mortality/morbidity statistics</td>
</tr>
<tr>
<td>Crime</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Environmental factors</td>
</tr>
<tr>
<td>Local voices – What issues are important locally?</td>
</tr>
<tr>
<td>Lifestyle/behavioural factors</td>
</tr>
<tr>
<td>Cultural issues</td>
</tr>
<tr>
<td>Service provision</td>
</tr>
<tr>
<td>Resource allocation</td>
</tr>
</tbody>
</table>

Identifying local partners

3.20 For any given target area there are likely to be several interested local agencies or interest groups. The chances of successfully meeting a target will be enhanced by involving as many of these as possible at all stages of the process.

3.21 Likely local partners are (again this is not an exhaustive list):

<table>
<thead>
<tr>
<th>Local Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Authorities</td>
</tr>
<tr>
<td>Local Authorities</td>
</tr>
<tr>
<td>PCGs</td>
</tr>
<tr>
<td>NHS Trusts</td>
</tr>
</tbody>
</table>
Mechanisms for involvement

3.22 The Health Improvement Programme process should provide a suitable forum for ensuring the involvement of local partners. Indeed, as part of the process so far, many authorities will already have been developing sets of local indicators and targets to support the HImp. Guidance for HImps was issued to all HAs and LAs as HSC 1998/167 : LAC (98) 23 – see Appendix 3 for more details.

Defining the targets

3.23 Once the issues to be addressed have been identified, the information needed to monitor progress and set realistic targets must be identified. In determining the information available the following issues should be considered:

<table>
<thead>
<tr>
<th>Are the data currently available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>At what geographic level are the data available?</td>
</tr>
<tr>
<td>Are the data of sufficient robustness and/or quality?</td>
</tr>
<tr>
<td>What is the evidence base?</td>
</tr>
<tr>
<td>Trends: availability, consistency and direction.</td>
</tr>
<tr>
<td>What is the population at risk?</td>
</tr>
<tr>
<td>Are denominators available (population or list-based)?</td>
</tr>
<tr>
<td>Who owns the data?</td>
</tr>
<tr>
<td>Are there any problems with access to the data?</td>
</tr>
<tr>
<td>Confidentiality/data protection issues.</td>
</tr>
<tr>
<td>Opportunities for data linkage.</td>
</tr>
</tbody>
</table>
3.24 If new collections or local surveys are required the following also need to be considered:
- Cost
- Required frequency
- Comparability with other sources (harmonisation)
- Common agreed definitions.

**Setting data quality criteria**

3.25 Authorities will need to make sure that any data collections are of high enough quality for their intended use. Feedback to data suppliers will be necessary.

3.26 HAs will probably have mechanisms in place to assure the quality of their current collections.

**Monitoring arrangements and responsibilities**

3.27 In most cases the Health Authority will be the most suitable partner to take responsibility for monitoring targets, but this will not always be the case.

3.28 Other local partners should take their fair share of responsibility for monitoring. Usually it will be obvious where a responsibility will fall (especially in the case of current data collections).

**Reporting**

3.29 Reporting of all target monitoring should be open and freely available.

**Review**

3.30 Target monitoring should be kept under regular review to ensure that the arrangements are working and still appropriate. Authorities could conduct this as part of their regular rolling review of HImP arrangements.
SECTION 4
TECHNICAL APPENDICES

This section provides a source of more detailed reference.

Appendix 1 Measures of progress (including examples of information templates)
Appendix 2 The National Health Inequalities Targets
Appendix 3 Health Improvement Programmes
Appendix 4 NHS Plan Implementation Programme for 2001/02
Appendix 5 National Service Frameworks
Appendix 6 The NHS Performance Assessment Framework
Appendix 7 Compendium of Clinical and Health Indicators
Appendix 8 Definition of National Mortality Targets
Appendix 9 Rationale for setting of national targets
Appendix 10 Health Inequalities - the Acheson Report
Appendix 11 What is Health Impact Assessment?
Appendix 12 Accident Prevention Task Force – supporting work
Appendix 13 Indicators and information sources developed as a result of other initiatives
Appendix 14 Summary of data sources
Appendix 15 Examples of good practice
Appendix 16 Sexual Health and Teenage Pregnancy strategies
Appendix 1

Measures of progress (including examples of information templates)

A list of potential measures is given below. These were originally derived from the work of a technical sub-group of the Chief Medical Officer’s OHN Working Group, and amended over time by other experts in the field, but are relevant to a wider group of interests. They usefully identify a range of measures to reflect many of the key factors which will need to be monitored to assess progress towards national goals and targets.

This list should be viewed as a starting point which can be built upon as time passes and as new data become available. It is not designed to be a comprehensive set of measures. The measures identified relate closely to potential indicators relevant to the health improvement domain of the NHS Performance Assessment Framework (see Section 1 and Appendix 6), and will be further developed in concert with the PAF.

It is important to stress that development of these measures of progress has been taken forward with the underlying principle that wherever possible, pre-existing indicators / measures of progress / recommendations / targets should be used. This principle means that the substantial majority of measures of progress will already be in the public domain, for example, in National Service Frameworks, various Government White Papers etc. Furthermore, wherever possible, measures of progress have been identified based on currently available data.

To assist the process of identifying suitable measures, the Statistics Division of the Department of Health have prepared a series of “templates” which specify the types of measures that are being proposed and the sources of data at national and local level that are thought to be available to support them. These are in draft form initially, and will develop on the web-site over time. Examples of these templates follow the list of potential measures.

The full set of templates will be included on the web-site in due course. It is also intended that the range of measures identified will be kept under review and developed or supplemented in the light of ongoing work to implement the NHS Plan and related initiatives. This list should therefore be viewed as a useful core of measures which will provide an overview of progress. Updates and additions will be presented on the web-site as necessary.
INITIAL LIST FOR DISCUSSION - Potential Measures of Progress
This is NOT a comprehensive list, but a starting point for a possible “basket” of indicators

(Proposed indicators may relate to one or more priority areas)

Lifestyle

1. Adult smoking prevalence for all adults aged 16 and over (cigarettes only)
2. Adult smoking prevalence for those in manual social classes
3. Smoking prevalence among children aged 11 to 15
4. Average percentage of food energy derived from total fat
5. Consumption of fruit and vegetables – population average
6. Fibrinogen levels in the population – population average
7. Proportion of population classified as obese (Body Mass Index over 30)
8. Proportion of population classified as having a healthy body weight (Body Mass Index between 20 and 25)
9. Proportion of population with plasma cholesterol level at or above 5.0 mmol/l [CHD NSF]
10. Proportion of population with high blood pressure (systolic BP above 140mmHg or diastolic BP above 85 mmHg) [Note new WHO guidelines and CHD NSF]
11. Proportion of population taking moderate intensity exercise at least 5 times per week
12. Proportion of children aged 2-15 undertaking physical activity
13. Proportion of people to whom having a suntan is very or fairly important
14. Number of people reporting sunburn in the last year
15. Proportion of men consistently drinking 4 or more units of alcohol a day and women consistently drinking 3 or more units a day [Indicator will relate to the proportion drinking this amount on at least one day during the past week]

Environment

16. Number of households exposed to excessive radon levels

Service

Cancer specific:

17. Proportion of women responding to invitation for breast screening
18. Proportion of target population screened for cervical cancer at least once in the previous 5 years
19. Proportion waiting for no more than one month from diagnosis to treatment – by 2005
20. Proportion waiting for no more than two months from urgent GP referral to treatment – by 2005
21. Proportion of patients seen within one month from urgent GP referral to treatment for children's cancer, testicular cancer and acute leukaemia – by 2001
22. Proportion of patients with breast cancer receiving treatment within one month of diagnosis – by 2001
23 Proportion of patients seen within two months from urgent GP referral to treatment for breast cancer – by 2002
24 Number of extra cancer specialists

Cancer measures of progress will also relate to a range of Performance indicators under development.

Circulatory disease specific:

25 Coronary Heart Disease (CHD) mortality rates by HA
26 Smoking prevalence by age and sex in England and in each region
27 Number and % of practices within a PCG/PCT with a systematic approach to following up people with CHD (new collection from 2001/02)
28 Number and proportion of people aged 35 to 74 years with recognised CHD whose records document advice about use of aspirin
29 Number of rapid access chest pain clinics established
30 Number and % of ‘category A’ calls to the ambulance service receiving a response within 8 mins [Note this is not a ‘cardiac specific’ target]
31 Number and % of patients eligible for thrombolysis receiving it within 30 minutes of hospital arrival (“door-to-needle time”). [N.B. target for 2002 is 30 mins, target for 2003 will be 20 mins]
32 Number and % of patients discharged from hospital with a diagnosis of AMI and who are eligible to be prescribed aspirin, statins, beta-blockers or ACE inhibitors, who receive such prescriptions
33 Age-sex standardised rates of CABG/million population
34 Age-sex standardised rates of PTCA/million population


Mental health specific:

35 By November 2001, each Local Implementation Team will have signed-off by the relevant NHS and Social Care Regional Office, their Stage 3 plan for implementing the MHNSF, and the mental health targets in the NHS Plan. Each health authority must reflect the LIT plans in their planning for 2002/03 and beyond.

36 By March 2002, each health authority must have identified all service users who require the assertive outreach approach, and prepared plans for a further 50 assertive outreach teams to ensure that all service users who need this approach will be in receipt of such services by 2003. Also, the national psychiatric re-admission rate must be reduced to 12.3% by end March 2002.

37 By March 2001, all specialist mental health service users on enhanced CPA should have a written care plan, available to staff providing care and to users at the time and place required to provide appropriate and effective care, which includes: the action to be taken in a crisis by the service user, the carer and the
care co-ordinator; advises the GP of the response required if the service user needs additional help; is regularly reviewed by the care co-ordinator; and informs the service user how to access services 24 hours a day, 365 days a year. By March 2002, this should be extended to cover all service users on CPA, and all patients discharged from inpatient care should have a written care plan at the time of discharge. By March 2002, the written care plan for those people on enhanced CPA must show plans to secure suitable employment or other occupational activity, adequate housing and their appropriate entitlement to welfare benefits, and all regular carers of people on enhanced CPA, including children with caring responsibilities, should have their own written care plan which addresses their caring, physical and own mental health needs.

38 By end March 2001, all health authorities should have in place protocols agreed and implemented between primary care and specialist mental health services for the management of: depression and post-natal depression; anxiety disorders; schizophrenia; those requiring psychological therapies; and drug and alcohol dependence. By end March 2002, all health authorities should have reviewed the operation of these protocols to ensure they are being used and operating effectively. In addition, health authorities will need to ensure that information about treatment and services are available for all people (regardless of age) presenting in primary care with mental health problems, including information about access to local self-help groups and support services such as housing and employment.

39 To help prevent suicides amongst high risk groups, by March 2002 all patients with a current or recent history of severe mental illness and/or deliberate self-harm, and in particular those who at some time during their admission were detained under the Mental Health Act because of a high risk of suicide, must be followed up by a face to face contact with a mental health professional within 7 days of discharge from inpatient hospital care. Also, every health authority and local council must have multi-agency protocols agreed and operational for the sharing of information relevant to reducing risk of serious harm to self or others.

40 By end March 2002, 60 staff will be recruited to provide prison in-reach services at selected prisons and 40 new secure beds will be provided to transfer those people no longer requiring the conditions of high security. These schemes will be discussed and agreed with Regional Offices.

Mental health measures of progress relate to the standards and milestones set out in the Mental Health National Service Framework, published September 1999.

For Accident specific measures, see Appendix 12, work to support Accident Prevention Task Force

Socio-economic
41 Proportion of population reporting high pace of work and low control
42 Proportion of working-age people living in workless households
43 Proportion of population living in low income households
44 Proportion of population living in poor housing
45 Lack of social support
46 11 year olds with poor literacy and numeracy skills and the number of school leavers with no qualifications
**General Health**

47 Expectation of life

48 Healthy life expectancy

Healthy life expectancy is a summary measure that combines mortality and morbidity into a single index. The “health” element can be assessed in various ways. Recent analytic work by the Office for National Statistics (ONS) has included the use of self-rated health – the General Household Survey question:

“over the last 12 months would you say your health has on the whole been good, fairly good or not good?”

This measure correlates with other separate measures of health and is a good predictor of mortality. Healthy life expectancy based on this measure is one of the 15 “headline” indicators in the Government’s Sustainable Development strategy (A better quality of life – a strategy for sustainable development for the UK), led by the DETR. These will be used to measure our future social, economic and environmental progress. This measure is also one of the DSS “Opportunity for All” indicators, and will also be one of the measures used to monitor progress towards the goals originally set out in OHN. ONS are carrying out further development work on this measure.

49 Infant mortality

Further health measures relating to child and adult health / morbidity / mortality will be defined as work progresses on monitoring the national inequalities targets, “to narrow the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country” as stated in Chapter 13 of the NHS Plan, and announced by the Secretary of State for Health in February 2001 (see Appendix 2 for definitions and details)
CANCER

Aim: reduce morbidity and mortality from cervical cancer

Indicator: Coverage of cervical cancer screening programmes.

Associated Target, Recommendation or Aspiration.
To increase the proportion of the target population (women aged 25-64) screened at least once in the previous 5 years.

National Sources: KC53 (aggregate return)

Local Sources: KC53

Data availability. Annual publication. More detail may be available on request.

Geographic: HA
Gender: Female only
Ethnicity: No
Social class: No
Age: Yes
Time period: Annual

Links to other initiatives: NHS Cervical Screening Programme

Comments: The National target for coverage is 80% of the target population by March 2002.
In 1998-99, 86 of 99 Health Authorities met or exceeded the target.
CIRCULATORY DISEASES

Aim: Reduce incidence of circulatory diseases. Improve the health of the population in general

Indicator: To reduce overall adult smoking rates in all social classes (NB there is a separate target for manual social classes only)

Associated Target, Recommendation or Aspiration.
To reduce adult (16 & over) smoking in all social classes so that the overall rate falls from 28% to 24% or less by the year 2010; with a fall to 26% by the year 2005. This was a published target in the “Smoking Kills” White Paper of December 1998, and relates specifically to cigarette smoking

National Sources: General Household Survey (GHS) – analysed for England. This is being used to monitor the “Smoking Kills” target. Health Survey for England (HSfE)

Local Sources: HSfE - Aggregation of data from a sequence of surveys will provide a sample big enough to obtain results at HA level. This is available on the DH website for 1994-1996. HAs may be able to buy a local “boost” to the sample.

Data availability. Biennial for GHS to 2000, then annual. Annual publication for HSfE. HA level data based on years 1994-1996 are available. Data at HA level will next be available in 2003 based on years 1998-2002.

Geographic: Standard Region (GHS), Regional Office area (HSfE & GHS), Health Authority (HSfE combining years)
Gender: Yes in both GHS, HSfE
Ethnicity: GHS data unpublished but specific analyses may be commissioned, HSfE collects data annually and the 1999 survey included a special focus
Social class: GHS, HSfE
Age: GHS, HSfE
Time period: 1974 to 1998 (GHS), HSfE annual since 1991

Links to other initiatives: Local indicators of progress will need to be consistent with monitoring arrangements for "Smoking Kills".

Comments: This is one of the three key targets in the Tobacco White Paper “Smoking Kills”. There is also a separate target for manual social classes only, set in the NHS Cancer Plan. A recent analysis of comparisons between GHS and HSfE concluded that both were suitable for measuring smoking prevalence, but recommended use of GHS because of its GB coverage in line with "Smoking Kills". It may be necessary to use different sources for different purposes.
Ethnic group collected in GHS but not published in relevant analyses. Focus on ethnicity in the 1999 Health Survey for England.
MENTAL HEALTH

Aim: Reduce the death rate from suicide and undetermined injury by at least a fifth.

Indicator: The suicide (and undetermined injury) rate in the general population.

Associated Target, Recommendation or Aspiration. Reduce the death rate amongst the general population where the cause of death is coded (using ICD 9) as E950-E959 or E980-E989 (excluding E988.8).

National Sources: Office for National Statistics (ONS) Mortality data

Local Sources: ONS Mortality statistics

Data availability. Annual publication.

Geographic: Post code which relates to the normal residence of the deceased. (Allowing aggregation to various geographic areas – data are not normally available at this level)
Gender: Yes
Ethnicity: Use country of birth as proxy
Social class: Every 10 years linked with Decennial population census
Age: Yes
Time period: Annual

Links to other initiatives: Sustainable Development Indicators – DETR

Comments: Small numbers may make calculation of rates difficult at local level - this may be overcome by aggregating years.

Includes unintentional injury deaths which are, in practice, mainly suicides.
GENERIC MEASURES

Aim: Reduce the incidence of circulatory diseases and improve the general health of the population

Indicator: Prevalence of healthy weight

Associated Target, Recommendation or Aspiration. Increase the proportion of the population classified as having a healthy body weight (Body Mass Index between 20 and 25kg/m²)

National Sources: Health Survey for England (HSfE)(anthropometric measures)

Local Sources: HSfE - Aggregation of data from a sequence of surveys will provide a sample big enough to obtain results at HA level. HAs may be able to buy a local “boost” to the sample.

Data availability. Annual publication (HsfE) Data based on years 1994-1996 are available at the HA level. Data for HAs will be next available in 2003 based on years 1998-2002.

Geographic: RO Area
Gender: Yes
Ethnicity: Yes
Social class: Yes
Age: Yes
Time period: Annual

Links to other initiatives:

Comments: Special focus on ethnicity in the 1999 Health Survey for England, on children and young adults in the 1997 survey and on older people in the 2000 survey.
Appendix 2

The National Health Inequalities Targets

The national health inequalities targets were announced in February 2001:

(1) Infant Mortality (deaths in the first year of life)

<table>
<thead>
<tr>
<th>Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap* in mortality between manual groups and the population as a whole</th>
</tr>
</thead>
</table>

* extrapolation of recent trends suggests a widening of the gap between the manual group and the population as a whole – the target therefore is challenging in that it requires that by 2010 that the (relative) gap narrows by 10%. The chart which follows illustrates the proposed target in terms of projections of recent trends.

Note: The chart shows that the national infant mortality rate for all social classes (births within marriage and joint registrations) is expected to fall for the first time below 5 deaths per thousand live births by 2006. If this trend continues, it is estimated that approximately 3,000 fewer infant deaths in total will occur between 1998 and 2010. This estimate is based on a crude extrapolation of current trends, compared to the baseline number of infant deaths in 1998, with no allowance for projected changes in the live birth rate.

Key Facts
3,379 deaths in England (1999), comprising:
Neonatal= 2,288; Postneonatal= 1,091
5.7 deaths per 1,000 births (1999)
Social gradient: SC5 rate about 1.7 times SC1
Main causes (different patterns for first month and remainder of infancy) (England 1999)
- Neonatal (1st month) deaths: Immaturity – 49%; Congenital anomalies – 26%
- Post-neonatal (28 days to 1 year): Sudden infant deaths – 18%; Congenital anomalies – 18%; Respiratory – 12%; Infections – 12%.
  (Source: Neonates – unpublished data, Postneonates – VS3 for England, from ONS)
Best EU rate = Luxembourg 3.5 deaths per 1,000 births (NB small numbers); Sweden 3.8 deaths per 1,000 births

Rationale for selection (summary)
- Measures: effect of prevention, parent support, health promotion & access to services including ante-natal care and neonatal intensive care
- Health gain: reduced death and morbidity
- Interventions: smoking control, breast feeding, parent support by health visitor & community, reduced poverty & improved maternal mental health, better access to health care - NHS Direct, primary care, A&E and hospital general & paediatric and neonatal intensive care
- This target is formulated in terms of socio-economic groups and thereby complements the area-based life expectancy target. It will be monitorable on an annual basis. Infant mortality reflects a range of influences within and outwith the health services and success in achieving the target should be a
measure of progress across a much broader front than the immediate measure of mortality in a very restricted age group.
Formulation of target
The diagram sets out the approach taken to setting the target. Note that
• the data presented for infant mortality are based on three year averages
• the data are derived from the ONS linked file – linking information on birth and
death registrations. (Levels may therefore differ slightly from some other
published national statistics)
• the trends in infant mortality are based on the most recent 5 data points – longer
term trends are illustrated as an inset and show a markedly different trend to the
most recent few years
• analysis of the projected trends has indicated a widening of the gap (between
manual and total population); therefore the target has been set to be a 10%
reduction on the level projected to be reached if a constant relative excess were
maintained between the present time and 2010 – thus the target is designed to be
challenging and to achieve a narrowing in the relative gap between the manual
group and the total population figure.

Further details of the underlying methodology will be presented in due course on the
inequalities web-site www.doh.gov.uk/healthinequalities
Some details will also be on the OHN technical issues web-site and associated sites.

Infant mortality
Detailed rationale for selection of this target

The infant mortality target is:

- chosen as an overall statistical indicator to identify reduction in inequality – ie not just a measure of improvement in the most disadvantaged groups
- An aggregate and high level measure of progress in the reduction of health inequalities in childhood
- Intended to be complementary to a life expectancy target expressed in terms of narrowing a gap between areas of the country with lowest life expectancy and the total population – jointly fulfil NHS Plan commitment to identify targets relating to socio-economic groups and areas
- A measure of NHS and wider government activity
- Planned to be linked to a second “layer” of targets/activities relating to all health authorities and taken forward by way of HImPs, LSPs etc
- Associated with the development of a National Service Framework for Children which will be addressing a broad range of aspects of child health

Background

1. International comparisons suggest that social class gradient is not inevitable, particularly as demonstrated in countries such as Sweden. Significant in-roads have been made into tackling the rates of infant mortality, which demonstrates that interventions are being targeted appropriately.

2. Although numbers of infant deaths are relatively small there remains scope for improvement – as illustrated by the social class gradient, Health Authority differences and international comparisons. Addressing inequalities in itself will have a relatively limited impact on the overall number of infant/childhood deaths at least in absolute terms. Importantly, as health-led interventions have already impacted significantly (cot deaths and immunisations) this target depends both on health service interventions and wider determinants outwith the direct remit of the NHS.

Setting an inequalities target around infants:

- Addresses a key population group (as identified in the Acheson report)
- Is supportive of cross-government activity
- Measures to address this age group will produce long-term benefits later in life
- Although set in terms of mortality will underpin a much wider range of initiatives addressing morbidity, disability, social care etc.

Noting however some of the potential difficulties with the target:

- Focuses on only one section of the population (in contrast to a life expectancy target)
- Small numbers
- No single identifiable strategy to achieve short-term reduction – many of the causes of death in this age group not immediately amenable to intervention
- Improved care during pregnancy likely to result in the birth of infants who would not previously have been viable, and would be at higher risk of subsequent death.

There are wide variations in infant mortality across the country - with the highest rate in 1999 being around three and a half times the lowest rate. However the annual number of deaths in any Health Authority is relatively small so there is substantial
year on year fluctuation. One approach would have been to set an area based target along the same lines as the life expectancy target – ie reducing the excess mortality in the worst quintile of Health Authorities.

However given the existence of other area based Government Interventions in Deprived Areas (GIDA) health targets – eg life expectancy - there are advantages in setting a national target in relation to socio-economic differences. This broadens the agenda to cover children not living in deprived areas or health authorities with the highest rates. And the target is formulated to cover a much larger part of the social class gradient rather than focusing only on the far ends of the spectrum.

The target is currently formulated using the former socio-economic groups as this is the form in which data are available. As data become available using the new National Statistics socio-economic classification – NS-SEC - it will – in 2002 - be possible to reset the target based on the new groupings.

A broad range of interventions will contribute to the achievement of the target including:

Health Service Provision eg
- Antenatal screening and ultrasound scanning
- Improvements to neo-natal care and referrals to paediatric intensive care
- DH Back to Sleep Campaign
- Reducing risk of respiratory disease through smoking cessation, nutrition and encouraging breastfeeding
- Immunisation – meningitis C and MMR
- NHS Direct and NHS Walk In centres

Other supporting DH programmes eg
- Smoking Kills
- Healthy Schools programme (nutrition and life skills) – with DfEE
- Sure Start Plus pilots focusing support on teenage mothers – with DfEE
- Quality Protects focusing on looked after children in particular and children in need generally – likely to lower teenage conception rates among this group
- Health visitors
- Primary care

Cross government initiatives and initiatives of other Government Departments eg
- Child poverty
- Teenage Pregnancy strategy
- Sure Start
Conclusion

- Strong argument for selection of **infant mortality** as best **summary measure** of health outcome in childhood; although set in terms of mortality this measure will reflect a much broader range of activities within and outwith the NHS;
- Infant mortality (and life expectancy) are well-understood terms by both the general public in the UK and internationally
- Strong argument for selection of **socio-economic-based measure** [NHS Plan commitment] and complements area-based life expectancy target
- Many of the major delivery mechanisms will be area-based. The proposed target is best viewed as part of a wider package including an additional inequalities target – for life expectancy - set in terms of areas, and combined with an action plan and basket of indicators that are to be taken forward by all HAs (and partners). Further development of this target to cover children at older ages is possible in due course when suitable data are available.
(2) Expectation of Life

"Starting with HAs, by 2010 to reduce by at least 10% the gap* between the quintile of areas with the lowest life expectancy at birth and the population as a whole.

The average life expectancy in the bottom quintile of Health Authorities is currently (1997-9) only at the level reached by the total population 9 years previously (in 1989). If we can achieve the proposed target by 2010 this would – on the basis of current trends – reduce this figure by about 1 year. (ie the average life expectancy in the bottom quintile of Health Authorities in 2010 would be at the level reached by the total population 8 years previously (in 2002).

* extrapolation of recent trends suggests, for both men and women, a widening of the gap between the bottom quintile and the population as a whole – the target therefore is challenging in that it requires that by 2010 that the (relative) gap narrows by 10%. The charts which follow illustrate the proposed target in terms of projections of recent trends.

Key Facts
National (1997-9): Males= 75.1y; Females= 79.8y
Worst 20% Health Authorities: Males= 72.9y; Females= 78.2y
Best EU: M= Sweden (76.7); F= France (83.2)
Main contributors (causes) – based on an analysis of data in the mid-1980s it has been estimated that complete elimination of the following causes would result in additional years of life as follows:

<table>
<thead>
<tr>
<th>Cause</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory system</td>
<td>7.4y</td>
<td>8.3y</td>
</tr>
<tr>
<td>Neoplasms (cancers)</td>
<td>3.3y</td>
<td>3.6y</td>
</tr>
<tr>
<td>Respiratory system</td>
<td>1.2y</td>
<td>1.1y</td>
</tr>
<tr>
<td>Accidents/suicides</td>
<td>1.0y</td>
<td>0.5y</td>
</tr>
</tbody>
</table>

NB ONS have been able to reproduce this analysis for 1999 for men only and this indicates potential gains in life expectancy from complete elimination of specific diseases of: circulatory disease 6.0y; cancer 3.6y; accidents 0.5y; suicides 0.4y; (respiratory diseases not yet computed)

Rationale for selection (summary)
• **Measures**: wider determinants, health prevention programmes, and improved access to care, resource allocation, and treatment
• **Health gain**: overall reduced death and an indirect measure of reduced morbidity
• **Interventions**: health including cancer plan, CHD NSF and smoking; wider determinants including Sure Start, opportunities for all and neighbourhood renewal.
• **An overall measure of the reduction in health inequality fits with targets being adopted in other countries and proposed by WHO. An area based target is therefore proposed and will form part of the Department’s Government Interventions in Deprived Areas (GIDA) commitment.}
Formulation of target
The diagram sets out the approach taken to setting the target. Note that
• the data presented for life expectancy are based on three year averages
• the data for Health Authorities have been made available by ONS
• the trends in life expectancy for Health Authorities are based on data back to 1991
• each year the quintile of Health Authorities with the lowest life expectancy will be (slightly) different
• analysis of the projected trends has indicated, for both men and women, a widening of the gap (between the quintile of HAs with lowest life expectancy and the total population); the target has been set to be a 10% improvement on the level projected to be reached if a constant relative excess were maintained between the present time and 2010 – thus the target is designed to be challenging and to achieve a narrowing in the relative gap between the areas with lowest life expectancy and the national average.

Further details of the underlying methodology will be presented in due course on the Department of Health and OHN technical issues web-sites and associated sites.
Expectation of Life in (1) Men (2) Women

**Life expectancy inequalities targets - males, exponential projections**

- (1) Worst quintile of HAs
- (2) Worst quintile of HAs - exponential projection
- (3) All population
- (4) All population - exponential projection
- (5) Worst quintile of HAs (constant relative difference from All population - exponential projection)
- (6) Narrow gap at 2010 by 10% (All population - exponential projection vs. Worst quintile of HAs - constant relative difference)

**Life expectancy inequalities targets - females, exponential projections**

- (1) Worst quintile of HAs
- (2) Worst quintile of HAs - exponential projection
- (3) All population
- (4) All population - exponential projection
- (5) Worst quintile HAs (constant relative difference from All population - exponential projection)
- (6) Narrow gap at 2010 by 10% (All population - exponential projection vs. Worst quintile HAs - constant relative difference)
Detailed rationale for selection of this target

The life expectancy target is:

- chosen as an overall statistical indicator to identify reduction in inequality – ie not just a measure of improvement in disadvantaged groups
- An aggregate and high level measure of progress in the reduction of health inequalities
- Intended to be complementary to an infant mortality target expressed in terms of narrowing a gap between manual social groups and the total population – jointly fulfil NHS Plan commitment to identify targets relating to socio-economic groups and areas
- A measure of NHS and wider government activity
- Planned to be linked to a second “layer” of targets/activities relating to all health authorities and taken forward by way of HImPs, LSPs etc
- Intended in part to fulfil DH’s obligations to identify area-based (GIDA) targets to reflect progress in addressing the major killers; also
- Initially formulated in terms of Health Authorities but this does not preclude working towards lower level formulations subject to availability of robust data

Specific issues:

(1) What are the main “routes” by which health inequalities will be addressed?
(a) Key problems: cancer, CHD (and other circulatory diseases), accidents, suicide (mental health). A fundamental set of interventions relevant to most of these topics will be measures to address smoking.
(b) Range of interventions: wider determinants (including poverty reduction); environment; health promotion; disease prevention; screening; treatment
(c) Approaches focused on individuals and/or those focused on areas
(d) Approaches focused on specific groups – eg ethnic groups, gender – and/or disadvantaged groups – eg “most deprived” socio-economic groups, those living in deprived areas
(e) Age-group based measures eg infants; children; adolescents; working population; older people

(2) What are the major delivery mechanisms by which health inequalities will be addressed?
- The main levers including resource allocation and performance management are area-based
- Commitment that reducing inequalities will be a key criterion for resource allocation
- Commitment to a new way of distributing resources to address inequalities in primary care services, and the tracking of the distribution of GPs – should lead to improved access for deprived communities
- By tying inequality to resources, it will become part of mainstream planning processes eg HImPs, SaFFs etc. Also essential to link with the setting of explicit priorities for the service.
- Achieving the proposed health target does not necessarily require extra resources within the identified HAs - existing resources may need, however, to be targeted more effectively within these (and other) HAs on particular groups, eg. the most deprived, those with relatively high CHD, etc. Operating on barriers to access to services will also be important.
• The new resource allocation objective must be complemented by performance management mechanisms. The expectation must be that NHS organisations in receipt of health inequalities finance will use those resources specifically to address health inequalities - equity audits and the like will be essential to monitor progress.

• Health inequalities and equitable access will be measured and managed through the NHS Performance Assessment Framework (PAF)

• In addition to the 2 national targets it is proposed to have a “basket” of inequality indicators. Performance managing these will drive across the board improvements. Necessary to identify appropriate process and “interim” targets set in terms of more specific service interventions – eg link to Cancer Plan and National Service Frameworks.

• Work on teenage pregnancy, and other targets which have been set locally will impact more on deprived communities.

• Lifestyle interventions eg smoking, diet, physical activity, alcohol

• HA activities eg screening programmes, efforts to reduce inequalities in access

• Action on race equality eg commitment to interpretation and translation at all NHS premises, and changes driven by the Race Relations (Amendment) Bill

• OGD activities eg on social exclusion, eradicating child poverty, Sure Start, unemployment, tax and benefit reform

• LSP activities

(3) Will the proposed measure be sensitive to change?

• Life expectancy changes relatively slowly therefore target needs to keep to a realistic timeframe – must accept relatively small changes over relatively long period of time and identify and monitor a range of further earlier-to-move indicators at national and local level – the “basket of indicators” including measures of process and intermediate outcome.

• The area-based measure chosen is closely aligned to the way in which levers and delivery mechanisms will operate – eg resource allocation and performance management

• Examples of measures which will potentially offer significant early gains include:
  - CHD and cancer screening and treatment (access to services)
  - measures to reduce accident mortality and suicide (eg new suicide prevention strategy)
  - measures aimed at reducing mortality in early life (better scope for rapid impact, greater weighting of life tables towards impact of deaths at younger ages) and later life (where the majority of deaths occur)

• The evidence base for assessing the impact of the broad range of measures on health outcome and particularly the differential impact on disadvantaged groups is very limited. Thus although some hypothetical scenarios may be possible they would be fragmentary and incomplete and therefore of only limited value in estimating impact on the life expectancy target.

• Large numbers are involved and annual data are available – both these factors should enhance sensitivity to change
Conclusion

- Strong argument for selection of life expectancy as best summary measure of health outcome reflecting a broad range of activities within and outwith the NHS
- Life expectancy (and infant mortality) are well-understood terms by both the general public in the UK and internationally
- Strong argument for selection of area-based measure [NHS Plan commitment; GIDA commitments]
- The lack of a strong evidence base across the broad range of interventions limits opportunity to quantify in a meaningful way the overall impact on the life expectancy target, but indirect evidence supports the case for such a target being a realistic but challenging measure of the success of efforts to reduce inequality.
- The major delivery mechanisms will be area-based and a target set in these terms will be an important measure of their success. However, for reasons stated, the proposed target is best viewed as part of a wider package including an additional inequalities target set in terms of socio-economic groups, and combined with an action plan and basket of indicators that are to be taken forward by all HAs (and partners). Further refinement of the proposed life expectancy target to cover more local level data is possible in due course when suitable data are available.
Appendix 3

Health Improvement Programmes

The Health Improvement Programme (HImP) will be the local strategy for improving health and healthcare. The HImP will cover the most important health needs of the local population, and how these are to be met by the NHS and its partner organisations through broader action on public health. The HImP will encompass the range, location and investment required in local health services to meet the needs of local people.

Guidance issued under HSC 1998/167 : LAC (98) 23 requires every Health Authority to lead the local development of a HImP, the first of which came into effect on 1st April 1999. HImPs will be developed ultimately to cover a 3 year rolling time frame with part of the programme reviewed in depth each year.

Health Authorities will work in partnership with the wide range of local interests, including those who use local services either as patients or carers, the organisations that represent them (such as CHCs, voluntary sector organisations, support and community groups) and the public themselves. It will be particularly important to take positive moves to involve those groups (e.g., children, older people, black and minority ethnic groups) who are under-represented or hard to reach through the NHS' traditional consultation methods and consultation partners.

The guidance makes it clear that Health Authorities will need to ensure over time that all concerned have the opportunity to contribute to the whole process of identifying needs and priorities, and assessing options for meeting them. It will be important to invest time in developing relationships, to set realistic timescales for contributions, and where necessary to develop new approaches and skills, for example of public involvement.

Each HImP should record who has been involved in its development and how. Health Authorities, Local Authorities, PCGs/Ts and NHS Trusts will be required to sign up to their commitment to deliver their own contribution to the HImP and to seek to cooperate with others in this. Other local partners will also be encouraged to record their commitments.

The HImP will ultimately combine a range of nationally and locally set targets. The national targets will need to be in accordance with the National Priorities Guidance, (see Appendix 4), the NHS Modernisation Fund and the NHS Plan. Local targets will be set to address issues and problems which are judged important locally by the partner organisations, with particular emphasis on addressing areas of major health inequality in local communities.

It will take time to develop fully HImPs that have involved all the local interests. A key priority for the first year was to build and strengthen local partnership arrangements. The first HImPs, beginning 1999/00, were not expected to be comprehensive. The aim should be to tackle a selected number of national and local issues whilst setting out the action planned to develop a fuller HImP for 2000/01 and a comprehensive HImP for the period covering 2002/03 to 2004/05. They should
make clear how far it has been possible to involve local interest in this first round, and how this will be built on in the future.
NHS Plan Implementation Programme for 2001/02

The NHS Plan Implementation Programme was published in December 2000, and can be found at

http://www.doh.gov.uk/nhsplanimpprogramme

The NHS Plan sets out a vision of a health service designed around the patient. The aim of the Plan is to provide a personalised service offering the standards that patients expect and staff want to provide.

This document identifies priorities for expansion and reform to enable the vision set out in the NHS Plan to become a reality. It provides guidance to the NHS and social care on priorities for the coming year.

This document sets out the framework for implementation, with guidance on national priorities, provisional milestones and outcome focused targets for NHS organisations and local government social services partners for the year 2001/02.

Previous years’ guidance highlighted a number of priorities on which the Government expects real progress to be made. Specific targets have now been set in most of these areas, and new targets to reduce health inequalities are currently being developed.

The Priorities

Improving Health  Smoking
Teenage Pregnancy
Drugs

Saving Lives  Cancer
Coronary Heart Disease and Stroke

Fast and Convenient Services  Waiting Lists and Times
Modern Primary Care

Caring for Vulnerable People  Older People’s Services
Children’s Services
Mental Health

Modernising Strategies  Quality
Staff
Information Technology

The priorities set out in this guidance should be reflected in the local Health Improvement Programme (HImPs).
National Service Frameworks

What will National Service Frameworks (NSFs) Do?

National Service Frameworks will set national standards and define service models for a specific service or care group, put in place programmes to support implementation and establish performance measures against which progress within an agreed timescale will be measured. Building on the frameworks for cancer and paediatric intensive care the first NSF, for mental health, was published in September 1999, and the coronary heart disease NSF was published in March 2000. Other NSFs to follow will include those on older people, children and on diabetes.

The NSF for CHD sets out an ambitious but achievable framework for reducing the burden of CHD in England and modernising CHD services. Together with action taken as a result of the NHS Plan and "Saving Lives: Our Healthier Nation", it will improve health, reduce unacceptable variations and promote fair, fast high quality services.

The full "National Service Framework for Coronary Heart Disease" can be accessed from the Department of Health website at www.doh.gov.uk/nsf/coronary.htm

The NHS Cancer Plan is the first ever comprehensive strategy linking cancer prevention, diagnosis, treatment, care and research. Developing aspects of the NHS Plan, the NHS Cancer Plan is a major programme of investment and reform involving the NHS, the voluntary sector, the community and families across the country to end the postcode lottery of care and treatment, modernise the NHS and deliver the fastest improving cancer services in Europe.

The full “NHS Cancer Plan: A plan for investment, A plan for reform” can be found at the Department of Health website at www.doh.gov.uk/cancer

Why are we developing them?

We need a systematic approach to establish service models to ensure patients receive greater consistency in the availability and quality of services across the NHS. They will provide the NHS with explicit standards and principles for the pattern and level of services required.

Who is involved?

Each NSF will be developed with the assistance of an expert reference group which will bring together health professionals, service users and carers, health service managers, partner agencies and others.

NSFs will address the whole system of care and will require partnerships with a wide range of organisations. This may include social care providers, the wider local authority, the voluntary sector, business and industry. In Trusts, Health and Local
Authority health and social care professionals etc and managers in partnership with users and carers will be involved.

For More Information

Visit the DH website at
http://www.doh.gov.uk/nsf/nsfhome.htm
Appendix 6

The NHS Performance Assessment Framework

The NHS Performance Assessment Framework has six areas.

**Health Improvement** to reflect the overarching aims of improving the general health of the population and reducing health inequalities, which are influenced by many factors, reaching well beyond the NHS.

**Fair Access** to recognise that the NHS’s contribution must begin by offering fair access to health services in relation to people’s needs, irrespective of geography, socio-economic group, ethnicity, age or sex.

**Effective Delivery of Appropriate Healthcare** to recognise that fair access must be to care that is effective, appropriate and timely, and complies with agreed standards.

**Efficiency** to ensure that the effective care is delivered with the minimum of waste and that the NHS uses its resources to achieve value for money.

**Patient/Carer Experience** to assess the way in which patients and their carers experience and view the quality of the care they receive, to ensure that the NHS is sensitive to the needs of service users.

**Health Outcomes of NHS Care** to assess the direct contribution of NHS care to improvements in overall health and complete the circle back to the over-arching goal of health improvements.

A set of **NHS Performance Indicators** has been developed to underpin the framework. The indicators look across a wide range of service areas. They allow comparison between health authority areas and in some instances between NHS trusts.

The latest set of NHS Performance Indicators can be found at [http://www.doh.gov.uk/nhsperformanceindicators/index.htm](http://www.doh.gov.uk/nhsperformanceindicators/index.htm)
Appendix 7

Compendium Of Clinical And Health Indicators

Contents of the Compendium

The Compendium of Indicators is currently available to “members of the NHS family”, and is a valuable source of health related data, compiled by the National Centre for Health Outcomes Development using source data mainly from the Office for National Statistics (ONS) and the Department of Health. It contains the Public Health Common Data Set (PHCDS) – comprising Population Health Outcome indicators and Our Healthier Nation indicators as well as populations for Primary Care Group (PCG) areas, selected data from the Health Surveys for England and the published version of Clinical indicators released by the NHS Executive. The CD-ROM also carries graphs and maps for selected indicators, not available previously to Health Authorities.

Future plans

The Compendium will also be available in the following formats:

- on the NHS website, (http://nww.nchod.nhs.uk/) – accessible only to those on the NHS net, and
- as a hard copy, (given the large volume of material in the Compendium, only a selection of indicators, drawn primarily from the restructured PHCDS, will be presented in the hard copy version).

It is proposed that the Cancer Survival, Clinical Effectiveness, Primary Care Effectiveness, Environmental Risk Indicators, and the Operation-Specific Mortality Indicators currently under development will also in due course be integrated into the Compendium

Latest data currently available electronically are up to 1999. Data up to 2000 are due to be published later in 2001.

Contents of the CD

The CD includes a Guide to the Compendium, which provides a description of the material supplied, definitions of the indicators, annexes with technical details and Excel and Lotus files which describe the structure, layout and names of the files for tables and maps/graphs.

The CD provides data from the 2000 PHCDS (data up to 1999) restructured into the condition/health topic based format of the Compendium, and accompanying maps/graphs for selected indicators. Also provided are data on PCG populations and data for Health Authorities from the Health Surveys for England

The tables (where possible) provide data for:
- England and Wales
• England
• Regional Offices
• Government Office Regions
• ONS area classification groups
• Health Authorities (boundaries as of April 1996)
• Local Authorities (boundaries as of April 1997).

Full list of indicators to be included on the OHN website in due course
Defining National Mortality Targets

To reduce mortality from:
- cancer;
- heart disease and stroke and related conditions;
- suicide and undetermined injury.

NB Accident target specified in OHN White Paper is covered in Appendix 12

Target year:

2010 for all targets.

Baseline year:


Sources of data:

Mortality targets: Office for National Statistics (ONS) mortality statistics from death registrations. Mortality rates are age standardised to allow for changes in the age structure of the population (using the European standard population as defined by the World Health Organisation).

Technical definitions for the targets:

Cancer - all malignant neoplasms - ICD-9 codes 140-208 inclusive.
Age group: under 75.
Target reduction by year 2010 - at least one fifth (20%).

Heart Disease and Stroke and related conditions - includes all circulatory diseases - International Classification of Diseases (ICD-9) codes 390-459 inclusive.
Age group: under 75.
Target reduction by year 2010 - at least two fifths (40%).

Suicide - suicide and undetermined injury - ICD-9 codes (E950-E959) plus (E980-E989) minus E988.8
Age group: all ages.
Target reduction by year 2010 - at least one fifth (20%).

Note: Suicide and undetermined injury
Official suicides are those in which the coroner or official recorder has decided there is clear evidence that the injury was self-inflicted and the deceased intended to kill himself. Unofficial suicides or open verdicts are those where there may be doubt about the deceased’s intentions. Research studies show that most open verdicts are in fact suicides. For the purposes of comparisons with other countries, the figures quoted are for official suicides, but for the purpose of measuring overall suicides in England, official suicides and open verdicts are combined.
International Classification of Diseases

The World Health Organisation maintains a statistical classification of diseases, injuries and causes of death, which is internationally recognised and used. Until the end of 2000, the ninth revision of this classification (ICD-9) was used in England for differentiating causes of death, whilst the tenth revision (ICD-10) has for several years been used for classifying hospital episodes. ICD-10 will be used for coding mortality as from the year 2001. The nearest equivalent ICD-10 codes for the mortality targets will be shown on the technical web site in due course.
Appendix 9

Rationale for setting of national targets

Introduction

1. This section describes the general principles behind the setting of targets, and explains the rationale for each of the four national targets in the White Paper.

National targets

2. The basic principle behind the White Paper targets was to identify a single target in each priority area which was realistic yet challenging.

3. A number of factors were taken into account, including:

a) the advice of experts (including those who responded as part of the consultation on the Green Paper and others such as members of the Chief Medical Officer’s “Our Healthier Nation” Working Group and its sub-group) - based on their knowledge of the range of interventions available and their likely impact over the period until 2010,

b) an analysis of international data - showing what has been achieved in the best performing countries and how quickly,

c) extrapolation of recent trends in this country,

d) in addition it is worth considering the possible effects of past and future interventions but these are very difficult to estimate with any precision because in many cases the exact causes of disease are still not fully understood and because many of these factors take time to exert their effects.
Factors considered in setting each of national targets:

1. **Circulatory diseases (heart disease, stroke and related conditions) target:**

   To reduce by at least two fifths (40%), the death rate from heart disease and related conditions in those aged under 75 years by the year 2010

   a) The views of experts (includes consultation responses and CMO’s Working Group):

   CMO's Working Group did not suggest a change to a morbidity target or a change of grouping but it suggested increasing the target level and raising the age cut-off as reflected in the final wording of the target.

   b) Examination of data from other countries: Examination of international trends for the under 75 age group suggests that a reduction of similar magnitude would bring England to a mortality level just below (i.e. better than) that currently occurring in France (much the best performing EU country), and substantially below (better than) that currently occurring in any of the other EU countries. However, it took France about 12 years to move from the present England level to the level required if the OHN target is to be achieved.

   Also, continuation of the current rate of reduction is not inevitable - in the USA, substantial reductions in CHD are now showing signs of levelling off. In England, the rate of reduction in stroke mortality, particularly among under 65s, has slowed in recent years.
2. **Cancer target:**

   To reduce by at least a fifth (20%) the death rate from all cancers amongst those aged under 75 years by the year 2010

   a) **The views of experts (includes consultation responses and CMO’s Working Group):**

   CMO’s Working Group did not suggest identifying targets for individual cancers but did recommend raising the age cut-off to under 75 years. They felt that the target level of 20% was appropriate.

   b) **Examination of data from other countries:** Data for the *under 75* age group show that a reduction of similar magnitude would result in a mortality level just below that currently occurring in Finland and Sweden - the best performing EU countries. However it took Finland around 19 years to move from the present England level to the level required if the OHN target is to be achieved.

   c) **The effects of interventions:**

   Work commissioned for CMO’s technical sub-group did attempt to estimate the relative impact of different types of interventions in achieving the proposed target – eg. improvements to lifestyle, screening and treatments – and these could be shown to “add up to” a total of 20%. Many of the methods used were indirect, and it was agreed that these estimates by themselves did not form an appropriate basis for setting the national target - however they could be used as a guide to identifying intermediate measures of progress.
3. **Mental health – suicide target:**

   To reduce by at least a fifth (20%) the death rate from suicide and undetermined injury in all age groups combined by the year 2010

   a) **The views of experts (includes consultation responses and CMO’s Working Group):**

   The group recommended that the target level be increased to one fifth (from an earlier proposed rate of one sixth), and that various supplementary measures of progress, including rates of deliberate self-harm, should be considered.

   b) **Examination of international trends:** Particular problems exist in interpreting international comparisons of suicide statistics. A substantial proportion of suicides in this country are assigned to the “undetermined” injury category. Overall, levels of suicide and undetermined injury deaths appear to be better than the EU average.
Appendix 10

Health Inequalities – the Acheson Report

In 1997 the Government commissioned Sir Donald Acheson and his team to review information on inequalities in health using data from a number of sources including the Office for National Statistics and the Department of Health. In the light of the evidence (and within the broad framework of the Government's overall financial strategy), the team were asked to identify future policy areas which would offer Government opportunities to:

- develop beneficial, cost-effective and affordable interventions to reduce health inequalities; and

The report highlights that any strategic response to tackling health inequalities requires contributions from all sectors. It recognises that poverty, housing, environment, education, employment, gender and ethnicity will all have a health impact, and that any action taken to tackle these other factors either nationally or locally will have an effect on people’s health and general well-being.

The Acheson report has had an important influence on the current health strategy *Saving Lives: Our Healthier Nation*, the aim of which is to improve the health of everyone and that of the worst off in particular. *Reducing Health Inequalities: An action report*, which was published alongside *Saving Lives: Our Healthier Nation*, sets out a wide range of action underway across Government to address health inequalities.

Both of these reports are available on the Health Inequalities section of the OHN website on:

http://www.ohn.gov.uk/ohn/ohn.htm

Addressing and monitoring health inequalities is an underlying theme of the NHS Plan. (See introductory remarks in section 1 of the main document)
What is Health Impact Assessment?

Health Impact Assessment (HIA) is still a relatively new and developing approach attracting increasing interest both nationally and internationally. In its simplist sense it provides a valuable aid to decision making which helps in the identification of potential health risks and benefits from a particular proposal - whether at the policy, programme or project levels. HIA can be applied at any time before, during or after implementation of a proposal but clearly can have greatest impact if used to inform policy and practice discussions ahead of implementation so that findings can directly inform developments.

It is now widely acknowledged that many factors can influence the health of individuals and populations and both the Our Healthier Nation health strategy and the recent NHS Plan place renewed focus on the importance of working in partnership with others to tackle the wider determinants of health many of which lie beyond the traditional health sector. In this context Health Impact Assessment offers a valuable tool to assist multi-sector agencies and organisations in assessing the potential impact of their policies and practices on the health of their populations. The Government has signalled its commitment to using HIA as a tool at national level and is supporting and encouraging agencies at all levels to adopt and apply the approach to their developing work. While HIA is relatively new there are other forms of impact assessment which have been around for some time, including: environmental, economic and social impact assessments, and work is underway to both capture learning from these and also to integrate health into them.

While there is no single agreed and 'correct' way to undertaking HIA, there are a number of stages to the process which are widely accepted as forming the basis of the approach, these include:
- Screening
- Scoping
- Appraisal of potential health impacts
- Decision-making
- Monitoring and evaluation

HIAs can be considered at two different stages of the policy process:

- A **prospective assessment** of a proposed new policy to identify its likely impacts on health. This would allow assessment of different policy options based on differing potential health impacts in order to seek to maximise health benefits;

- A **retrospective assessment** of evaluation of a policy following implementation i.e. an assessment which monitors how a policy is affecting or has affected health. Such an assessment can also be used to modify a policy or inform future policy direction.
What the Department of Health is doing

There is limited, but growing, experience in the UK of undertaking HIAs. However, much of the work undertaken to date has been designed for and applied at a project level (such as the proposed second runway at Manchester airport or the redevelopment of the former Alconbury military airbase) rather than at policy level. Methodological expertise has been developed around the country and this is being tested through its practical application to projects on the ground. Academics working on the methods and application of HIA are developing approaches which are appropriate for differing situations. It is not the Department of Health’s intention to be prescriptive about the exact methods to be used, although there should be confidence in both the methodology and the results. Methods will be developed with users so that HIA is tested for robustness and responsiveness to their needs.

The Department of Health is working closely with experts nationally and internationally to further develop the methodology. The emerging picture is that this will be an iterative and interactive process, engaging with a wide range of partners on a number of pilot projects. The Department is committed to the development of robust and easy to use methodologies. It is also important that the costs of undertaking HIAs are not prohibitive.

Useful reference documents are:


Much useful further material, including a full copy of the Short Guide to HIA, can be found on the following websites:

http://www.ohn.gov.uk/ohn/making/impact.htm

http://www.londonshealth.gov.uk
Appendix 12

Accident Prevention Task Force – supporting work

The Task Force to advise on the prevention of accidental injuries, promised in the White Paper, “Saving Lives: Our Healthier Nation” held its initial meeting on 22 November 2000. The Task Force is chaired by the Department of Health and involves other Government Departments as observers. Details of members are given. Its terms of reference are, as announced by the Public Health Minister, Yvette Cooper, in a Parliamentary answer on 24 July 2000:

“Taking account of Saving Lives and other initiatives in hand to reduce the burden of accidental injury, advise the Chief Medical Officer on:

the most important priorities for immediate action in order to meet the target

the development of an implementation plan, consulting with other stakeholders where necessary

whether the necessary delivery structures are in place to take forward the implementation plan

how progress on the implementation plan should be monitored how to develop and publicise a more unified approach to accident prevention across Government and the National Health Service”.

A report with recommendations should be submitted to CMO within one year of its first meeting.

Accident Task Force Membership

Wendy Broome--Senior Road Safety Officer, Hertfordshire County Council.
Professor Yvonne Carter--Professor of General Practice and Primary Care.
Ashley Martin--Peterborough City Council, Director of the Institute of Home Safety.
Dr. Stephen Morton--Director of Public Health, East Lancashire HA; Co-ordinator of the NW Regional Accidents Task Force.
David Moss--Chief Executive, Southampton University Hospitals NHS Trust.
Dr. Gabriel Scally--Director of Public Health, South West Regional Office.
Carol Sherriff--Director of the Child Prevention Accident Trust.
Dr. Liz Towner--University of Newcastle upon Tyne, Department of Community Child Health.

The Task Force website is at www.ohn.gov.uk/ohn/priorities/aitf
MEASURES OF PROGRESS ON ACCIDENTAL INJURY

1) The target specified in the OHN White Paper is to reduce the death rate from accidents by one fifth by 2010 and to reduce the rate of serious injury from accidents by at least one tenth by 2010. A milestone for achievement of a 12% fall in mortality rates by 2005 was also identified. Meeting the target will require action across many sectors of national and local government as well as by communities and individuals. The Chief Medical Officer’s Our Healthier Nation Working Group concluded that the greatest gains towards reaching the target would result from reducing injury (or its severity) in:

- Children up to 15 years (especially those from manual and unskilled households)
- Young people aged 16-24 years involved in road traffic accidents
- Older people who are at risk of stumbling or falling

2) Accident prevention includes the primary prevention of accidents and the secondary prevention or reduction of injury in accidents. This involves many Government Departments and agencies, some with a primary role in casualty reduction, others with a general role to promote safety and others still whose activities have a strong influence on the wider factors affecting the likelihood of accidents. Success in achieving the target will depend upon a strong co-ordinated approach across all these sectors at national and local level.

3) At national government level the Department of the Environment, Transport and the Regions is responsible for road safety. The DETR published in March 2000 a new road safety strategy, setting casualty reduction targets for 2010. The Department of Trade and Industry is responsible for the prevention of home accidents. The Home Office is concerned with fire safety policy. The Health and Safety Executive is responsible for ensuring that risks to people's health and safety from work activities are properly controlled, and are co-operating with the Department of Health in the Healthy Workplaces Initiative. Many other policies such as the New Deal for Communities or the Sure Start programme, may play a significant part in reducing accident rates, although not concerned directly with casualty reduction.

4) Accidents happen as a result of complex interaction between many factors starting with underlying social, environmental and economic determinants; immediate personal circumstances (e.g. alcohol consumption, tiredness), safety awareness and knowledge in the individual, as well as the mechanisms of the accident itself. Precise causation is often difficult to determine. An injury event may well have been triggered by an identifiable individual action but the nature and severity of the outcome may depend on many of the “upstream” factors mentioned above.

5) Measures of progress towards reducing accidental injury will need to take into account all of these factors as well as secondary prevention measures, such as protective equipment which does not prevent accidents but may reduce the
severity of injury sustained, and tertiary prevention, timely and effective emergency treatment.

6) In all aspects of accident prevention there is a need to balance the prevention of accidental injury with the need to encourage healthy activity. Policies on road safety must be consistent with the need to promote walking and cycling.

7) Three further publications relating to accident prevention are planned which will follow on from this technical supplement and should provide further assistance to those in the field:

- two discussion documents containing further ideas and options for the development and setting of local indicators and targets. One will be focused on children and the other on older people

- an "Overview" of accident data, which will bring together and present headline data from a variety of sources along with advice on where to obtain further data
Accidents
The interaction between factors

- **PRIMARY**
  - Level 1: WIDER DETERMINANTS
    eg: poverty, employment
  - Level 2: SAFER ENVIRONMENT
    eg: safe housing, traffic calming
  - Level 3: BEHAVIOURAL FACTORS
    eg: observing highway code, risk awareness in the home

- **SECONDARY**
  - Level 4: PROTECTIVE EQUIPMENT
    eg: seat belts, hip protectors

- **TERTIARY**
  - Level 5: EMERGENCY TREATMENT
# ACCIDENTS

**TARGET**

To reduce the death rate from accidents by at least 20% and to reduce serious injury by at least 10% by 2010

## Key Disaggregations

- (a) by location (e.g. home, work etc.)
- (b) by type (e.g. fire, drowning etc.)

## Potential Key Measures

### Lifestyle

- cycle helmet wearing
- seat belts
- drink-driving
- physical activity (especially in elderly)

### Environment

- public transport investment
- suitable housing - meeting fitness standards
- deaths per mile travelled by cyclists and pedestrians
- traffic control and calming measures
- smoke alarm ownership

### Services

- accident prevention advice
- identification of high risk individuals
- rapid response by ambulances
- A&E care
- appropriate rehabilitation, discharge, community support

### Social and economic

- working days lost through injury
- poverty
- employment
- education

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Further indicators to be added, to link directly with actions identified.
A range of indicators in the Accidents area were identified to enable monitoring of progress towards the OHN target:

1) Existence of a dedicated accident prevention co-ordinator and an agreed accident prevention policy in local agencies
2) People admitted to hospital as a result of a pedestrian injury
3) Mortality rates due to house fires among children and the elderly
4) Rates of hospital admission where main external cause is a fall
5) Mortality rates due to drowning
6) Local initiatives to prevent accidents (e.g. traffic calming schemes, provision of safety apparatus etc)
7) Emergency hospital admissions of people age 75 and over due to accidental injury
8) Young people age 16-24 killed as a result of a pedestrian accident

RATIONALE FOR SETTING OF NATIONAL TARGETS

Introduction

1. This section describes the general principles behind the setting of targets, and explains the rationale for each of the four national targets in the White Paper.

National targets – general approach

2. The basic principle behind the national targets was to identify a single target in each priority area which was realistic yet challenging.

3. A number of factors were taken into account, including:

   a) the advice of experts (including those who responded as part of the consultation on the Green Paper and others such as members of the Chief Medical Officer’s “Our Healthier Nation” Working Group and its sub-group) - based on their knowledge of the range of interventions available and their likely impact over the period until 2010,

   b) an analysis of international data - showing what has been achieved in the best performing countries and how quickly,

   c) extrapolation of recent trends in this country,

   d) in addition it is worth considering the possible effects of past and future interventions but these are very difficult to estimate with any precision because in many cases the exact causes of disease are still not fully understood and because many of these factors take time to exert their effects.
Factors considered in setting each of the OHN accidents target:

a) The views of experts (includes consultation responses and CMO’s Working Group)

CMO's Working Group concluded that a separate meeting of accident experts was needed. Such a meeting was held in September 1998, and heard evidence from experts in medical practice, in academic institutions, from local government and from a number of other Government Departments. The consensus which emerged was that, on the basis of past trends, it was considered feasible to set a target reduction for mortality of 20%. However, for serious injury, evidence presented by colleagues from DTI (home and leisure accidents) suggested that a target reduction of 20% by 2010 might be missed - a target reduction of 10% was still challenging but more feasible. While DETR have set challenging targets for reducing road casualties, DTI's predictions indicate that serious injuries from home accidents are not set to fall markedly, so that caution was needed in setting a feasible overall target for accident morbidity.

b) Examination of trends in other countries: Levels of accident mortality are among the best in the European Union. However, in important areas such as child pedestrian accidents, we are amongst the worst in the EU, indicating considerable scope for improvement.

c) Extrapolation of past trends in England: While trends in mortality data are well established, information to enable robust assessment of recent trends for morbidity information is more limited because of recent coding changes in Hospital Episode Statistics (HES). A continuation of the recent trend in mortality rates would suggest a fall of 27% by the year 2010. However, most of the recent fall in rates has been among young people, with trends in the rates among older people (65+) remaining almost static. As accidental deaths among older people account for approximately half of all accidental deaths, there would need to be substantial improvements in this age group for the overall rate to continue reducing at its previous pace.
Definition of National Accident Target

To reduce by at least one fifth (20%) the death rate from accidents among people of all ages by the year 2010 and to reduce by at least one tenth (10%) the rate of serious injury from accidents among people of all ages by the year 2010

Target year:

2010, as for all targets.

Baseline year:


Serious injury from accidents target: the hospital admission rate for the year 1995/96.
(baseline is a single year because it is based on large numbers, and there are problems with consistency of definitions for previous years because of the change to ICD 10 coding starting in 1995/96).

Sources of data:

Mortality target: Office for National Statistics (ONS) mortality statistics from death registrations. Mortality rates are age standardised to allow for changes in the age structure of the population (using the European standard population as defined by the World Health Organisation).

Serious injury target: Hospital Episode Statistics.

International Classification of Diseases

The World Health Organisation maintains a statistical classification of diseases, injuries and causes of death, which is internationally recognised and used. Currently, the ninth revision of this classification (ICD-9) is used in England for differentiating causes of death, but the tenth revision (ICD-10) is used for classifying hospital episodes. It is planned that ICD-10 will be used for coding mortality as from the year 2001. The nearest equivalent ICD-10 codes for the mortality targets will be shown on the technical web site in due course.
Accidents – target definitions

- mortality from accidents and adverse effects - ICD-9 codes E800-E949 inclusive
  Age group: all ages
  Target reduction by year 2010 - at least one fifth (20%).

- serious accidental injury relating to hospital admissions defined by ICD-10 codes as below
  Age group: all ages
  Target reduction by year 2010 - at least one tenth (10%).

The injury must be sufficiently serious to require a hospital stay of four days or more

- Primary diagnosis must indicate an injury, ie is in range S00 through T98X
- External cause code must be in one of the following ranges:
  V01 - V99 Transport accidents
  W00 - X59 Other external causes of accidental injury (mostly falls)
  Y40 - Y84 Complications of medical and surgical care
- Length of stay must exceed 3 days.

As some records with a primary diagnosis indicating an injury do not contain a valid external cause code, these codes will be scaled out in proportion to the records with a valid cause code before applying the second rule above. Coding of external cause is consistently improving and this correction will decrease in importance as coding approaches 100%.
ACCIDENTS

Aim: Reduction in incidence of accidental injury and improve general health.

Indicator: The annual per capita growth in emergency admissions due to accidents in people aged 75 and over.

Associated Target, Recommendation or Aspiration. To limit the per capita growth in emergency admissions due to accidents in people aged 75 and over to an annual average of 3%.

National Sources: Hospital Episode Statistics (HES)
Common Information Core (CIC)

Local Sources: HES
CIC

Data availability. On request from DH

Geographic: Post code (Allowing aggregation to various geographic areas – data are not normally available at this level)
Gender: Yes
Ethnicity: Possible, but issues over data quality and completeness
Social class: 
Age: Yes
Time period: Annually

Links to other initiatives: NHS and PSS Performance Assessment Frameworks

Comments:
Appendix 13

Indicators and information sources developed as a result of other initiatives

The approach set out in this document to develop a set of indicators or measures of progress is becoming increasingly common across government. Several Government Departments and Agencies have also developed indicators in support of specific initiatives. Many of these sets of indicators include health specific indicators and also indicators of things which have an impact on health – indeed it could be argued that all Government actions have some effect on health, however indirect.

The number of initiatives and of the indicators developed for each mean that it is not practical to list here every single indicator. Instead we present a brief outline of selected initiatives and a brief overview of the indicators developed for each which are of particular relevance to health. Note that some initiatives are still under development and their indicators have not yet been finalised; where this is the case a contact for further information is given.

Linkages to relevant Government and other organisations’ web sites will be an important feature of the OHN web site.

This Appendix:

- presents some examples of initiatives which have identified sets of indicators covering a broad range of factors relevant to health and health inequalities, for example:
  - Sustainable Development
  - Central-Local Government Information Partnership
  - Opportunity for All – Tackling Poverty and Social Exclusion
  - A New Deal for Transport – Better for Everyone
  - Smoking Kills
  - Race Equality

- presents some examples of initiatives which have identified or developed information sources covering multiple or specific topics relevant to health and health inequalities
  - National Strategy for Neighbourhood Renewal – Policy Action Team 18
  - Workplace Initiatives
  - Consumer Safety – Prevention of Home Accidents
Sustainable Development
Department of the Environment, Transport and the Regions

In May 1999 the UK Government published ‘A better quality of life’: a strategy for Sustainable Development in the United Kingdom.

The Strategy has four main aims:
• social progress which recognises the needs of everyone
• effective protection of the environment
• prudent use of natural resources
• maintenance of high and stable levels of economic growth and employment.

To help measure progress, the Strategy includes a series of indicators. The Government has revised the national set of sustainable development indicators first published in 1996. The new set of about 150 indicators is referred to throughout the Strategy, and will be at the core of future reports on progress.

One important new element is a subset of 15 key headline indicators, intended to focus public attention on what sustainable development means, and to give a broad overview of whether we are achieving a "better quality of life for everyone, now and for generations to come". They cover the social, economic and environmental dimensions of sustainable development, including people’s everyday concerns – like health, jobs, crime, air quality, traffic, housing, educational achievement, wildlife and economic prosperity. One of these headline indicators is ‘healthy life expectancy’ which is one of the key OHN indicators (see Appendix 1).

In December 1999 the Government published ‘Quality of life counts’, which sets out the core indicators, including the headline indicators, in more detail illustrating past and current trends.
(Ref: http://www.environment.detr.gov.uk/sustainable/quality/life/index.htm)

In addition to the release of individual data series as they become available, the Government will bring together and publish the latest information about progress against each of the headline indicators in its annual review.

There has also been extensive work at local level by local authorities and Local Agenda 21 groups to develop indicators, which can be used to monitor sustainable development at local scale. In July 2000 a new handbook ‘Local quality of life counts’ was launched. This offers ideas for measuring sustainable development and quality of life in local communities. It gives a menu of 29 indicators, from which local authorities in England may wish to consider using a selection for reporting on their LA21 and Community Strategies. These local indicators build on the work already carried out at local as well as national levels, and include versions of nine of the national headline indicators. One of the indicators covers mortality by cause and corresponds to the four priority areas of OHN, ie cancer, circulatory disease, accidents and mental health (see Section 1). The handbook was developed by a joint initiative between central government, the Audit Commission, Local Government Association, Improvement and Development Agency and local authorities under the Central Local (Government) Information Partnership (CLIP) Task Force on Sustainable
At a **regional level** there has also been considerable work to develop indicators of sustainable development by Government Offices for the Regions, Regional Development Agencies and also others working in partnership on regional sustainable development frameworks. The Government is planning to publish later this year regional information on the 15 ‘headline’ issues, where data are available, for the nine English Government Office Regions. In some cases it will not be possible to reproduce the national indicator at a regional level so ‘proxy’ information may be included.

Contact for national, regional and local indicators:

Emma Snelling  
Environment Protection Statistics and Information Management Division  
Zone 5/H11 Ashdown House  
123 Victoria Street  
London SW1E 6DE  
Tel: 020 7944 6518  
E-mail: qolc@detr.gov.uk

Website:  [http://www.environment.detr.gov.uk/sustainable/quality/life/index.htm](http://www.environment.detr.gov.uk/sustainable/quality/life/index.htm)

**Quality of Services** (‘Best Value’):

The Local Government Act introduced in December 1998 gives local authorities a duty of achieving sustainable improvements in cost and quality of services (‘Best Value’). Details of “Best Value” performance indicators are at:

[http://www.local-regions.detr.gov.uk/bestvalue/indicators/bvaudit/index.htm](http://www.local-regions.detr.gov.uk/bestvalue/indicators/bvaudit/index.htm)

The White Paper *Modern Local Government: In Touch with the People* published in July 1998 includes proposals to modernise local government. The text of the White Paper is at:

[http://www.local-regions.detr.gov.uk/lgwp/index.htm](http://www.local-regions.detr.gov.uk/lgwp/index.htm)
Opportunity for all - Tackling Poverty and Social Exclusion
Department of Social Security

Underlying Rationale for the Indicators developed as part of the strategy

Poverty and social exclusion affect many different aspects of peoples’ lives. They exist when people are denied opportunities to work, to learn, to live healthy, active and fulfilling lives and to live out their retirement years in security. Peoples’ well being is affected by their incomes, especially when they are trapped on low incomes for long periods, by lack of access to good quality health education and housing and the quality of the local environment. Social exclusion is a short hand label for what can happen when individuals or areas, suffer from a combination of linked problems that can trap individuals and areas in a spiral of disadvantage.

The Government’s approach to tackling poverty and social exclusion is to:

- Tackle the causes of poverty and social exclusion, not just the symptoms;
- Create a fairer society, in which everyone has opportunities to maximise their potential; and
- Invest in individuals and communities to equip them to take control of their lives.

The indicators reflect these strategic priorities.

The indicators fall into three main categories. Those that focus on incomes, those that focus on wider aspects of welfare such as education, housing, health and the quality of local environments and those that capture factors that affect people during their lives and increase the risk that they experience deprivation at a later point.

A New Deal for Transport - Better for Everyone
Department of the Environment, Transport and the Regions

The White Paper *A New Deal for Transport - Better for Everyone*, published on 20 July 1998, set out a new approach to transport policy which has relevance throughout the United Kingdom, and which embodies new, modern thinking on integrating transport with other aspects of Government policy.

The White Paper outlines an integrated transport policy:

- integration *within and between different types of transport* - so that each contributes its full potential and people can move easily between them;
- integration *with the environment* - so that our transport choices support a better environment;
- integration *with land use planning* - at national, regional and local level, so that transport and planning work together to support more sustainable travel choices and reduce the need to travel;
- integration with *policies for education, health and wealth creation* - so that transport helps to make a fairer, more inclusive society.

On 20 July 2000 DETR published *Transport 2010 – The 10 Year Plan*. The Plan sets out increased public and private funding totalling £180 billion across the decade from 2001/02 to 2010/11 to deliver the government’s priorities for transport as set out in the White Paper. £132 billion of this total figure will be public spending.

All modes of transport will benefit from this spending, and the Plan will ensure that transport plays its full part in delivering the Government’s wider objectives, contributing in particular to the renaissance of our cities and the revitalisation of the countryside.

The Plan will also contribute to further reductions in air pollution, beyond those achieved and already predicted for the next ten years, as well as contributing to meeting our climate change targets to reduce greenhouse gas emissions.

DETR will be publishing a regular set of indicators in “Transport Trends”.

Enquiry E-mail Addresses:

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<th>Function</th>
</tr>
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<tr>
<td><a href="mailto:bt_ilt@detr.gov.uk">bt_ilt@detr.gov.uk</a></td>
<td>Integrated and Local Transport - Buses and Taxis</td>
</tr>
<tr>
<td><a href="mailto:buses_ilt@detr.gov.uk">buses_ilt@detr.gov.uk</a></td>
<td>Integrated and Local Transport - Bus Policy</td>
</tr>
<tr>
<td><a href="mailto:charging@detr.gov.uk">charging@detr.gov.uk</a></td>
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<tr>
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<td>Economics, Local Transport and General</td>
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<tr>
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<td></td>
</tr>
</tbody>
</table>
road_safety@detr.gov.uk
tsptl@detr.gov.uk

Road Safety
Integrated and Local Transport – Statistics

Web site: http://www.detr.gov.uk/itwp/index.htm
**NHS Cancer Plan**
Department of Health

The **NHS Cancer Plan** is the first ever comprehensive strategy linking cancer prevention, diagnosis, treatment, care and research. Developing aspects of the NHS Plan, the NHS Cancer Plan is a major programme of investment and reform involving the NHS, the voluntary sector, the community and families across the country to end the postcode lottery of care and treatment, modernise the NHS and deliver the fastest improving cancer services in Europe.

Targets include specifically:

Reduce smoking among **manual social groups**

Improve diet by
- The national “five a day” programme
- The school fruit scheme

Improve detection of cancer by
- Raising public awareness
- Improving screening services

Improve treatment by
- Cutting waiting times
- Investment in staff and equipment
- Redesigning services
Smoking Kills
Department of Health

Aim: to halt the rise in children smoking

Target: to reduce smoking among children from 13% to 9% or less by the year 2010; with a fall to 11% by the year 2005. This will mean approximately 110,000 fewer children smoking in England by the year 2010.

Note: This target is for improvements measured against a baseline of 13 per cent smoking prevalence among 11-15 year olds in 1996. Children smoking in this target means those aged 11-15 who smoke at least one cigarette a week.

Aim: to establish a new downward trend in adult smoking rates in all social classes

Target: to reduce adult smoking in all social classes so that the overall rate falls from 28% to 24% or less by the year 2010; with a fall to 26% by the year 2005. In terms of today's population, this would mean 1.5 million fewer smokers in England.

Note: This target is for improvements measured against a baseline of 28 per cent smoking prevalence among men and women aged 16 and over in 1996. Adult smoking means anyone aged 16 or over who smokes at least one cigarette a day. The objective is not only to see smoking in all socio-economic groups reduce to a new average figure of 24% by 2010, but also to reduce the difference in smoking rates between manual and non-manual groups. We therefore want to see a rate of change in manual groups greater than that in non-manual groups.

Aim: to improve the health of expectant mothers and their families

Target: to reduce the percentage of women who smoke during pregnancy from 23% to 15% by the year 2010; with a fall to 18% by the year 2005. This will mean approximately 55,000 fewer women in England who smoke during pregnancy.

Note: This target is for improvements measured against a base line of 23 per cent of women in England who smoked during pregnancy in 1995.

The full text of Smoking Kills is available at http://www.official-documents.co.uk/document/cm41/4177/4177.htm
**Race Equality issues**  
**Home Office**

The Home Office published, on 27 March 2000, a document entitled “Race equality in public services”, which sets out Government plans to use “performance management as a tool to promote public services of equal worth to all”.

A number of indicators on race equality and health are proposed, including:

Death rates from coronary heart disease, stroke and related illnesses by country of birth. Mental health – measures of psychological health, suicide rates, calls to NHS Direct and measures of patient and carer experience of using NHS services – by ethnic groups/country of birth where available.

The full title of the document is:  
“Race equality in public services: driving up standards and accounting for progress”

The text can be accessed at  
[http://www.homeoffice.gov.uk/reu/reu.htm](http://www.homeoffice.gov.uk/reu/reu.htm)
National Strategy For Neighbourhood Renewal – Policy Action Team 18
Cabinet Office Social Exclusion Unit

The Remit of PAT 18

PAT 18 was asked to report on:

- the scope for a coherent cross-government strategy to get more up to date information on deprived areas and collect more of it on a consistent basis;
- how this can be done without generating undue bureaucracy;
- evidence of good practice by individual local authorities [and other agencies], and how this could be spread more widely; and
- the role of Regional Development Agencies in aggregating area information.

Its goal was to identify how to overcome the barriers to obtaining quality, small area information and to prepare an action plan with targets to do this.

In fulfilling this remit the report sets out:
- What information is needed, and why we need it
- The problems in getting it
- What is going on to deal with these problems
- What needs to change, and
- An Action Plan of how we intend to get there.

The report of the PAT does not set out a set of performance measures, management targets, or other indicators of success and organisational competence. That is seen as the job of others – the national strategy for neighbourhood renewal; local people; neighbourhood managers; and of initiatives such as Best Value, Public Service Agreements, and Modernising Government. The PAT sees its work as enabling and empowering these others in terms by ensuring the presence of an infrastructure which will allow them to focus on small areas across a wide range of issues.

More detail can be found on the Social Exclusion Unit web site: http://www.cabinet-office.gov.uk/seu/index.htm
Consumer Safety – Prevention of home accidents
Department of Trade and Industry

On 1 November 1999, Dr Kim Howells, Consumer Safety Minister at DTI, addressed the Royal Society for the Prevention of Accidents Home Safety Congress. He identified home safety as a key issue for Government.

The report “Research on the pattern and trends in home accidents”, which has analysed the DTI’s Home Accident Surveillance System (HASS) data in depth, was published on the same day. It is the most comprehensive study of home accident figures to date. About 4,000 people are killed in home accidents every year, and this research will play a vital role in enabling all those involved in home safety (at national and local level) to increase awareness on safety issues and reduce injuries.

A summary of the report is at http://www.dti.gov.uk/CACP/ca/trends.htm
Appendix 14

Summary of data sources

Some useful key national sources

- HSfE - Health Survey for England
- GHS - General Household Survey
- NFS - National Food Survey
- NDNS - National Diet & Nutrition Survey
- HES - Hospital Episode Statistics
- LFS - Labour Force Survey

The Office for National Statistics (ONS) produce a large range of useful data sources. References to these can be found on the National Statistics web site at http://www.statistics.gov.uk

The following lists of sources may be helpful:

A list of statistical publications from the Department of Health, covering public health and health care.

Separate compilations of statistical information sources and reference publications relating to Cancer, CHD and Stroke, Mental Health and Accidents (further updates of these will be available on the web version)

A direct link to the DH statistical publications website is given below. Of particular interest may be:


Statistical Publications
Department of Health

This section provides a list of the Department of Health’s statistical publications relating to Public Health and Health Care.

Note that publications with references such as 1999/25 are Statistical Bulletins that contain summary information. Other publications, such as those with ISBN numbers, are usually more detailed. Most publications relate to England.

See the DH statistics website [http://www.doh.gov.uk/public/stats1.htm](http://www.doh.gov.uk/public/stats1.htm) for up to date information.

Statistical bulletins and most other publications are available from:
Department of Health
PO Box 777
London
SE1 6LX

Tel: 0541 555 455
Fax: 01623 724 524
Email: doh@prologistics.co.uk

Public Health

Indicators of the Nation’s Health

Knowledge of the Solar UV Index 2000/4

Public Health Common Data Set (only available within the NHS)

The Health Survey for England

Summary of Key Findings booklet available for 1994 survey onwards.

- Health Survey for England 1991 ISBN 0 11 691532 3 £27.50
- Health Survey for England 1992 ISBN 0 11 691569 2 £27.50
- Health Survey for England 1993 ISBN 0 11 691614 1 £38.00
- Health Survey for England 1994 ISBN 0 11 321895 8 £40.00
- Health Survey for England 1995 ISBN 0 11 322021 9 £60.00
- Health Survey for England 1996 ISBN 0 11 322091 X £60.00
- Health Survey for England 1997: The Health of Young People ISBN 0 11 322266 1 £70.00
- Health Survey for England 1997: Adult Reference Tables
- Health Survey for England: Cardiovascular Disease 1998 ISBN 0 11 322307 2 £75.00
- Health Survey for England: Minority Ethnic Groups 1999 ISBN 0 11 322448 6 £85.00
- Geographical Variation in Health Indicators by Health Authority 1994-1996

The Prevalence of Back Pain in Great Britain in 1999/18

Health Related Behaviour

Statistics from the Regional Drugs Misuse Databases for six months ending:

- March 1998 1999/7
- September 1998 1999/19
- March 1999 1999/33
- September 1999 2000/33
- March 2000 2000/13
Statistics on smoking: England
1976 to 1996
1978 onwards
1998/25
2000/17

Statistics on Smoking Cessation Services in Health Action Zones:
England 1999-00 (provisional)

Statistics on Smoking Cessation Services in Health Authorities and Health Action Zones in England April -June 2000 (provisional)

Statistics on alcohol: 1976 onwards
1999/24

2000/18

Sun Exposure: Adults' Behaviour and Knowledge 1997
1998/3

Morbidity

Epidemiological Overviews:
- Asthma
- Coronary Heart Disease
- Stroke
- Health of Elderly People
- Elderly People Companion Papers
- Health related behaviour- an epidemiological overview

ISBN 0 11 321897 4 £11.00
ISBN 0 11 321667 X £11.00
ISBN 0 11 321668 8 £11.00
ISBN 0 11 321485 5 £10 30
ISBN 0 11 321486 3 £6.00
ISBN 0 11 321976 8 £13.99

Fertility

1997/28

Health Care

Access to GPs and Clinics Services outside office hours,
England 1999
ISBN 1 84182 105 5

National Surveys of NHS Patients: General Practice 1998
ISBN 1 84182 104 7 £10.00

Survey of Health and Local Authority Registration and Inspection Units:
1998-99
1999-2000

(i) Primary and Community Care

General Ophthalmic Services

General Ophthalmic Services Activity Statistics:
October 1998 to March 1999 and year ending 31 March 1999
April to September 1999
October 1999 to March 2000 and year ending 31 March 2000

General Ophthalmic Services Statistics
Consultation tables 1999 - 2000
NHS sight tests, vouchers, workforce, premises

NHS Optical Voucher Survey 1998

1999/27
Sight Tests Volume and Workforce Survey, 1997-98 (annual report)

**Pharmaceutical Services**

Community pharmacies in England and Wales
31 March 1999
1999-2000
1999/20

General Pharmaceutical Services in England and Wales 1990-91 to 1998-99
1999/29

Prescription Cost Analysis: England
1998 ISBN 1 84182 045 8 £12.00
1999 ISBN 1 84182 223 X £12.00

Statistics of prescriptions dispensed in the community: England
1988 to 1998
1989 to 1999
1999/17
2000/20

**Community Health and Prevention**

Ambulance Services, England:
1998-99
1999-2000
1999/16
2000/14

Breast Screening Programme, England:
1997-98
1998-99
1999/9
2000/7

Cervical Screening Programme: England
1997-98
1998-99
1999-2000
1999/2
1999/32
2000/30

Chiropody services 1999-2000

Clinical psychology services 1999-2000

Community maternity Services England 1999-2000

NHS Contraceptive Services, England
1997-98
1998-99
1999-2000
1999/5
1999/30
2000/27

NHS Immunisation Statistics, England:
1997-98
1998/38
1998-99
1999/28
1999-2000
2000/26


Patient care in the community, Community psychiatric nursing, England, 1999-2000

Patient Care in the Community, District Nursing - community information, England 1999-2000


Physiotherapy services 1999-2000

Specialist care nursing 1999-2000

Speech and language therapy services England 1999-2000

(ii) Hospitals

NHS Quarterly Review

Private hospitals, homes and clinics –
England Regional Health Authority and Regional Office Areas registered under Section 23 of the Registered Homes Act 1984, Vol 1 ISBN 1 85839 495 3 £7.00

Private hospitals, homes and clinics –
District Health Authority summaries registered under section 23 of the Registered Homes Act 1984, Vol 2 ISBN 1 85839 496 1 £11.00

Hospital Inpatient Activity

Available adult intensive care and high dependency provision at 14 July 2000: England

Bed availability and occupancy
£8.00
1999-2000 ISBN 1 84182 252 3 £8.00


Hospital Episode Statistics:
  Vol 1: Finished Consultant episodes by diagnosis and operative procedure; injury/poisoning by external causes
  Vol 2: Finished Consultant episodes administrative tables
  Vol 3: Finished Consultant episodes: waiting times
CD-ROM: Hospital episode statistics, England 1995-96

Hospital waiting list statistics:
  Monthly
  England Quarter ended 30 September 2000 ISBN 1 84182 296 5 £10.00
  England (Responsible Population based) Quarter ended 30 September 2000 ISBN 1 84182 297 3 £8.00

Imaging and radio diagnostics, 1999-2000 ISBN 1 84182 225 4


Ordinary and day case admissions 1997-1998 ISBN 1 85839 958 0 £7.00

Waiting Times for Suspected Breast Cancer Patients, England, Quarter ending:
  31 December 1999
  31 March 2000
  30 June 2000
  30 September 2000

Hospital Outpatient Activity
NHS day care facilities 1999-2000 ISBN 1 84182 070 9

Outpatients and ward attenders:
£8.00
1999-2000 ISBN 1 84182 253 1 £8.00

Waiting times for first outpatient appointments: quarter ending
31 March 2000 2000/12
30 September 2000 2000/29

Waiting times for first outpatient appointments in England:
Detailed statistics, Quarter ended 30 September 2000 ISBN 1 84182 295 7 £11.00

Patient's Charter


Mental Health & Learning Disability

Electro-Convulsive Therapy (ECT):
Survey covering period from January to March 1999 1999/22

Inpatients formally detained in hospital under the Mental Health Act 1983 and other legislation, England
1989-90 to 1999-2000 2000/19

Inpatients formally detained in hospitals under the Mental Health Act 1983 and other legislation, NHS trusts, high security psychiatric hospitals and private facilities: 1998-1999
Cancer - Reference publications


Coronary Heart Disease and Stroke – Reference Publications


Health Education Authority, Riddoch C, Puig-Ribera A, Cooper A. Effectiveness of physical activity promotion schemes in primary care: a review. London: Health Education Authority, 1998 (Health promotion effectiveness reviews; no. 14).


Mental health - summary of data sources

ONS (formerly OPCS) Surveys of Psychiatric Morbidity in Great Britain

Adults living in private households

Adults living in institutions

OPCS Surveys of psychiatric morbidity in Great Britain. These surveys were commissioned by the DH, the Scottish Home and Health Department and the Welsh Office. The aims of these surveys were to provide up-to-date information about the prevalence of psychiatric problems among adults in Great Britain as well as their associated social disabilities and uses of services.

Four separate surveys were carried out from April 1993 to August 1994:

1) 10,000 adults aged 16-64 years living in private households (fieldwork: April 1993 - Sept 1993)
2) A supplementary sample of 350 people aged 16 to 64 years with psychosis living in private households (fieldwork October 1993 to December 1993)
3) 1,200 people aged 16-64 living in institutions specifically catering for people with mental illness (fieldwork April 1994 to July 1994)

Health Survey for England (Stress, Anxiety and Depression)

Health Survey for England, 1994 onwards (Questions asked from year to year are varied).

Primary and community care

GP Services

OPCS, Morbidity Statistics for General Practice, Fourth National Study
ONS, Key Health Statistics from General Practice
Prescription Pricing Authority data

Community services

Korner community returns : KT24, KC57 and KC58
Korner activity return : KH14
PSS returns (DC3 and HH1)

Beds and Places - Hospitals and Residential Care

Combined data from a number of sources : Korner and PSS activity returns

SH3, KO3
KH03, KO36, RAC5, RAC5(S) and RAU1
NHS Hospital activity

Mental handicap

Episodes with a psychiatric diagnosis
Hospital Episode Statistics (HES) system

Other in-patient activity
KP90 return (from 1996-97)

Other NHS activity
Dept of Health form KH09

Management of patients (MHA Activity, CPA, and emergency re-admissions)

Korner activity return MHE, KH15, KO37 and KP90
DH annual return SSDA 702
Common Information Core - Quarterly Monitoring

Residential care home activity and supported residents

Korner activity return : KO36
PSS returns : RAC5, RAC5 (S) RA (Form B), RAU1 and RO36

Workforce

Medical workforce census
Non-medical workforce census
Korner activity return : KO36

Suicides and self harm

ONS data on cause of death: published annually by ONS in DH series
ONS data on cause of death : Published in Health Inequalities, 1997
Public Health Common Data Set (PHCDS)
Hospital Episode Statistics (HES)

Expenditure

Uses combined data for NHS and PSS Services
Health Select Committee(FPA-PES) and RO3 return
Accidents – guide to data sources

This is a brief summary of the main data sources, extracted from a draft of the forthcoming Public Health Information Strategy accidents overview

Guide to Data Sources

ONS (Office for National Statistics) mortality statistics

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<thead>
<tr>
<th>Annual publication</th>
<th>Mortality Statistics: Injury and Poisoning 1998 Series DH4 no. 23</th>
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<tr>
<td>Description</td>
<td>Detailed analysis of deaths attributed to accidents, poisoning and violence in England and Wales.</td>
</tr>
<tr>
<td>Requests for Further information</td>
<td>For requests for mortality data, background information on this publication, on unpublished tables and on data quality contact the ONS Vital Statistics Outputs Branch. Telephone: 01329 813758</td>
</tr>
</tbody>
</table>

What information is collected?

The Office for National Statistics (ONS) compiles mortality statistics which are based on registrations of deaths. These registrations are made by local registrars of births and deaths, and in most cases are required within five days of the death occurrence. The deaths are analysed by age, sex, cause and place of occurrence for each of the main types of accident for the reference year.

How is it collected?

The basic information on the particulars of the deceased and the primary cause of death comes from the medical certificate of cause of death (MCCD) as completed by the certifying medical practitioner. All deaths from external causes (injuries) must also be referred to a coroner who, following an inquest, will record further information including occupation, location of accident, and road user type for motor vehicle accidents. In a small proportion of cases the coroner will decide that no inquest is necessary and therefore this extra information will not be recorded. Registrars supply details of all deaths to ONS each week. ONS processes and tabulates the data, publishing figures weekly, monthly, quarterly and annually.

Coding System

The presentation of deaths by cause alters from time to time with the introduction of a revised International Classification of Diseases (ICD). The current classification is the Ninth Revision and has been in use since 1979. The Eighth Revision was used from 1968-78, and the Seventh Revision from 1958-67. The Tenth Revision is to be introduced with the 2001 deaths data.
Each death is given two codes, one indicating the nature of the injury sustained (e.g. fracture of skull) and one indicating the external cause (e.g. fall from ladders or scaffolding).

*Local breakdowns available?*

Breakdowns are available for Government Office Regions, standard regions [?], NHS regions, counties (England and Wales), health authorities, local authority districts, wards and postcode sectors.

*Data quality issues?*

Almost 100% of cases are recorded. However due to the time needed to complete some inquests, deaths may not appear in the published statistics in the same year of occurrence. For the same reason, figures may include a proportion of deaths occurring in a previous year.

An area of concern is the amount of cases where an inquest is not carried out and place of accident is therefore not recorded. Most of these cases involve fracture/fall deaths among older people. The number of home deaths recorded in this way is therefore probably under-represented.
Road Traffic Accidents

<table>
<thead>
<tr>
<th>Title</th>
<th>Road Accidents Great Britain: 1999 The Casualty Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Detailed analysis of personal road injury accidents in Great Britain, and their consequent casualties, including accident circumstances and vehicle involvement.</td>
</tr>
<tr>
<td>Further information</td>
<td>Information is also available on disk. For information on how to purchase this and requests for more detailed analyses telephone 0207 944 3078 or email <a href="mailto:roadacc_stats@detr.gov.uk">roadacc_stats@detr.gov.uk</a></td>
</tr>
</tbody>
</table>

What information is collected?

Information about road accidents involving vehicles on public highways (including footways) that result in human injury or death and which are reported to the police within 30 days of their occurrence. The information collected includes personal details of casualties, injury type and severity (fatal, serious or slight), road details, vehicle details, weather and other conditions.

How is it collected?

Information is collected by police officers attending road accidents resulting in human injury or death, or from members of the public who report road injury accidents at a police station. Data are recorded on STATS19 form and entered onto local databases held by the local highway authority. Submissions from these are made monthly to DETR. In other cases, the police process their own data and submit directly to DETR.

The figures are linked to additional information on traffic, vehicle numbers and population to compile the annual road accident statistics reports. In addition, information is taken from the vehicle register using the vehicle registration mark to give further information such as the age of vehicles involved in accidents and the make and model types.

Coding system

Cases are grouped into three severity levels; fatal, serious and slight. The definitions of severity used in the survey are designed to enable the police to make a reasonable estimate of the severity of the injury at the scene of the accident without reference to a medical opinion.

Data quality issues

In the majority of cases the police do not use a standard STATS19 form for data collection. Instead, data are collected on their own forms.notebooks and later coded for STATS19 when the data are processed.
Very few, if any, fatal accidents do not become known to the police. However, there is evidence that an appreciable proportion of non-fatal injury accidents are not reported to the police and thus are not included in DETR’s statistics. A study in 1990 in one region found that 36% of all road casualties were in accidents not reported to the police. Recent more comprehensive research has confirmed this level of under-reporting.

No details on the nature of the injury, medical outcome or subsequent treatment are collected. The categorisation of injuries into serious or slight often requires further investigation of the medical diagnosis and treatment. However this information is not always available which can lead to some misclassification.
Home and Leisure Accidents

<table>
<thead>
<tr>
<th>Title</th>
<th>Home Accident Surveillance System including Leisure Accidents: 22nd Annual Report 1998 data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available from</td>
<td>DTI Consumer Safety Publications Orderline. Telephone: 0870 1502 500 or email <a href="mailto:dtipubs@echristian.co.uk">dtipubs@echristian.co.uk</a> (free of charge)</td>
</tr>
<tr>
<td>Source</td>
<td>Department of Trade and Industry (DTI), Home and Leisure Accident Surveillance System (HASS/LASS)</td>
</tr>
<tr>
<td>Description</td>
<td>Detailed analysis of home and leisure accidents based on interviews with patients attending A&amp;E departments in the UK.</td>
</tr>
<tr>
<td>Further information</td>
<td>A report into the patterns and trends in home accidents using HASS data was recently published in “Research on the pattern and trends in home accidents” also available from the DTI orderline (see above). Specific requests for analysis of HASS and LASS data can be made to DTI on 0207 215 2114</td>
</tr>
</tbody>
</table>

What information is collected?

Data are collected by DTI from 18 A&E Departments in the UK (15 in England). This represents approximately a 5% sample of attendances in all A&E units which attend to more than 10,000 cases per annum, operate a 24-hour service and take ambulance cases. Data are collected on all cases of accidental injury except road traffic accidents and accidents in the workplace. Information is gathered on the immediate circumstances of the accident, location, details of the injury and details of products involved.

How is it collected?

Information is gathered in the sample hospitals by specially trained interviewers, employed by the hospitals but contracted to work exclusively on HASS/LASS. Patients are interviewed as soon as practicable by face-to-face interview using a standard questionnaire. Information from the interview is supplemented with information from the hospital’s medical records. Information is checked and validated and transferred to the DTI’s central database within a few weeks of interview.

Coding System

HASS/LASS uses its own detailed codes for type of accident, activity definition, injury definition, body part definition and sport category definition.

Local breakdowns available?

The sample of hospitals used is broadly representative of the national picture but as it is unlikely that any one hospital will fully represent the region in which it is situated, HASS/LASS estimates are only really valid for the country as a whole.

Data quality issues?

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Once the sample data have been taken from the 18 sample hospitals they are converted into national estimates. The smaller the number of HASS/LASS cases for a particular combination of variables, the less statistical confidence there is in the national estimate derived from it. For all accidents the national estimate can be qualified using confidence limits.

HADD (Home Accident Deaths Database)

As relatively few accidental deaths occur during or after A&E treatment, the DTI set up HADD in 1982 to discover the part played by consumer goods in fatal accidents. Source data from ONS is recoded to the HASS/LASS system in order to compare data on fatal and non-fatal accidents. Some under-recording and inconsistencies exist in the data for 1993–5. DTI intend to build a new version of HADD beginning with 1999 as a pilot year, but in the meantime rely on ONS for data on home accidental deaths.
Fire Statistics

<table>
<thead>
<tr>
<th>Title</th>
<th>Fire Statistics United Kingdom 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available from</td>
<td>Home Office. Telephone 020 7273 2084 or email <a href="mailto:rds.ho@gtnet.gov.uk">rds.ho@gtnet.gov.uk</a></td>
</tr>
<tr>
<td>Source</td>
<td>Home Office, from Fire Brigade reports</td>
</tr>
<tr>
<td>Description</td>
<td>Detailed information on all UK fires in buildings, vehicles and outdoor structures and any fires involving casualties or rescues.</td>
</tr>
<tr>
<td>Further information</td>
<td>An electronic version is available in pdf format at <a href="http://www.homeoffice.gov.uk/rds/pubflf.htm">http://www.homeoffice.gov.uk/rds/pubflf.htm</a>. Further enquiries about the figures included can be made to the Home Office on 01923 89 2900</td>
</tr>
</tbody>
</table>

What information is collected?

Also some limited information on ”secondary” and chimney fires

How is it collected?

Home Office fire statistics (for injuries) are compiled from reports (FDR1) submitted to the Home Office relating to fires attended by local authority fire brigades. Data for fatal and non-fatal injuries from fires are available by location and cause. Records of fire deaths submitted by fire brigades are checked against death certificates from ONS meaning that all deaths recorded are attributable to fire and deaths are included where they occurred weeks or months after the fire. Injury is collected on the nature of injury from fire (eg burns, overcome by gas or smoke, physical injuries, shock, precautionary check ups).
Work Related Accidents

<table>
<thead>
<tr>
<th>Title</th>
<th>Hard copies available free of charge from HSE Books Telephone: 01787 881165, or on the internet at <a href="http://www.hse.gov.uk/hsestats.htm">http://www.hse.gov.uk/hsestats.htm</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Available from</td>
<td>Health and Safety Executive (HSE), from the RIDDOR database of accidents reported by employers</td>
</tr>
<tr>
<td>Source</td>
<td>This bulletin presents the latest statistics available on reports to HSE and local authorities in Great Britain for the year April 1998 to March 1999. It represents a summary of: workplace injuries to workers, employees, the self-employed, and members of the public; dangerous occurrences; and gas safety statistics</td>
</tr>
<tr>
<td>Description</td>
<td>Further information can be obtained from the HSE Operations Unit. Telephone 0151-951-4842 or email <a href="mailto:public.enquiries@hse.gov.uk">public.enquiries@hse.gov.uk</a></td>
</tr>
<tr>
<td>Further information</td>
<td>More detailed and wider ranging information is available in “Health and Safety Statistics 1999/2000” from HSE books (see above) ISBN 0-7176-1867-6 (£17.50)</td>
</tr>
</tbody>
</table>

What information is collected?

Details on all incidents legally reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995.

How is it collected?

Employers send details of legally reportable accidents to HSE inspectorate or to Local Authorities, depending on the type of workplace. These forms are then coded and interpreted locally and the local data is sent to the central HSE database. Further information may be gathered following detailed investigation of accidents. All fatal accidents and around 6% of all non-fatal accidents are investigated.

Data quality issues?

There is evidence that only a third of non-fatal reportable accidents are actually reported under RIDDOR.
Hospital Episode Statistics (HES)

<table>
<thead>
<tr>
<th>Title</th>
<th>Hospital Episode Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual publication</td>
<td>Standard tables containing data for 1999-2000 are published on the HES website</td>
</tr>
<tr>
<td>Available from</td>
<td>HES website address: <a href="http://www.doh.gov.uk/hes">http://www.doh.gov.uk/hes</a></td>
</tr>
<tr>
<td>Description</td>
<td>The standard tables contain analyses of NHS in-patient care by diagnosis, operation, Healthcare Resource Group, consultant speciality, NHS Trust, Health Authority, and external cause</td>
</tr>
<tr>
<td>Requests for Further information</td>
<td>For requests for HES data, contact the HES enquiry point. Telephone: 020 7972 5529</td>
</tr>
</tbody>
</table>

What information is collected?

Hospital Episode Statistics (HES) provides information on in-patient care delivered by NHS hospitals in England from 1989. HES covers all NHS Trusts in England (there are separate organisations for Northern Ireland, Scotland and Wales). Although private hospitals are not covered, HES does include private patients who were treated in NHS hospitals. HES data is split into years, which run from 1 April to 31 March in the following year.

Personal, medical and administrative details are collected for each NHS hospital in-patient, including the patients’ age, sex and ethnic group, the date of admission to hospital, the admission method, waiting time, length of stay in hospital, diagnosis (plus details of accidents and poisoning which resulted in hospitalisation), and details of any operation. A record is generated for each Consultant Episode (the period during which an admitted patient is under the care of a particular medical consultant within a hospital provider).

How is it collected?

Patient records are created, maintained and stored by individual hospital providers on local databases. The information is relayed via an NHS wide data network, the NHS Wide Clearing Service (NCWS), and is collected and stored centrally on the NWCS database. Quarterly and annual data extracts are taken from the NWCS database and sent to the team that runs the HES system. The records in each extract are subjected to a sequence of checks. Following the checking process, the HES database for each year is gradually assembled. The annual extract replaces the quarterly information.

Coding System

Diagnosis and external cause are coded using the International Classification of Diseases (ICD). ICD-10 has been used by HES since April 1995 (so it was first used for the 1995-96 HES data year). For data years before 1995-96 ICD-9 was used.

Operations are coded using the Office of Population Censuses and Surveys Tabular List of the Classification of Surgical Operations and Procedures version 4.2 (OPCS-4.2).
**Local breakdowns available?**

Breakdowns are available for NHS Trusts, health authorities, and GP practices. Breakdowns are also available for area of residence by local authority.

**Data quality issues?**

Data quality issues arise because rigorous validation is not applied to the data at the source. Many of the source systems in the NHS allow the local use of extended or modified codes that are not nationally valid. There is an implicit responsibility on the NHS to map their locally valid values to nationally valid values in their HES submissions. There is a continuing need to cross-check the consistency of values between fields as well as validate individual values in fields.

Another problem for data quality is that of a record being submitted to HES and subsequently being revised by the data provider locally. This can result in a discrepancy between the numbers of episodes in HES and those held on local systems.

The quality of all submitted data is monitored by the HES team, who liaise closely with NHS Trusts to resolve problems. To ensure that HES data is consistent and unambiguous, a number of checks are applied. Every record is interrogated: first to ascertain whether it can be accepted, then to determine whether inappropriate entries should be overwritten, and finally an audit is carried out of the field contents so that a comprehensive set of quality reports can be generated. The checking process does not resolve all issues of missing or incomplete data, but addresses the most commonly known ones.

The extent to which HES fulfils its aim of capturing all finished consultant episodes (FCEs) is judged by comparing it with the Korner aggregate return, KP70. KP70 is completed independently of HES and provides annual totals of FCEs, thus giving a baseline against which HES can be assessed. Correcting factors are applied to HES data that deviates from the baseline.

This procedure, called grossing, involves comparing the KP70 and HES figures by consultant speciality. A further stage in the process involves applying a second factor to compensate for missing or invalid diagnoses. Grossing is therefore applied selectively; it helps ensure consistency and comparability across the whole database.

For further information about HES data quality, a Data Quality Indicator (DQI) is published and is available for data years 1997-98 and 1998-99. (Contact the HES enquiry point on 020 7972 5529 for details).
Derivation of serious accidental injury figures

Length of stay is recorded in HES as duration of spell. A spell may consist of one or more episodes (period of healthcare under one consultant). Spell duration is only recorded in the last episode of a spell. Using admissions to get a count of spells exceeding 3 days undercounts by around 10% because admissions records relate to the first episode of a spell, so duration of spell will appear for one episode spells only. Some of these cases with spell duration missing will have a first episode duration of more than 3 days, so spell duration (although not known) must also be more than 3 days. An estimate of how many of the remaining missing cases have spell duration greater than 3 days has been made by using discharges rather than admissions. The distribution of spell duration for the remaining missing cases has been estimated by assuming that it is the same as that for discharge records where the primary diagnosis indicates an injury, in spells where there is more than one consultant episode.

The following worked example, using example data based on actual HES data, illustrates the procedure for deriving serious injury figures.

1. Run a HES query to obtain a table of cause code by spell duration for all injury admissions, and a table of cause code by episode duration for all injury admissions.

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accidental injury</td>
</tr>
<tr>
<td>Duration of episode</td>
<td></td>
</tr>
<tr>
<td>0 thru 3</td>
<td>266,551</td>
</tr>
<tr>
<td>4 thru 9999</td>
<td>140,772</td>
</tr>
<tr>
<td>Other</td>
<td>503</td>
</tr>
<tr>
<td>Total</td>
<td>407,826</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accidental injury</td>
</tr>
<tr>
<td>Duration of spell</td>
<td></td>
</tr>
<tr>
<td>0 thru 3</td>
<td>251,806</td>
</tr>
<tr>
<td>4 thru 9999</td>
<td>128,517</td>
</tr>
<tr>
<td>Other</td>
<td>27,503</td>
</tr>
<tr>
<td>Total</td>
<td>407,826</td>
</tr>
</tbody>
</table>

2. Form a table of cause code by spell duration for all injury admissions as follows: take figures for spell duration 0 thru 3 days from spell duration table above; take figures for spell duration 4 thru 9999 days from episode duration table above; calculate other spell duration figures to ensure column totals equal the column totals in the spell duration table above.

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accidental injury</td>
</tr>
<tr>
<td>Duration of spell</td>
<td></td>
</tr>
<tr>
<td>0 thru 3</td>
<td>251,806</td>
</tr>
<tr>
<td>4 thru 9999</td>
<td>140,772</td>
</tr>
<tr>
<td>Other</td>
<td>15,248</td>
</tr>
<tr>
<td>Total</td>
<td>407,826</td>
</tr>
</tbody>
</table>
3. Split ‘other’ causes between accidental injury and non-accidental injury in the proportions of the figures in those columns.

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Cause</th>
<th>Accidental injury</th>
<th>Non-accidental injury</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of spell</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 thru 3</td>
<td>321,709</td>
<td>102,787</td>
<td>424,496</td>
<td></td>
</tr>
<tr>
<td>4 thru 9999</td>
<td>183,343</td>
<td>12,323</td>
<td>195,666</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>18,818</td>
<td>5,417</td>
<td>24,235</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>523,870</td>
<td>120,527</td>
<td>644,397</td>
<td></td>
</tr>
</tbody>
</table>

4. This leaves over 20,000 admissions with no recorded spell duration. The distribution of these can be estimated by assuming the same distribution as in discharge records where there is more than one episode.

<table>
<thead>
<tr>
<th>Discharges, multi episode spells</th>
<th>Cause</th>
<th>Accidental injury</th>
<th>Non-accidental injury</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of spell</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 thru 3</td>
<td>5,616</td>
<td>2,497</td>
<td>1,765</td>
<td>9,878</td>
<td></td>
</tr>
<tr>
<td>4 thru 9999</td>
<td>14,967</td>
<td>1,380</td>
<td>6,374</td>
<td>22,721</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>49</td>
<td>5</td>
<td>25</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20,632</td>
<td>3,882</td>
<td>8,164</td>
<td>32,678</td>
<td></td>
</tr>
</tbody>
</table>

5. Applying the ratios of spell duration 0 thru 3 to spell duration 4 thru 9999 for accidental and non-accidental injury from the above discharges table to the admission figures with missing spell duration gives:

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Cause</th>
<th>Accidental injury</th>
<th>Non-accidental injury</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of spell</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 thru 3</td>
<td>5,134</td>
<td>3,489</td>
<td>8,623</td>
<td></td>
</tr>
<tr>
<td>4 thru 9999</td>
<td>13,684</td>
<td>1,928</td>
<td>15,612</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>18,818</td>
<td>5,417</td>
<td>24,235</td>
<td></td>
</tr>
</tbody>
</table>

6. Adding the estimates from the above table to the original admissions figures gives:

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Cause</th>
<th>Accidental injury</th>
<th>Non-accidental injury</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of spell</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 thru 3</td>
<td>326,843</td>
<td>106,276</td>
<td>433,119</td>
<td></td>
</tr>
<tr>
<td>4 thru 9999</td>
<td>197,027</td>
<td>14,251</td>
<td>211,278</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>523,870</td>
<td>120,527</td>
<td>644,397</td>
<td></td>
</tr>
</tbody>
</table>
Derivation of A&E attendance figures

A&E attendance figures for **home and leisure accidents** are presented in this overview as national estimates for England broken down by accident mechanism, age, and sex.

A&E attendance data is obtained from the Home Accident Surveillance System (HASS) and the Leisure Accident Surveillance System (LASS). HASS/LASS data is gathered by interviewing patients at A&E units in a representative sample of 18 hospitals across the UK. (15 of these hospitals are in England). The data available for **home accidents** consists of A&E attendance figures for the sample of hospitals broken down by accident mechanism, age, and sex, together with national estimates for the UK broken down by accident mechanism only. (Figures for the total annual A&E attendance for each hospital in the HASS/LASS sample are also available). Similar data is available for **leisure accidents**. The HASS/LASS data has been converted into the national estimates for England presented in this overview using the following process:

1. For **home accidents** data from HASS:

   • Obtain a national estimate for England for each accident mechanism by multiplying the national estimate for the UK for that accident mechanism by the following ratio:

   \[
   \frac{\text{Total A&E attendance (home accidents) for the English hospitals in the HASS/LASS sample}}{\text{Total A&E attendance (home accidents) for all hospitals in the HASS/LASS sample}}
   \]

   • For each accident mechanism, distribute the England national estimate for that accident mechanism across the age group/sex categories in proportion to the HASS/LASS sample figures for the age group/sex categories for that accident mechanism. This gives England national estimates for **home accidents** broken down by accident mechanism, age, and sex.

2. Repeat the above steps for **leisure accidents** data from LASS to give England national estimates for **leisure accidents** broken down by accident mechanism, age, and sex.

3. Add the England national estimates for **home accidents** to the England national estimates for **leisure accidents**. This gives England national estimates for **home and leisure accidents** combined broken down by accident mechanism, age, and sex.
External cause categories

Mortality, serious injury, hospital admissions, and A&E attendance figures are presented in this overview for various external cause categories (motor vehicle traffic accidents, falls, poisoning, etc.). The data is not classified in this way at source. External cause is coded for mortality data (obtained from ONS) using ICD–9, and for serious injury and hospital admissions data (obtained from HES) using ICD–10. A&E attendance data (obtained from HASS/LASS) has its own set of accident mechanism categories. The table below lists the ICD–9 and ICD–10 codings and the HASS/LASS accident mechanism categories which have been used to correspond to the external cause categories appearing in this overview.

There is no exact mapping between the ICD–9 and ICD–10 codes; however, the ICD–9 and ICD-10 codings given for each external cause category below have been matched so that as closely as possible they code the same external cause.

The accident mechanism categories used for A&E attendance data do not match the external cause categories used in this overview very closely. In addition, A&E attendance figures are for home and leisure accidents only. They do not cover motor vehicle traffic accidents or work accidents. Mortality, serious injury, and hospital admissions figures are not restricted to home and leisure accidents, so care must be taken when making comparisons with A&E attendance figures.

Notes for Table A
1 For codes V02 to V04, 4th digit code 9 (Unspecified whether traffic or non-traffic) is split pro-rata between 4th digit code 0 (Non-traffic) and 4th digit code 1 (Traffic); the Traffic proportion of 4th digit code 9 is included in the MVTA, pedestrian injured external cause category
2 The Thermal effect category covers both the Fire and flames and the Burns and scalds categories; there are no separate A&E attendance accident mechanism categories corresponding to Fire and flames and Burns and scalds individually
3 The Suffocation category covers both the Drowning and the Choking categories, and also includes other threats to breathing; there are no separate A&E attendance accident mechanism categories corresponding to Drowning and Choking individually
4 The full list of accident mechanism categories used for A&E attendance data is: Fall on same level, Fall on/from stairs, Fall on/from ladder, Fall from building, Other fall, Struck – explosion, Struck – moving object, Struck – static object, Struck – other, Pinch/crush (blunt), Cut/tear (sharp), Puncture, Bite/sting, Foreign body, Suffocation, (Suspected) poisoning, Chemical effect, Thermal effect, Electric/radiation, Acute overexertion, Other. Note that motor vehicle traffic accidents are not included
### Table A  External cause categories and corresponding codings for mortality, serious injury, hospital admissions, and A&E attendance data

<table>
<thead>
<tr>
<th>External cause category</th>
<th>ICD–9 code (used for mortality data)</th>
<th>ICD–10 code (used for serious injury and hospital admissions data)</th>
<th>A&amp;E attendance data cause category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Main code</td>
<td>4th digit code</td>
<td>Main code</td>
</tr>
<tr>
<td>1 Motor vehicle traffic accidents (MVTA)</td>
<td>E810 to E819</td>
<td>All</td>
<td>Items 2 to 6 below, together with: V81 to V82</td>
</tr>
<tr>
<td>2 MVTA, vehicle occupant injured</td>
<td>E810 to E819</td>
<td>.0, .1 only</td>
<td>V30 to V38 V39 V40 to V48 V49 V50 to V58 V59 V60 to V68 V69 V70 to V78 V79 V84 to V86</td>
</tr>
<tr>
<td>3 MVTA, motorcyclist injured</td>
<td>E810 to E819</td>
<td>2, .3 only</td>
<td>V20 to V28 V29</td>
</tr>
<tr>
<td>4 MVTA, pedal cyclist injured</td>
<td>E810 to E819</td>
<td>.6 only</td>
<td>V12 to V14 V19</td>
</tr>
<tr>
<td>5 MVTA, pedestrian injured</td>
<td>E810 to E819</td>
<td>.7 only</td>
<td>V02 to V04 V09</td>
</tr>
<tr>
<td>6 MVTA, unspecified person injured</td>
<td>E810 to E819</td>
<td>.9 only</td>
<td>V87 V89</td>
</tr>
<tr>
<td>7 Other transport accidents</td>
<td>E800 to E809, E820 to E849</td>
<td>All</td>
<td>V01 to V99 excluding item 1 above</td>
</tr>
<tr>
<td>8 Falls</td>
<td>E880 to E888</td>
<td>All</td>
<td>W00 to W19</td>
</tr>
<tr>
<td>9 Poisoning</td>
<td>E850 to E869</td>
<td>All</td>
<td>X40 to X49</td>
</tr>
<tr>
<td>10 Poisoning by drugs</td>
<td>E850 to E858</td>
<td>All</td>
<td>X40 to X44</td>
</tr>
<tr>
<td>11 Poisoning by alcohol</td>
<td>E860</td>
<td>All</td>
<td>X45</td>
</tr>
<tr>
<td>12 Fire and flames</td>
<td>E890 to E899</td>
<td>All</td>
<td>X00 to X09</td>
</tr>
<tr>
<td>13 Dwelling fires</td>
<td>E890</td>
<td>All</td>
<td>X00</td>
</tr>
<tr>
<td>14 Burns and scalds</td>
<td>E924</td>
<td>All</td>
<td>X10 to X19</td>
</tr>
<tr>
<td>15 Natural and environmental factors</td>
<td>E900 to E909</td>
<td>All</td>
<td>W50 to W64 W85 to W99 X20 to X39 X50 to X57</td>
</tr>
<tr>
<td>16 Drowning</td>
<td>E910</td>
<td>All</td>
<td>W65 to W74</td>
</tr>
<tr>
<td>17 Choking</td>
<td>E911 to E912</td>
<td>All</td>
<td>W78 to W79</td>
</tr>
<tr>
<td>18 Choking on food</td>
<td>E911</td>
<td>All</td>
<td>W78 to W79</td>
</tr>
<tr>
<td>19 Choking (non-food)</td>
<td>E912</td>
<td>All</td>
<td>W80</td>
</tr>
<tr>
<td>20 All causes</td>
<td>E800 to E949</td>
<td>All</td>
<td>V01 to V99 W00 to X59 Y40 to Y84</td>
</tr>
</tbody>
</table>
Examples of good practice

1. Local Authority contribution to Our Healthier Nation – Kent
2. Partnership initiatives and related projects - Kingston and Richmond HA
3. Reducing inequalities – a generalised worked example.

These examples set out work activity in the year 2000. These examples and further ones will be on the OHN website in due course. Contributions for this section will be gratefully received. Please e-mail to Technical-Supplement@doh.gsi.gov.uk
Local Authority contribution to Saving Lives-Our Healthier Nation

Contribution from Kent Social Services

Introduction

The contribution made by LAs to the Public Health of their communities is recognised in the White Paper. Many LAs have developed partnerships around health issues, sometimes because of concerns about health facilities, e.g. Horsham, Hertsmere, or because community surveys have identified health as a local concern, e.g. Havant. Joint work with Health Authorities on specific projects can be widened into a strategic approach to health combining many different agencies and schemes and moving from social services to the corporate LA as the examples below show.

LAs will need to weigh up the options against resources, the pattern of joint work, public involvement and other factors. Hopefully the experiences of other LAs will assist decision making and perhaps make it easier to engage other partners as the benefits gained else where can be seen.

Getting Started

Community-led

Concerns about health facilities are often major issues for local communities, particularly plans to close hospitals or move A&E Units. Debates about community hospitals can be particularly difficult for HAs due to public affection and concerns about future availability of services. These issues generate local campaigns to maintain the status quo with considerable energy and activity. This can be developed into a wider community examination of the health needs of an area and the services that should be provided. HA plans to alter the mix of services and facilities in an area can be used as the starting point for a debate about the communities needs and wishes. Similarly concerns about the lack of local services can act as a trigger point. Both these approaches draw in elected members quickly enabling quick decisions to be made about the strategic priority of the issues e.g. Horsham.

The LA can make a particular contribution to these debates as it can act as an independent broker and/or advocate of local concerns, involved in joint work with the HA but able to stand aside and represent local views. This can reduce fears that decisions will be made without serious consideration of public wishes which so often leads people to adopt a rigid stance against change. Opening the debate into a wider examination of health issues can lead to greater public acceptance of change, better use of existing resources with some reconfigurations to meet local needs, greater partnership and so more efficiency amongst agencies and greater public understanding of health promotion.

Survey-led

Surveys of communities often throw up health issues as a priority e.g. cancer in Havant. This enables further engagement with the community based on this priority. Such surveys
might be part of other activity e.g. building a Community Plan, and might come from
neighbourhood work e.g. Bradford’s Neighbourhood Forums, Norwich Community
Forum. Standard community development techniques can be used to build from these
surveys resulting in the formation of local plans. These then draw in members who
respond to the emerging plans.

Mapping needs and facilities is a useful precursor to a survey. Many LAs have
established audit or scrutiny committees as a way of building support for a health
strategy. These can be started with a mapping exercise e.g. Hertsmere, Macclesfield
where a health audit was conducted

Surveys are only worth doing if there is a clear plan for analysing the data and turning it
into information and then for using it to guide action with a feedback to the local
community. Survey fatigue is a growing problem with communities subjected to similar
questions from a range of agencies and left wondering why the questions are asked if no-
one seems to act on them.

Structures to support the health agenda

A number of methods can be used to translate the local issues, either identified through
surveys or raised directly by communities, into action plans. The stage at which elected
members become involved is quite crucial. Their support enables access to more
resources, gives legitimisation and provides a vehicle to engage with the planning
systems of statutory agencies.

Exploring an issue through a commission of inquiry with a similar role to a Select
Committee has proved effective e.g. Horsham. This works well when a local concern is
raised but it is not agreed that this is an issue for the LA, or when the role of the LA in
regard to it is unclear, e.g. Hertsmere.

Surveying the community can be done in a number of ways. Macclesfield carried out an
audit similar to their Crime Audit and have set up a Health Partnership Audit sub-group
to monitor the effectiveness of their joint work. Havant’s survey of Warren Park showed
that residents were more concerned with cancer than other issues. This steered joint work
showing a responsiveness to local communities.

Scrutiny committees examining a wide range of health issues including the local NHS
services have been established and have examined the wider health role of the LA e.g.
policy panels set up in Birmingham to work like Select Committees taking evidence from
a wide range of agencies and individual experts. These committees have moved away
from traditional LA committee structures which usually only consider written advice
from the LAs own officers.

Joint planning mechanisms, usually set up by SSDs have expanded to become fully joint
mechanisms to develop health strategies, often including the HImpS e.g. Oxfordshire.
These can include the JCCs.

Public Involvement
Building a partnership with the public is time consuming and difficult. Although public involvement and consultation are common features of LA/HA joint strategies, real partnership is not so common. Usually this is achieved over a period of time and requires the establishment of local institutions, either Healthy Living Centres or similar, e.g. Hertsmere, or a formal group e.g. South Leeds Health for All, or a combination of the two.

The DETR “Guidance on Enhancing Public Participation in Local Government” is an excellent guide with sound and practical advice, case examples, a useful bibliography including LA-produced material and performance measures. However these do tend to be more process-oriented than outcome-oriented but this reflects the current state of play. The DETR Paper “Achieving Best Value through Public Engagement” is also useful with a focus on Best Value that might assist other partners.

**Specific examples of good practice from South East England**

<table>
<thead>
<tr>
<th>Good Practice</th>
<th>Hertsmere/Borehamwood</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Concerns about the lack of NHS facilities together with the Director of Public Health’s Report showing the extent of need led to the establishment of a strategic health overview group. This group brought together the many agencies and forged a joint view of what was possible with existing and achievable resources assisted by an exercise to map local facilities. This showed that some were underused and could support more activity, e.g. a LA home is used for mental health, greater use of a local clinic. A SRB bid was built on this work and paid for a community shop to be a local resource centre. This experience of moving from a lack of a central health resource, i.e. a community hospital, building a coalition for change around a realistic appraisal of what was needed and was possible has resulted in a wide range of community resources targeting locally identified health care needs.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Good Practice</th>
<th>Surrey/Woking</th>
</tr>
</thead>
</table>
|               | **Healthy Woking is an integrated planning system bringing together the work of county and district councils, HA etc. It found over 30 existing planning groups, with overlaps and poor communication and replaced them with a simpler more effective structure which released staff time. The outcomes have included:-**  
|               | **• Integrated primary care service**  
|               | **• Prescribed leisure**  
|               | **• Healthy workforce**  
|               | **• Preventing falls**  
|               | **• Integrated transport**  
|               | **• Welfare benefits take-up campaigns**  
|               | **• Support to employment**  
|               | **Evaluation is through a mix of techniques including quality of life surveys etc.** **|
### Good Practice Oxfordshire

The HImP is supported by a formal partnership between the key agencies. A HImP Partnership Board with members and staff sets the direction with support from a Steering Group containing officers from LA and NHS bodies. This formal structure has enabled the integration of a wide set of plans into a cohesive HImP with good linkage between objectives, methods, working groups and accountability. The link between the county council and the district councils is noteworthy. It might be the case that large geographical areas require a strong formal structure to bring together the different agencies and to drive a clear strategy whereas smaller areas can be more informal and fluid and perhaps depend more on personal relationships to drive change. The minutes and documents are available on the Oxfordshire CC website ([http://www.oxfordshire.gov.uk/listbycode.idc-c=hi.htm](http://www.oxfordshire.gov.uk/listbycode.idc-c=hi.htm)) and as the working groups list the members this does increase the transparency of the planning system.

### Good Practice Suffolk

Developed strategy based on research into across the UK. This survey (results available on the Suffolk website: [http://www.suffolkcc.gov.uk/modernising/pp/supportinfo.html](http://www.suffolkcc.gov.uk/modernising/pp/supportinfo.html)) enabled the rapid development of joint strategy using the experience of others. Suffolk obtained details from nearly 100 LAs and identified best practice. A Health Commission of members was set up to develop a Health Strategy using this knowledge together with Suffolk CC’s own experience of joint work with other partners including the HAs. This strategy is very comprehensive and ties together a number of activities around the issue of health inequalities, e.g. trading standards focus on goods purchased by socially excluded/disadvantaged groups such as second hand vehicles, fireworks, furniture. Suffolk seem to have speeded up the development of strategy through using others’ experience in a comprehensive and coherent way.

### A useful reference document:

“Making T.H.E. links: Integrating sustainable Transport, Health and Environmental policies: A guide for local authorities and health authorities” – published by the Health Education Authority in collaboration with Department of Health and DETR.

It contains detailed guidance for those working locally, particularly senior managers, for the development of shared plans on transport, health and environmental issues.
Models of Good Practice - Kingston and Richmond Health Authority

Healthy Communities Programme

The joint ownership of health by Local Authorities has opened new opportunities for partnership working. It has assisted in broadening the definition of health to incorporate such factors /determinants as housing, employment, education, economic development, transport and the environment, all of which have an impact on wellbeing.

Needs assessment exercises targeting areas of social deprivation, were conducted through negotiation with local residents, who were keen to assist in the preparation, collection of data and analyses of the findings. The process was based on "listening" to the expressed needs of local communities as they after all, are best placed to know them - not assuming that health professionals know best!

Information was shared with Local Authorities and planned initiatives were "project managed" by local residents.

The involvement, support and commitment of Local Authorities was crucial to the success of the overall programme and pilot projects set up in both Richmond and Kingston are proving to be effective and well received.

Additional Examples of Partnership initiatives

- The secondment of a senior manager from the HA to the Royal Borough of Kingston (RBK) and London Borough of Richmond Upon Thames (LBRUT) to devise a strategic plan to promote health within and across borough boundaries.

- The piloting of a multi agency training programme entitled JUMPP (Joined Up Multi Professional Programme) to assist in the effective delivery of the HImP. The programme covered a period of five months, culminating in a Whole Systems Event and the formulation of five test bed partnership projects, all of which were community based.

- The joint funding of a LA based Healthy Kingston Co-ordinator whose role is to ensure co-ordination of local strategies and national targets ie HImP

- Public Participation training and the development of learning sets to enable wider adoption and practice - capacity building for professionals, user empowerment programmes for service users and community education for local population groups.

- Growth in community development practice and community involvement in needs assessment exercises and project managed initiatives.
**Disease Management Nurse**

The main purpose of the post is to support PCGs and practices in implementing evidence based high standards of care. It is a full time post being shared by two nurses who also work as practice nurses and hence retain considerable credibility with their peers. The post holders are based in the Public Health Department and are accountable to the Director of Public Health. A key aim of the initiative is to provide GP practices with individual support tailored to their particular needs. Crucially, the idea, the job description and work programme have all been developed and agreed by a broad cross-section of partners to ensure widespread ownership and support from the outset.

The programme of work is directed by clinical governance group comprising PCG clinical governance leads, GP and nurse tutors and members from public health bodies. The initiative has focused initially on coronary heart disease (CHD), particularly on secondary prevention in primary care. Practices are being helped to develop accurate disease registers and data quality is being improved by using agreed READ codes. Mechanisms are being established to enable the regular review of computer records to improve clinical care and for recording and recalling patients who have recently had a myocardial infarction.

A further aspect of the role focuses on primary care training needs in relation to the HIImP and, in particular, on secondary prevention of coronary heart disease. Training needs are being assessed with the intention of encouraging multi-disciplinary and multi-agency training where possible and local training is being set up through GP tutors, nurse trainers and community and primary care development managers. Individual practices will be supported through assessment of their training needs and the development and implementation of appropriate training programmes.
Achieving mortality targets whilst at the same time reducing geographical inequality.

Each health authority is expected to produce a programme of action to achieve a reduction in mortality rates of at least the percentage specified in the OHN White Paper. Additional steps should be taken to reduce geographical and other inequalities within the health authority area. This section provides some background on target setting in relation to the reduction of geographical inequalities.

If geographical inequality is to be reduced and the area with the lowest base line death rate must achieve a reduction of at least the target reduction specified in the White Paper, then the areas with the highest base line death rates must achieve more than the target reduction and greater than the reduction achieved by the area with the lowest base line rate. In the example which follows reduction in geographical inequality is presented in terms of the simplest situation where reduction in inequality is addressed only in terms of the “best” performing and “worst” performing areas. The methodology could be developed further to identify suitable target reductions for other areas falling between the best and the worst. In “real life” we would not expect progress to be exactly linear.

This example presents the three year average age standardised mortality rates for 1995 to 1997 (presented as 1996) – these years being the baseline for the OHN targets. In the example the best performing area is assumed to meet the minimum OHN target reduction of 40%, the target for all circulatory diseases. The table then identifies the rate to which the worst performing area would have to fall if reductions in inequality between the best and worst areas were to be reduced by 10%, 20%, or 50%. The table also sets out the percentage fall in mortality that would therefore be required to achieve the stated reductions in inequality in the worst performing area.

| ACHIEVING OHN MORTALITY TARGETS WHILST AT THE SAME TIME REDUCING INEQUALITY |
|-----------------------------|----------------------|---------------------|----------------------|----------------------|
| **Comparing the best and worst performing areas** |
| **Assuming that the best area is tasked to meet, but not exceed, the OHN mortality percentage reduction target,** what must the reduction be in the worst area to reduce inequality by the stated amount? |

<table>
<thead>
<tr>
<th>OHN MORTALITY TARGET AREA</th>
<th>1996 Baseline Rate</th>
<th>Minimum Target Reduction 40%</th>
<th>Maximum Acceptable rate in 2010 60%</th>
<th>10% Reduction in inequality</th>
<th>25% Reduction in inequality</th>
<th>50% Reduction in inequality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest Best</td>
<td>100.00</td>
<td>60.00</td>
<td>60.00</td>
<td>60.00</td>
<td>60.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Highest Worst</td>
<td>160.00</td>
<td>96.00</td>
<td>92.40</td>
<td>87.00</td>
<td>78.00</td>
<td></td>
</tr>
<tr>
<td>Inequality</td>
<td>60%</td>
<td>60%</td>
<td>54%</td>
<td>45%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Fall in mortality to be achieved by worst area</td>
<td>40%</td>
<td>42%</td>
<td>46%</td>
<td>51%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Baseline data for health authorities is contained in: PHCDS, 1998 - 3 year averages (1995-1997)

Reduction in inequality is calculated as a percentage reduction of the baseline inequality.

In this example, the size of the inequality in the baseline year between the best and worst performing areas for circulatory disease is 60% - ie the rate in the worst area is 1.6 times that in the best area. For the purpose of illustration it is assumed that the best performing area meets but does not exceed the minimum 40% reduction. If both areas achieved the minimum OHN target reduction of 40% then the mortality rate in the worst area would fall to 96 per 100,000 but the size of inequality would in relative terms remain unchanged at 60%. A reduction in inequality of 10% would be achieved.
if the rate in the worst area fell to 92.4 per 100,000 – this would imply a reduction of 42% on its base line level. And a reduction in inequality of 50% would be achieved if the rate fell to 78 per 100,000, requiring a reduction in the worst area of 51%.
This example is illustrated below.

**Achieving mortality targets whilst at the same time reducing geographical inequality.**
A specific example of the reduction required by the worst performing area, if the best performing area does no more than meet the mortality target.

The figures in this example were calculated using the following method.

**HOW TO CALCULATE THE FIGURES IN A SPREADSHEET (Using rounded figures)**

A  Baseline Inequality percentage = ((High baseline - Low baseline) / Low baseline) x 100  ie: ((160-100)/100)x100 = 60

B  2010 Low Rate = Low baseline - (low baseline x target reduction expressed as a percentage)  ie: 100-(100x40%) = 60

C  2010 High Rate = High baseline - (high baseline x target reduction expressed as a percentage)  ie: 160-(160x40%) = 96

D  Remaining percentage inequality following **% reduction in inequality = A x ((100 - **% reduction in inequality)/100))  
   ie: [25% reduction in inequality] 60x((100-25)/100)) = 45

E  High Rate for **% Reduction in inequality = B + (B x D)  ie: [25% reduction in inequality] 60+(60x45%) = 87

F  Low Rate for **% Reduction in inequality remains the same as "B" throughout (60)

G  Fall in mortality in highest ranked area for each level of reduction = ((High baseline - C) / High baseline) x 100  
   ie: [25% reduction in inequality] ((160-87)/160)x100 = 46

Notes: There is no need to multiply by 100 in "A" or "G" or divide by 100 in "D" if using a spreadsheet with the cells formatted for percentages. **% reduction is "10" or "25" or "50" or whatever amount is being targeted.
Appendix 16

Sexual Health and HIV Strategy

Following the merger of the Sexual Health and HIV Strategies earlier this year considerable progress has been made with producing an integrated Strategy. The Strategy will set a programme of action on sexual health and HIV for England. The plan is to issue a draft for consultation very shortly.

Key Points

♦ The Strategy will set a coherent framework for improvements in service delivery and health promotion to address the increasing level of sexual ill-health in this country.

♦ The Strategy has been developed in consultation with a wide range of people including young people, people from black and ethnic minorities, and gay men and lesbian women. Key stakeholders for example service providers and commissioners have also played a major role in developing the strategy.

♦ The aims of the Strategy reflect the core principles underpinning the NHS Plan including shaping services around the needs of individual patients, responding to different needs of different populations, improving quality and providing a comprehensive range of services

Teenage Pregnancy


The Teenage Pregnancy Unit has developed a methodology for calculating indicative local targets at social services authority level for the reduction of the teenage conception rates among under 18s by 2010, in line with meeting the national goals. The methodology draws on ward level data and is intended to address the inequality between authorities with the highest and lowest rates of teenage pregnancy. The variable reduction targets all fall in the range of 40% to 60%. Achieving these targets will mean that no local authority will have a teenage conception rate of more than 41 per 1000 women aged 15-17, and inequality between areas with the highest rates and the average will have reduced by 26%.

Health and Local Authorities have considered their indicative conception rate target and the majority have agreed to work towards delivering the 40% to 60% reduction by 2010, proposed by the Teenage Pregnancy Unit, and the 15% reduction target in the NHS Plan. Further discussions are taking place with two areas which have expressed concerns.

Further details are available on the website [www.teenagepregnancyunit.gov.uk](http://www.teenagepregnancyunit.gov.uk)