DH Department of Health

Health Profile of England

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NHS

READER INFORMATION

Policy HR/workforce Management Planning Clinical	Estates Performance IM & T Finance Partnership Working
Document purpose	For Information
Gateway reference	6776
Title	Health Profile of England
Author	DH (Central Health Monitoring Unit, Health Improvement Directorate – Public Health)
Publication date	Tuesday, 10th October 2006
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Directors of PH
Circulation list	Local Authority CEs
Description	The Health Profile of England (HPE) provides national and regional data which local areas can compare against their own Health Profiles. The indicators focus particularly on six priority areas identified in the "Choosing Health" White Paper. The HPE is intended for public service professionals and officials within the local community.
Cross reference	Choosing Health – Making Healthier Choices Easier (2004)
Superseded documents	
Action required	
Timing	
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For recipient's use	

Foreword

Understanding our nation's health is central to stepping up action to improve it. In 2004, the White Paper *Choosing Health*[405] emphasised the crucial role that good information and analysis has in supporting efforts to improve health and reduce health inequalities. Information is key to understanding where we are and what needs to change, prioritising national action and designing effective responses to local differences.

In the next stage of improvement and reform in the NHS we need a decisive shift from top-down to bottom-up as we develop a devolved and self-improving service where the main drivers are patients, commissioners and clinicians rather than targets and performance management. Effective commissioning depends on sound information and analysis to assess health needs, and monitor progress. Effective commissioning will drive development of local capability and capacity. Information is critical to all those contributing to health improvement, not only in health services but also in local authorities and elsewhere; and at all levels – national, regional and local.

The Health Profile of England brings together key indicators that provide a picture of the 2004 health status of people in England. It describes and benchmarks the successes already achieved and health challenges we faced when Choosing Health was published in 2004. It demonstrates both the scale of the problem we confront in tackling preventable ill health, and the unacceptable geographical variation in health and the inequalities this brings.

This report is one of a series of public health information resources that have been produced as part of the *Informing Healthier Choices*[415] strategy. Specifically, the *Health Profile of England* offers at national level a complementary set of information to that provided by Local Health Profiles produced by the Association of Public Health Observatories earlier this year. In combination, they enhance the information available to all who contribute to health improvement at local as well as national level.

As is so often the case with health information at population level, the time taken to gather, validate and analyse data from many different sources means that the report does not fully reflect recent progress and current activities, for example, the tremendous work being done by schools and local authorities working closely with their health and other partners on a wide range of activities to improve the health of their local communities and reduce health inequalities, with Local Area Agreements placing health at the centre of community planning. That does not diminish the value of the *Health Profile* as a reference resource for strategic planning. One of the goals of *Informing Healthier Choices*[415] is to develop real time public health data. We are making progress, but for the present, the analysis set out in this report provides a more complete and useful picture than we have previously had.

The overall picture presented by the *Health Profile* reveals much that is positive, for example:

- Life expectancy continues to rise and is now at its highest ever level
- Substantial recent falls have occurred in mortality from our major targeted killers – circulatory diseases and cancer. Recently released data for 2005 show continuing success in this area
- Infant mortality is now at its lowest ever level

However, the report shows that many challenges remain, for example

- Increasing rates of obesity in children
- Rising rates of diabetes
- High rates of teenage pregnancies
- Persistence of longstanding health inequalities

Each of these areas is the focus of substantial Government activity. Success will require action across many different fronts, both nationally and locally.

The *Health Profile of England* includes indicators that cover a broad range of determinants. Just as we must address the more immediate determinants of health and health inequalities such as smoking, sexually transmitted infections, alcohol consumption and poor diet, so must we address the more fundamental determinants such as poverty, education and housing. The report highlights substantial progress in these "wider determinants" of health.

Although efforts to address health inequalities will often take time to achieve their full impact, significant progress is possible in the short-term. For example almost one in five of Spearhead areas – the disadvantaged areas on which activity is particularly focused – are on-track to deliver their share of the life expectancy inequalities target, with a further two in five on-track for either the male or female element. These early signs of success need to be built upon in order to reverse the widening national trend.

The *Health Profile of England* provides an invaluable resource for commissioners. It will serve as a benchmark on which we can judge progress in years to come. The challenge we now face is to make this sort of information available to individuals, voluntary organisations and business at community level in ways that empower them to take more ownership of strategies and action for better health.

Caroline Flint MP
Minister of State for Public Health

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[Throughout the Health Profile of England superscript numbers signpost links to selected key websites listed in Appendix 4.]

What the *Health Profile of England* shows – the general picture

A more detailed assessment of health trends is presented in individual sections. However, in summary, the profile illustrates:

A general improvement in health outcomes

- The report shows recent improvements in a number of critical areas, eg:
  - declining mortality rates in targeted killers (cancers, all circulatory diseases and suicides)
  - increasing life expectancy, now at its highest ever level
  - reducing infant mortality, now at its lowest ever level.

However, in some areas **particular challenges remain** to achieve and sustain progress, eg:

  - rising rates of diabetes.

Similarly for the **determinants of health**:

- although we are **making improvements in some important areas**, eg:
  - occurrence of smoking
  - quality of housing stock
  - child poverty
- there are a **number of areas of concern**, eg:
  - increasing levels of obesity in adults and children
  - high levels of teenage pregnancy.

And even where we are seeing improvements, **health inequalities are often present**.

The report illustrates various inequalities by:

  - geography – within England, across the UK, across Europe
  - gender
  - ethnicity
  - socio-economic group
  - age.

- In **some cases, these are improving over time**, eg:
  - reducing absolute gap between disadvantaged areas and the national average for cancer and circulatory disease mortality rates.
- But **in others, gaps are static or widening**, eg:
  - inequality in infant mortality between routine and manual workers and the national average
  - inequality in life expectancy at birth between disadvantaged areas and the national average
  - socio-economic inequality in childhood obesity.

Further information on health inequalities can be found in: *Tackling Health Inequalities: Status report on the Programme for Action*.[424]

Introduction

Explains the aims and structure of the document

The *Health Profile of England* provides a collection of national and regional data to be used as a yardstick against which local areas can compare their own health profile data. Local health profiles[301] are available from www.communityhealthprofiles.info. The indicators used in the *Health Profile of England* focus particularly – but not exclusively – on the six priority areas identified in *Choosing Health: Making healthy choices easier*[405]:


Tackling health inequalities


Reducing the number of people who smoke and protecting people from secondhand smoke


Reducing obesity and improving diet and nutrition


Improving sexual health


Improving mental health and well-being


Reducing harm and encouraging sensible drinking

The *Health Profile of England* is intended to be of use to public service professionals and officials within the local community – such as local councillors and primary care trust (PCT) directors of public health – who are in a position to exert influence over the planning, commissioning, procurement and delivery of programmes that will support health improvement. But the document will also be of interest to a much wider audience – anyone with an interest in the profile of health and health determinants in England.

The context for the document

The *Health Profile of England* fits in with a number of initiatives and activities, which are at the heart of efforts to improve people's health. Some of the key elements are summarised below. For all of these, information in the health profile is vital to:

- describe and quantify the burden of disease and the factors that determine it
- aid the commissioning process by identifying areas for action
- identify which health outcomes and determinants will be associated with greatest impact on health, and social, gains
- identify, in association with research and development, key interventions and quantify their potential impacts

- support health economic analyses, regarding cost effectiveness etc.
- monitor progress
- model outcomes.

(1) *Choosing Health: Making healthy choices easier*[405]

This document set out priority areas requiring particular attention and identified, among other issues:

- actions needed to improve health
- the need to develop information and intelligence about people's health
- the need to build on the messages made in earlier reports by Sir Derek Wanless regarding improved use of information on the population and its health status:
  - *Securing Our Future Health: Taking a Long-Term View – an independent review by Derek Wanless* (2002)[421]
  - *Securing good health for the whole population: Final report* – February 2004[420]

Choosing Health[405] specified the development of a standard set of local health information – now published as local health profiles[301] – and made a commitment to publish a national report in 2006.

(2) Public Service Agreements (PSA)[305]

A number of PSA targets are specifically associated with the achievement of health improvement. These include targets relating to:

- overall life expectancy
- circulatory disease and cancer mortality
- suicide
- health inequalities
  - life expectancy
  - infant mortality
  - inequalities in circulatory disease and cancer mortality
- adult smoking
- obesity (shared with Department for Education and Skills (DfES) and Department for Culture, Media and Sport (DCMS))
- teenage conceptions (shared with DfES)
- drug misuse.

(3) The developing agenda to reform and develop the services that impact on and support health improvement

For example, this agenda in relation to:

(a) *Health Reform in England: update and next steps*[412] with its strong drive for better information for the public about health and health services and its identification of the need for 'high-quality

information that is accessible and can be tailored to individual needs ... (and) ensure that choice is meaningful'.

(b) Commissioning

- information is needed to underpin the appropriate commissioning of services. This document will help to inform commissioners of the priority areas that need addressing.
- benchmarking with other regional and national data should help inform the commissioning process.

(c) *Our health, our care, our say: a new direction for community services*[416]

This White Paper sets a new direction for the whole health and social care system. It stresses the role of information – 'To make sure change happens, we need high-quality information to help people choose and access services'.

Related documents and products

The *Health Profile of England* should not be looked at in isolation. A component of *Informing healthier choices: Information and intelligence for healthy populations*,[415] it is part of a wider family of products, which taken together will facilitate access to key information about health and health determinants nationally and locally.

The family of health profile products comprises – the *Health Profile of England*, 386 local health profiles (of local authority areas)[301] and an associated website and web-based tool. The local health profile reports have been produced by the Association of Public Health Observatories[101], and there has been close liaison in the development of the local and national profiles.

There is also a broader family of reports and indicator sets that together form a valuable resource for assessing trends in the health of the nation. These include annual reports such as the *Chief Medical Officer's Annual Report on the state of the public health*[404], the *Department of Health Departmental Report*[408] and an array of reports produced by organisations such as the Office for National Statistics (ONS)[106], the Healthcare Commission[103], the Association of Public Health Observatories (APHO)[101] and individual public health observatories, and the Information Centre for Health and Social Care.[105]

In addition to these reports, much information on population health is now readily available via websites and publications of organisations such as those listed. There are also a number of sites that present information on health and its determinants as part of comprehensive databases and indicator sets.

Links to some of these reports and websites are signposted in Appendix 4.

The rationale for inclusion of particular indicators

The detailed rationale for the inclusion of particular indicators is presented in Appendices 2 and 3. The diversity of the indicators selected is a reflection of the many and varied factors that impact on health.

The coverage of the indicators in various parts of this document is not intended to be comprehensive but to illustrate the broad range of factors determining health outcomes, for example:

- 'wider determinants' – eg: occupation, education, income, housing etc.
- lifestyle factors – eg: smoking, diet, alcohol, drug misuse etc.
- preventative health care – eg: screening, immunisation
- health care utilisation – eg: use of sexual health services such as genito-urinary medicine clinics.

Timeliness of data

Data have been incorporated into the *Health Profile of England* until 31 July 2006.

The layout of the document

In order to provide an informative description of the health profile of the country, it is important to look at a number of different aspects of the selected indicators. Across the document will be found selected analyses relating to differences:

- over time – short term, medium term and long term
- between places – between different regions, sub-regional and also international
- according to personal characteristics – such as age, gender, socio-economic status, ethnicity etc.

In understanding trends, it is important to recognise that some changes can be expected to occur rapidly, for example the impact of treatment on survival from conditions such as heart attacks, but that often health improvements take longer before they become apparent. A review of trends needs to focus not only on health outcomes, but also on processes, risk-factor changes and intermediate (early) outcomes. This enables us to develop an earlier indication of progress (or problems) and see a much fuller picture. In the *Health Profile of England*, the indicators cover this spectrum of measures.

The approach taken has been to:

- provide information across each of the domains of health and its determinants, using the framework established for the local health profiles[301]
- assess a broad range of trends, highlighting important inequalities, including those by socio-economic groupings and by ethnicity.

In terms of the structure of the document, there are four main sections, each intended to fulfil a different function.

SECTION 1:

The national perspective on the indicators presented in the local health profiles[301]. Tables of regional variation are included. Where related data are accessible at national level, the national time trends have also been presented.

SECTION 2:

The six *Choosing Health*[405] priority areas are included, with a focus on metrics relevant to delivery.

SECTION 3:

A chartbook in which different aspects of each indicator are highlighted. The charts present a wide-ranging assessment, looking variously at international comparisons, inequalities by ethnicity, social position, age, gender and location, and some of the links between them.

SECTION 4:

A snapshot summary of health and well-being in England, a high-level summary tabulation of social and demographic indicators (with a major focus on health).

In addition to the four main sections, there are:

- web links and source notes, signposted throughout the document
- a list of additional links and sources in Appendix 4 to facilitate access to key data sources
- further appendices that present definitions and rationales for the indicators used.

To enhance the role of the *Health Profile of England* as a signpost to a range of information and data sets, rather than a traditional bibliography of sources, the numerical signposts throughout the document refer to Appendix 4. This contains a list of selected key web links to further information – source publications, data and indicator sets and organisations. Each web link is preceded by a brief description of the nature of signposted information.

There is also a technical document, available from the *Choosing Health* area of the DH website at www.dh.gov.uk/choosinghealth, to provide expanded metadata and explanations underpinning the information presented in this profile.

Linkages

It is important to look at various factors in combination rather than in isolation. Appendix 1 includes a tabulation (Table 5.1) that identifies some of the linkages between different charts, for example, the links between nutrition and physical activity as determinants of obesity, and between teenage conceptions and the associated higher risks of infant mortality.

Generally, it needs to be understood that there are multiple linkages between different indicators and so changing trends in one indicator may be caused by, or have implications for, other indicators.

Conclusion

This document is not a comprehensive review of health and its determinants. It is focused on a limited set of indicators that, taken together, provide a good indication of progress and challenges in critical areas.

Monitoring these trends identifies progress in important areas, for example cancer and circulatory disease mortality. There is an underlying trend towards improving life expectancy, and there is good evidence of progress in a number of key areas. However, in a number of areas, opportunities still exist to achieve or consolidate progress.

SECTION 1

Local Health Profile Indicators – The National Perspective

This section uses the indicator set devised for the local health profiles (of local authority areas)[301] to present current regional data (aggregated from the *Health Profile* data) and a national time trend, using national sources. Table 1.1 shows the most recent **regional data**. These will be accessible through an interactive data tool on the website www.communityhealthprofiles.info.

The *Health Profile of England* offers opportunities to present additional data, both in respect of further regional data and national time-trend data. Table 1.2 presents regional data from national sources for some of the *Health Profile* 'GAP' indicators (i.e. those for which local-level data are not currently available). This table follows a similar layout to that used for the *Health Profile* regional data.

Table 1.3 illustrates national time trends. Where possible, trends have been provided for **existing** national indicators, for example those routinely used to monitor and report on PSA targets, so the national measure does not always match the local health profile indicator.

Key Points from regional breakdown and national time trend

- There is a consistent 'north/south' divide, with poorer health in the north of England in comparison with the south in almost all cases.
- The proportion of the population living within the most deprived fifth of areas in England is over seven times greater in the North East than in the South East.
- Older people in the North East, Yorkshire and the Humber, and London are more likely to receive help to live at home than older people in other areas.
- Although now slowly increasing, the proportion of people in England eating five portions of fruit and vegetables a day is low, ranging from just over a quarter of the population of London and the South East to around a fifth or less of the population in Yorkshire and the Humber and the North East.
- The proportion of obese children rose by over 40% between 1995 and 2004. In the decade ending 2004, the proportion of obese men rose by over 50%, whilst the proportion of obese women rose by 36%. In 2004, almost a quarter of the adult population was obese. There is not a strong and consistent pattern of obesity across the regions.
- There is a distinct 'north/south' divide for female life expectancy at birth. In all regions from the Midlands northwards, female life expectancy is significantly shorter than in the regions to the south. The difference is around one year of life. For men in the north, life expectancy at birth is around two years shorter than for men in the south.
- Mortality under 75 years from cancer and from all circulatory diseases has fallen for each year since the Our Healthier Nation strategy mortality target baselines were set in the mid-1990s.
- Road deaths and serious injuries, calculated in relation to estimated traffic flow, fell by 40% in the decade to 2005.
- The proportion of people who consider themselves to be in 'poor health' has increased since the mid-1990s. The proportion of men in the North East who assess their health as 'not good' is approaching double that in the South East.
- Five year olds in the West Midlands and in the South East have, on average, one decayed, missing or filled tooth. In the North West and in Yorkshire and the Humber they have, on average, over two.

Table 1.1 – Health Profile of England (National Profile of Health and Well-being)

Summary of Indicators – Regions (using local health profile data)

	Indicator	Period	Unit[1]	England	North East	North West	Yorkshire and the Humber	East Midlands	West Midlands	East of England	London	South East	South West
	Our communities												
1	Deprivation	2001	%	20.0	37.8	32.9	29.6	17.4	26.5	6.2	26.5	5.1	8.5
2	Air quality	2001	combined	0.22	0.16	0.21	0.22	0.25	0.23	0.24	0.37	0.25	0.18
3	Poor quality housing	2005	%	41.57	nd	nd	nd	nd	nd	nd	nd	nd	nd
4	Children in poverty	2001	%	21.3	27.8	25.3	23.0	19.0	22.9	15.6	29.9	14.2	16.1
5	GCSE achievement (five A*–C)	2004/05	%	54.7	53.5	53.8	51.2	52.5	54.2	56.6	55.2	57.5	56.0
6	Violent crime	2004/05	cr per 1,000	19.6	16.3	21.1	20.3	18.6	19.4	16.2	27.2	16.4	17.1
7	Older people supported at home	2005	cr per 1,000	80.2	103.2	87.7	96.2	75.8	81.3	79.0	93.3	60.9	65.9
	Giving children and young people a healthy start												
8	Smoking in pregnancy [GAP]												
9	Breastfeeding[GAP]												
10	Obese children[GAP]												
11	Physically active children [GAP]												
12	Teenage pregnancy (under 18)	2001–03	cr per 1,000	42.4	50.5	45.1	46.9	40.6	47.1	34.0	51.1	34.1	35.5
	The way we live												
13	People who smoke	2000–02	%	26.0	30.3	27.4	28.0	26.6	24.6	24.7	26.0	23.7	25.0
14	Binge drinking	2000–02	%	18.2	25.1	23.0	21.5	17.8	15.9	16.7	15.4	15.5	15.8
15	Healthy eating (five a day)	2001–02	%	23.8	16.8	22.2	20.4	22.6	22.8	23.9	27.6	28.9	23.3
16	Physically active adults [GAP]												
17	Obese adults	2000–02	%	21.8	23.9	21.6	22.6	25.1	24.2	20.9	20.3	20.4	19.2
	How long we live, and what we die of												
18_f	Life expectancy at birth – females	2002–04	years	80.9	79.6	79.7	80.4	80.7	80.6	81.6	81.1	81.8	82.0
18_m	Life expectancy at birth – males	2002–04	years	76.6	75.0	75.1	75.8	76.5	75.9	77.6	76.5	77.7	77.8
19_f	Deaths from smoking – females	2002–04	easr	78.8	108.6	98.6	89.4	76.7	76.4	66.1	78.1	67.8	65.3
19_m	Deaths from smoking – males	2002–04	easr	176.0	217.3	206.9	193.8	174.0	181.5	156.7	180.6	155.8	151.5
20	Early deaths – circulatory disease	2002–04	easr	96.7	116.9	115.7	102.0	99.2	103.1	82.4	103.3	81.4	80.0
21	Early deaths – cancer	2002–04	easr	121.6	140.0	134.7	128.9	119.7	123.0	113.0	120.1	113.5	112.6
22	Infant deaths (under one year)	2002–04	cr per 1,000	5.2	4.8	5.6	5.9	5.5	6.9	4.4	5.4	4.2	4.4
23	Road injuries and deaths	2003–04	per mVkm	7.3	6.1	7.3	8.6	7.6	6.1	7.2	14.3	5.7	5.9
	Health and ill health in communities												
24_f	Feeling 'in poor health' – female	2001	%	7.9	10.2	9.6	9.0	7.9	8.6	6.6	8.4	6.1	6.8
24_m	Feeling 'in poor health' – male	2001	%	7.7	10.5	9.5	8.8	7.6	8.2	6.2	7.9	5.7	6.7

	Indicator	Period	Unit[1]	England	North East	North West	Yorkshire and the Humber	East Midlands	West Midlands	East of England	London	South East	South West
	Health and ill health in communities – *continued*												
25	Mental health treatment	2005	%	0.55	0.51	0.61	0.51	0.52	0.51	0.51	0.63	0.54	0.53
26	Alcohol related hospital stays	1998–03	easr	165	238	264	174	151	154	111	154	124	156
27	Drug misuse treatment	2004/05	cr per 100,000	718	888	1155	910	680	708	518	612	385	809
28	People with diabetes	2005	%	3.3	3.5	3.5	3.4	3.5	3.6	3.2	3.3	3.0	3.2
29	Children's tooth decay (five year olds)	2003/04	mean number	1.49	1.71	2.17	2.05	1.29	1.02	1.18	1.57	1.04	1.50
30	Sexually transmitted infections (gonorrhoea) [GAP]												

Key:

GREEN = significantly higher 'performance' than national average or target rate

AMBER = 'performance' indistinguishable from, or consistent with, national average or target rate

RED = significantly lower 'performance' than national average or target rate

NO SHADE = significance not calculated

nd = no regional aggregation due to incomplete local data

[1] See appendices for fuller description of indicators. See column 'LHP Definition' in Table 5.1 for definition of target unit

combined = based on the average of four indices (Nitrogen Dioxide, Particulates, Sulphur Dioxide, Benzene)

cr = crude rate of reference population (varies by indicator)

mVkm = 100 million vehicle kilometres

easr = European age-standardised rate

Refer to Table 5.1 in Appendix 1 for expanded indicator definitions. The rationale for the selection of these indicators is tabulated in Appendix 2. 'GAP' indicators are those for which robust data cannot yet be obtained at the level of disaggregation required for the local health profiles[301]. In the case of indicator 30 – Sexually transmitted infections (gonorrhoea), disaggregated data are available, but not at local authority level.

Additional regional data and national time trends

The aim of the local health profiles is to focus on the health indicators most relevant to the assessment of health and its determinants at local level. For the *Health Profile of England*, aggregation of local data to regional and national level has been possible in some cases, and all relevant data are presented.

For some indicators, data at the requisite local level were unavailable – in these cases the health profile indicators have been identified as 'GAP' indicators. Table 1.2 shows the **regional** perspective for these 'GAP' indicators, using, where available, data from **national** sources.

Table 1.2 – Health Profile of England (National Profile of Health and Well-being)

Summary of Indicators – Regions (national source)

	Indicator	Period	Unit	England	North East	North West	Yorkshire and the Humber	East Midlands	West Midlands	East of England	London	South East	South West
	Giving children and young people a healthy start												
8	Smoking in pregnancy [GAP]												
9	Breastfeeding [GAP]												
10	Obesity in children [(1)]	2001–02	%	13.7	18.3	15.0	11.4	14.5	15.8	14.1	18.2	13.4	14.0
11	Physically active children [(2)]	2004–05	%	69	70	68	67	70	70	73	68	69	74
	The way we live												
16_f	Physically active females [(3)]	2004	%	25	20	25	31	23	22	23	23	27	27
16_m	Physically active males [(3)]	2004	%	37	40	36	42	41	34	37	33	38	41
	Health and ill health in communities												
30	Sexually transmitted infections (gonorrhoea) [(4)]	2004	rate*	41.8	23.4	37.7	44.6	30.8	42.1	22.2	103.7	23.6	22.0

* rate of new episodes per 100,000 population

[1] *Health Survey for England: Obesity in Children under 11*
www.dh.gov.uk/PublicationsAndStatistics/PublishedSurvey/HealthSurveyForEngland/HealthSurveyResults/fs/en

[2] DfES, *An evaluation of the school sport partnership programme 2005*

[3] H*ealth Survey for England 2004*. Unpublished special analysis – data are weighted to account for non-response. Note that for consistency with historic data, unweighted data are quoted in the Table 1.3 trend

[4] Health Protection Agency, STI Data Resource, Diagnoses and Rates of Selected STIs Seen at GUM Clinics, United Kingdom: 2000–2004. National, regional and strategic health authority summary tables.
www.hpa.org.uk/infections/topics_az/hiv_and_sti/epidemiology/datatables2004.htm

Trend data over time are presented in Table 1.3, for each of the health profile indicator areas. In several cases, indicators different from those presented in the local health profiles[301] have been used to ensure consistency with routine national reporting (for example, with regard to national PSA targets). The rationale for the selection of indicators of the national trend is tabulated in Appendix 3.

Table 1.3 – Health Profile of England (National Profile of Health and Well-being)

Summary of Indicators – (national trend)

	Indicator	Period	Unit	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
	Our communities													
1	Deprivation (employment) (a)	Cal	%	71.8	72.4	73.5	73.9	74.6	75.2	75.2	75.2	75.0	75.0	75.0
2a	Air quality – PM10 (urban background)	Cal	µg/m³	31	32	30	26	24	23	23	23	26	22	23
2b	Air quality – PM10 (Roadside)	Cal	µg/m³				33	32	32	32	31	35	31	32
2c	Air quality – ozone (Urban background)	Cal	µg/m³	51	48	46	49	56	52	52	53	60	56	56
2d	Air quality – ozone (Rural)	Cal	µg/m³	72	68	68	68	73	68	68	68	75	73	70
3a	Poor quality housing – social sector (b)	Cal	%		52.6					38.9		35.3	31.3	
3b	Poor quality housing – vulnerable private sector (b)	Cal	%		57.1					42.7		37.2	34.5	
4a	Children in poverty – before housing costs	Fin	%	21	24	24	24	23	20	20	20	20	19	
4b	Children in poverty – after housing costs	Fin	%	31	33	32	33	32	30	29	28	28	28	
5	GCSE achievement (five A*-C) (c) (j)	AY	%	43.5	44.5	45.1	46.3	47.9	49.2	50.0	51.6	52.9	53.7	56.3
6a	Violent crime (BCS)	Fin*	EW pta	1,046		897		832		669	665	640	565	561
6b	Overall crime (BCS)	Fin*	EW n000	19,351		16,712		15,015		12,618	12,341	11,725	10,850	10,912
7a	Older people supported at home – any service	Fin	p1, 65+										80	
7b	Older people supported at home – intensive home care (d)	Fin	%				22.8	24.8	26.1	27.2	28.6	30.1	32.0	
	Giving children and young people a healthy start													
8	Smoking in pregnancy	Cal	%	23					19					17
9	Breastfeeding (at six weeks)	Cal	EW %	44					43					
10	Obese children (e) (i)	Cal	%	9.9	10.6	10.9	11.6	13.4		13.1	15.5	13.7	14.3	
11	Physically active children (PE and school sport) (f)	AY	%										62	69
12	Teenage pregnancy (under 18) (j)	Cal	p1, f15	41.6	45.9	45.5	46.6	44.8	43.6	42.5	42.6	42.1	41.5	
	The way we live													
13	People who smoke – adults	Cal	%				28		27	27	26	25	25	
14af	Drinking – adult females	Cal	%				21		22	22	22	22	22	
14am	Drinking – adult males	Cal	%				39		38	39	37	40	39	
14bf	Binge drinking – adult females	Cal	%				8		9	10	10	9	10	
14bm	Binge drinking – adult males	Cal	%				22		21	22	21	23	22	
15f	Healthy eating – adult females (i)	Cal	%							25	25	26	27	
15m	Healthy eating – adult males (i)	Cal	%							22	22	23	24	
16f	Physically active adults – females (i)	Cal	%			21	21					24	24	
16m	Physically active adults – males (i)	Cal	%			32	34					35	35	
17f	Obese adults – females (i)	Cal	%	17.5	18.4	19.7	21.2	21.1	21.4	23.5	22.8	23.4	23.8	
17m	Obese adults – males (i)	Cal	%	15.3	16.4	17.0	17.3	18.7	21.0	21.0	22.1	22.9	23.6	

Table 1.3 – Health Profile of England (National Profile of Health and Well-being) (continued)

Summary of Indicators – (national trend)

	Indicator	Period	Unit	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
	How long we live, and what we die of													
18f	Life expectancy – females (g)	Cal 3	yr	79.5	79.6	79.8	79.9	80.1	80.4	80.6	80.7	80.9		
18m	Life expectancy – males (g)	Cal 3	yr	74.3	74.5	74.8	75.0	75.3	75.7	76.0	76.2	76.6		
19f	Deaths from smoking – females	Cal 3**	sr						83.0	80.0	80.1	78.3		
19m	Deaths from smoking – males	Cal 3**	sr						194.3	182.8	180.6	174.2		
20	Early deaths – circulatory disease	Cal 3	sr	146.9	141.3	135.4	128.5	121.8	114.5	108.2	102.8	96.7		
21	Early deaths – cancer	Cal 3	sr	144.3	141.2	138.5	134.9	132.0	128.8	126.5	124.0	121.6		
22	Infant deaths (under one year) (j)	Cal	p1,lb	6.1	6.0	5.9	5.6	5.7	5.6	5.4	5.2	5.3	5.0	5.0
23	Road injuries and deaths	Cal	pmVkm	11.3	10.9	10.4	9.7	9.1	8.9	8.6	8.2	7.7	6.9	6.5
	Health and ill health in communities													
24f	Feeling in 'poor health' – females (i)	Cal	%	5	5	7	7	7	6	7	7	6	8	
24m	Feeling in 'poor health' – males (i)	Cal	%	5	6	6	7	7	7	7	8	7	7	
25	Mental health treatment (Suicide rates)	Cal 3	sr	9.23	9.16	9.32	9.57	9.66	9.30	8.90	8.65	8.56		
26	Alcohol related hospital stays (k)	Fin 5	sr									164.7		
27a	Drug misuse treatment – numbers in treatment (j)	Fin	n				85,000					125,545	160,450	179,600
27b	Drug misuse treatment – retained in treatment (j)	Fin	%									52	53	56
28f	People with diabetes – females (i)	Cal	%				2.5					3.6		
28m	People with diabetes – males (i)	Cal	%				3.3					4.8		
29	Children's tooth decay	AY	pc		1.63		1.47		1.43		1.47		1.49	
30a	Sexually transmitted infections – gonorrhoea (j)	Cal	p100	20.6	24.5	25.5	25.7	31.7	41.6	45.3	49.1	47.1	41.5	36.7
30b	Sexually transmitted infections – chlamydia (h) (j)	Cal	p100	60.4	66.9	79.8	89.9	103.9	124.7	137.9	157.3	171.3	185.6	192.1

Key:

Period: Cal = Calendar year; Cal 3 = Calendar year - three-year average; Fin = Financial year; Fin 5 = Financial year - five-year average; AY = Academic year (eg 2003/04 AY shown at 2004)

*Financial year from 2001/02, Calendar year previously; ** 1999–2001 and 2000–2002, average = 2 years over 3 (ICD10 data not available for 2000)

Unit: % = per cent; µg/m^3 = micro grms / cubic metre; pta = per 10,000 adults; n000 = number in thousands; sr = age standardised rate (to European standard population) per 100,000 population

p1, 65+ = per 1,000 people aged 65 and over; p1, f15 = per 1,000 females aged 15 to 17; p1, lb = per 1,000 live births; pmVkm = per 100 million vehicle kilometres; n = number; pc = per child; p100 = per 100,000 population; EW = Data are for England and Wales

Notes overleaf

Notes for Table 1.3

(a) Figures at Quarter 2 (Apr–Jun) each year, seasonally adjusted.
(b) Social sector: % of social sector homes that are non-decent; Vulnerable private sector: % of vulnerable private sector households living in non-decent homes.
(c) From 1996/97 includes GCSEs and GNVQs, from 2003/04 includes GCSEs and other equivalent qualifications approved for use pre-16.
(d) Data from 2002/03 have been adjusted to exclude clients formerly in receipt of preserved rights.
(e) Data shown for 1999 are 2-year average for 1999-2000.
(f) Based on a survey of schools in school sport partnerships. The number of schools covered by school sport partnerships (and hence the survey) increased between 2003/04 and 2004/05. For schools included in both surveys, PE and school sport participation increased from 62% to 71%.
(g) National life expectancy figures produced by the Government Actuary's Department (GAD).
(h) Trend should be interpreted with caution as may be due to improved testing.
(i) Unweighted data (for non-response) from the Health Survey for England. (Weighting for non-response was introduced in the Health Survey for England in 2003. Unweighted data are shown for all years for consistency).
(j) Latest data are provisional.
(k) Directly standardised rate of persons per 100,000 population, admitted to hospital with conditions directly related to the consumption of alcohol, pooled for the 5 years 1998/99 to 2002/03.

SECTION 2

Choosing Health: Making Healthy Choices Easier – Priority Areas

The *Choosing Health* delivery plan (March 2005)[407] defined the steps that will be taken by the Department of Health (DH), the NHS and across government to implement *Choosing Health*[405]. It outlined clearly the priorities for delivery at national, regional and local levels and what will be done by whom and when. It brought into one place all of the actions on the *Choosing Health*[405] commitments, alongside related *Public Service Agreements*[305] and local targets to improve health.

Choosing Health: Making healthy choices easier (November 2004)[405] and the associated delivery plan[407] identified six specific public health priorities for action. These areas and some of the reasons for their selection are set out below.

Public health priority areas for action identified in the *Choosing Health* delivery plan[407] are:

Tackling health inequalities

because there are large socio-demographic and geographical differences in health experience and expectations. Despite overall improvements, there remain big – and, in some communities, increasing – differences in health between those at the extremes of the social scale.

Reducing the number of people who smoke

because it leads to heart disease, strokes, cancer and many other fatal diseases; because many people felt this was an area in which they needed more support in addressing the problem; because many people were concerned about the effects of secondhand smoke; and because many parents were concerned about their children taking up smoking.

Reducing obesity and improving diet and nutrition

because the rapid increase in child and adult obesity over the past decade is storing up very serious health problems for the future if it is not addressed effectively now. Effective action on diet and exercise now will help to tackle future heart disease, cancer, diabetes, stroke, high blood pressure, high cholesterol and a range of factors critical to our health.

Improving sexual health

because risk-taking sexual behaviour is increasing across the population; because diagnoses of HIV, chlamydia, genital warts and syphilis have increased in recent years; because sexually transmitted infections can lead to cancer, infertility and death; and because delay in diagnoses and treatment can lead to more people being infected.

Improving mental health and well-being

because mental well-being is crucial to good physical health and making healthy choices; because stress is the commonest reported cause of sickness absence and a major cause of incapacity; and because mental ill-health can lead to suicide.

Reducing harm and encouraging sensible drinking

because alcohol misuse is associated with deaths from stroke, cancer, liver disease, injury and suicide; because it places a burden on the NHS, particularly on accident and emergency departments; and because it is related to absenteeism, domestic violence and violent crime.

This section presents brief reports of progress in these six priority areas. The major focus of these reports is on the metrics that identify progress in these areas. Data and some charts are presented to illustrate progress. Additional aspects of progress are illustrated in the chartbook section. The *Choosing Health Progress Report* (May 2006)[406] detailed progress in relation to the various commitments set out in the *Choosing Health* delivery plan.[407]

Tackling health inequalities

Target

By 2010, to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

The PSA target is underpinned by two more detailed objectives:

- Starting with children under one year, by 2010 to reduce by at least 10% the gap in infant mortality between routine and manual groups and the population as a whole.
- Starting with local authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

Key Points

Progress towards targets

INFANT MORTALITY

- Infant mortality rates have declined in the routine and manual group since the baseline period; however, the rate of decline has been faster in other groups. As a result, the trend shows a widening in the relative gap (ie percentage difference) between infant mortality in the routine and manual group and the total population between the target baseline 1997–99 and the latest period 2002–04. (See Fig 2.1 on page 18)
- In 1997–99, the rate for the 'routine and manual' socio-economic group was 13% higher than the rate for the total population. This difference increased to 19% in 2001–03 and has remained the same in 2002–04.

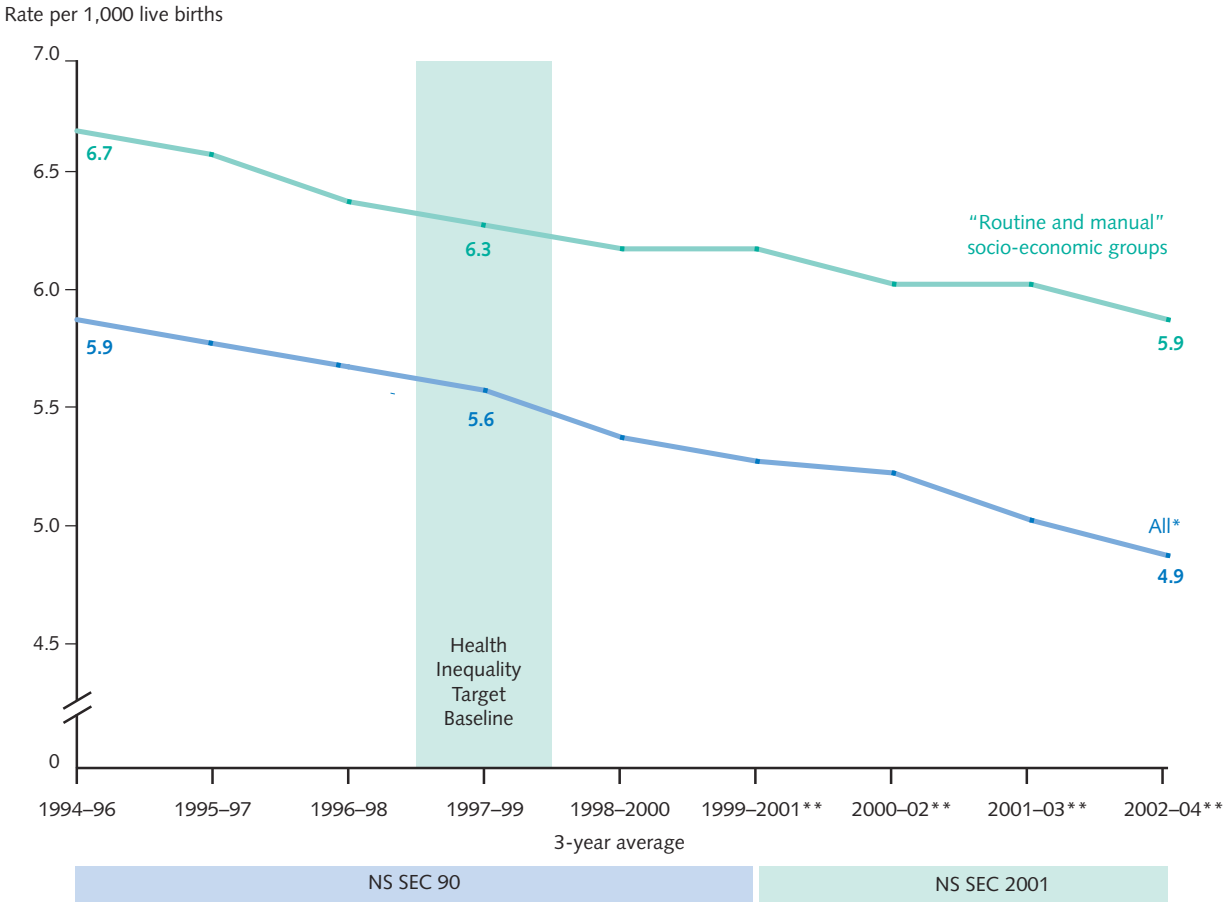
LIFE EXPECTANCY

- Latest data for 2002–04 indicate that the relative gap in life expectancy between England and the Spearhead Group of the fifth of areas with the worst health and deprivation indicators is wider than at the baseline (1995–97) for both males and females. For males the relative gap is 1% wider than at the baseline, for females 8% wider. (See Fig 2.2 on page 19)

The Health Inequality PSA targets are fully described on the DH website at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/HealthInequalitiesGeneralInformation/HealthInequalitiesGeneralArticle/fs/en?CONTENT_ID=4131685&chk=z4zsTt

INFANT MORTALITY

Fig 2.1 Infant mortality in England and Wales by socio-economic group



*All ' relate to inside marriage and joint registrations outside marriage, not including 'social class not specified' for 1995 and 1999. Sole registration and unlinked births are excluded
**using NS SEC for 2001 and later years' data
Information on the father's occupation is not collected for births outside marriage if the father does not attend the registration of the baby's birth
Figures for live births are a 10% sample coded for father's occupation

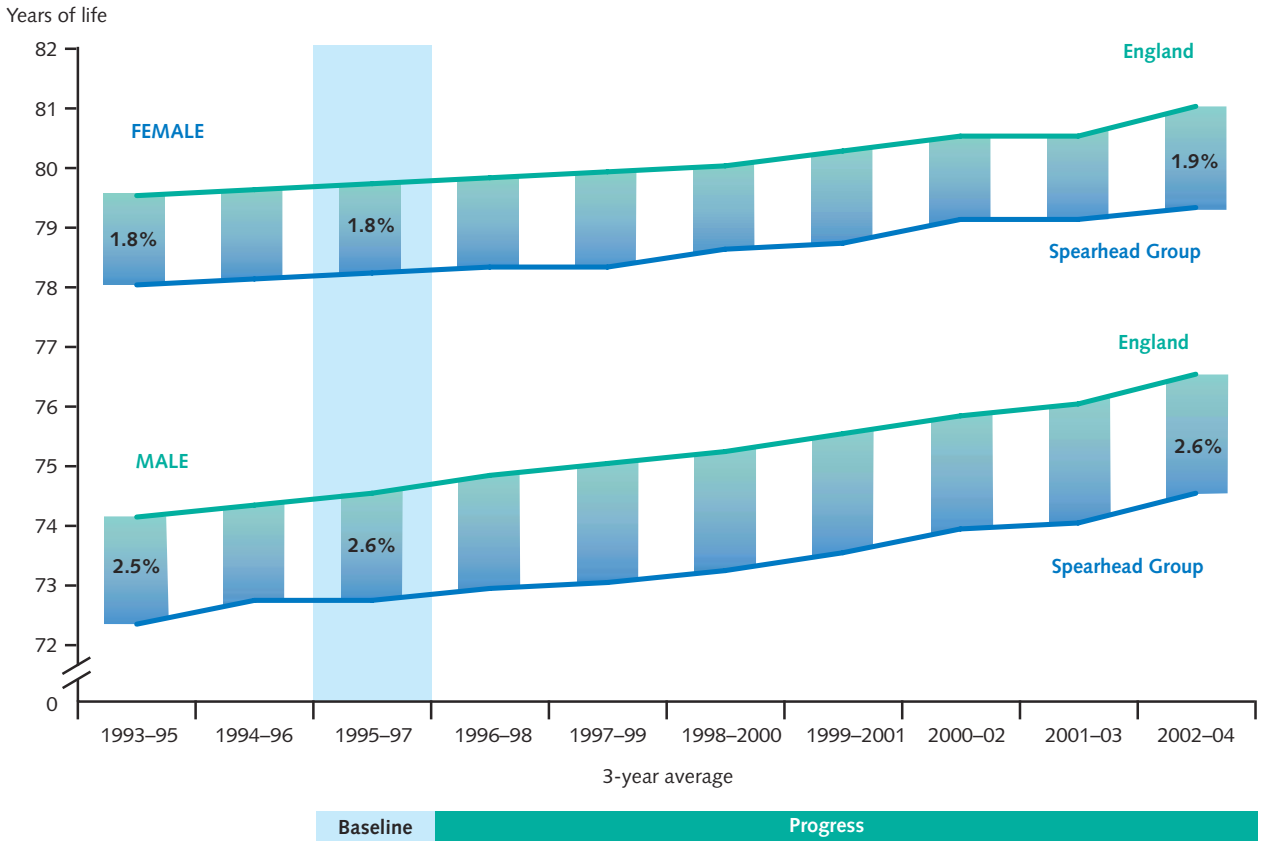
Source: Office for National Statistics

- The target is a 10% reduction in the relative gap in infant mortality rates between 'routine and manual' socio-economic groups and the population as a whole (i.e. infant deaths inside marriage and outside marriage registered by both parents) from the baseline year of 1998 (the average of 1997–99) to the target year 2010 (the average of 2009–11).

More information on progress towards the infant mortality target is available on the Department of Health website: www.dh.gov.uk/assetRoot/04/12/43/11/04124311.pdf

LIFE EXPECTANCY

Fig 2.2 The inequality gap in female and male life expectancy at birth in England



Inequality gap, in years
(The relative gap between life expectancy at birth in England and the Spearhead Group as a proportion of life expectancy for England (%))

Source: Office for National Statistics

The Spearhead Group is made up of 70 local authorities and 88 primary care trusts (prior to the reorganisation of October 2006) that map to them, based upon the local authority areas that are in the bottom fifth nationally for three or more of the following five indicators:

- Male life expectancy at birth
- Female life expectancy at birth
- Cancer mortality rate in under 75s
- Circulatory disease mortality rate in under 75s
- Index of Multiple Deprivation 2004 (Local Authority Summary), average score.

- The target is a 10% reduction in the relative gap (i.e. percentage difference) in life expectancy at birth between the fifth of local authority areas with the worst health and deprivation indicators (the Spearhead Group) and England as a whole.
- Life expectancy at birth has improved for England as a whole and for the Spearhead Group of local authority areas. Although life expectancy has improved more slowly in the Spearhead Group than for England as a whole, 19% of Spearhead Group areas are on track to deliver their share of the target with a further 41% on track for either the male or female element.
- Further data on a set of 12 headline indicators for health inequalities relevant to the PSA target are set out in *Tackling Health Inequalities: Status report on the Programme for Action* (August 2005).[424]

More information on progress towards the life expectancy target is available on the Department of Health[102] website: www.dh.gov.uk/assetRoot/04/12/43/10/04124310.pdf

And a more detailed review of progress in addressing health inequalities targets is available in the status report on health inequalities[424] www.dh.gov.uk/assetRoot/04/11/76/98/04117698.pdf

General points

- The main causes of deaths contributing to the gap in life expectancy between Spearhead Group areas and the country as a whole are:
  - Circulatory diseases account for the largest proportion of excess deaths in Spearhead Group areas. Most circulatory diseases deaths are attributable to coronary heart disease (CHD) (70% in males and 63% in females).
  - Cancers and respiratory diseases, particularly lung cancer and chronic obstructive airways disease respectively, then account for a major proportion of the remainder of deaths.
  - The remaining third are attributable to a range of causes including injury, digestive diseases, poisoning, infectious and parasitic diseases, and deaths under 28 days.
- A publication commissioned as part of the UK's EU presidency in the latter half of 2005 identified inequalities in mortality to be present in each of 21 countries reviewed (see box on page 21). The report is available on the Department of Health website: www.dh.gov.uk/assetRoot/04/12/15/84/04121584.pdf

Health Inequalities: Europe in profile

Prof. Johan P. Mackenbach

An independent, expert report on health inequalities in Europe was commissioned by, and published under the auspices of, the UK presidency of the EU (October 2005).

The primary aim of this independent paper was to review the evidence on the existence of socio-economic inequalities in health in the EU and its immediate neighbours. It presented data on inequalities in mortality in 21 countries, on inequalities in self-assessed health in 18 countries, and on inequalities in smoking in 23 countries.

The report makes clear that much progress has been achieved, but many challenges still remain. EU member states should be encouraged to take advantage of every opportunity to learn from each other about the value of different policy approaches to reducing health inequalities through the systematic sharing of evidence.

Rates of mortality were found to be consistently higher among those with a lower rather than higher socio-economic position. The size of these inequalities was often substantial, and had increased in many European countries over the past decades.

Inequalities in mortality from circulatory diseases accounted for almost half of the excess mortality in lower socio-economic groups in most countries. Inequalities in cancer mortality were often less clear, particularly among women.

Rates of morbidity were usually found to be higher among those with a lower educational, occupational or income level. No clear trends were found in these inequalities.

The report signposted various research that had shown that health inequalities were mainly caused by a higher exposure of lower socio-economic groups to a wide range of unfavourable material, psychosocial and behavioural risk factors. Smoking was likely to be an important contributor to health inequalities in many European countries because the prevalence of smoking tended to be higher in lower socio-economic groups, particularly among men. There were important differences between countries, however, in such inequalities.

Reducing the number of people who smoke and protecting people from secondhand smoke

Targets

The key target for smoking is that set out in the Public Service Agreements (PSA)[305] published in July 2004. The PSA includes the target:

to reduce adults' smoking rates to 21% or less by 2010, with a baseline year of 2002, with a reduction in prevalence among routine and manual groups to 26% or less.

There are two further smoking prevalence targets from the White Paper *Smoking Kills*[423]:

- To reduce smoking among children from 13% to 9% or less by the year 2010; with a fall to 11% by the year 2005.
- 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.

The Tobacco Programme supports the HM Revenue and Customs PSA target to reduce the illicit market share for cigarettes to no more than 13% by 2007/08.

Key Points

Progress towards targets

Overall smoking in England has decreased from:

- 28% of adults in 1998 to 25% in 2004 (see Chart 13a on page 54)
- 13% in 1998 to 9% in 2005 for children aged 11 to 15 years
- 33% in 2001 to 31% in 2004 among adults in routine and manual groups.

- In 2005, 17% of mothers smoked throughout pregnancy.
- Adult smoking rates in England are the lowest on record, and indicate that the Government is on track to meet the overall target of 21% smoking prevalence in 2010.
- However, routine and manual groups need special focus, as prevalence in these groups is not coming down as fast. In 2004, 25% of all adults smoked in England, rising to 31% for routine and manual groups, with only 18% smoking in the managerial and professional group (see Chart 13b on page 54).

- A higher proportion of girls aged 11 to 15 years smoke than boys. For 16 to 19 year olds, this difference is less pronounced and amongst 20 to 24 year olds in the most recent years, a greater proportion of men than women smoke. The proportion of people smoking in these age groups is generally lower in 2004 than at the start of the decade.

General points

- Smoking rates are highest now in adults in their 20s and early 30s.
- The Health Development Agency estimate that between 1998 and 2002 the number of smoking-attributable deaths in England was, on average, 86,500 for each year (see Chart 19a on page 57).
- Around 10 million adults in England smoke.
- Some 51% of people say their workplace is completely smokefree. This is skewed towards managerial and professional groups being more likely to work in smokefree environments than routine and manual groups. All workplaces will be smokefree by 2007.
- Both cigarettes and hand rolling tobacco (HRT) are liable for tobacco duty; however, in 2003–04, 16% of cigarettes were purchased illicitly, for example by smuggling the cigarettes into the country without paying such duty. Also, the estimated illicit market share of HRT was 55% in 2003-04.

Progress measures

Table 2.1 Prevalence of cigarette smoking by sex: 1982–2004

Persons aged 16 and over, England

	Unweighted							Weighted					
	1982	1986	1990	1992	1994	1996	1998*	1998*	2000	2001	2002	2003	2004
Percentage smoking cigarettes													
Men	37	34	31	29	28	28	28	29	29	28	27	27	26
Women	32	31	28	27	25	27	26	26	25	25	25	24	23
Total	35	32	29	28	26	28	27	28	27	27	26	25	25

*Trend table shows unweighted and weighted figures for 1998 to give an indication of the effect of the weighting.

Weighting has been applied since 1998 (1) to compensate for non-response, and (2) to enable the sample to be weighted up to match known population distributions.

Source: Office for National Statistics (ONS), General Household Survey 2004, Table 8.6.

(See Chart 13a on page 54)

Table 2.2 Prevalence of cigarette smoking by sex and socio-economic classification of the household reference person: England, 2001–04

Persons aged 16 and over, England

	Weighted			
Socio-economic classification of household reference person	2001	2002	2003	2004
Percentage smoking cigarettes				
All persons				
Managerial and professional	19	19	18	18
Intermediate	27	26	26	23
Routine and manual	33	31	32	31
Total[1]	27	26	25	25

[1]Where the household reference person was a full-time student, had an inadequately described occupation, had never worked or was long-term unemployed these are not shown as separate categories but are included in the total.

Source: Office for National Statistics (ONS), General Household Survey 2004, Table 8.9.

(See Chart 13b on page 54)

Table 2.3 Prevalence of cigarette smoking amongst children aged 11 to 15, by sex: 1982–2005

Children aged 11 to 15, England

	1982	1984	1988	1992	1996	1998	2000	2001	2002	2003	2004	2005
Percentage regularly smoking cigarettes												
Boys	11	13	7	9	11	9	9	8	8	7	7	7
Girls	11	13	9	10	15	12	12	11	11	11	10	10
All children	11	13	8	10	13	11	10	10	10	9	9	9

Source: The Information Centre for Health and Social Care, Drug use, smoking and drinking among young people in England in 2005.

Table 2.4 Prevalence of smoking before or during, and throughout pregnancy by mother's age: 2000 and 2005

England

Age	Percentage who smoked before or during pregnancy[1]		throughout pregnancy	
	2000	2005	2000	2005
20 or under	64	68	39	45
20 – 24	52	49	29	28
25 – 29	36	29	19	14
30 – 34	25	23	12	9
35 or over	23	20	12	9
All mothers[2]	35	32	19	17

[1]Smoked at some point in the 12 months before, or during, their pregnancy.

[2]Excludes mothers who did not supply sufficient information for classifying their smoking status, but includes some mothers for whom age was not recorded.

Source: The Information Centre for Health and Social Care, Infant Feeding Survey 2005, Early results, Table 9E.

(See Chart 8a on page 51)

Reducing obesity and improving diet and nutrition

Target

The PSA target on obesity is 'halting the year-on-year rise in obesity among children aged under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.' (shared with the Department for Education and Skills and the Department for Culture, Media and Sport).

Key Points

Progress towards target

The monitoring data presented in Tables 2.5 to 2.7, indicate:

- There are substantially higher levels of obesity in the most recent years compared with the mid-1990s.
- Among adults aged over 16 years, obesity levels have been consistently higher in females than in males. The rate of increase in obesity amongst men has been faster than for women, so the gender difference in the most recent years is markedly smaller than in the early 1990s.
- The trend of rising obesity among children highlights the challenge of achieving the childhood obesity target (see Figure 2.3 on page 27).

General points

- Two-thirds of men and approaching 60% of women are now either overweight or obese.
- If current trends continue, nearly a third of boys and girls aged under 11 will be obese or overweight by 2010.
- Several further metrics highlight progress in relation to addressing factors associated with obesity:
  - by 2010, each year an increase of one percentage point in the percentage of children meeting CMO recommendations on physical activity (60 minutes of physical activity every day).
    - In 2002, 55% of boys and 48% of girls aged 2 to 10 years of age achieved this level.

- by 2010, each year an increase of one percentage point in the percentage of adults meeting CMO recommendations on physical activity (30 minutes of moderate intensity physical activity on at least five days a week).
  - In 2004, 25% of women and 37% of men (using weighted data) met the CMO recommendations (see Chart 16a on page 55 – unweighted trend). The levels drop off with age.
- by 2008, increase the number of adults and young people aged 16 and above who engage in at least 30 minutes of moderate intensity level sport, at least three times a week, by 3% (DCMS PSA target).
  - The provisional baseline figure in 2006 is 19.1%.
- DCMS/DfES have a PSA target to enhance the take up of sporting opportunities by 5 to 16-year-olds. The downward trend in activity in schools is being reversed. Across 11,400 schools taking part in the 2004/05 school sport survey:[417]
  - 69% of pupils now spend at least two hours in a typical week on high-quality PE and school sport. (The figure in 2003/04 was 62%.)
- One of the aims of the Travelling to School initiative is to increase the proportion of children walking or cycling to school.
  - Between 1992–94 and 2004, the proportion of primary-aged children walking to school declined from 61 to 50%, with an increase from 30 to 41% in the proportion being driven to school.

Progress measures

The challenge of the childhood obesity target

In the tables below, to retain consistency over the time period covered, unweighted data are used throughout.

Table 2.5 Obesity prevalence among 2 to 10 year olds in England

	1995	1996	1997	1998	1999/2000	2001	2002	2003	2004
Obesity (%)	9.9	10.6	10.9	11.6	13.4	13.1	15.5	13.7	14.3

Source: Obesity among children under 11, Joint Health Surveys Unit. UK reference curves used to classify obesity (95th percentile)

Table 2.6 Obesity prevalence among 11 to 15 year olds in England

	1995	1996	1997	1998	1999/2000	2001	2002	2003	2004
Males	13.5	13.8	15.6	16.3	18.1	18.8	19.8	20.4	23.7
Females	15.4	15.0	16.2	17.5	16.3	17.7	19.2	21.9	26.2

Source: Health Survey for England 2004 – updating of trend tables to include 2004 data, Table 12. UK reference curves used to classify obesity (95th percentile)

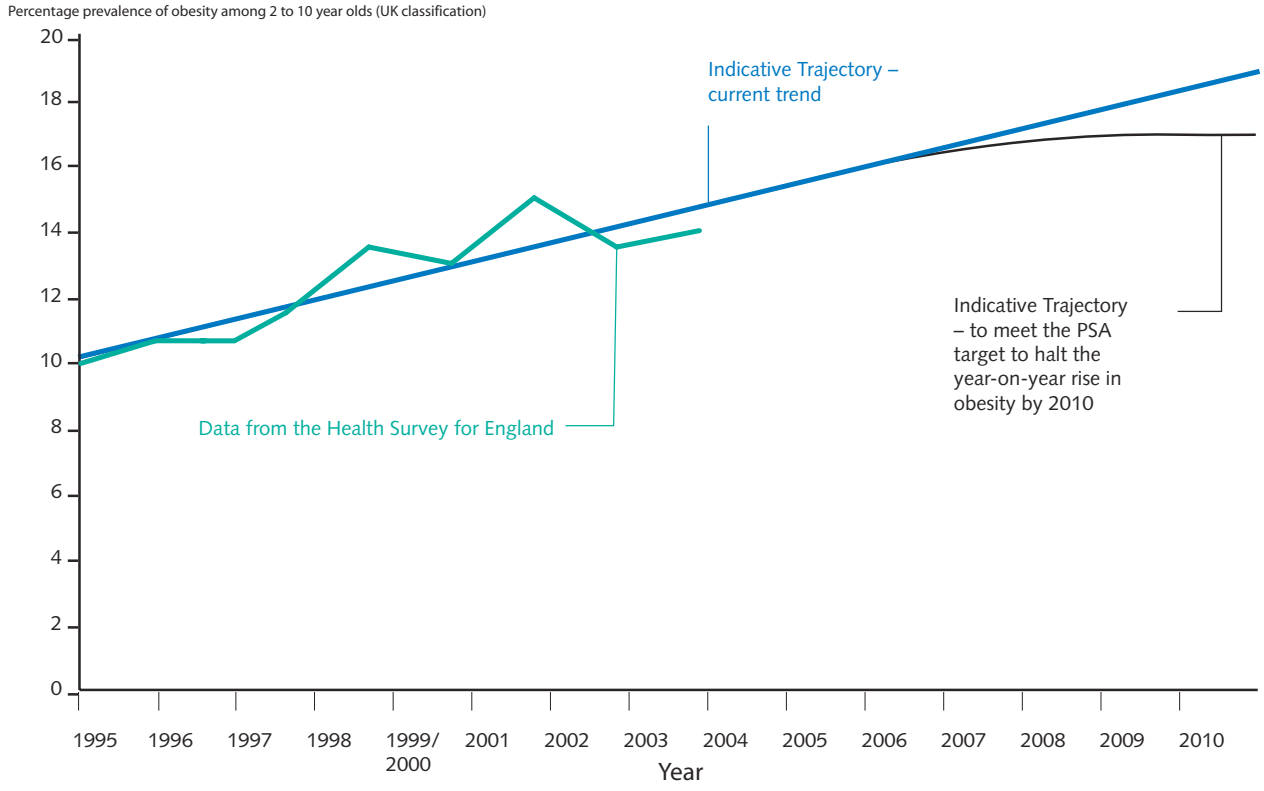
Table 2.7 Obesity prevalence among adults aged 16 or over in England

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Males	13.2	13.8	15.3	16.4	17.0	17.3	18.7	21.0	21.0	22.1	22.9	23.6
Females	16.4	17.3	17.5	18.4	19.7	21.2	21.1	21.4	23.5	22.8	23.4	23.8

Source: Health Survey for England 2004 – updating of trend tables to include 2004 data, Table 6

Fig 2.3 The challenge of the childhood obesity target

Obesity prevalence trends from 1995–2004
for 2 to 10 year olds, with possible trajectories
from 2004–2010



Produced by the DH Standards and Quality Analytical Team (SAT)

1. Data for 1995 to 2004 are from the Health Survey for England (HSE) and data points from 2004 to 2010 represent a possible trajectory not based on the delivery plan, which is merely indicative of possible changes.
2. Trend from 1995 to 2004 is indicative, as the sampling of children in HSE was not consistent across the years.
3. The year datapoint for 1999/2000 reflects the combination of data from two survey years.
4. Trajectory is based on the assumption of a linear decrease in the year-on-year increase in obesity from the 1995–2004 trend.
5. Note that data are from a sample survey and will therefore be subject to sampling errors.
6. Trends produced using the 'weighted least squares' technique.
7. UK BMI percentiles classification used to define obesity levels in children of each age and sex.

The national Childhood Height and Weight data collection programme

A key component of both influencing and monitoring obesity prevalence is through the establishment of a national Childhood Height and Weight data collection programme. The programme enables local data on childhood obesity to be collected to inform local planning and targeting of local resources and interventions; to enable tracking of local progress against the PSA target on obesity, and local performance management; and to improve understanding of the pattern, associated factors and causes of the obesity 'epidemic' among children.

Primary care trusts have now measured all schoolchildren in the Reception Year (ages 4 to 5) and those in Year 6 (ages 10 to 11 years). Height and weight data will be used for the calculation of Body Mass Index (BMI) in order to monitor obesity prevalence at a population level.

Improving sexual health

Target

PSA target for 2005–08: To tackle the underlying determinants of ill health and inequalities by reducing the under 18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health. (Joint Department of Health and Department for Education and Skills target).

Supporting indicators

Primary care trusts' local delivery plans (LDP) now include three sexual health elements in addition to reducing under 18 conception rates. PCTs are expected to ensure the delivery of all their agreed LDP commitments.

- The percentage of the sexually active population aged 15 to 24 accepting screening for chlamydia (to be phased in, in line with the roll-out of the National Chlamydia Screening Programme).
- The percentage of patients attending genito-urinary medicine (GUM) clinics who are offered an appointment to be seen within 48 hours of contacting a service, aiming to reach 100% by 2008. This is identified as a priority in the NHS operating framework for 2006/07.
- The number of new diagnoses of gonorrhoea per 100,000 population.

PCTs are also rated against their performance on the percentage of NHS-funded abortions performed under 10 weeks' gestation.

In addition to the above, assessment of trends in HIV is a key component of monitoring progress of the Sexual Health and HIV Strategy. Amongst other elements, the Strategy aims to:

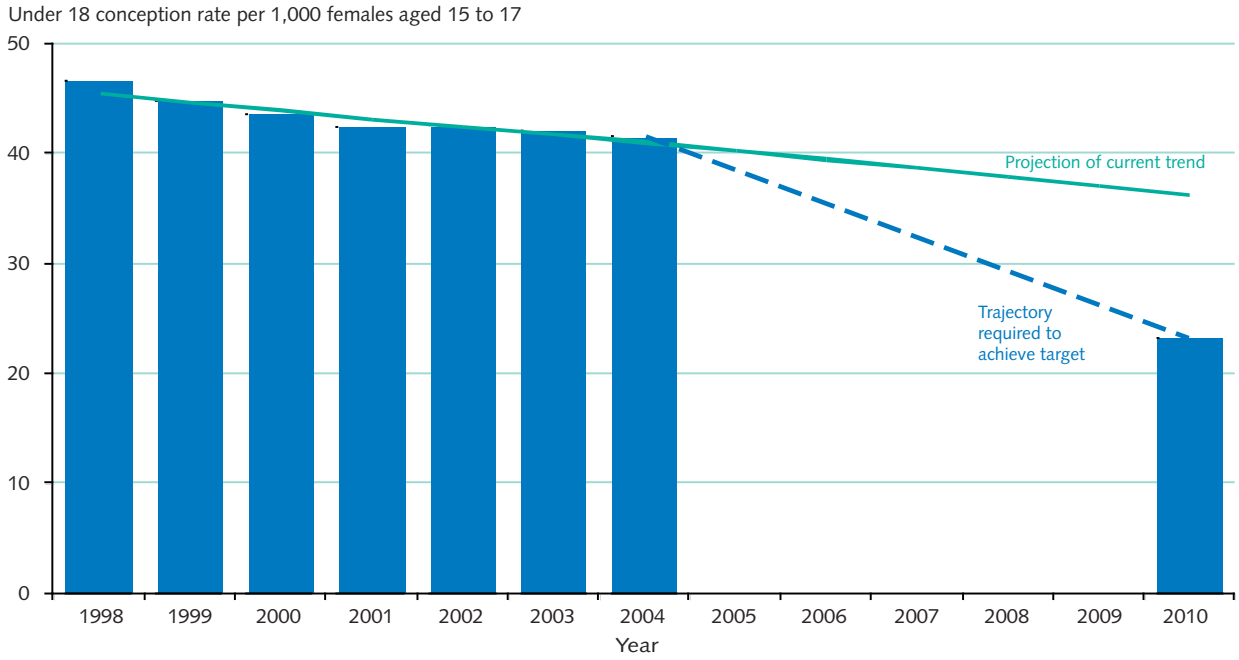
- reduce the transmission of HIV and sexually transmitted infections (STIs)
- reduce the prevalence of undiagnosed HIV (and STIs).

Because of the diverse range of targets and indicators in this priority area, key points are presented in individual sub-sections.

Progress measures

(1) Teenage pregnancies in England

Fig 2.4 Teenage pregnancies in England



Source: DfES, Teenage Pregnancy Unit, using ONS data

Key Points

- The under 18 conception rate has declined by 11.1% between 1998 and 2004, from 46.6 to 41.5 conceptions per 1,000 females aged 15 to 17.
- The national reduction masks considerable variation in progress between local authorities. While 80% of areas have seen reductions in their rates, 20% have rates that are static or increasing since the baseline.
- The range of progress between local authorities is dramatic – from a 42% decline to a 43% increase from 1998 to 2004.
- The under 16 conception rate has declined by 15.2% over the same period, from 8.8 to 7.5 conceptions per 1,000 females aged 13 to 15.

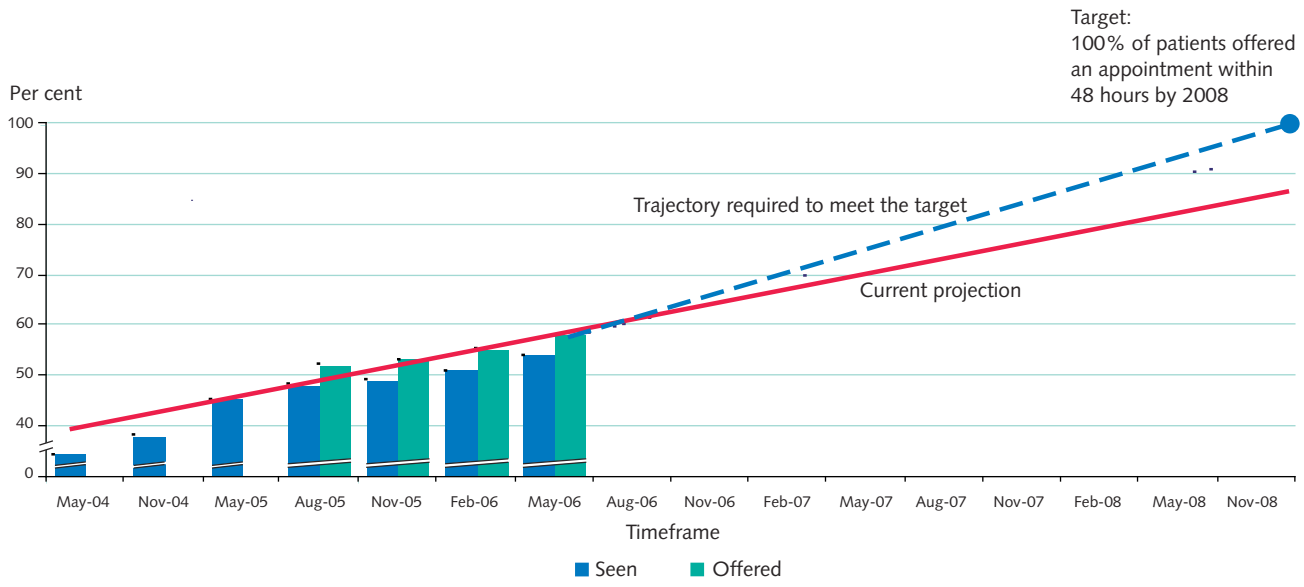
(2) The National Chlamydia Screening Programme

Key Points

- Chlamydia diagnoses in the UK rose by 4% from 2004 to 2005. (The rise in cases could be due to a number of reasons, including increases in high-risk sexual behaviours among young people associated with STI transmission, the introduction of very sensitive laboratory tests, and more recently the introduction of screening among asymptomatic sexually active young people.)
- Data collected through the National Chlamydia Screening Programme show that the number of chlamydia screens carried out has increased. In the first year to March 2004, there were 17,393; the second year to March 2005 there were 63,274 and in the third year to March 2006 there were 99,672. Since the programme began, 180,339 chlamydia tests have been carried out in non-GUM clinic settings.
- The overall percentage of individuals who tested positive as part of the chlamydia programme was 10.4% of women and 10.7% of men.
- The National Chlamydia Screening Programme is made up of programme areas (consortia of PCTs) which in the first three years covered over 25% of PCTs in England. Full national coverage is expected by the end of March 2007.

(3) Genito-urinary medicine – waiting times

Fig 2.5 Genito-urinary medicine waiting times in England: Offer of an appointment within 48 hours



Source: Health Protection Agency, GUM Waiting Times Audit

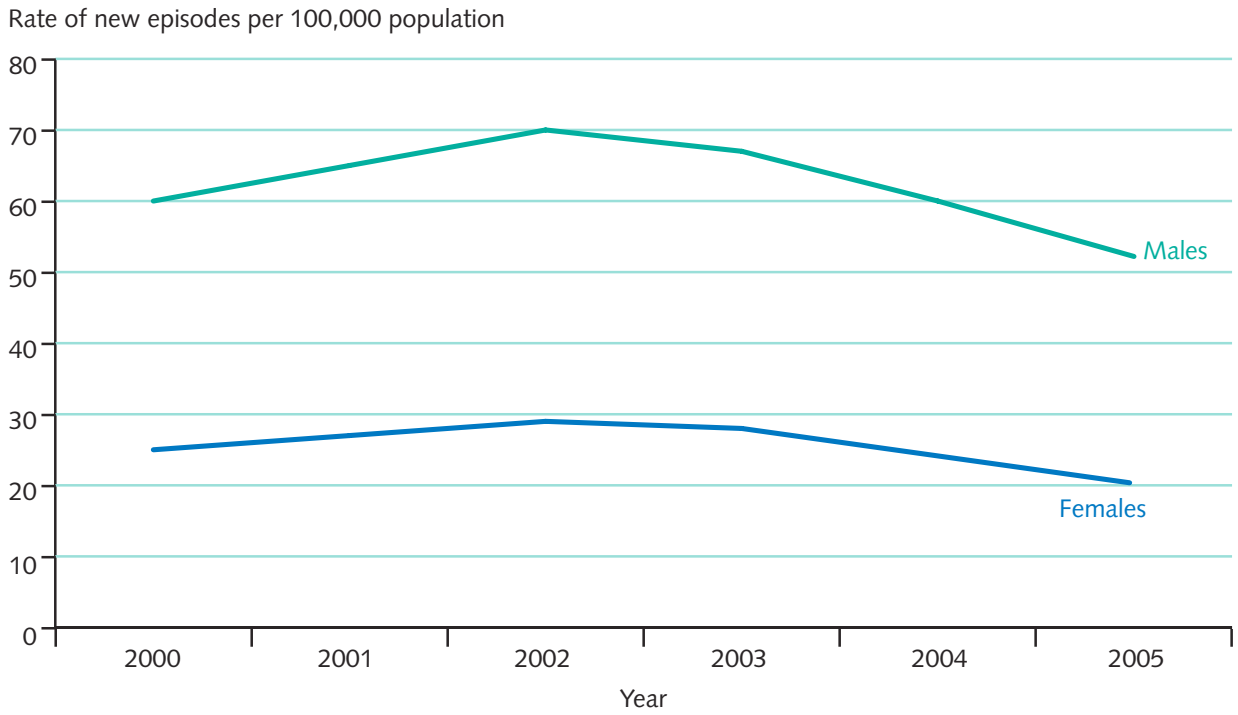
Key Points

- GUM Waiting Times Survey (May 2006) shows that 54% of clinic attenders were seen within 48 hours with a further 4% offered an appointment within 48 hours.

The data demonstrate (in Figure 2.5) a continuously improving picture since the survey began in May 2004. However, within this improving national picture, there are large regional variations in access. Given the focus on ensuring key progress towards the GUM access target in 2006/07 the Department of Health, through the establishment of a national support team, have been identifying and working with those areas that need to make the most progress.

(4) Trends in gonorrhoea rates in England

Fig 2.6 New episodes of gonorrhoea in England



Source: Health Protection Agency, HIV and Sexually Transmitted Infections, 2005 Data Tables

Key Points

- The presence of gonorrhoea is considered to be an effective marker for transmission of sexually transmitted infections generally, due to the nature of its transmission and the prevalence of symptomatic infection. A long-term trend showing diagnosis of gonorrhoea from 1925 is presented in Chart 30a on page 63.
- Gonorrhoea rates in England reduced by just over 10% from 2003 to 2004, and by a further 13% from 2004 to 2005.

(5) Abortions

Key Points

- The overall abortion rate in England for both 2004 and 2005 was 18.1 per 1,000 women aged 15 to 44. The under 18 abortion rate also stayed the same at 18.0 abortions per 1,000 women aged 15 to 17.
- The majority (89 per cent) of abortions are performed at 12 weeks' gestation or under; in 2005, 67% were at under 10 weeks.
- The percentage of NHS-funded abortions performed at under 10 weeks' gestation was 64% in 2005.
- Following a steady rise in the percentage of repeat abortions, from 28% in 1995 to 32% in 2005, a need was identified for PCTs to deliver more effective contraceptive education and provision.

(6) HIV

Key Points

HIV in the UK is concentrated amongst men who have sex with men and people from, or with links to, other high-HIV prevalence countries. It is estimated that there were 58,300 HIV-infected adults aged over 15 living in the UK at the end of 2004, of whom 34% were unaware of their infection.

Improving mental health and well-being

Target

The White Paper, *Saving Lives: Our Healthier Nation*[419] set a target to reduce suicide by at least 20% by 2010, compared to a 1997 baseline.

Supporting indicators

Choosing Health[405] said: 'We will ensure that Standard One of the National Service Framework for Mental Health, which deals with mental health promotion, is fully implemented. … We will have delivered if we improve the mental health and well-being of the general population.'

Key Points

Progress towards targets

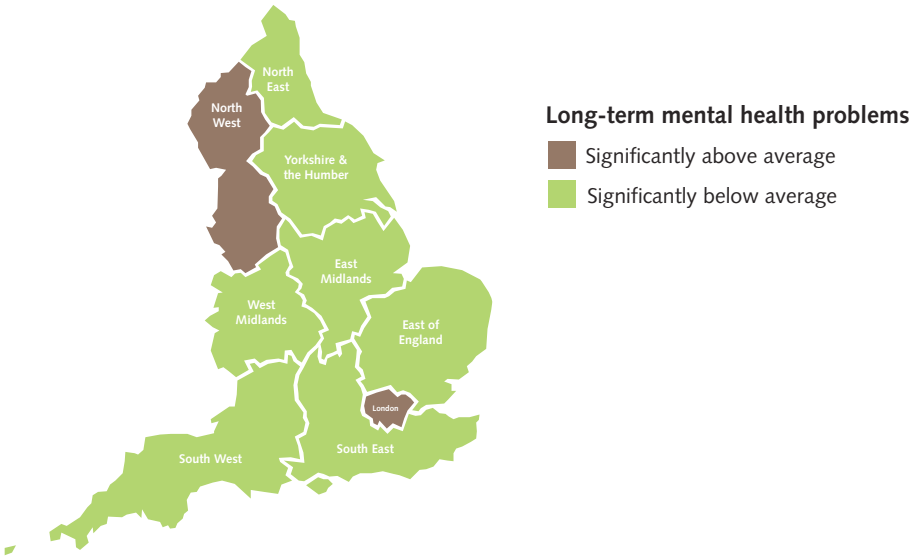
- Data for the three years 2002/03/04 show suicide rates to be 8.6 deaths per 100,000 population.
- Suicide rates have reduced by 6.6% since the 1995/96/97 baseline, a continuation of a broad downward trend since the early 1980s.

General points

- Mental health problems are as frequent as common physical disorders such as asthma.
- One in four GP consultations involves a mental health issue.
- 900,000 people on incapacity benefit are off work because of a mental health problem. Many would like to return to work, but many employers would not take on someone with a history of mental ill health.
- The cost of mental illness has been estimated at £77 billion per annum.
- People with severe mental illness (SMI) are 1.5 times more likely to die prematurely than those without, partly due to suicide, but also to death from respiratory and other diseases.
- One in six of the general population has common mental health problems at any one time.

Fig 2.7 Patients with severe long-term mental health problems

Adults aged 16 and over in England, by region, 2004/05



The proportion of registered patients who have severe long-term mental health problems (defined by those who require and have agreed to follow-up). (Unadjusted disease 'prevalence' per 100 registered patients)

Source: North East Public Health Observatory analysis of QMAS data

Two regions, London and the North West, have a significantly higher proportion of registered patients receiving follow-up for severe mental illness (both over 0.6% of their registered population). The other seven regions all have significantly lower proportions of patients recorded, with the lowest percentage of patients in West Midlands at 0.5%.

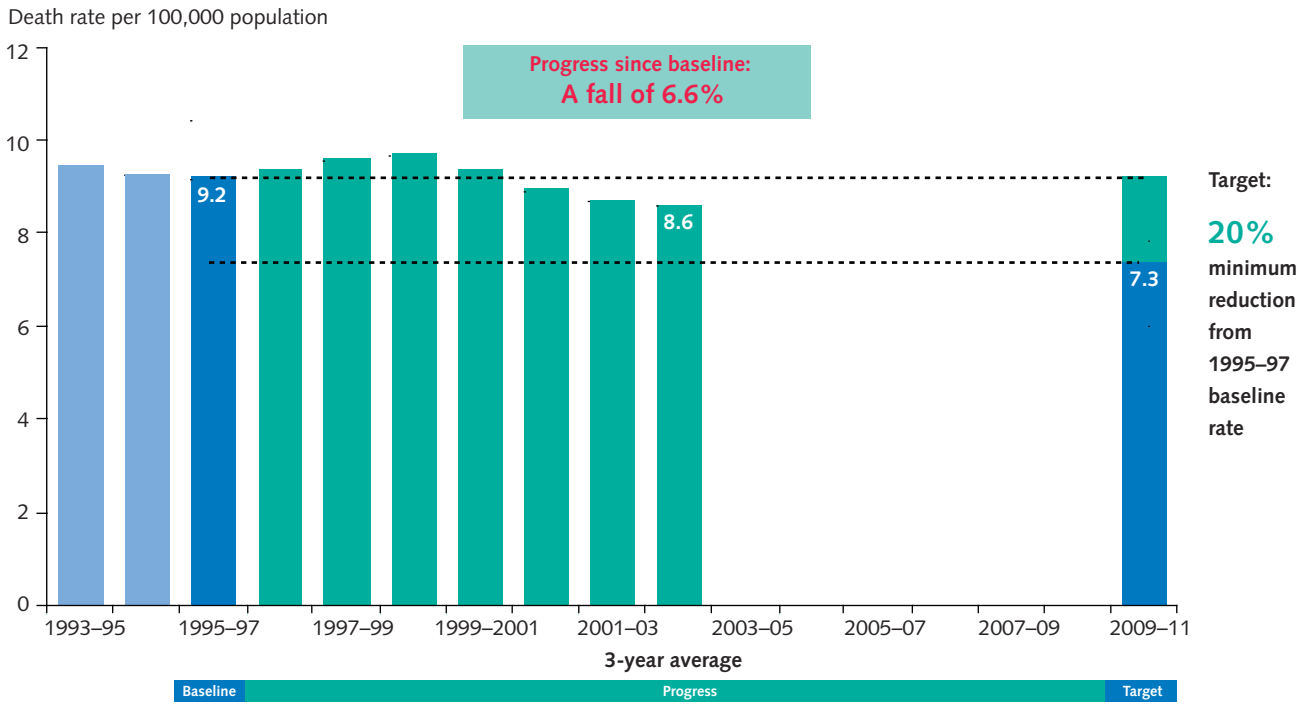
Progress measures

(1) Suicide rates

Suicide rates are clearly influenced by many factors, and changes in suicide rates are an important indicator at national level of the mental health of the country.

Fig 2.8 Mental health target

Death rates from suicide and injury and poisoning of undetermined intent in England 1993–2004 and target for the year 2010



Directly age-standardised rates, standardised using the European standard population

Source: ONS mortality data (ICD9 E950–E959, and E980–E989, excluding E988.8 (inquest adjourned); ICD10 X60–X84, and Y10–Y34 excl. Y33.9 (verdict pending))

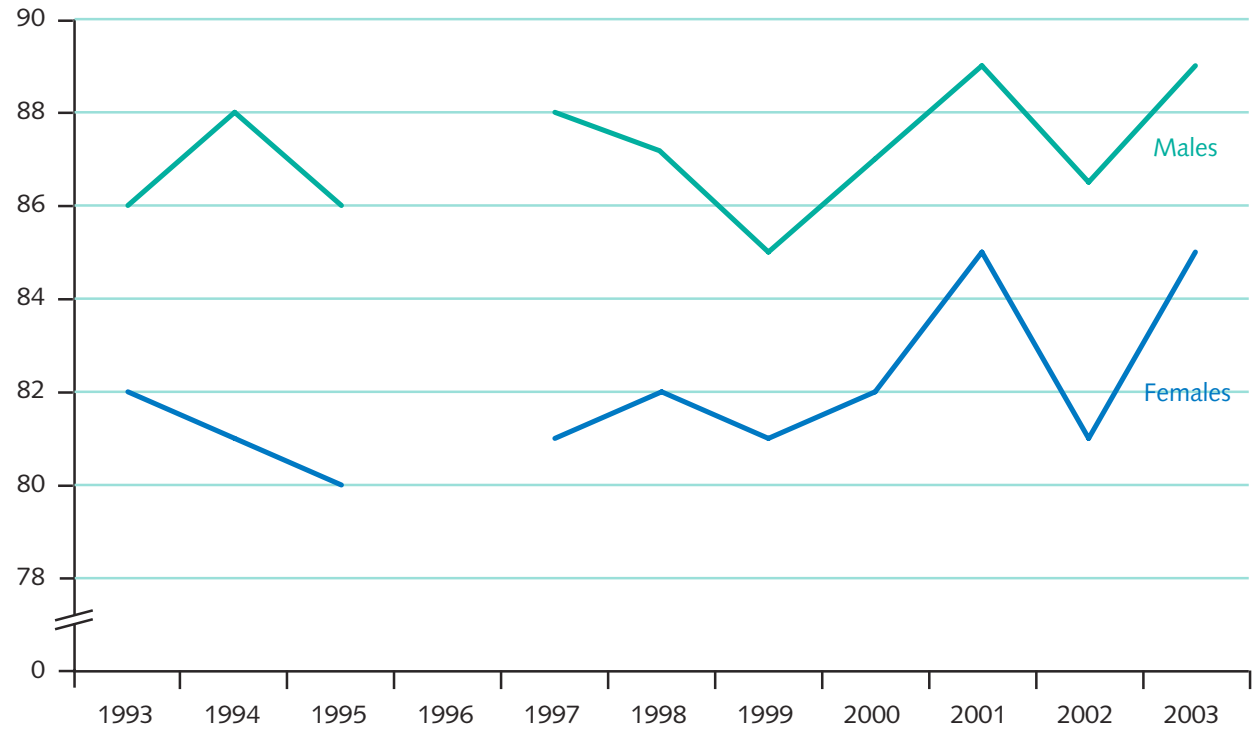
(2) Mental well-being in the community

The General Health Questionnaire (GHQ12), completed by people taking part in the *Health Survey for England*,[413] provides one measure of psychological well-being. It is designed to detect possible psychiatric morbidity in the general population. The questionnaire is based upon 12 questions that ask about happiness as well as symptoms of possible psychiatric disorder. A score of four or more indicates informants with a possible psychiatric disorder, so the percentage of people with a score of less than four is a crude measure of community mental well-being (although it does not capture all aspects of positive mental health).

Fig 2.9 Mental well-being (trends in psychosocial well-being)

Adults aged 16 and over, England

Percentage of adults with a GHQ12 score of less than 4



Note: Data for the year 1996 are not available

Source: Health Survey for England 2003

Key Points

- There is no very clear trend in mental well-being in adults, although rates are currently higher in males and females than earlier in the period under review (1993–2003).

Reducing harm and encouraging sensible drinking

Target

There are no PSA or PCT local delivery plan targets specific to tackling alcohol misuse. However, work on alcohol misuse supports other Department of Health PSAs, including reducing mortality rates from major killer diseases where alcohol may be a contributing factor (e.g. cancer and circulatory disease), also reducing suicide and health inequalities, as well as supporting, for example, the Home Office's PSA on crime reduction.

Supporting indicators

The aim of the *Alcohol Harm Reduction Strategy for England*[401] is 'to prevent any further increase in alcohol-related harms in England'. The *Alcohol Harm Reduction Strategy* will be reviewed by September 2007 to see if the trends are moving in the right direction and to focus on what needs to happen next.

Because of the diverse range of indicators in this priority area, key points are presented in individual sub-sections.

Key Points

Progress measures

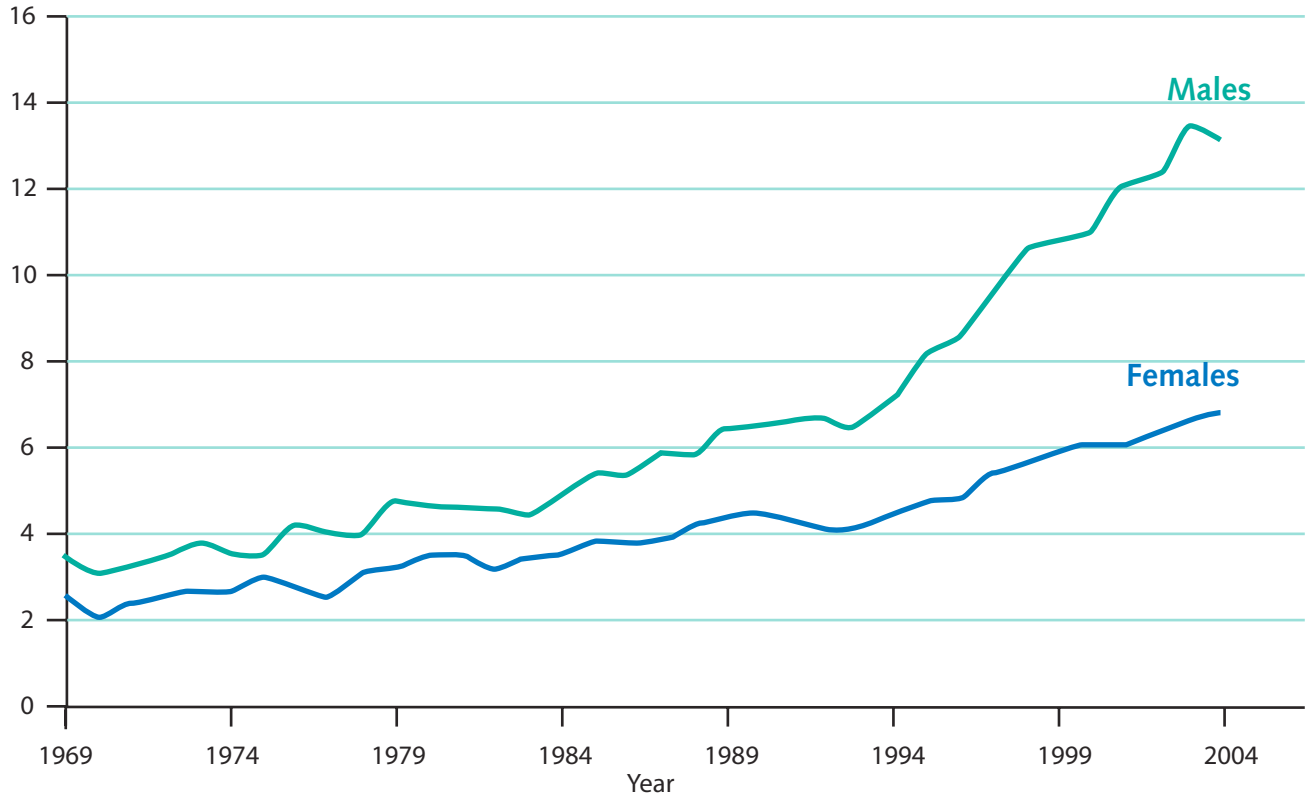
Among the measures that will reflect progress in this area are:

- reducing the proportion of adults drinking more than double the maximum daily amount on at least one day in the last week (eight units for men/six units for women)
- reducing the number of hospital admissions due to alcohol poisoning
- reducing mortality attributable to alcohol.

(1) Chronic liver disease and cirrhosis

Fig 2.10 Mortality from chronic liver disease and cirrhosis in England

European age standardised rate per 100,000 population



Source: ONS mortality statistics (ICD8 then ICD9 Code 571 (to 2000) ICD10 K70, K73–74 (from 2001))

Key Points

- Death rates from chronic liver disease and cirrhosis have been rising since the 1970s.
- During the 1990s, the increase became much more pronounced, especially amongst men.
- In recent years, there have been marked increases in mortality rates, particularly in young men, with the death rates rising over seven times higher than the rate in the early 1990s.
- The highest number of deaths occur in middle-aged men.
- The *Chief Medical Officer's Annual Report*[404] for 2001 highlighted the problem of liver cirrhosis. The report discussed underlying reasons for the large rise in cirrhosis deaths particularly in age groups 35 to 44 and 45 to 54 years.
  www.dh.gov.uk/PublicationsAndStatistics/Publications/AnnualReports/CMOAnnualReportsArticle/fs/en?CONTENT_ID=4005607&chk=OLFIRE

(2) Alcohol-related deaths (ONS definition)

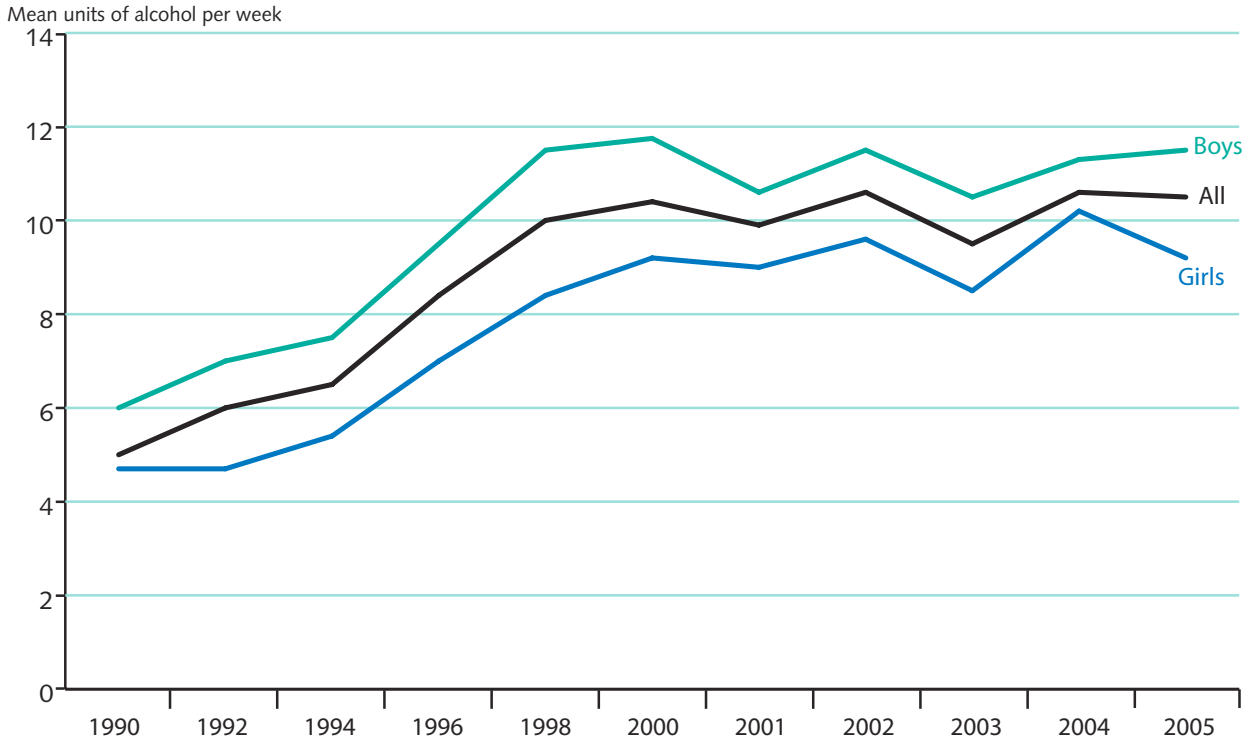
Key Points

- The Office for National Statistics (ONS)[106] has published data on geographical variations in 'alcohol-related deaths' in England and Wales (2005). www.statistics.gov.uk/pdfdir/alcdeaths0305.pdf
- The ONS definition of alcohol-related deaths includes those causes regarded as most directly due to alcohol consumption. It includes deaths from causes such as alcoholic liver disease, cirrhosis of the liver and mental and behavioural disorders due to alcohol use. It does not include deaths from external causes, apart from alcohol-related poisoning.
- Alcohol-related deaths in England and Wales rose throughout the 1980s and 1990s. Alcohol-related deaths are much more common for males than females.
- There were very different rates of alcohol-related deaths in the English regions in 2001–03:
  - The highest rates were in the North West and North East and the lowest rates in the East of England, South West and South East.
  - The rate for the North West was almost double that for the East of England (15.1 and 7.7 deaths per 100,000 population respectively).

(3) Alcohol consumption – children and adults

(a) Children

Fig 2.11 Children aged 11 to 15: Mean alcohol consumption of those who had drunk in the last seven days, by sex in England



Source: Drug use, smoking and drinking among young people in England in 2005: headline figures, Table 15

Key Points

Amongst children aged 11 to 15 who had drunk in the last week:

- The average weekly consumption of alcohol increased from 5.3 units in 1990 to 10.4 in 2000, and has remained around that level since.
- With the exception of 2004, figures in 2005 show a continuing trend since 2001 of girls consuming about 2 units of alcohol fewer than boys (9.5 units compared with 11.5 units) in the last week.

(b) Adults

Key Points

- Between 1998 and 2004, there was little change in the proportions of men and women exceeding the daily benchmarks (see Note).
- Younger people were more likely than older people to exceed the daily benchmark.
- Amongst the 16 to 24 age group, average male consumption rose from 20 to 25 units per week between 1997 and 2004.
- Just under half (47%) of men aged 16 to 24 had drunk more than 4 units on at least one day during the previous week compared with a fifth of men aged 65 and over.
- 1.2 million violent incidents (around half of all violent crimes (see Chart 6a on page 50)) and 360,000 incidents of domestic violence are linked to alcohol misuse.

Note: The daily benchmark

The *General Household Survey*[411] has included questions on daily benchmarks since 1998, following the publication of an inter-departmental review of the effects of drinking, which concluded that 'it was more appropriate to set benchmarks for daily than for weekly consumption of alcohol, partly because of concern about the health and social risks associated with single episodes of intoxication. The report considered that regular consumption of between three and four units a day for men and two to three units a day for women does not carry a significant health risk, but that consistently drinking above these levels is not advised'.

SECTION 3

Chartbook

These charts are presented to provide additional dimensions in the areas covered by the indicators. Charts have been selected to illustrate important or 'interesting' variations. Charts illustrate time trends or geographic distribution (including international comparisons), gender, ethnic and social group and age dimensions. They are illustrative of the further dimensions of the indicators that can be explored.

An index of charts is tabulated below.

Chartbook – Index of Charts

LHP No.	Indicator	Chart No.	Chart description
Our communities			
1.	Deprivation	1a	Life expectancy at birth by deprivation quintile
		1b	Distribution of deprived areas across England
2.	Air quality	2a	Trend in levels of ozone and PM10
		2b	Trend in days when air pollution is moderate or higher
3.	Poor quality housing	3a	Households living in non-decent housing by sector
		3b	Households living in non-decent housing by ethnic identity
4.	Children in poverty	4a	Trend in children living in poverty
5.	GCSE achievement (five A*–C)	5a	Percentage of 16 year olds achieving five or more GCSE grades A*–C (or equivalent) by ethnicity
		5b	Proportion of 16 year olds achieving five or more GCSE grades A*–C (or equivalent) by free school meals eligibility
6.	Violent crime	6a	Trend in violent crime (reported in the British Crime Survey)
7.	Older people supported at home	7a	Trend in percentage of older people supported at home helped to live independently: Receiving intensive home care
		7b	Older people being helped to live at home: Receiving any amount of care by region

Giving children and young people a healthy start			
8.	Smoking in pregnancy	8a	Proportion of women who smoked during pregnancy by social group
9.	Breastfeeding	9a	Prevalence of breastfeeding at birth and at six weeks by mother's socio-economic classification (NS-SEC)
		9b	Prevalence of breastfeeding at birth and at six weeks by mother's ethnic group
10.	Obese children	10a	Trend in obesity in children by manual or non-manual social group
		10b	Obesity in children by socio-economic group
11.	Physically active children	11a	Schoolchildren who spent two hours in a typical week on high-quality PE and school sports by level of eligibility for free school meals
12.	Teenage pregnancy	12a	Trend in percentage of all live births to mothers aged under 20 years (EU-15 countries)
		12b	Trend in teenage conceptions by deprivation quintile
The way we live			
13.	People who smoke	13a	Trend in smoking prevalence in adults by sex
		13b	Trend in prevalence of cigarette smoking by sex and gradient in socio-economic classification of the household reference person
14.	Binge drinking	14a	Adults exceeding twice the recommended daily benchmarks of alcohol consumption on at least one day during the last week by age and sex
		14b	Trend in pure alcohol consumed (EU-15 countries)
15.	Healthy eating	15a	Trend in the average amount of fruit and vegetables available (EU-15 countries)
		15b	Percentage eating five portions or more of fruit and vegetables per day by sex and region
16.	Physically active adults	16a	Trends in high levels of physical activity amongst adults by sex
		16b	High levels of physical activity amongst adults by ethnicity
17.	Obese adults	17a	Adult obesity by selected European countries
		17b	Adult obesity by region of England

How long we live and what we die of			
18	Life expectancy	18a	Trend in life expectancy at birth by social class and sex
		18b	Life expectancy at birth by region
	Healthy life expectancy	18c	Trend in life expectancy and healthy life expectancy at birth by sex
		18d	Healthy life expectancy at birth by sex and UK country
19.	Deaths from smoking	19a	Smoking attributable mortality by region
		19b	Trend in premature mortality from lung cancer by sex
20.	Early deaths – circulatory disease	20a	Trend in inequality gap in circulatory disease mortality in people under age 75
		20b	Circulatory disease mortality by country of birth
21.	Early deaths – cancer	21a	Premature mortality from cancer (age under 65) (EU-15 countries)
		21b	Trend in inequality gap in cancer mortality in people aged under 75
sm	Suicide	sm1	Trend in mortality rate from suicide and injury and poisoning of undetermined intent in young men
		sm2	Number of deaths from suicide and injury and poisoning of undetermined intent by age and sex
22.	Infant deaths	22a	Long-term trend in infant mortality
		22b	Infant mortality rates by socio-economic group
23.	Road injuries and deaths	23a	Trend in death rates from motor vehicle traffic accidents (EU-15 countries)
		23b	Road accident casualties to children by deprivation quintile
Health and ill health in communities			
24.	Feeling 'in poor health'	24a	Prevalence of 'Bad' or 'Very Bad' self-reported health by ethnicity and sex
		24b	Trend in prevalence of 'Bad' or 'Very Bad' self-reported health, by sex
25.	Mental health treatment	25a	Proportion of men and women with high GHQ 12 score (age standardised) by equivalised household income
		25b	Prevalence of mental disorders in children by educational qualification of parent

26.	Alcohol related hospital stays	26a	Trend in alcohol related hospital admissions
		26b	Correlation between deprivation and alcohol attributable mortality in the North West of England
27.	Drug misuse treatment	27a	In contact with drug treatment by region of residence
		27b	All clients in structured drug treatment by main drug
28.	People with diabetes	28a	Trend in prevalence of doctor-diagnosed diabetes by sex
		28b	Prevalence of doctor-diagnosed diabetes by ethnicity
29.	Children's tooth decay	29a	Trend in average number of decayed, missing or filled teeth per child by age
		29b	Decayed, missing or filled teeth at age 12 across European Union
30.	Sexually transmitted infections	30a	Long-term trend in the number of diagnoses of gonorrhoea by sex
		30b	Trend in rates of gonorrhoea by age and sex

Table 3.2 sets out the different dimensions addressed by each of the charts. The indicators can each be assessed by dimensions such as gender, ethnicity, social group, location and age.

The table supplements the links between different indicators highlighted in Table 5.1 in Appendix 1. The list of chart linkages in Table 5.1 is illustrative rather than comprehensive. It is intended to reinforce the point that review of individual indicators is made more powerful if trends in associated indicators are also assessed. For example, many of the wider determinants will impact on trends in key health outcomes including life expectancy and infant mortality. Similarly, smoking is a risk factor for many individual causes of ill health and mortality.

KEY ICONS

- Tackling health inequalities
- Reducing number of people who smoke and protecting people from secondhand smoke
- Reducing obesity and improving diet and nutrition
- Improving sexual health
- Improving mental health and well-being
- Reducing harm and encouraging sensible drinking

Table 3.2 – Dimensions addressed by individual charts

HP No.	Indicator	Chart no.	Key area	Time trend	Regional	United Kingdom	International	Age	Gender	Deprivation	Socio-economic	Ethnicity
Our communities												
1.	Deprivation	1a							✔	✔		
		1b			✔					✔		
2.	Air quality	2a		✔								
		2b		✔		✔						
3.	Poor quality housing	3a		✔							✔	
		3b		✔								✔
4.	Children in poverty	4a		✔							✔	
5.	GCSE achievement (five A*–C)	5a							✔			✔
		5b		✔							✔	
6.	Violent crime	6a		✔								
7.	Older people supported at home	7a		✔								
		7b			✔							
Giving children and young people a healthy start												
8.	Smoking in pregnancy	8a									✔	
9.	Breastfeeding	9a				✔					✔	
		9b				✔						✔
10.	Obese children	10a		✔							✔	
		10b									✔	
11.	Physically active children	11a									✔	
12.	Teenage pregnancy (under 18)	12a		✔		✔	✔					
		12b		✔						✔		

HP no.	Indicator	Chart no.	Key area	Time trend	Regional	United Kingdom	International	Age	Gender	Deprivation	Socio-economic	Ethnicity
The way we live												
13.	People who smoke	13a		✔					✔			
		13b		✔					✔		✔	
14.	Binge drinking	14a						✔	✔			
		14b		✔		✔	✔					
15.	Healthy eating	15a		✔		✔	✔					
		15b			✔				✔			
16.	Physically active adults	16a		✔					✔			
		16b							✔			✔
17.	Obese adults	17a				✔	✔					
		17b			✔				✔			
How long we live, and what we die of												
18.	Life expectancy	18a		✔					✔		✔	
		18b			✔				✔			
	Healthy life expectancy	18c		✔					✔			
		18d				✔			✔			
19.	Deaths from smoking	19a			✔							
		19b		✔					✔			
20.	Early deaths – circulatory diseases	20a		✔						✔		
		20b										✔
21.	Early deaths – cancer	21a		✔			✔					
		21b		✔						✔		
sm	Suicide	sm1		✔				✔				
		sm2						✔	✔			
22.	Infant deaths (under one year)	22a		✔								
		22b									✔	

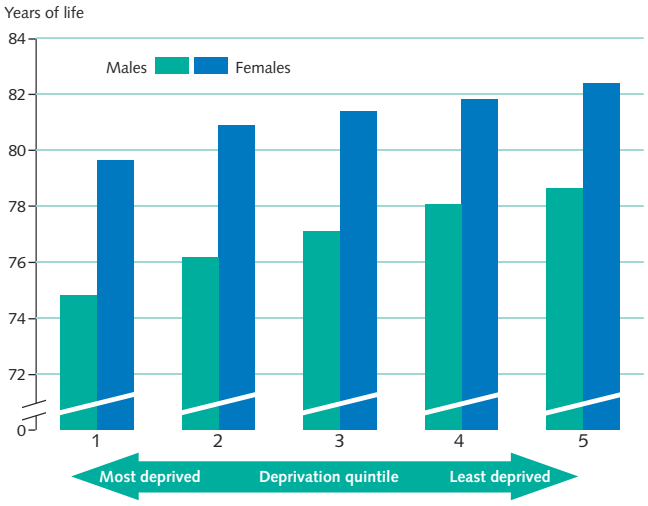
HP no.	Indicator	Chart no.	Key area	Time trend	Regional	United Kingdom	International	Age	Gender	Deprivation	Socio-economic	Ethnicity
How long we live and what we die of (continued)												
23.	Road injuries and deaths	23a		✔		✔	✔					
		23b	⚖	✔						✔		
Health and ill health in communities												
24.	Feeling 'in poor health'	24a	☺ ⚖						✔			✔
		24b	☺	✔					✔			
25.	Mental health treatment	25a	☺ ⚖						✔		✔	
		25b	☺ ⚖								✔	
26.	Alcohol related hospital stays	26a	🍷 ☺	✔								
		26b	🍷 ⚖		✔					✔		
27.	Drug misuse treatment	27a	☺ ⚖		✔							
		27b	☺									
28.	People with diabetes	28a	🍎	✔					✔			
		28b	🍎 ⚖						✔			✔
29.	Children's tooth decay	29a		✔				✔				
		29b				✔	✔					
30.	Sexually transmitted infections	30a	⚥	✔					✔			
		30b	⚥	✔		✔		✔	✔			

National Profile of Health and Well-being in England

INDICATOR 1 Deprivation

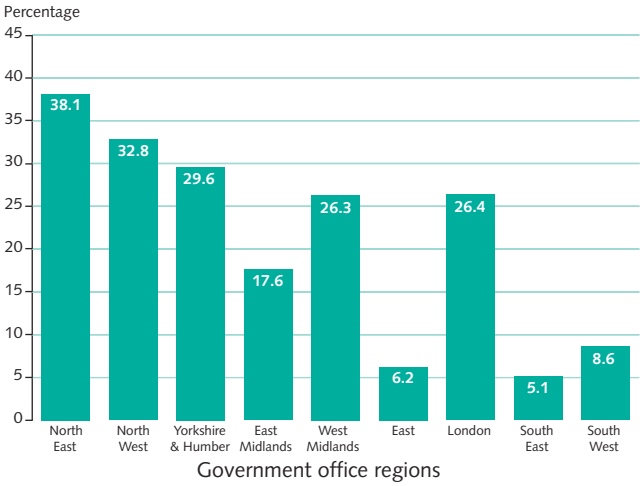
People in affluent areas live longer than those in deprived areas.

Chart 1a: Life expectancy at birth by deprivation quintile
England, 2002–04



Source: DH analysis using data from the Office for National Statistics (ONS)
Web link: www.statistics.gov.uk/StatBase/Product.asp?vlnk=14459&Pos=&ColRank=1&Rank=422

Chart 1b: Percentage of Super Output Areas (SOAs) in each region falling within the most deprived 20% of SOAs in England



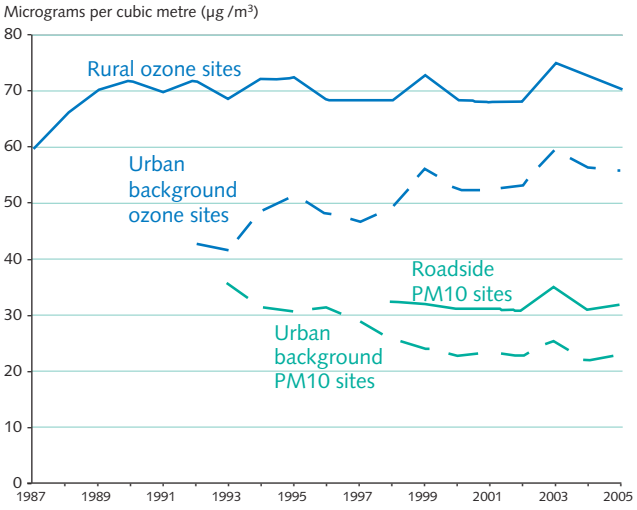
Source: Department for Communities and Local Government
Web link: www.communities.gov.uk/index.asp?id=1128444

Men in the least deprived fifth of areas live, on average 3 years longer than those in the most deprived areas. For women, the difference is around 2 years. Deprived areas are concentrated in the North of England, West Midlands and London

INDICATOR 2 Air quality

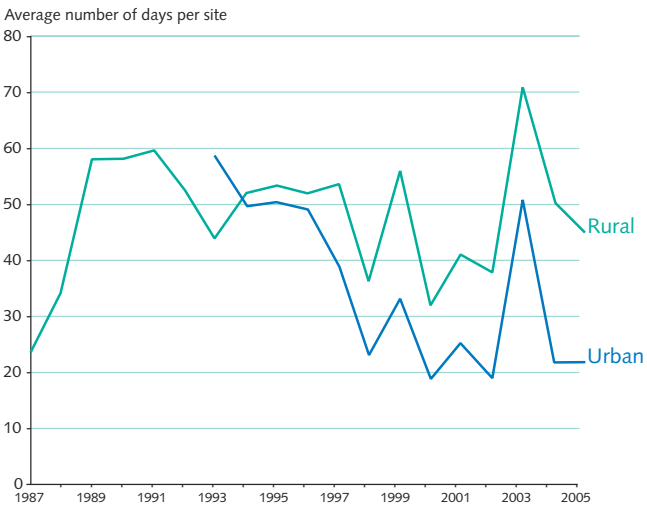
Air quality shows a complex picture. The number of pollution days in urban areas has decreased since the early 1990s, while there has been no clear trend in rural pollution days.

Chart 2a: Levels of ozone and PM10
England



Source: Defra, netcen
Web link: www.defra.gov.uk/news/2006/060424d.htm

Chart 2b: Days when air pollution is moderate or higher*
England



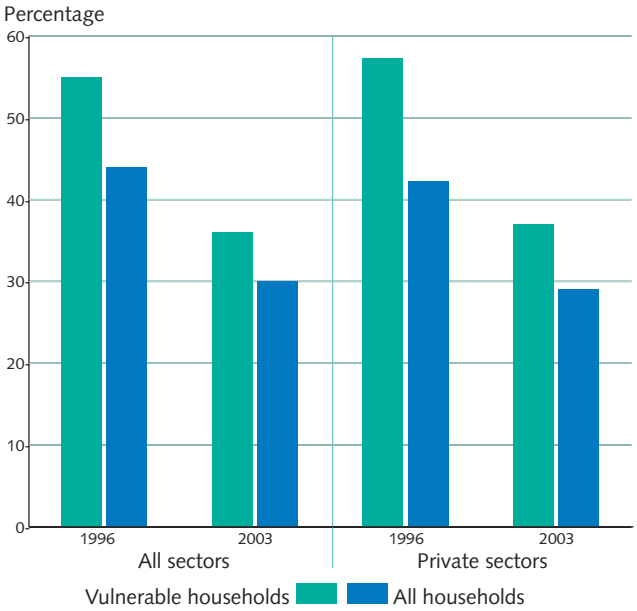
*Based on five pollutants
Source: Defra, netcen
Web link: www.defra.gov.uk/news/2006/060424d.htm

Particulates and ozone pollution are the two pollutants thought to have the greatest health impact. Urban background particulate levels are generally showing a decreasing trend. Rural ozone levels show no clear long-term trend, whilst urban background ozone levels have generally increased since 1993. In urban areas, the number of days on which levels of any one of a basket of five pollutants were 'moderate or higher' was substantially lower in 2005 than in 1993, reflecting a general decline in urban pollution. Rural areas show little overall trend. These figures are volatile from one year to the next, reflecting the variability in levels of ozone, more of which is produced in hot sunny weather, as was the case in 2003.

INDICATOR 3 Poor-quality housing

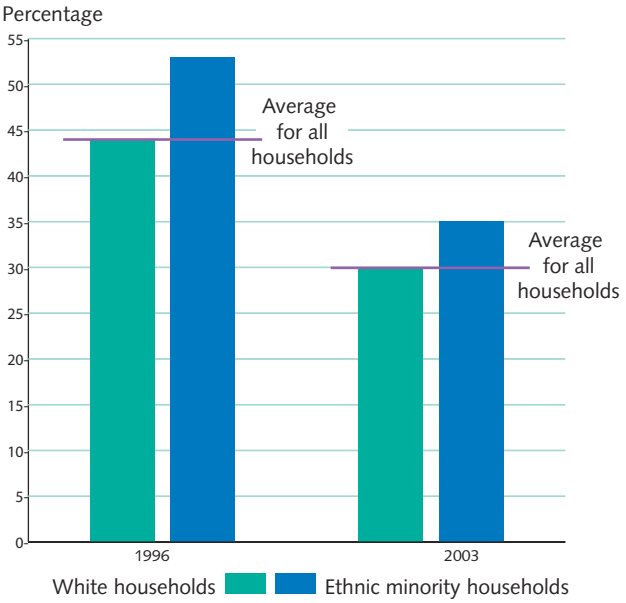
The proportion of households living in non-decent housing is falling, however inequalities persist.

Chart 3a: Households living in non-decent housing by sector
England, 1996 and 2003



Source: English House Condition Survey, 2003, Department for Communities and Local Government
Web link www.communities.gov.uk/index.asp?id=1155278

Chart 3b: Households living in non-decent housing by ethnic identity
England, 1996 and 2003



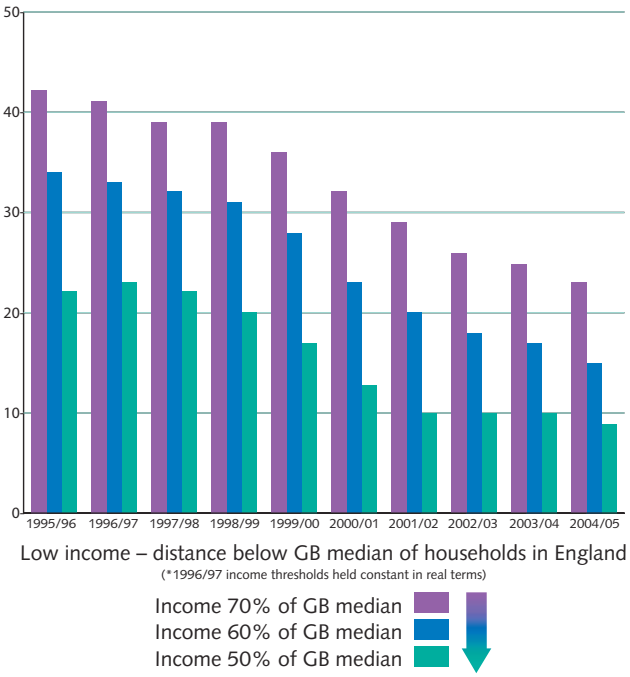
Source: English House Condition Survey, 2003, Department for Communities and Local Government
Web link www.communities.gov.uk/index.asp?id=1155278

Proportions living in non-decent housing are higher in vulnerable households and ethnic minority households. Vulnerable households are those in receipt of at least one of the principal means-tested or disability-related benefits.

INDICATOR 4 Children in poverty

Child poverty has been reducing since the mid 1990s.

Chart 4a: Children living in poverty
Percentage of children living in low-income households, after housing costs by absolute measure of low income*, England



Source: Department for Work and Pensions, Households Below Average Income, HBAI 1994/95–2004/05
Web link www.dwp.gov.uk/asd/hbai.asp (chapter_4_excel_hbai06.xls sheet OFA)

Findings of the Households Below Average Income survey for 2004/05 include the following:

In the decade to 2004/05, there was a marked fall in the proportion of children below low-income thresholds held constant in real terms.

In 2004/05, children in single-parent families were much more likely to live in low-income households than those in families with two adults. However, there has been a reduction in the risk of relative low income for children in lone-parent families since 1997/98.

Children in families containing one or more disabled persons were more likely to live in low-income households than those in families with no disabled persons.

Children living in households headed by someone from an ethnic minority were more likely to live in low-income households in 2004/05 than their white counterparts. This was particularly the case for those headed by someone of Pakistani or Bangladeshi origin, where a large majority of children were in households below 60% of median income.

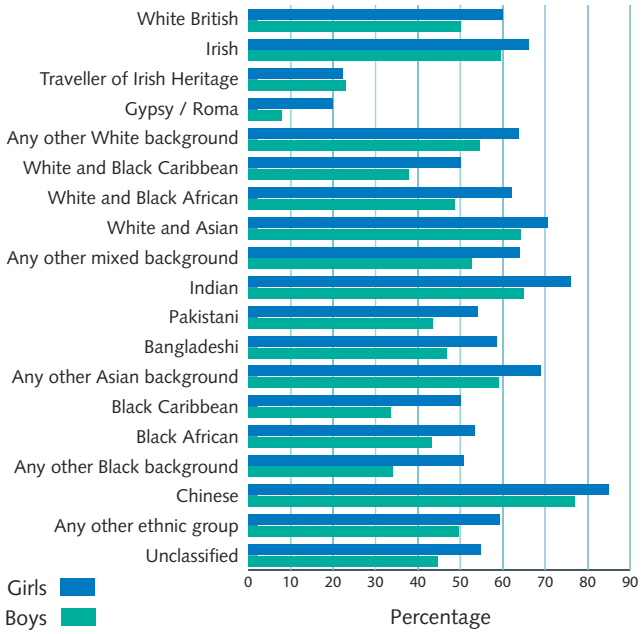
The risk of living in a low-income household tended to decrease for children as the age group of the mother increased.

In 2004/05, children in Inner London had a higher risk of low income than for any other region, with around half of children in households below 60% of median income After Housing Costs. Those in the South East, Eastern and South West regions were least at risk on both Before Housing Costs and After Housing Costs measures.

INDICATOR 5 GCSE achievement (five A*–C)

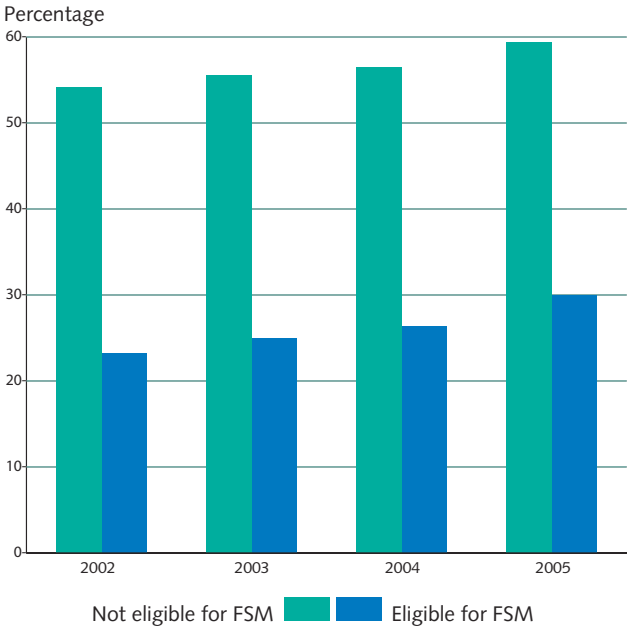
Educational attainment is improving; however substantial inequalities remain.

Chart 5a: Percentage of 16 year olds achieving five or more GCSE grades A*–C (or equivalent) by ethnicity
England, 2005



Source: DFES National Curriculum assessment, GCSE & equivalent attainment by pupil characteristics (Table 11)
Web link www.dfes.gov.uk/rsgateway/DB/SFR/s000640/index.shtml

Chart 5b: Proportion of 16 year olds achieving five or more GCSE grades A*–C (or equivalent), by free school meals (FSM) eligibility
England, 2002–2005



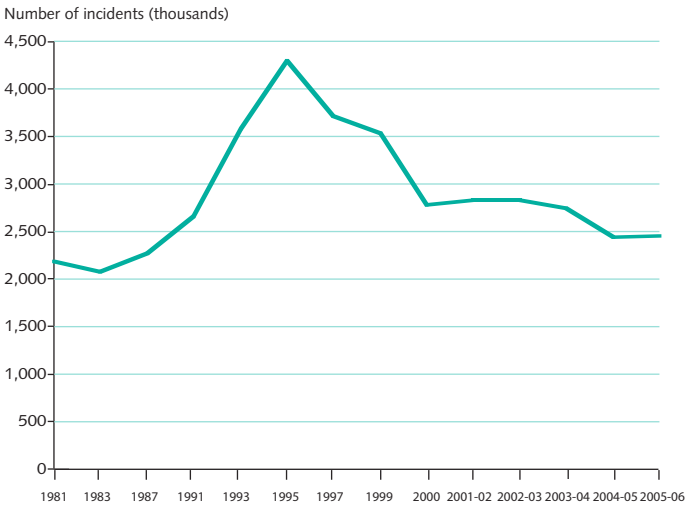
Source: DFES National Curriculum assessment, GCSE & equivalent attainment by pupil characteristics (Table 11)
Web link www.dfes.gov.uk/rsgateway/DB/SFR/s000640/index.shtml

Attainment amongst children from Indian and Chinese backgrounds was greater than for White British children. Conversely, attainment amongst children from Black backgrounds was generally less. Attainment is lower among children eligible for free school meals than for those not eligible although there are signs of improvement over recent years.

INDICATOR 6 Violent crime

Violent crime falls from a peak in 1995.

Chart 6a: Violent crime (recorded in the British Crime Survey)
England and Wales



Source: The British Crime Survey (BCS)
Web link: www.homeoffice.gov.uk/rds/pdfs06/hosb1206.pdf

The British Crime Survey (BCS) is a nationally representative survey of adults living in private households. The BCS can provide a better reflection of the true extent of crime (of the types of crimes it covers such as violence) because it includes crimes that are not reported to the police. BCS violent crime includes common assault, wounding, robbery and snatch theft. Violent crime measured by the BCS has fallen significantly since a peak in 1995.

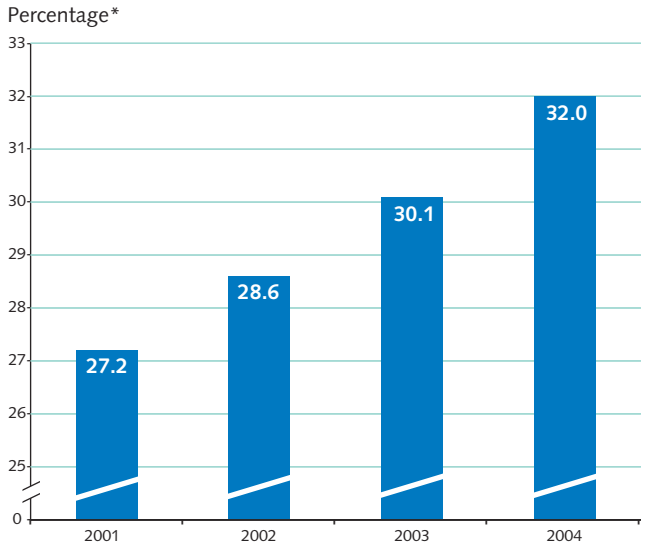
The most recent BCS figures show violent crime has remained stable since last year but there have been substantial falls since the mid-1990s (a fall of 43%, representing 1.8 million fewer crimes since 1995).

As crime has fallen over the past 10 years, people are becoming less worried about crime — according to BCS only one in six people are particularly worried by violent crime, compared with one in four in 1998.

INDICATOR 7 Older people supported at home

An increasing proportion of older people are being supported intensively to live at home independently. The total care picture varies by region.

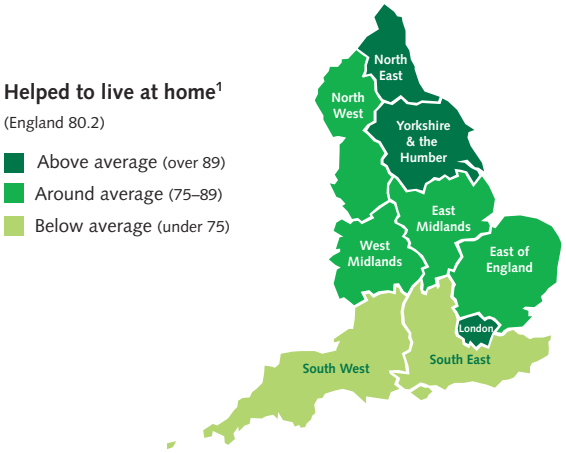
Chart 7a: Percentage of older people supported at home helped to live independently: Receiving intensive home care*
England, 2001–04



*Proportion of older people being supported intensively to live at home as compared with the total being supported by social services intensively at home or in residential care, at 31 March each year.
Source: DH community care statistics

Web link www.dh.gov.uk/PublicationsAndStatistics/Statistics/StatisticalWorkAreas/StatisticalSocialCare/StatisticalSocialCareArticle/fs/en?CONTENT_ID=4086767&chk=4eMvuk

Chart 7b: Older people being helped to live at home: Receiving any amount of care by region
March 2005



[1] The number of people aged 65 and over helped to live at home per 1,000 persons aged 65 and over (age-specific rate).
Some variations may be due to differences in interpretation of what qualifies as being helped to live at home.

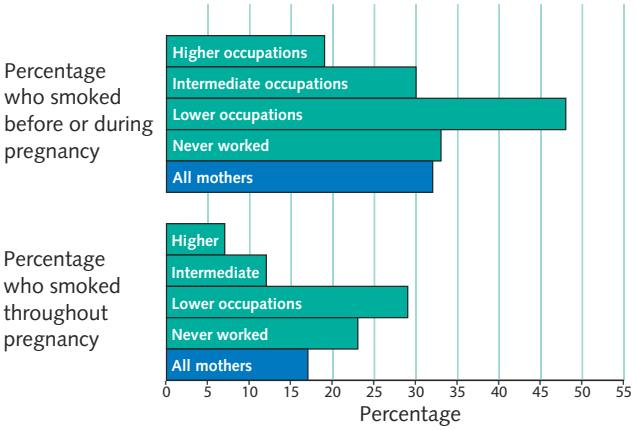
Source: Information Centre for Health and Social Care, Referrals, Assessments and Packages of Care (RAP) Return
Office for National Statistics (ONS) mid-year population estimates, analysed by the Association of Public Health Observatories Local Health Profile Project
Web link: www.apho.org.uk/apho/net/viewResource.aspx?id=2909

There is an increasing proportion of older people being supported intensively to live at home independently. Larger proportions of older people in the North East, Yorkshire and the Humber and London are helped to live at home than in other areas.

INDICATOR 8 Smoking in pregnancy

Mothers in lower social groups are more likely to smoke during pregnancy.

Chart 8a: Proportion of women who smoked during pregnancy by social group*
England, 2005



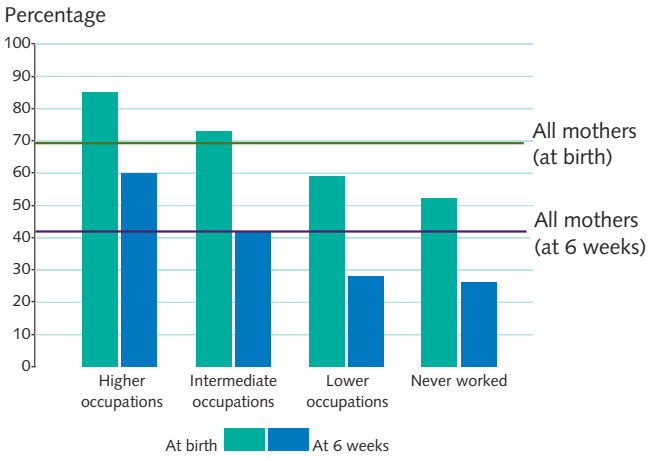
* Mothers socio-economic classification (NS-SEC)
Source: Information Centre for Health and Social Care, Infant Feeding Survey 2005: Early Results (Table 8e), page 9
Web link www.ic.nhs.uk/pubs/breastfeed2005/ifstables/file

Mothers in lower social groups are two and a half times as likely to smoke before or during pregnancy, and over four times as likely to smoke throughout pregnancy. Between 2000 and 2005, the gap in smoking levels between mothers in different socio-economic groups increased for England. While the proportion of mothers in higher occupations who smoked before or during pregnancy decreased from 22% to 19%, for mothers in lower occupations, the proportion increased from 46% to 48%. For mothers in the 'never worked' category, however, there was a fall from 48% in 2000 to 33% in 2005.

INDICATOR 9 Breastfeeding

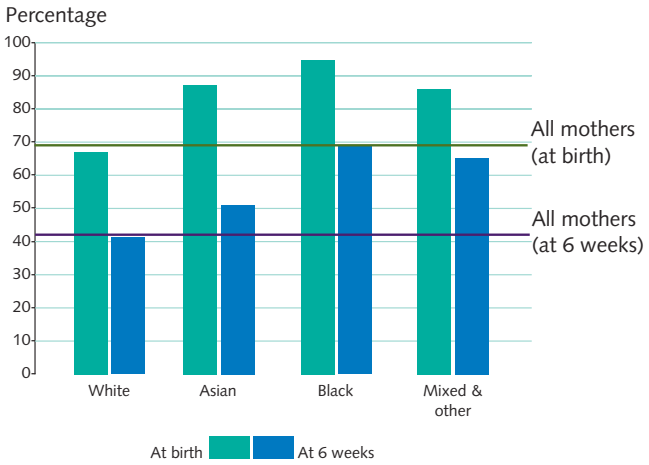
Mothers in higher social groups and in ethnic minorities are more likely to breastfeed.

Chart 9a: Prevalence of breastfeeding at birth and at six weeks by mother's socio-economic classification (NS-SEC)
United Kingdom, 2000



Source: British Market Research Bureau, on behalf of DH:
Infant Feeding Survey 2000 (Table 2.14) page 29
Web link www.dh.gov.uk/assetRoot/04/05/97/63/04059763.pdf

Chart 9b: Prevalence of breastfeeding at birth and at six weeks by mother's ethnic group
United Kingdom, 2000



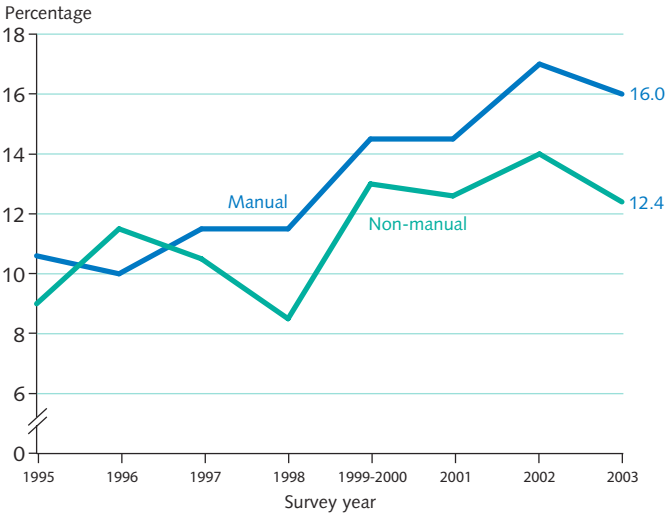
Source: British Market Research Bureau, on behalf of DH:
Infant Feeding Survey 2000 (Table 2.16) page 30
Web link www.dh.gov.uk/assetRoot/04/05/97/63/04059763.pdf

Levels of breastfeeding are lower amongst mothers from lower socio-economic groups, and a larger proportion give up breastfeeding by six weeks. Headline figures for 2005 indicate continuation of this pattern at birth, although there were notable increases in breastfeeding rates (at birth) from 59% to 65% among mothers in routine and manual occupations, and from 52% to 65% among mothers who never worked. The proportion of mothers who breastfeed is higher amongst minority ethnic groups than in the white population.

INDICATOR 10 Obese children

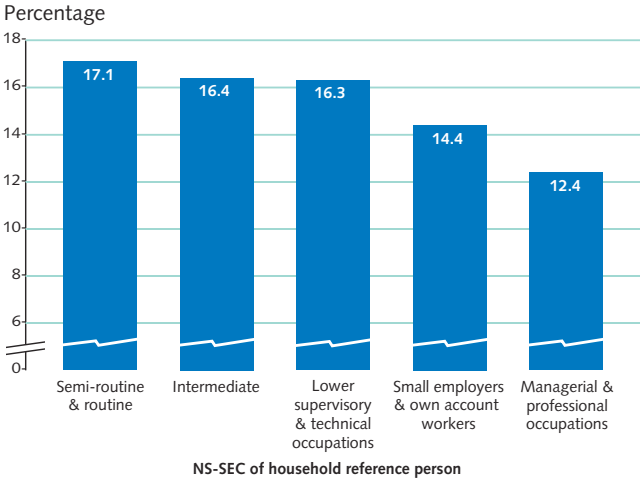
There is a rising trend in child obesity, with higher levels in manual groups.

Chart 10a: Obesity in children aged 2 to 10 by manual or non-manual social class
England



Source: Obesity among children under 11, Joint Health Surveys Unit, Table 4
Web link: www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics/PublicationsStatisticsArticle/fs/en?CONTENT ID=4109245&chk=WB/AR1

Chart 10b: Obesity in children aged 2 to 10 2001-02 by socio-economic group
England



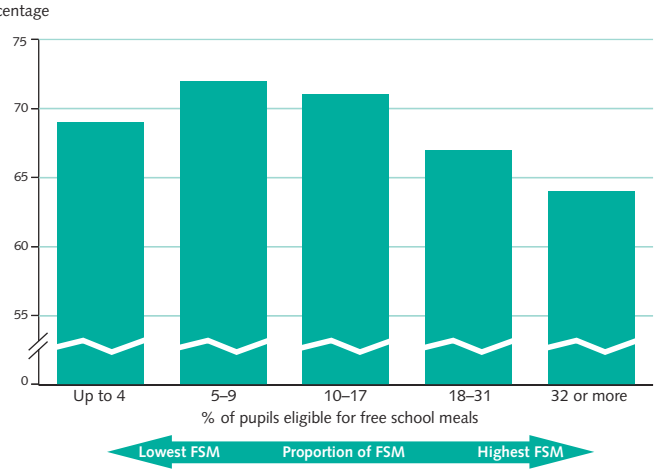
Source: Obesity among children under 11, Joint Health Surveys Unit, Table 9
Web link www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics PublicationsStatisticsArticle/fs/en?CONTENT ID=4109245&chk=WB/AR1

Although there are fluctuations, childhood obesity shows a rising trend. For most years there were no significant differences in levels of obesity between children living in manual households compared with those living in non-manual households. 1998, 2002 and 2003 are exceptions, and the emerging trend will need to be kept under review. The proportion of obese children aged 2–10 in the routine and semi-routine socio-economic groups is almost one and a half times higher than for children in managerial and professional socio-economic groups.

INDICATOR 11 Physically active children

There is less exercise taken in schools where many children get free school meals.

Chart 11a: Percentage of pupils who participated in at least two hours of high-quality PE and out-of-hours school sport in a typical week by percentage of pupils eligible for free school meals (FSM)[1]
England, 2004/05



[1] Based on survey of schools in school sport partnerships only

Source: DFES, The National PE, School Sport and Club Links Strategy (PESSCL): School Sports Survey Report 2004/05
Web link www.teachernet.gov.uk/docbank/index.cfm?id=9045

Participation in high-quality PE and sport at school is lower in those schools where a high proportion of children are eligible for free school meals, than in those schools where eligibility is lower.

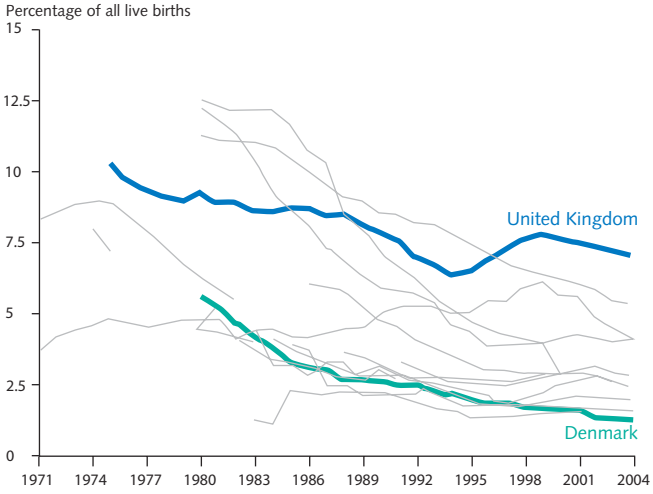
Lowest FSM: In schools where up to 4% of pupils are eligible for free school meals, 69% of pupils participate in at least two hours of high-quality PE and out-of-hours school sport in a typical week.

Highest FSM: In schools where 32% or more pupils are eligible for free school meals, 64% of pupils participate in at least two hours of high-quality PE and out-of-hours school sport in a typical week.

INDICATOR 12 Teenage pregnancy

There are higher levels of teenage pregnancy in the United Kingdom and in deprived areas.

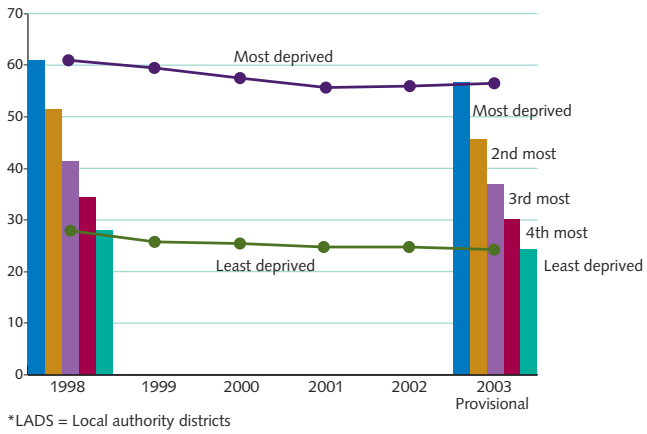
Chart 12a: Percentage of all live births to mothers aged under 20 years
EU-15 countries



Note: EU average is not available for these data. Rates for highest and lowest countries are highlighted. The grey lines represent the remaining EU-15 countries. The EU-15 are those countries who were members prior to the 2004 expansion.

Source: WHO, Health for All Database – Jun 2006
Web link: www.euro.who.int/hfadb

Chart 12b: Teenage conceptions by deprivation quintile (of LADS*)
England
Under 18 conceptions
per 1,000 female population aged 15 to 17



*LADS = Local authority districts

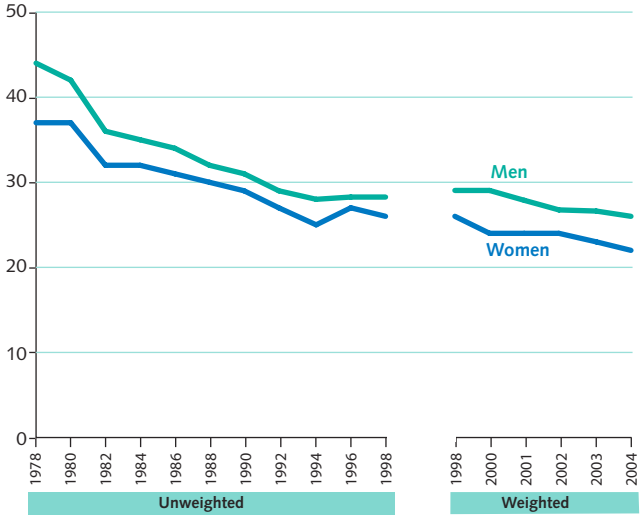
Source: ONS data, DH: Tackling health inequalities: Status report page 34
Web link www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4117696&chk=OXFbWI

Amongst the 15 European Union member states prior to expansion in 2004, the United Kingdom has the highest proportion of births to mothers aged under 20. Teenage conceptions are more than twice as likely to occur in the most deprived areas, than in the least deprived. The gap has persisted over the period illustrated.

INDICATOR 13 People who smoke

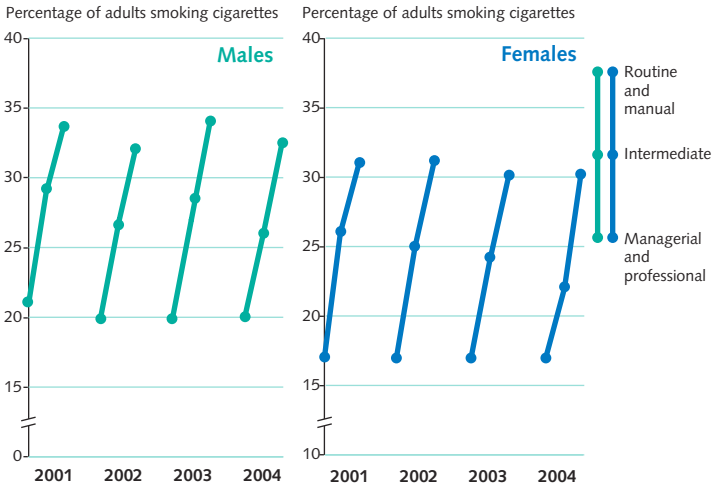
Prevalence of smoking has reduced, but is still higher among manual workers than professionals.

Chart 13a: Smoking prevalence by sex
Adults aged 16 or over, England
Percentage of adult population



Source: Data supplied by the Information Centre for Health and Social Care from the ONS General Houshold Survey 2004
Web link www.statistics.gov.uk/StatBase/Product.asp?vlnk=5756

Chart 13b: Prevalence of cigarette smoking by sex and gradient in socio-economic classification of the household reference person
Adults aged 16 and over, England



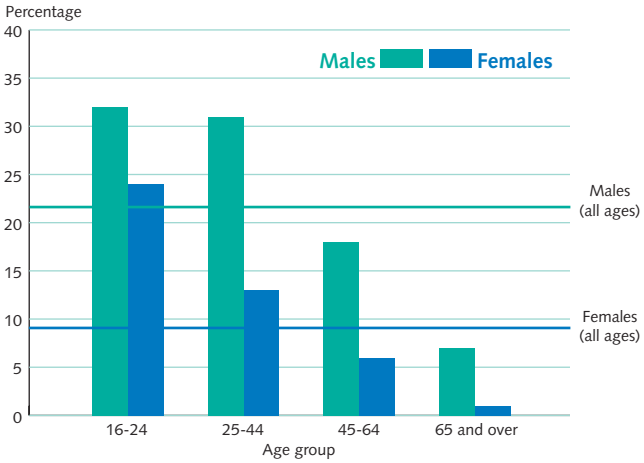
Source: ONS, General Household Survey 2004 (Table 8.9)
Web link www.statistics.gov.uk/StatBase/Product.asp?vlnk=5756

The prevalence of smoking in the adult population has fallen markedly since the late 1970s, with the percentage of men who smoke remaining higher than that for women. There is a strong and persistent socio-economic gradient.

INDICATOR 14 Binge drinking

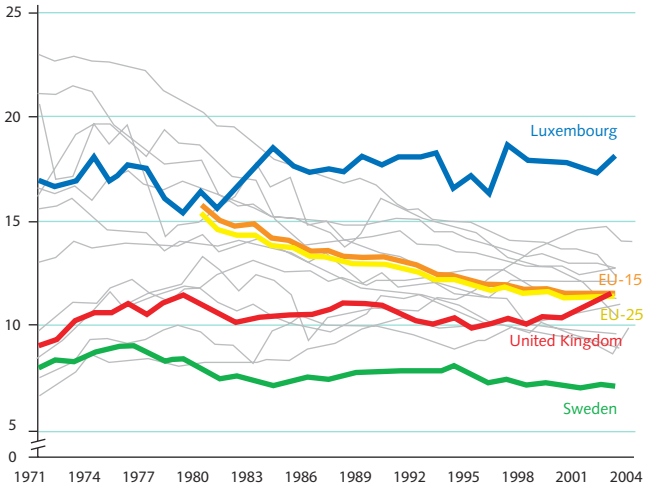
Young people are more likely to drink heavily. The gap in alcohol consumption between the UK and the EU average has disappeared.

Chart 14a: Adults exceeding twice the recommended daily benchmarks of alcohol consumption on at least one day during the last week (heavy drinking).
By age group, Great Britain, 2004



Source: General Household Survey 2004, (Table 9.2), (GHS 04_09 drinking.xls)
Web link www.statistics.gov.uk/StatBase/Product.asp?vlnk=5756

Chart 14b: Pure alcohol consumed
Aged 15 and over, EU-15 countries
Annual consumption, litres per person



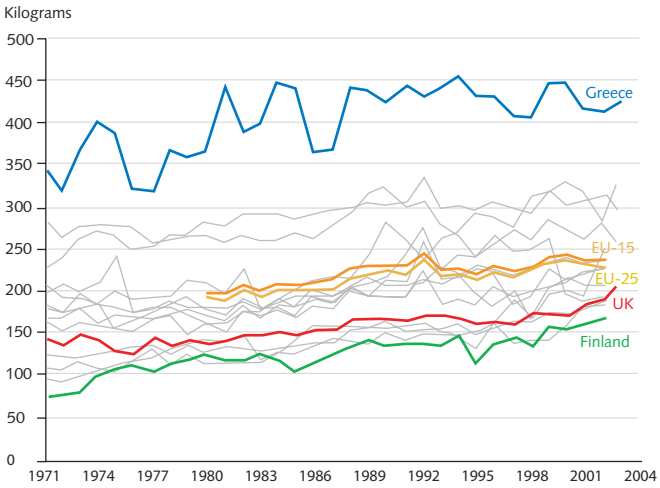
Note:The EU-15 countries are shown, with the highest and lowest countries highlighted, along with data from the United Kingdom and the averages for the EU-15 and the EU-25. The EU-15 are those who were members prior to the 2004 expansion.
Source WHO, Health for All Database – Jun 2006
Web link www.euro.who.int/hfadb

Around one third of men aged 16 to 24 had drunk on at least one day during the previous week more than twice the four units daily benchmark, compared with only 7% of men aged 65 and over. Amongst women aged 16 to 24, around one quarter exceeded twice the three units daily benchmark, compared with 1% of those aged 65 and over. Falling levels of alcohol consumption in many EU countries and static or rising trends in the UK have closed the gap with the EU average.

INDICATOR 15 Healthy eating

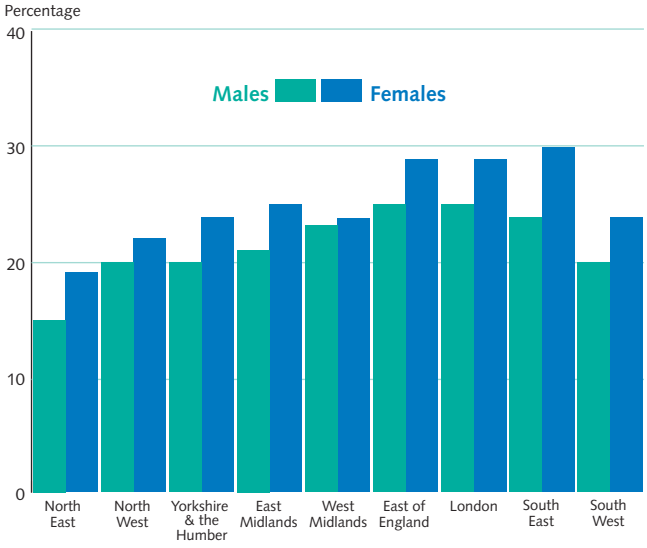
The United Kingdom lags behind most of Europe on fruit and vegetables, and northern England generally lags behind the south.

Chart 15a: Average amount of fruit and vegetables available
Per person per year



Note: The EU-15 countries are shown, with the highest and lowest countries highlighted, along with data from England and the averages for the EU-15 and the EU-25. The EU-15 are those who were members prior to the 2004 expansion.
Source: WHO, Health for All Database – Jun 2006
Web link www.euro.who.int/hfadb

Chart 15b: Percentage eating five portions or more of fruit and vegetables per day
By government office regions, males and females aged 16 and over, 2003



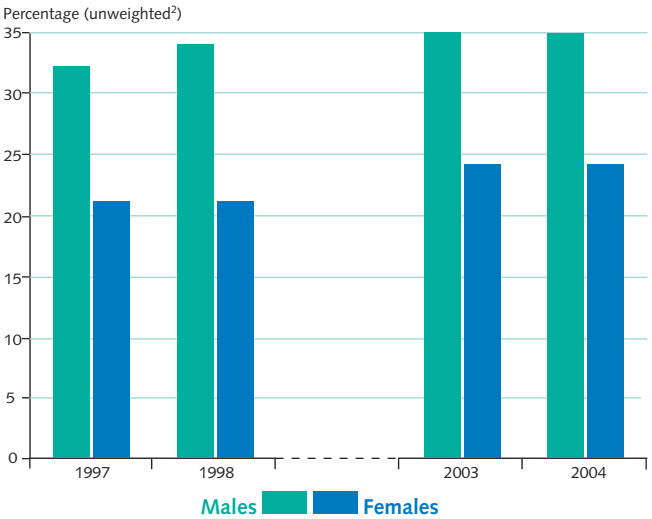
Source: Health Survey for England 2003, table 46, page 94
Web link www.dh.gov.uk/PublicationsAndStatistics/PublishedSurvey/HealthSurveyForEngland/HealthSurveyResults/fs/en

There has been some improvement in the average availability of fruit and vegetables, but the United Kingdom remains well below the EU average. There are marked regional differences within England in relation to the proportion eating five portions or more a day, as well as mean fruit and vegetable consumption and proportions who consumed no fruit and vegetables.

INDICATOR 16 Physically active adults

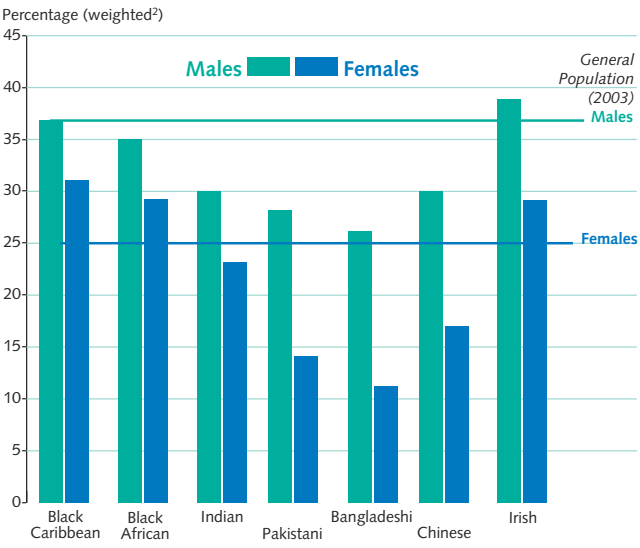
For both men and women, the proportion achieving the physical activity recommendations has risen between 1997 and 2004. Many ethnic minority groups take less exercise than the average.

Chart 16a: High levels of physical activity[1] by sex
Aged 16 and over, England 1997–2004



[1] 30 minutes or more of at least moderate activity on at least five days a week
[2] Unweighted data are used to provide a consistent trend
Source: Health Survey for England 2004, Department of Health (Table 17)
Web link www.dh.gov.uk/healthsurvey

Chart 16b: High levels of physical activity[1] by ethnicity
Aged 16 and over, England 2004



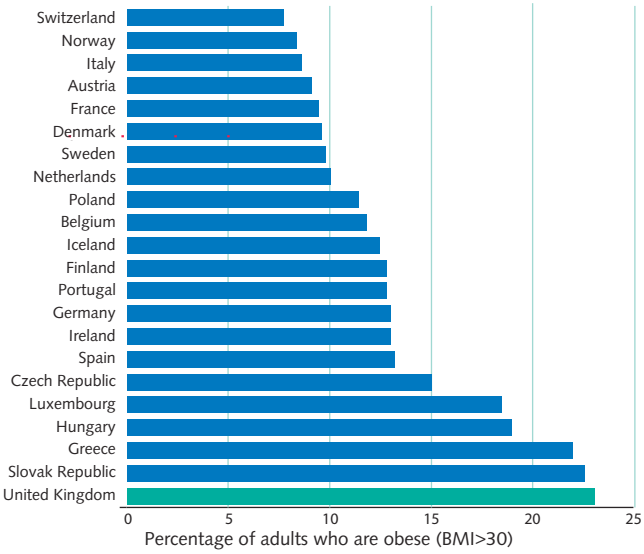
[1] 30 minutes or more of at least moderate activity on at least five days a week
[2] Weighted data are used to reduce non-response bias, thereby producing estimates that more accurately reflect the characteristics of the general population
Source: Health Survey for England 2004, Health of Ethnic Minorities (Table 8.1)
Web link www.ic.nhs.uk/pubs/hlthsvyeng2004ethnic/HSE2004Headlineresults.pdf/file

The proportion achieving the recommended levels for physical activity between 1997 and 2004 rose from 32% to 35% in men and 21% to 24% in women. Health Survey for England results for 2004 indicated that Asian men and women were less likely to meet the physical activity recommendations than the general population.

INDICATOR 17 Obese adults

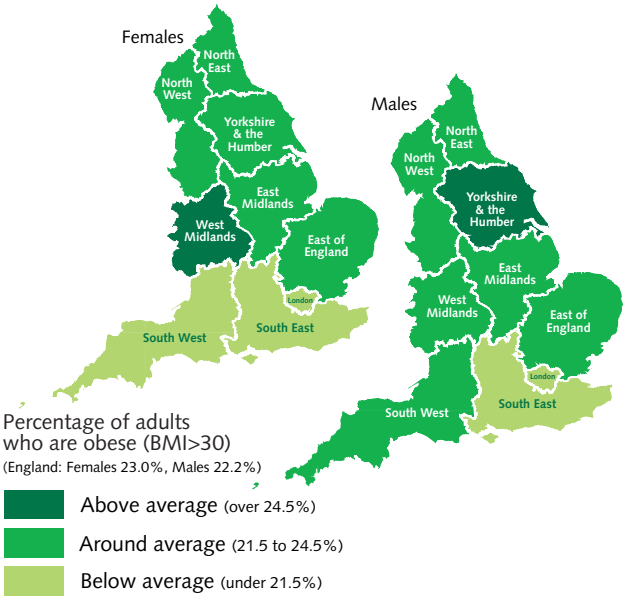
Prevalence of obesity in the United Kingdom is among the highest in Europe; in England in 2003, prevalence was highest in the West Midlands for women and in Yorkshire and the Humber for men.

Chart 17a: Adult obesity by selected European countries, c.2002–03



Source: OECD Fact book, 2006, Table 8
Web link caliban.sourceoecd.org/vl=1438066/cl=27/nw=1/rpsv/factbook/10-01-03.htm

Chart 17b: Adult obesity by region of England
Females and males, aged 16 and over, Government Office Regions, 2003



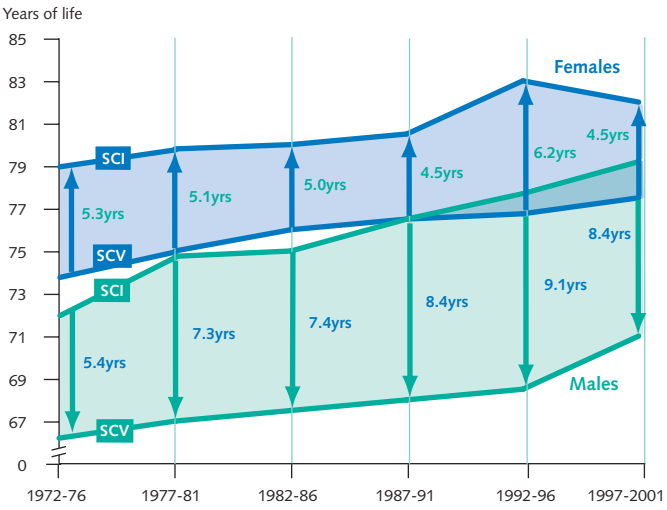
Source: Health Survey for England 2003, Table 6.10
Web link: www.dh.gov.uk/assetRoot/04/09/89/11/04098911.pdf

The United Kingdom population has the highest prevalence of obesity among the European countries illustrated, including the EU-15 countries (those who were members of the European Union prior to 2004). Within England, women living in the West Midlands were most likely to be obese, whilst those living in London, the South East and the South West showed the lowest prevalence. For men, the prevalence of obesity was greatest amongst those living in Yorkshire and the Humber, while those living in London showed the lowest prevalence. These figures differ from those shown in Table 1.1, which relate to all adults for the years 2000–02 combined. Year on year changes can be volatile, due to small sample numbers.

INDICATOR 18 Life expectancy

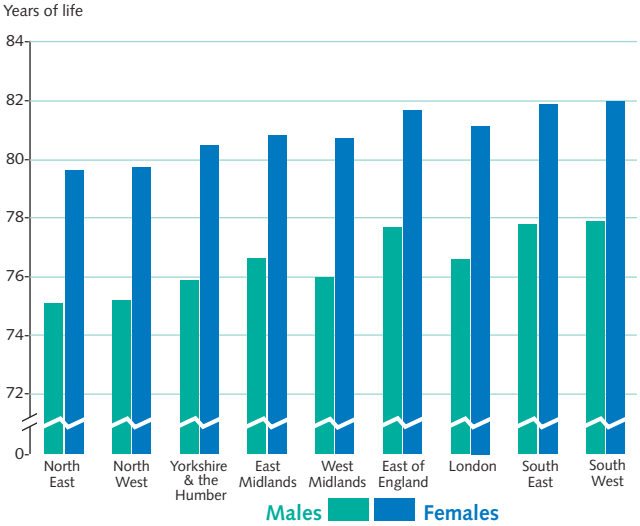
There is longer life expectancy in higher social classes, and in the south.

Chart 18a: Life expectancy at birth by social class and sex
England and Wales



Source: ONS Longitudinal Study – National Statistics Website
Web link: www.statistics.gov.uk/CCI/SearchRes.asp?term=life+expectancy

Chart 18b: Life expectancy at birth by region
2002–04



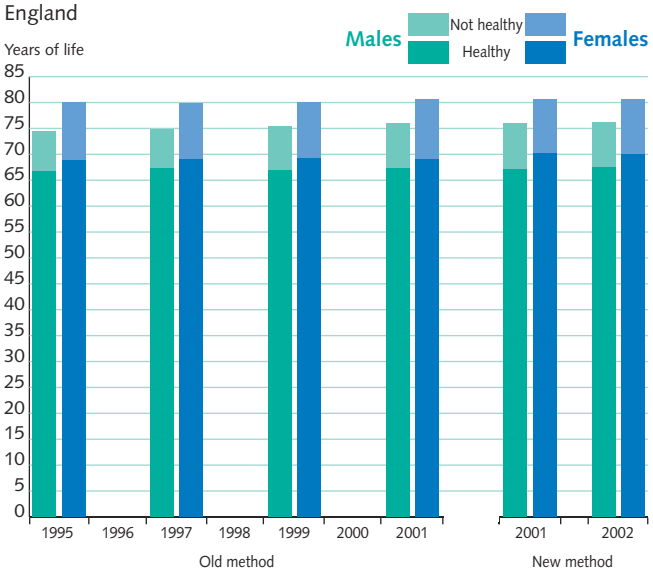
Source: ONS Data – available from National Centre for Health Outcomes Development, Compendium of Clinical and Health Indicators (Nov 2005 release)
Web link www.nchod.nhs.uk/ (table 0e3_186no_04_v1.xls)

The gap in life expectancy between old social classes I and V grew between the mid-1970s and mid-1990s. Men and women in the South East and South West of England live on average over two years longer than those in the North East and North West.

INDICATOR 18 Healthy life expectancy

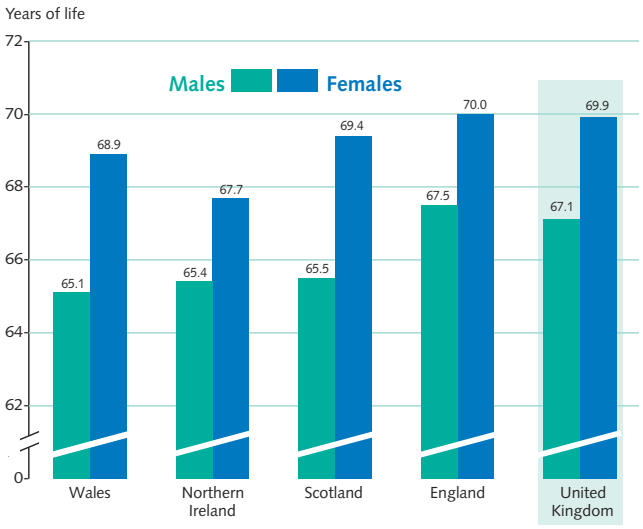
Improvements in life expectancy at birth are not being fully matched by gains in healthy years of life. Within the United Kingdom, people in England have the most years of healthy life.

Chart 18c: Life expectancy and healthy life expectancy at birth, by sex
England



Source: Office for National Statistics (ONS) Health Statistics Quarterly 29, Spring 2006
Web link www.statistics.gov.uk/StatBase/Product.asp?vlnk=6725&More=N

Chart 18d: Healthy life expectancy at birth by sex and UK country
2002



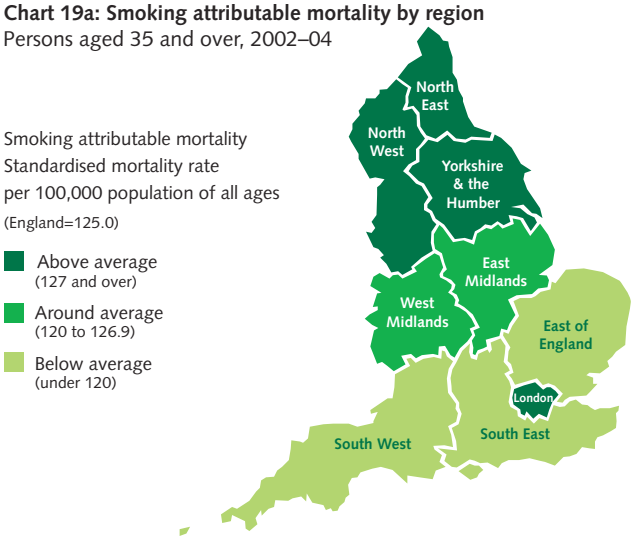
Source: Office for National Statistics (ONS) Health Statistics Quarterly 29, Spring 2006
Web link www.statistics.gov.uk/StatBase/Product.asp?vlnk=6725&More=N

The healthy life expectancy (HLE) measure used here is defined as expected years of life in (self-reported) good or fairly good health. It thus combines the length of life with expected years in perceived good health. The trend illustrated here reflects slight improvements in life expectancy at birth not being fully matched by gains in healthy years of life. Thus additional years of life gained over the last decade are not all spent in good health. For males, healthy life expectancy at birth in England is significantly higher than in other countries of the UK, whilst for females, it is only significantly higher than Northern Ireland.

INDICATOR 19 Deaths from smoking

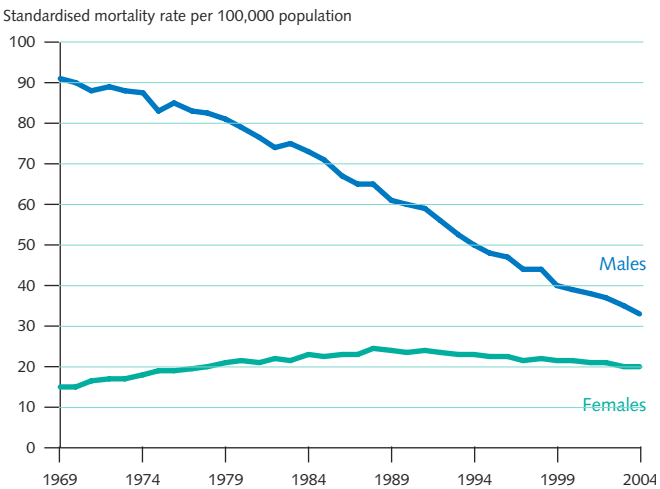
Smoking deaths are higher in northern England and London. The gap in lung cancer deaths between men and women has reduced.

Chart 19a: Smoking attributable mortality by region
Persons aged 35 and over, 2002–04



Source: Office for National Statistics (ONS) mortality data and mid-year population estimates analysed by the Association of Public Health Observatories Community Health Profile Project
Web link www.apho.org.uk/apho/net/viewResource.aspx?id=2909

Chart 19b: Premature mortality from lung cancer by sex
Males and females under age 75, England



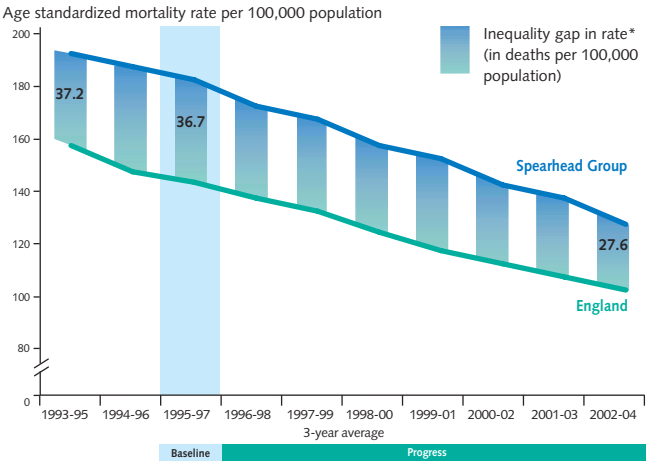
Source: ONS mortality statistics (ICD8 then ICD9 (to 2000), ICD10 C33–C34 (from 2001)).
Web link www.statistics.gov.uk/

Although the estimated smoking attributable mortality rate for men is more than double that for women, in 2002-04 the regional pattern is similar for both. The regional distribution for persons is shown on the map. For men, the West Midlands is also above average and for women, London is around average. Male death rates from lung cancer at ages under 75 have decreased substantially since the late 1960s, whereas those for women increased until the late 1980s, but have fallen slightly in recent years.

INDICATOR 20 Early deaths – circulatory diseases

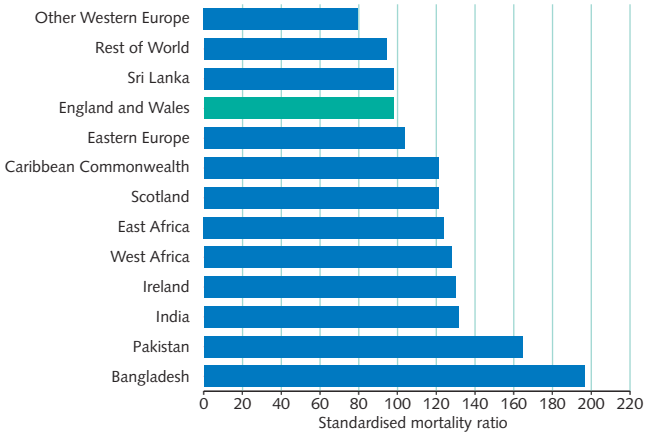
Deaths from circulatory diseases continue to fall; inequalities by geography and country of birth persist, but some narrowing has occurred in respect of a key group of disadvantaged areas.

Chart 20a: Inequality in premature mortality from circulatory diseases
People under age 75, England and 'Spearhead Group' of local authorities, 1993–2004



* The absolute gap between rate for England and rate for Spearhead Group.
Source: Department of Health, Departmental Report 2006, Chapter 2, page 16
www.dh.gov.uk/PublicationsAndStatistics/Publications/AnnualReports/DHAnnualReportsArticle/fs/en?CONTENT_ID =4134613&chk= KQuYrZ Local authority data can be found at NCHOD Compendium of Clinical and Health Indicators, using ONS data
Web link www.nchod.nhs.uk/

Chart 20b: Circulatory disease, standardised mortality ratio by country of birth for deaths registered in England and Wales
People aged 20 to 69, England and Wales 1999–2003



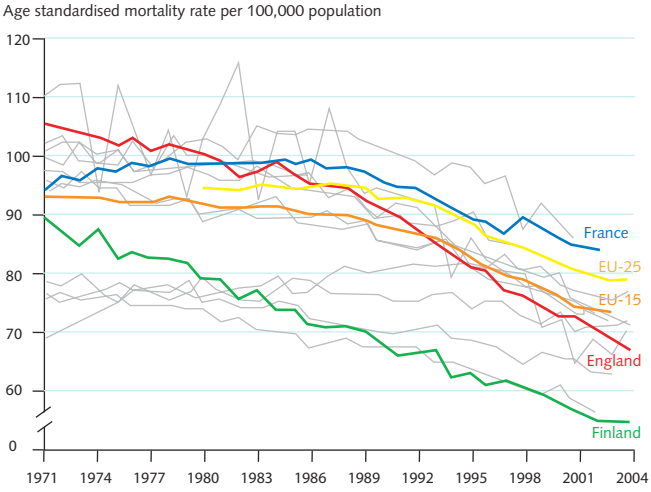
Source: London Health Observatory on behalf of the Association of Public Health Observatories (APHO), Indications of Public Health in the English Regions
Chapter 4: Ethnicity and Health, Figure 6.1
Web link www.apho.org.uk/apho/viewResource.aspx?id=2679

Good progress has been made in reducing premature mortality from circulatory diseases. The absolute gap between England as a whole and the Spearhead Group, the fifth of areas with the worst health and deprivation indicators, has reduced. However, the mortality rate in the Spearhead Group remains high in comparison with the rate in England. Country of birth is used here as a proxy for ethnicity – the analysis therefore has to be interpreted with caution. Mortality rates amongst many minority ethnic groups are generally higher than in people born in England and Wales.

INDICATOR 21 Early deaths – cancer

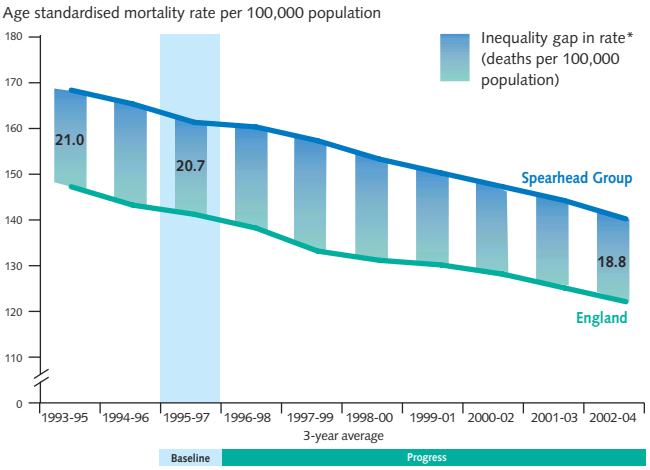
Deaths from cancer continue to fall, with levels in England being below the EU average; geographical inequalities persist, but some narrowing has occurred in respect of a key group of disadvantaged areas.

Chart 21a: Premature mortality from cancer
People aged under 65, EU–15 countries



The EU-15 countries are shown, with the highest and lowest countries highlighted, along with data from England and the averages for the EU-15 and the EU-25. The EU-15 are those who were members prior to the 2004 expansion. Source: WHO, Health For All Database – Jun 2006
Web link: www.euro.who.int/hfadb

Chart 21b: Inequality in premature mortality from cancer
People under age 75, England and 'Spearhead Group' of local authorities, 1993–2004



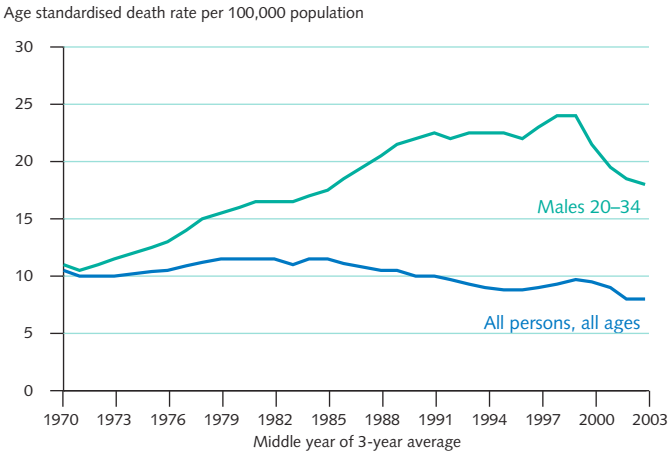
* The absolute gap between rate for England and rate for Spearhead Group.
Source: Department of Health: Departmental Report 2006, Chapter 2, page 16
www.dh.gov.uk/PublicationsAndStatistics/Publications/Annualreports/DHAnnualReportsArticle/fs/en?CONTENT_ID=4134613&chk=KQuYrZ
Local authority data can be found at NCHOD Compendium of Clinical and Health Indicators, using ONS data
Web link www.nchod.nhs.uk/

Cancer mortality in England has fallen faster than the average of the 15 European Union members prior to expansion in 2004. However, inequality remains within England. The absolute gap between the England average and the Spearhead Group average has narrowed since 1995–97.

INDICATOR SM Suicide

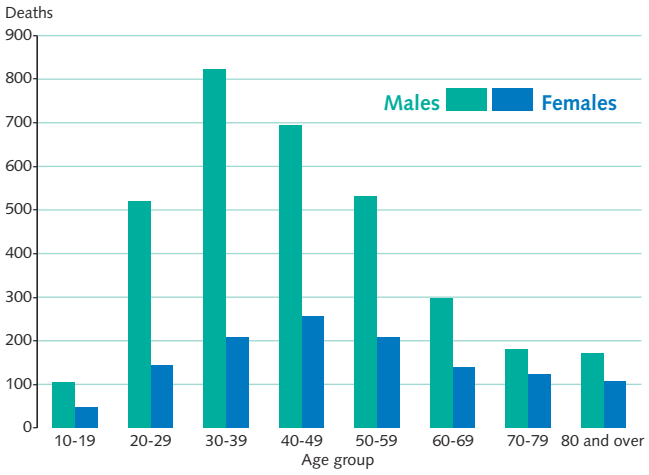
The majority of suicide deaths occur under the age of 60 years; the rising trend in suicides in young men has reversed in the most recent years.

Chart sm1: Mortality rate from suicide and injury and poisoning of undetermined intent in young men (aged 20 to 34) and overall
Three-year average rate, plotted against middle year of average, England (1969–2004)



Source: ONS mortality data (ICD10 X60-X84, Y10–Y34 excl. Y33.9 (verdict pending))
Web link www.statistics.gov.uk/StatBase/Product.asp?vlnk=618&Pos=&ColRank+1&Rank=224

Chart sm2: Number of deaths from suicide and injury and poisoning of undetermined intent
By age group, England 2004



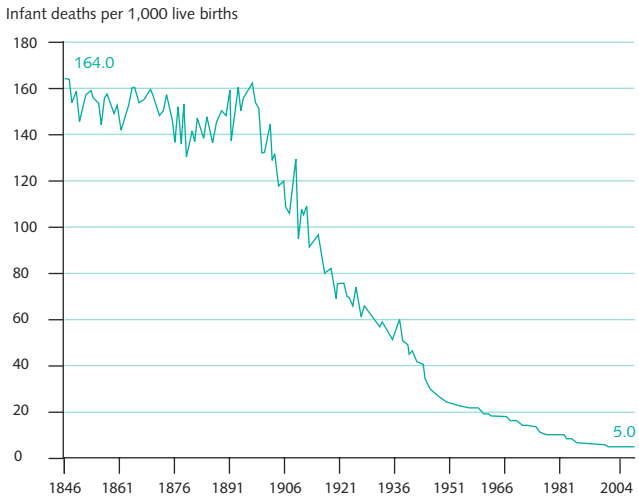
Source: ONS mortality data (ICD10 X60-X84, Y10–Y34, excl Y33.9 (verdict pending))
Web link www.statistics.gov.uk/StatBase/Product.asp?vlnk=618&Pos=&ColRank=1&Rank=224

Over the last third of the 20th century, suicide rates amongst young men rose steeply. It seems that this trend may now have been reversed. The highest numbers of suicide deaths occur at young and middle ages.

INDICATOR 22 Infant deaths

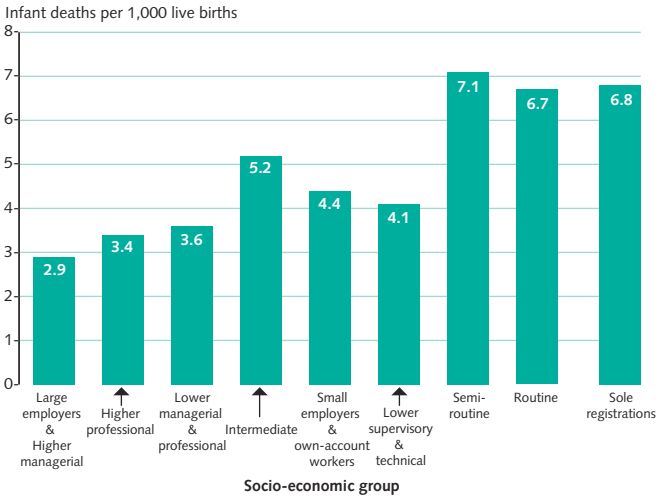
Deaths in infancy are at their lowest ever levels, but inequalities persist.

Chart 22a: Infant mortality
England and Wales



Source: Office for National Statistics DH series, then Health Statistics Quarterly
Web link www.statistics.gov.uk/statbase/Product.asp?vlnk=6305

Chart 22b: Three-year average infant mortality rates by socio-economic group (NS-SEC)
England and Wales 2002–04



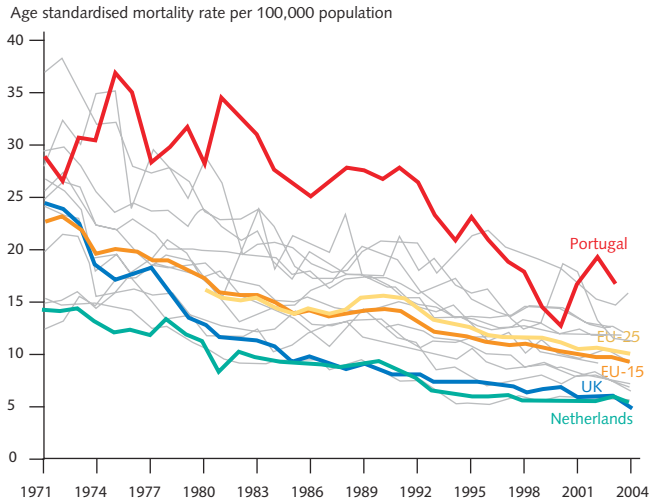
Source: Office for National Statistics (ONS)
Web link www.statistics.gov.uk/statbase/Product.asp?vlnk=6305

Following continuing high levels throughout the 19th century, improvements in nutrition and environmental and social determinants and health care resulted in a major reduction in infant mortality rates over the 20th century. By the close of the 20th century, infant mortality rates were over 30 times lower than at the start. However, inequalities remain. Infant mortality is nearly two and a half times higher in the routine socio-economic group than in the higher managerial group. High rates also occur amongst births outside marriage registered solely by the mother.

INDICATOR 23 Road injuries and deaths

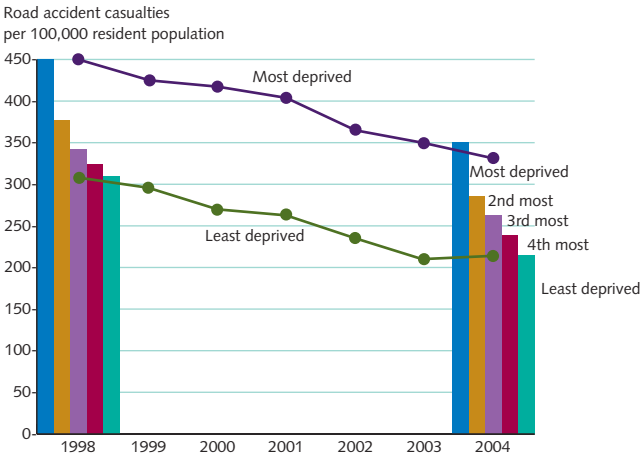
The United Kingdom has one of the lowest rates of death from motor vehicle traffic accidents in Europe. Casualties amongst children are higher in deprived areas.

Chart 23a: Death from motor vehicle traffic accidents
Persons, all ages, EU-15 countries



The EU-15 countries are shown, with the highest and lowest countries highlighted, along with data from the United Kingdom and the averages for the EU-15 and the EU-25. The EU-15 are those who were members prior to the 2004 expansion.
Source: WHO, Health For All Database – Jun 2006
Web link: www.euro.who.int/hfadb

Chart 23b: Road accident casualties by deprivation quintile,
Children aged 0 to 15, England



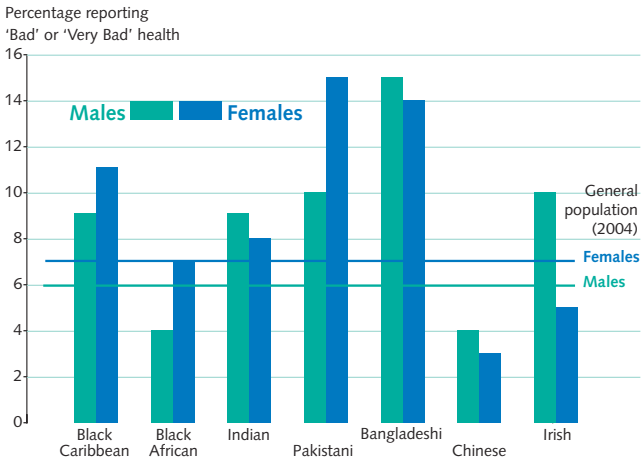
Source: DfT data analysed by DH
Web links www.dft.gov.uk/stellent/groups/dft.transstats/documents/page/dft.transstats.041303.hcsp
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4117696&chk=OXFbWI

For many years, the United Kingdom has had one of the lowest rates of death from motor vehicle traffic accidents in the European Union. For road accident casualties among children in England there is a persistent inequality gradient associated with deprivation, even though rates continue to fall.

INDICATOR 24 Feeling 'in poor health'

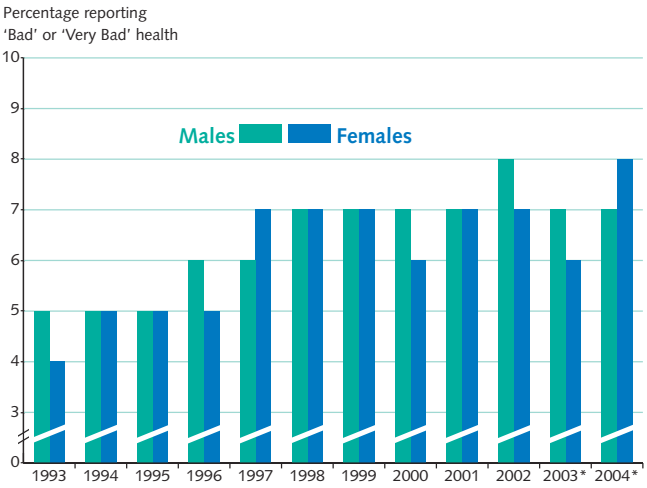
Levels of self-reported poor health vary among ethnic groups; after a rise in the early 1990s, levels of self-reported poor health have changed little.

Chart 24a: Prevalence of 'Bad' or 'Very Bad' self-reported health
Aged 16 and over, England 2004



Source: Health Survey for England 2004, Health of Ethnic Minorities (Table 2.1)
Web links www.dh.gov.uk/PublicationsAndStatistics/PublishedSurvey/HealthSurveyForEngland/HealthSurveyResults/fs/en
www.ic.nhs.uk/pubs/hlthsvyeng2004ethnic/HSE2004Headlineresults.pdf/file

Chart 24b: Trend of 'Bad' or 'Very Bad' self-reported health
Aged 16 and over, England 1993–2004



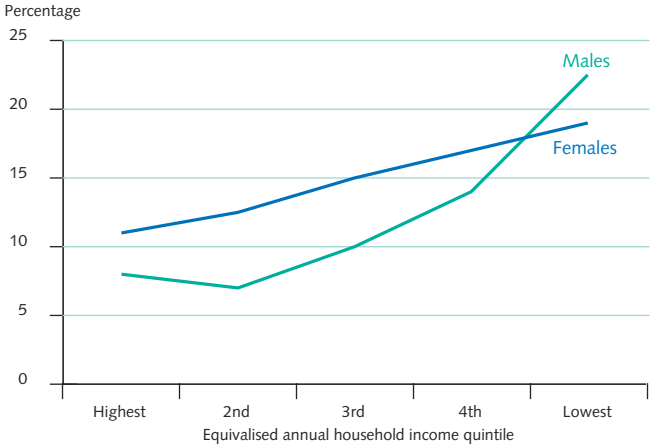
* Data for 2003 onwards are unweighted, to be consistent with prior years
Source: Health Survey for England 2004: (Trend Table 14)
Web link www.dh.gov.uk/PublicationsAndStatistics/PublishedSurvey/HealthSurveyForEngland/HealthSurveyResults/fs/en

About one in seven Bangladeshi men and one in 10 Pakistani men reported 'Bad' or 'Very Bad' health. The lowest prevalence of bad/very bad health was among Black African and Chinese men (4%) and men in the general population (6%). Amongst women, highest rates of poor health were reported by Bangladeshi and Pakistani women and lowest rates among Chinese women. Time trends in self-reported poor health show higher levels now than 10 years previously. However, three-quarters of the population report their health to be 'Good or 'Very Good'.

INDICATOR 25 Mental health treatment

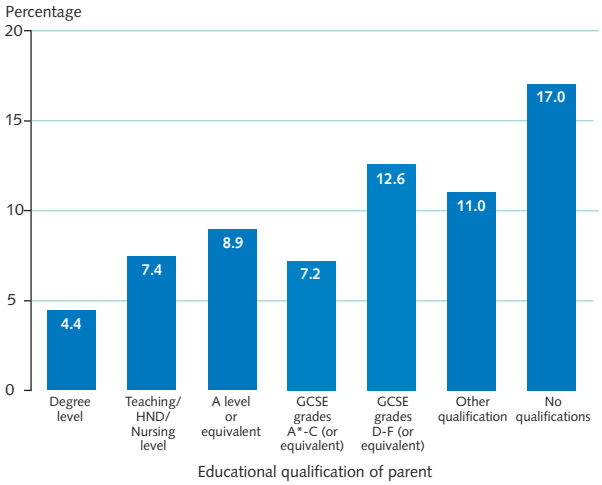
Mental ill health in adults rises as income falls. The prevalence of mental disorders increases among children whose parents had lower educational qualifications.

Chart 25a: Proportion of men and women with high GHQ score (age standardised), by equivalised household income
Adults aged 16 and over, 2003



Source: ONS Health Survey for England, 2003 (Table 10.23), page 329
Web link www.dh.gov.uk/healthsurvey

Chart 25b: Prevalence of mental disorders in children by educational qualification of parent
Great Britain 2004



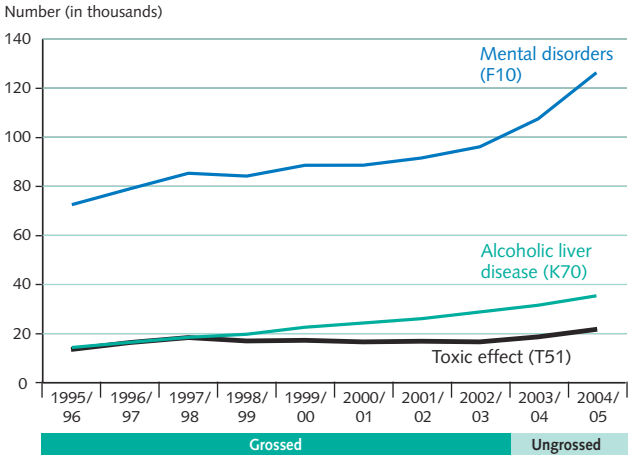
Source: Mental health of children and young people in Great Britain, 2004 (Table 4.6), Figure 4.10
Web link www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics/PublicationsStatisticsArticle/fs/en?CONTENT_ID=4118332&chk=0JUjTo

In 2003, across all household types, 11% of men and 15% of women had a high General Health Questionnaire (GHQ) score (4 or more), which is considered indicative of possible psychiatric ill health. In both sexes, the prevalence of high GHQ scores increased as household income decreased, more so in men than in women. The prevalence of mental disorders is greater among children whose parents had no educational qualifications (17%) compared with those who had a degree-level qualification (4%).

INDICATOR 26 Alcohol related hospital stays

Alcohol-related hospital admissions are increasing, and there are higher drink-related deaths in deprived areas.

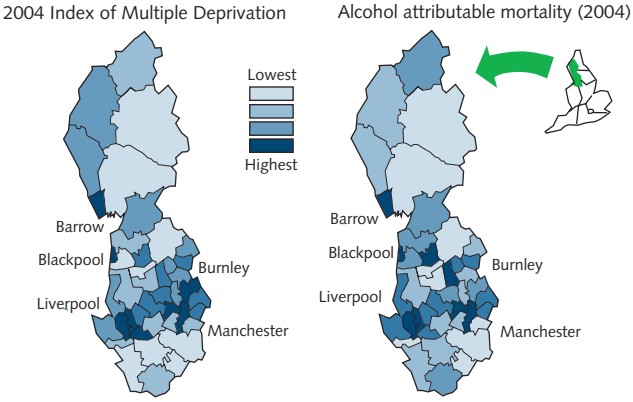
Chart 26a: Alcohol-related hospital admissions*
Selected conditions, by number of admissions, England



*Primary and secondary diagnosis by ICD 10 code

Source: Hospital Episode Statistics, Information Centre 2006
Web link www.ic.nhs.uk/pubs/alcoholeng2006 Table 5.2

Chart 26b: Correlation between deprivation and alcohol attributable mortality in the North West of England



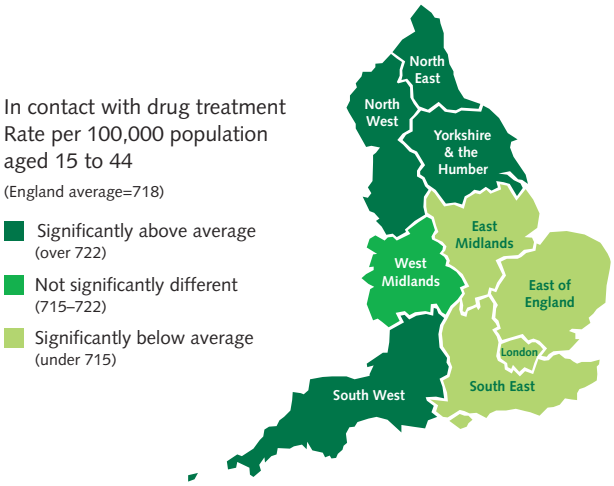
In the North West of England, premature death rates (people aged under 75) attributable to alcohol in the most deprived quintile of poulation are over three times the rate for the most affluent quintile. This stronger relationship is also apparent by geodemographic grouping with persons in the Urban Challenge lifestyle areas – the least affluent – being five times more likely to die from an alcohol attributable cause than those in the Mature Oaks areas – the most affluent.
Source: Wood J, Hennell T, Jones A, Hooper J, Tocque K, Bellis MA – the most affluent Where Wealth means Health: Illustrating Inequality in the North West, North West Public Health Observatory, January 2006
Web link www.nwpho.org.uk/inequalities/

Alcohol-related hospital admissions have risen by over 80% in the last 10 years. In particular, alcoholic liver disease has more than doubled in the period. The North West of England, where alcohol consumption is amongst the highest in England, experiences a disproportionately high health burden from alcohol misuse. There is a strong correlation between deprivation and areas with high alcohol attributable mortality.

INDICATOR 27 Drug misuse treatment

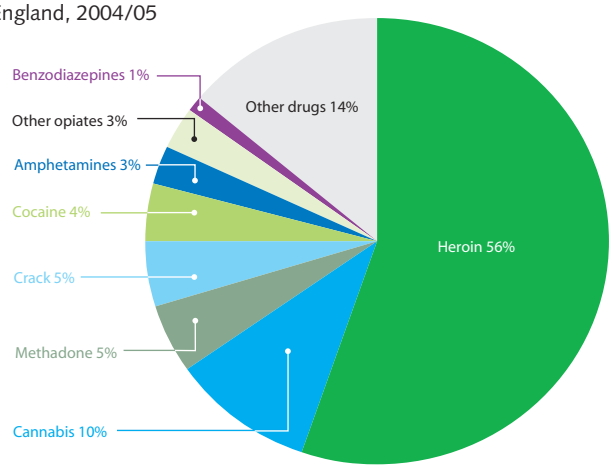
Drug treatment levels vary by region; heroin is the most common drug of misuse among those in structured drug treatment.

Chart 27a: In contact with drug treatment by region of residence
People aged 15 to 44, England, 2004/05



Source: National Statistics via the National Treatment Agency for Substance Misuse analysed by the Association of Public Health Observatories Health Profile Project.
Web Link: www.apho.org.uk/apho/net/viewResource.aspx?id=2909

Chart 27b: All clients in structured drug treatment, by main drug
England, 2004/05



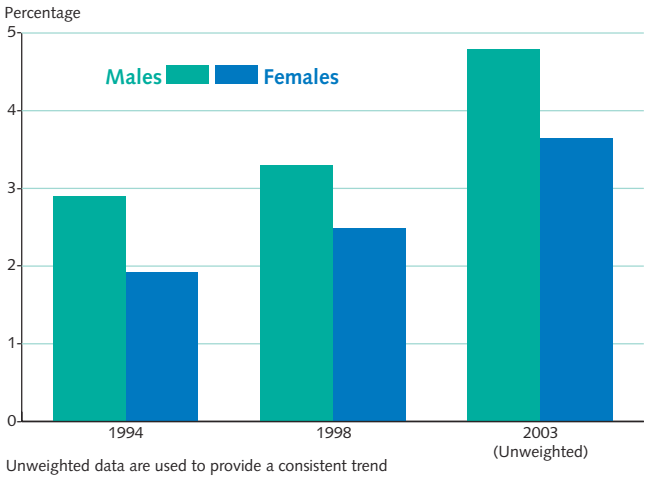
Total number of cases in structured drug treatment in England=160,505
Note: Percentages do not add up due to rounding.
Source: Department of Health, using National Statistics via the National Treatment Agency for Substance Misuse
Web link www.nta.nhs.uk/

A high rate of drug users in treatment is likely to indicate that there is a significant problem with drug misuse in the community. The present indicator reflects various factors including the underlying prevalence of drug use and the success with which it is detected and treated. Regional variation is evident but explanations are likely to be complex. Amongst clients in structured drug treatment, heroin is the most important single drug of misuse. Between 1999 and 2004, heroin/morphine was mentioned in almost half of male drug-related deaths and a quarter of such deaths in females.

INDICATOR 28 People with diabetes

The prevalence of diabetes is increasing. It particularly affects several minority ethnic groups.

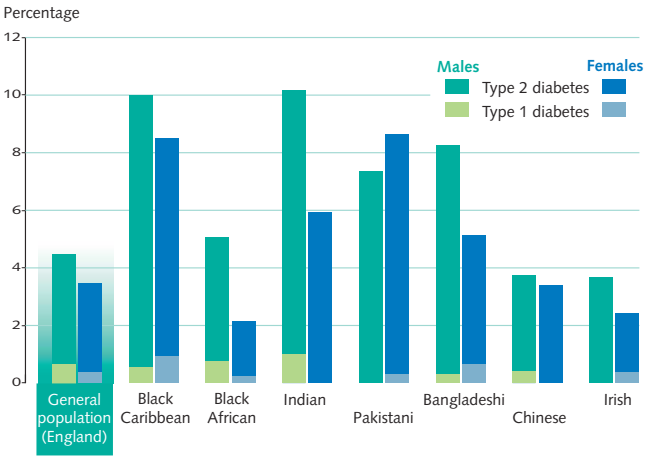
Chart 28a: Prevalence of doctor-diagnosed diabetes by sex
Aged 16 and over, England 1994,1998, 2003



Unweighted data are used to provide a consistent trend

Source: Health Survey for England 2003 Volume 2, Chapter 8, (Table 8.11), page 240
Web link www.dh.gov.uk/PublicationsAndStatistics/PublishedSurvey/HealthSurveyForEngland/HealthSurveyResults/fs/en

Chart 28b: Prevalence of doctor-diagnosed diabetes by ethnicity
Aged 16 and over, England 2004



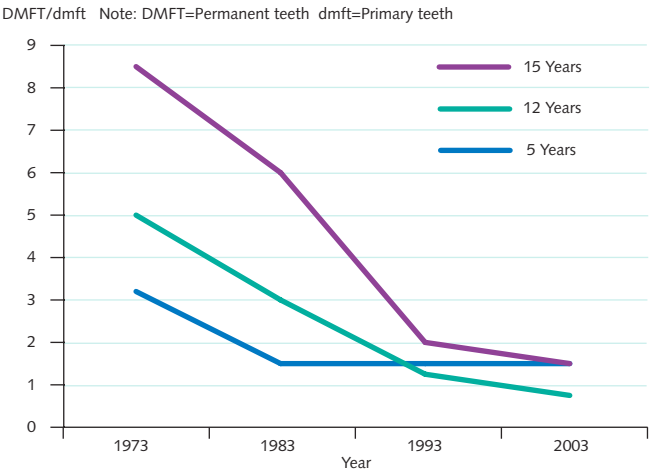
Source: Health Survey for England 2004 Health of Ethnic Minorities (Table 3.3)
Web links www.dh.gov.uk/PublicationsAndStatistics/PublishedSurvey/HealthSurveyForEngland/HealthSurveyResults/fs/en
www.ic.nhs.uk/pubs/hlthsvyeng2004ethnic/HSE2004Headlineresults.pdf/file

Over the 10 years from 1994 to 2003, the prevalence of diabetes increased by around two-thirds for men and almost doubled for women. The prevalence of diabetes is much higher than average in people from several minority ethnic groups. With one in 10 affected, prevalence of doctor-diagnosed diabetes amongst Black Caribbean and Indian men is approaching two and a half times higher than the general population. There is a similar gap between Black Caribbean and Pakistani women and the average for women in England.

INDICATOR 29 Children's tooth decay

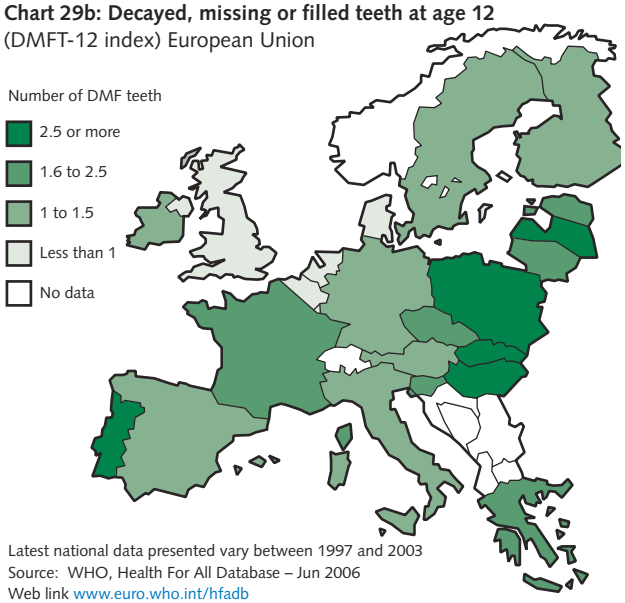
Oral health is improving: dental decay for 12 year olds and 15 year olds is at the lowest level since records began. Twelve-year-old children in England now have among the best oral health in Europe.

Chart 29a: Average decayed, missing or filled teeth per child by age
England



Source: National Children's Dental Surveys 1973 to 2003. Harker R and Morris J (2005) Office for National Statistics, London
Web link www.dh.gov.uk/assetRoot/04/12/38/85/04123885.pdf

Chart 29b: Decayed, missing or filled teeth at age 12
(DMFT-12 index) European Union



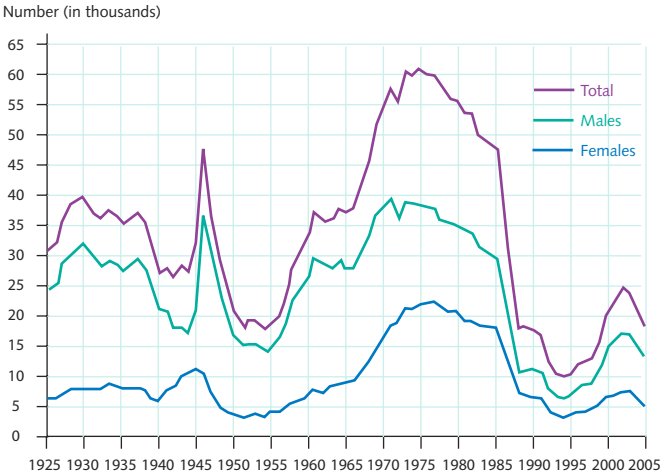
Latest national data presented vary between 1997 and 2003
Source: WHO, Health For All Database – Jun 2006
Web link www.euro.who.int/hfadb

The oral health of children in England is the best since records began. In the early 1970s, around 30% of children started school with no experience of tooth decay; by 2003 this figure had risen to 59%. The number of decayed, missing and filled (DMF) teeth in older children reduced considerably over the last third of the 20th century. However, after reducing in the 1970s, the number of DMF teeth in five year olds has remained roughly the same since 1983. Twelve-year-old children in England now have among the best oral health in Europe, as measured by the World Health Organization (WHO).

INDICATOR 30 Sexually transmitted infections

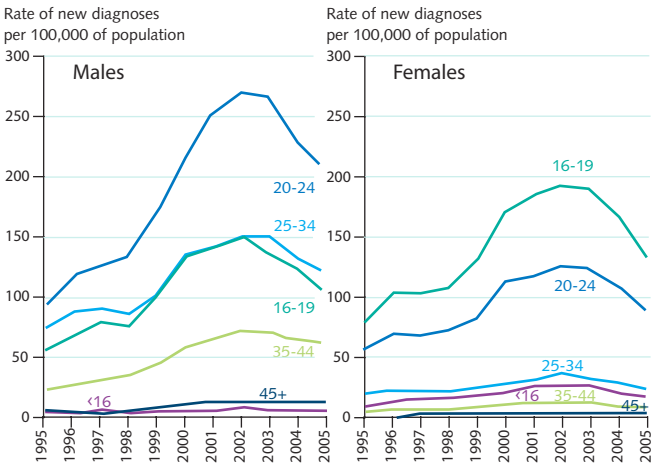
There was a peak in gonorrhoea cases in the 1970s. Recent rises since the mid-1990s may once again be reducing.

Chart 30a: Number of diagnoses of gonorrhoea by sex
GUM clinics, England and Wales 1925–2005



Source: Health Protection Agency (HPA), KC60 and STISS/ISD(D)5 returns from GUM clinics, England.
Web link www.hpa.org.uk/infections/topics_az/hiv_and_sti/epidemiology/datatables2005.htm (Data tables)

Chart 30b: Rates of gonorrhoea by sex and age group
United Kingdom 1995–2005



Source: Health Protection Agency (HPA), KC60 and STISS/ISD(D)5 returns from GUM clinics, England
Web link www.hpa.org.uk/infections/topics_az/hiv_and_sti/epidemiology/datatables2005.htm (Data tables)

Gonorrhoea is the second most commonly diagnosed bacterial sexually transmitted infection in England. Established reporting procedures mean that trend data are currently more robust than those for chlamydia. Current rates are substantially lower than during the mid 1970s and early 1980s. However, there were rises around the turn of the century, particularly amongst young men and women. There are signs that the rate may once again be reducing.

SECTION 4

A Snapshot of Health and Well-being in England 'The State of the Nation's Health'

A snapshot tabulation of the state of health and well-being in England is included to illustrate the broader context for the profile. This has been developed from a template originally used in the production of community profiles by NHS Scotland, published in 2004 www.healthscotland.com/profiles.

The following commentary highlights some key points on recent trends for selected indicators presented in the snapshot tabulation.

Selected Key Points:

Comments generally relate to the underlying trend over the last five years of available data, and give a broader assessment than the change arrows in the snapshot tabulation. The arrows are based on comparison of the endpoints of the time period only rather than the underlying trend across all years in the period, for reasons explained in the note on interpretation below.

Population

- The live birth rate and the overall population are rising.
- Over the last five years, the proportion of the population aged 65 and over has remained the same. The proportion aged 15–64 has increased slightly, while the proportion of the population who are aged under 15 years has decreased slightly (these are very small changes of 1 percentage point).

Our communities

- The number of homeless families with children in temporary accommodation has increased in recent years, although it has started to fall in the most recent quarters. Child poverty is falling.
- Attainment of five GCSEs at grades A*–C has increased in recent years, and the proportion of adults of working age with no qualifications has fallen.

Giving children and young people a healthy start

- Teenage conception rates are falling.
- The prevalence of child obesity is increasing.

- The proportion of schoolchildren drinking alcohol has decreased slightly in recent years. Smoking and drug misuse among schoolchildren have been relatively stable over recent years, with small fluctuations.
- MMR immunisation rates have been falling, although there was a slight increase in the last year.

The way we live

- Smoking prevalence is falling among both males and females. Alcohol consumption and drug misuse have been stable over the last five years, with small fluctuations from year to year.
- Obesity prevalence is rising for both males and females. There have been slight increases in physical activity levels and fruit and vegetable consumption in recent years.

How long we live, and what we die of

- Life expectancy at birth is increasing for both males and females. Gains in life expectancy are not being fully matched by gains in healthy life expectancy.
- Overall mortality rates are falling across age groups (including infant and perinatal mortality) and for the major causes of premature death (circulatory diseases and cancer).
- Suicide rates have fallen over the last five years, although there was a slight increase in the last year.
- Accident mortality rates have fluctuated over the last few years, and are slightly higher than five years ago.
- Accident mortality rates for older people are increasing.

Health and ill health in communities

- Although rates of mortality from cancer are reducing, the picture is mixed with regard to cancer incidence.
- Diabetes prevalence has risen among adults over the past five years, continuing an earlier trend.
- Gonorrhoea rates have fallen in the most recent years, following a rise since the mid-1990s.

Interpretation of snapshot tables

Snapshot tables are presented for each domain. They are a high-level summary showing the latest data and the direction of change since the last year, and since five years previously.

The direction of change is shown regardless of magnitude and without regard to statistical significance, as it proved impossible, in such a wide ranging set of data, to apply a consistent standard by which to interpret change. The five-year direction of change is based on comparison of the endpoints of the time period only. It is not an assessment of the underlying trend and does not take account of possible fluctuations during the period.

The colours of the arrows give a general guide – green indicates an improvement (eg. an increase in life expectancy or a decrease in mortality rates), red indicates a deterioration (eg. an increase in obesity or a decrease in childhood immunisation rates). Grey arrows indicate either no change, or a change which is neither 'good' nor 'bad' (eg. population changes).

The arrows are most usefully viewed as a group within each table. This gives a rough impression of change for each domain. 'How long we live, and what we die of' (Table 5E), for example, shows a majority of green arrows, whilst for 'Health and ill health in communities' (Table 5F) there is more of a balance between red and green. However, it should be kept in mind that the data included within the snapshot are a limited selection.

Within the snapshot there is a focus on health data, however wider determinants are critical factors underlying health trends and several important factors have been included.

Table 5A – Snapshot of health and well-being in England

Population	Year	Number	Measure		Change* 5yr	Change* 1yr
Total population – females	2004	25,539,200	as number	n	↑	↑
Total population – males	2004	24,553,900	as number	n	↑	↑
Population aged under 15 – females (a)	2004	4,438,000	17	%	↓	↓
Population aged under 15 – males (a)	2004	4,666,700	19	%	↓	↔
Population aged 15 to 64 – females (a)	2004	16,530,200	65	%	↑	↔
Population aged 15 to 64 – males (a)	2004	16,455,900	67	%	↑	↔
Population aged 65 and over – females (a)	2004	4,571,000	18	%	↔	↔
Population aged 65 and over – males (a)	2004	3,431,200	14	%	↔	↔
Minority ethnic community population (a)	2001	4,459,470	9	%	nd	nd
Lone parent families with dependent children (b)	2001	1,515,123	25	%	nd	nd
Lone pensioner households (c)	2001	2,939,465	14	%	nd	nd
Live births	2004	607,200	12.1	cr	↑	↑

Population notes

(a) Measure = % of total population (male/female/persons as appropriate).
(b) Measure = % of all families with dependent children.
(c) Measure = % of all households.

General notes

*Arrows provide a snapshot of change in the measure (based on comparison of endpoints of time period only). Full assessment of the trend requires consideration of a more complete run of years. Change is assessed based on rounded figures. Changes may not be statistically significant.
GREEN = improving trend; **RED** = deteriorating trend
Data are for England except where otherwise stated.
cr = crude rate (per 1,000 population unless otherwise stated)
EW = England and Wales data
sr = age standardised rate (per 100,000 population – to the European standard population)
P = provisional data
n = number
yr = years
nd = no data

Table 5B – Snapshot of health and well-being in England

Our communities	Year	Number	Measure		Change* 5yr	Change* 1yr
Employment (a) (b)	2005	23,253,000	75.0	%	↓	↔
Air quality – PM10 (Urban background) (c)	2005		23	cn	↔	↑
Air quality – PM10 (Roadside) (c)	2005		32	cn	↔	↑
Air quality – Ozone (Urban background) (d)	2005		56	cn	↑	↔
Air quality – Ozone (Rural) (d)	2005		70	cn	↑	↓
Poor-quality housing – Social sector (e) (f)	2004	1,252,000	31.3	%	↓	↓
Poor-quality housing – Vulnerable private sector (e) (g)	2004	1,033,000	34.5	%	↓	↓
Homeless families with children (h) (i)	2005/06P	71,560	as number	n	↑	↓
Children in poverty – before housing costs (j)	2004/05		19	%	↓	↓
Children in poverty – after housing costs (j)	2004/05		28	%	↓	↔
GCSE achievement (five at grades A*–C) (k)	2004/05P	358,598	56.3	%	↑	↑
Participation in higher education (ages 17–30) (l)	2004/05P	271,000	42	%	↑	↔
Adults with no qualifications (a)	2005		12.9	%	↓	↓
Violent crime incidents (EW) (m) (o)	2005/06	2,420,000	561	cr	↓	↓
Overall crime incidents (EW) (n) (o)	2005/06	10,912,000	as number	n	↓	↑
Older people supported at home (any service) (p) (q)	2004/05	641,906	80	cr	nd	nd
Older people supported at home (intensive home care) (r)	2004/05	92,255	32.0	%	↑	↑

Our communities notes

cn = concentration (micrograms/cubic metre).
(a) Based on working-age population (16 to 59/64 years old for females/males).
(b) Figures at Quarter 2 (April – June) each year, seasonally adjusted.
(c) Annual mean concentration.
(d) Annual mean of the daily maximum eight-hour running mean concentration.
(e) '5yr change' based on 2004 vs 1996 comparison.
(f) Number and % of social sector homes that are non-decent.
(g) Number and % of vulnerable private sector households living in non-decent homes.
(h) Homeless families with dependent children in temporary accommodation. Based on data for quarter ending 31 March each year. 2004/05 (used for '1yr change') and 2005/06 data are provisional.
(i) '5yr change' based on 2005/06 vs 2001/02 comparison.
(j) Living in relative low-income households (below 60% of Great Britain median income).
(k) Based on pupils aged 15 at start of academic year, all schools (including non-maintained schools). From 1996/97 includes GCSEs and GNVQs, from 2003/04 includes GCSEs and other equivalent qualifications approved for use pre-16.
(l) Measure = the sum, for each year of age between 17 and 30, of the % of the age group who participate in higher education for the first time, for at least six months.
(m) For violent offences, cr= per 10,000 adults. BCS violence includes common assault, wounding, robbery and snatch theft. Homicides are excluded.

Our communities notes (continued)

(n) Rate cannot be calculated for overall crime incidents as this combines data collected by household and by person victimised.
(o) '5yr change' based on 2005/06 vs 1999 comparison.
(p) For older people helped to live at home, cr= per 1,000 population aged 65 and over.
(q) 2004/05 data for older people helped to live at home are not comparable with previous years.
(r) Number of households receiving intensive home care, and as % of the total being supported by social services intensively at home or in residential care.

General notes

*Arrows provide a snapshot of change in the measure (based on comparison of endpoints of time period only). Full assessment of the trend requires consideration of a more complete run of years. Change is assessed based on rounded figures. Changes may not be statistically significant.
GREEN = improving trend; **RED** = deteriorating trend
Data are for England except where otherwise stated
cr = crude rate (per 1,000 population unless otherwise stated)
EW = England and Wales data
sr = age standardised rate (per 100,000 population – to the European standard population)
P = provisional data
n = number
yr = years
nd = no data

Table 5C – Snapshot of health and well-being in England

Giving children and young people a healthy start	Year	Number	Measure		Change* 5yr	Change* 1yr
Smoking in pregnancy (a)	2005		17	%	↓	nd
Breastfeeding (at six weeks) (EW) (b)	2000		43	%	↓	nd
Obese children (aged 2 to 10) (c) (d)	2004		14.3	%	↑	↑
Physically active children (PE and school sport) (e)	2004/05		69	%	nd	↑
Healthy eating (five a day) – children (f)	2004		13	%	nd	↑
Schoolchildren smoking (g) (h)	2005		9	%	↓	↔
Schoolchildren drinking (g) (i)	2005		22	%	↓	↓
Schoolchildren drinking – mean consumption (g) (i)	2005		10.5	un	↑	↓
Schoolchildren misusing drugs (g) (j) (k)	2005		19	%	↓	↑
Teenage pregnancy (under 18 conceptions) (l)	2004P	39,545	41.5	cr	↓	↓
Teenage pregnancy (under 16 conceptions) (m)	2004P	7,179	7.5	cr	↓	↓
Low birthweight babies (n)	2004	46,212	7.6	%	↔	↓
Immunised by first birthday (dTaP/IPV/Hib) (o)	2004/05		90	%	↓	↓
Immunised by first birthday (MenC) (p)	2004/05		90	%	nd	↔
Immunised by second birthday (MMR) (p)	2004/05		80.9	%	↓	↑
'Looked after' children (q)	2005	60,900	55	cr	↑	↔

Giving children and young people a healthy start notes

(a) % of mothers who smoked throughout pregnancy.
(b) % of babies being breastfed at six weeks of age.
(c) % of children aged 2 to 10 classified as obese (defined using UK BMI percentiles classification).
(d) '5yr change' based on 2004 vs 1999/2000 comparison.
(e) % of pupils in school sport partnership schools who spend a minimum of two hours in a typical week on high-quality PE and school sport. The number of schools in a school sport partnership increased between 2003/04 and 2004/05 – full coverage of schools will not be achieved until September 2006.

Giving children and young people a healthy start notes (continued)

(f) % consuming five or more portions of fruit and vegetables per day, ages 5–15. Weighted data (for non-response) from the Health Survey for England.
(g) Ages 11 to 15.
(h) Regular smokers (usually smoke at least one cigarette a week).
(i) Based on pupils who drank in week before interview. For mean consumption, un = units of alcohol per week.
(j) Pupils who had taken drugs in the last year at time of interview.
(k) '5yr change' based on 2005 vs 2001 comparison.
(l) For under 18 conceptions, cr = per 1,000 females aged 15–17.
(m) For under 16 conceptions, cr = per 1,000 females aged 13–15.
(n) Live births <2,500g. Measure = as % of all live births with stated birthweight.
(o) Mean of % immunised for each of Diphtheria, Tetanus, Polio, Whooping Cough, and Hib (Haemophilus influenzae type b). In 2004/05 the % immunised for each of these conditions individually was the same, at 90%.
(p) MenC = meningococcal group C; MMR = measles, mumps and rubella.
(q) Children looked after by local authorities, at 31 March. cr = per 10,000 children under 18.

General notes

*Arrows provide a snapshot of change in the measure (based on comparison of endpoints of time period only). Full assessment of the trend requires consideration of a more complete run of years. Change is assessed based on rounded figures. Changes may not be statistically significant.
GREEN = improving trend; **RED** = deteriorating trend
Data are for England except where otherwise stated.
cr = crude rate (per 1,000 population unless otherwise stated)
EW = England and Wales data
sr = age standardised rate (per 100,000 population – to the European standard population)
P = provisional data
n = number
yr = years
nd = no data

Table 5D – Snapshot of health and well-being in England

The way we live	Year	Number	Measure		Change* 5yr	Change* 1yr
People who smoke – adult females (a) (b)	2004		23	%	↓	↓
People who smoke – adult males (a) (b)	2004		26	%	↓	↓
Smoking cessation (four-week quitters) (c)	2004/05	298,124	56	%	↑	↓
Drinking – adult females (a) (d)	2004		22	%	↑	↔
Drinking – adult males (a) (d)	2004		39	%	↔	↓
Binge drinking – adult females (a) (e)	2004		10	%	↑	↑
Binge drinking – adult males (a) (e)	2004		22	%	↔	↓
Healthy eating (five a day) – adult females (f)	2004		27	%	nd	↑
Healthy eating (five a day) – adult males (f)	2004		23	%	nd	↑
Physically active adults – females (a) (g) (h)	2004		25	%	↑	↑
Physically active adults – males (a) (g) (h)	2004		37	%	↑	↑
Obese adults – females (h)	2004		23.2	%	↑	↑
Obese adults – males (h)	2004		22.7	%	↑	↑
Adults misusing drugs (any drug) (EW) (i)	2004/05	3,544,000	11.3	%	↓	↓
Adults misusing drugs (Class A drugs) (EW) (i)	2004/05	1,012,000	3.2	%	↑	↓

The way we live notes

Adults = aged 16 and over unless otherwise stated.
(a) '5yr change' based on 2004 vs 1998 comparison.
(b) Prevalence of cigarette smoking.
(c) Successfully quit at four-week follow-up (self-report). Measure = % of number setting a quit date. '5yr change' based on 2004/05 vs 2000/01 comparison. Actual numbers of people giving up smoking have increased over the last year.
(d) Exceeding recommended alcohol consumption limits (more than three or four units on at least one day a week for females/males respectively).
(e) Drinking more than six or eight units on at least one day a week for females/males respectively.
(f) Consuming five or more portions of fruit and vegetables per day. Weighted data (for non-response) from the Health Survey for England.
(g) Achieving a minimum of five days a week of 30 minutes or more moderate-intensity activity.
(h) Weighted data (for non-response) from the Health Survey for England. '5yr change' based on comparison of unweighted data.
(i) 16 to 59 year olds reporting having used drugs in the year before interview. '5yr change' based on 2004/05 vs 1998 comparison.

General notes

*Arrows provide a snapshot of change in the measure (based on comparison of endpoints of time period only). Full assessment of the trend requires consideration of a more complete run of years. Change is assessed based on rounded figures. Changes may not be statistically significant.
GREEN = improving trend; **RED** = deteriorating trend
Data are for England except where otherwise stated.
cr = crude rate (per 1,000 population unless otherwise stated)
EW = England and Wales data
sr = age standardised rate (per 100,000 population – to the European standard population)
P = provisional data
n = number
yr = years
nd = no data

Table 5E – Snapshot of health and well-being in England

How long we live, and what we die of	Year	Number	Measure		Change* 5yr	Change* 1yr
Life expectancy at birth – females	02/03/04		80.9	yr	↑	↑
Life expectancy at birth – males	02/03/04		76.6	yr	↑	↑
Life expectancy at age 65 – females	02/03/04		19.4	yr	↑	↑
Life expectancy at age 65 – males	02/03/04		16.5	yr	↑	↑
Healthy life expectancy at birth – females (a)	2002		70.0	yr	↔	↓
Healthy life expectancy at birth – males (a)	2002		67.5	yr	↔	↑
Healthy life expectancy at age 65 – females (a)	2002		14.1	yr	↔	↓
Healthy life expectancy at age 65 – males (a)	2002		12.1	yr	↓	↑
Deaths: All causes – all ages	2004	480,717	626.1	sr	↓	↓
Deaths: All causes – aged under 15	2004	4,284	51.1	sr	↓	↓
Deaths: All causes – aged 15 to 64	2004	77,568	232.3	sr	↓	↓
Deaths: All causes – aged 65 and over	2004	398,865	4,175.2	sr	↓	↓
Smoking attributable deaths (b)	2004	81,500	113.5	sr	↓	↓
Alcohol attributable deaths (ONS definition)	2004	6,125	11.4	sr	↑	↑
Deaths: All circulatory diseases	2004	178,053	218.1	sr	↓	↓
Coronary heart disease	2004	86,170	109.3	sr	↓	↓
Stroke	2004	49,561	57.3	sr	↓	↓
Deaths: All cancers	2004	126,048	179.3	sr	↓	↓
Lung cancer	2004	26,418	38.3	sr	↓	↓
Breast cancer – females	2004	10,288	28.5	sr	↓	↓
Prostate cancer – males	2004	8,531	10.4	sr	↓	↓
Colorectal cancer	2004	13,202	18.2	sr	↓	↓
Deaths: All respiratory diseases	2004	65,092	77.5	sr	↓	↓
Deaths: Suicide and 'undetermined' injury	2004	4,518	8.6	sr	↓	↑
Deaths: Accidental injury	2004	10,407	15.9	sr	↑	↓
Deaths: Accidental injury – aged 65 and over	2004	5,844	59.4	sr	↑	↑
Road injuries and deaths (killed or seriously injured) (c)	2005	27,945	6.5	cr	↓	↓

Table 5E – Snapshot of health and well-being in England (continued)

How long we live, and what we die of	Year	Number	Measure		Change* 5yr	Change* 1yr
Infant deaths (d)	2005P	3,080	5.0	cr	↓	↔
Perinatal deaths (e)	2005P	4,910	8.0	cr	↓	↓
Excess winter deaths (f)	2004/05P	29,700	19.6	%	↓	↑

How long we live, and what we die of notes

(a) Expected years of life in good/fairly good health (self-assessed). Data from 2001 based on new methodology (2001 figures were produced using both methods for comparison). '5yr change' based on 1997 vs 2001 comparison (figures based on old method).
(b) Using proportion of deaths by cause, quoted in Table 5 of The Smoking Epidemic (HDA/NICE 2004).
(c) Road accident casualties killed or seriously injured. cr = per 100 million vehicle kilometres (denominator based on traffic flows for all motor vehicles from National Road Traffic Survey).
(d) For infant mortality, cr = crude rate per 1,000 live births.
(e) For perinatal mortality, cr = crude rate per 1,000 live births and stillbirths.
(f) Difference between number of deaths in the four winter months (December to March) and average number of deaths in the preceding autumn (August to November) and following summer (April to July). Measure = % of the average non-winter deaths.

General notes

*Arrows provide a snapshot of change in the measure (based on comparison of endpoints of time period only). Full assessment of the trend requires consideration of a more complete run of years. Change is assessed based on rounded figures. Changes may not be statistically significant.
GREEN = improving trend; **RED** = deteriorating trend
Data are for England except where otherwise stated.
cr = crude rate (per 1,000 population unless otherwise stated)
EW = England and Wales data
sr = age standardised rate (per 100,000 population – to the European standard population)
P = provisional data
n = number
yr = years
nd = no data

Table 5F – Snapshot of health and well-being in England

Health and ill health in communities	Year	Number	Measure		Change* 5yr	Change* 1yr
Self-assessed 'very bad/bad' health – adult females (q)	2004		7	%	↑	↑
Self-assessed 'very bad/bad' health – adult males (q)	2004		6	%	↔	↓
Limiting longstanding illness – adult females (q)	2004		27	%	↑	↑
Limiting longstanding illness – adult males (q)	2004		23	%	↑	↔
Cancer incidence (excluding nmsc) – females (a)	2003	114,740	340.3	sr	↑	↑
Cancer incidence (excluding nmsc) – males (a)	2003	112,732	388.8	sr	↓	↓
Cancer incidence: Lung – females	2003	12,253	33.2	sr	↓	↑
Cancer incidence: Lung – males	2003	17,549	59.2	sr	↓	↓
Cancer incidence: Breast – females	2003	36,509	120.3	sr	↑	↑
Cancer incidence: Prostate – males (b)	2003	26,798	90.3	sr	↑	↓
Cancer incidence: Colorectal – females	2003	13,018	33.6	sr	↓	↓
Cancer incidence: Colorectal – males	2003	15,504	52.9	sr	↓	↑
Hospital admissions: Circulatory diseases (c)	2004/05	872,366	1,387	sr	↓	↓
Hospital admissions: Respiratory diseases (c)	2004/05	668,005	1,257	sr	↑	↑
Hospital admissions: Intentional self-harm (c)	2004/05	79,640	161	sr	↑	↑
Mental ill health – adult females (d) (q)	2004		15	%	↓	↔
Mental ill health – adult males (d) (q)	2004		11	%	↓	↔
Drug misuse treatment (in structured treatment) (e)	2005/06P	179,600	as number	n	↑	↑
Drug misuse treatment (retained in treatment) (f)	2005/06P	33,500	56	%	nd	↑
People with diabetes – adult females (g) (q)	2003		3.4	%	↑	nd
People with diabetes – adult males (g) (q)	2003		4.3	%	↑	nd
Children's tooth decay (dmft, five yrs old) (h) (i)	2003/04		1.49	cr	↑	↑
Sexually transmitted infections – gonorrhoea (j)	2005P	17,880	35.7	cr	↓	↓
Sexually transmitted infections – chlamydia (j) (k)	2005P	96,204	192.1	cr	↑	↑

Table 5F – Snapshot of health and well-being in England (continued)

Health and ill health in communities	Year	Number	Measure		Change* 5yr	Change* 1yr
Diagnoses of HIV-infected individuals aged 15 and over (l)	2004	6,668	162.7	cr	↑	↓
Tuberculosis case reports (m)	2004	6,895	13.8	cr	↑	↑
Flu vaccinations at age 65 and over (n)	2004	5,621,400	71	%	↑	↔
Congenital abnormalities notified (EW) (o) (p)	2004	6,358	98.9	cr	↓	↓

Health and ill health in communities notes

Adults = aged 16 and over.

(a) nmsc = non melanoma skin cancer
(b) Trend should be interpreted with caution as may be due to improved detection following increased testing.
(c) Inpatient admissions to NHS hospitals. Data for 1999/2000 (used for '5yr change') are grossed for both coverage and missing/invalid clinical data; data for 2003/04 (used for '1yr change') and 2004/05 are ungrossed, i.e. are not yet adjusted for shortfalls.
(d) Self-reported psychosocial health (GHQ12 score 4+).
(e) '5yr change' based on 2005/06 vs 1998/99 comparison.
(f) Clients who had remained in treatment for 12 weeks or more at time of discharge. Measure = % of discharged clients.
(g) Doctor-diagnosed diabetes (self-reported).
(h) For decayed, missing and filled teeth, cr = per child.
(i) '1yr change' based on 2003/04 vs 2001/02 and '5yr change' based on 2003/04 vs 1997/98.
(j) Based on diagnoses in GUM clinics. cr = per 100,000 population.
(k) Trend should be interpreted with caution as may be due to impact of introduction of National Chlamydia Screening Programme.
(l) Data as at end September 2005. cr = per 1,000,000 population (aged 15 and over). Numbers, particularly for recent years, will rise as further reports are received (so trend should be interpreted with caution).
(m) Tuberculosis case reports from Enhanced Tuberculosis Surveillance (with rates based on Office for National Statistics mid-year population estimates), as at 26 June 2006, prepared by Health Protection Agency Centre for Infections. cr = per 100,000 population.
(n) '5yr change' based on 2004 vs 2000 comparison.
(o) Trend should be interpreted with caution as level of recording is variable.
(p) For congenital abnormalities, cr = per 10,000 total births.
(q) Weighted data (for non-response) from the Health Survey for England. '5yr change'" based on comparison of unweighted data.

General notes

*Arrows provide a snapshot of change in the measure (based on comparison of endpoints of time period only). Full assessment of the trend requires consideration of a more complete run of years. Change is assessed based on rounded figures. Changes may not be statistically significant.
GREEN = improving trend; **RED** = deteriorating trend
Data are for England except where otherwise stated.
cr = crude rate (per 1,000 population unless otherwise stated)
EW = England and Wales data
sr = age standardised rate (per 100,000 population – to the European standard population)
P = provisional data
n = number
yr = years
nd = no data

SECTION 5

Appendices

Appendix 1 – Expanded Description of Local and National Indicators

This appendix details the indicators selected for inclusion in the local health profiles[301] (LHP). The indicators are grouped by domain. The left of Table 5.1 lists the indicators and their definitions – these underpin the regional data presented in Table 1.1. The rationales for why they were selected to be LHP indicators are presented in Appendix 2.

The indicators and definitions used for the national analyses in Tables 1.2 and 1.3 are set out to the right of Table 5.1. The rationales for these indicators are presented in Appendix 3.

Indicator linkages

Each indicator does not exist in isolation, and it is important to draw out links between different indicators. Linkages may be direct or indirect – some examples of linked indicators are suggested in Table 5.1, where action in respect of one indicator may be associated with trends in other indicators.

Table 5.1 – The definitions of the local authority health profiles indicator set and the national trend data

No.	LHP indicator	LHP definition	National trend indicator	National trend definition	Example related indicators
Our communities					
1.	Deprivation	Number and percentage of people living in the most deprived national quintile of Lower Super Output Areas	Deprivation (Employment)	Percentage of working age people in employment. (Working age is defined as 16 to 59 for women and 16 to 64 for men).	This is a generic indicator, related to many others – wider determinants, risk factors, morbidity and mortality outcomes
2.	Air quality	Combined air quality indicator based on the addition of four indices (Nitrogen Dioxide, Particulates, Sulphur Dioxide, Benzene)	Air quality (a) PM10 (Urban background) (b) PM10 (Roadside) (c) Ozone (Urban background) (d) Ozone (Rural)	Annual levels of particulate matter (PM10) and ozone. For PM10, annual level is the annual mean concentration (micrograms per metre cubed). For ozone, annual level is the annual mean of the daily maximum eight hour running mean concentration (micrograms per metre cubed).	18) Life expectancy 18) Healthy life expectancy 24) Feeling in poor health
3.	Poor quality housing	Percentage of local authority dwellings that fall below the 'Decent Homes Standard'	Poor-quality housing (a) social sector (b) vulnerable private sector	(a) Percentage of social sector dwellings that fall below the 'Decent Homes Standard' (b) Percentage of vulnerable private sector households living in homes that fall below the 'Decent Homes Standard' (Vulnerable households are households in receipt of at least one of the principal means-tested or disability related benefits)	1) Deprivation 6) Violent crime 7) Older people supported at home 18) Healthy life expectancy 24) Feeling in poor health
4.	Children in poverty	Number and percentage of children under 16 living in 'low income households' (Child Poverty Index)	Children in poverty (a) before housing costs (b) after housing costs	Percentage of children in England living in households with relative low income (below 60% of Great Britain median income in each year), before and after housing costs. (A child is an individual aged under 16, or an unmarried 16- to 18-year old on a course up to and including A level standard).	1) Deprivation 3) Poor-quality housing 5) GCSE achievement 12) Teenage pregnancy 29) Children's tooth decay
5.	GCSE achievement (five A*–C)	Percentage of 15-year-old pupils in schools maintained by LEAs achieving five or more A*–C GCSE grades	GCSE achievement (five A*–C)	Percentage of pupils aged 15 at the start of the academic year achieving five or more GCSE grades A*–C (or equivalent) in all schools in England	1) Deprivation 3) Poor-quality housing 4) Children in poverty 12) Teenage pregnancy 18) Life expectancy

Table 5.1 – The definitions of the local authority health profiles indicator set and the national trend data – continued

No.	LHP indicator	LHP definition	National trend indicator	National trend definition	Example related indicators
6.	Violent crime	Violent offences recorded per 1,000 population	(a) Violent crime (b) Overall crime	(a) British Crime Survey violent crime victimisation rate per 10,000 adults (b) Number of incidents of crime (all British Crime Survey crime) Indicators cover crime against adults (ages 16 and over) living in private households. British Crime Survey violent crime includes common assault, wounding, robbery and snatch theft (homicide is not included).	1) Deprivation 3) Poor-quality housing 4) Children in poverty 14) Binge drinking 18) Healthy life expectancy 24) Feeling in poor health 27) Drug misuse treatment
7.	Older people supported at home	Older people aged 65 or over helped to live at home (per 1,000 population aged 65 or over)	Older people supported at home (a) any service (b) intensive home care	(a) As LHP (covers older people receiving any community-based service) (b) Number of older people aged 65 and over supported intensively to live at home as a percentage of the total being supported by social services intensively at home or in residential care	18) Healthy life expectancy 24) Feeling in poor health
Giving children and young people a healthy start					
8.	Smoking in pregnancy	Proportion of women who continue to smoke throughout pregnancy	Smoking in pregnancy	Percentage of mothers who continue to smoke throughout pregnancy	22) Infant mortality
9.	Breastfeeding	Breastfeeding at six weeks	Breastfeeding	Prevalence of breastfeeding at six weeks (percentage of babies who are being breastfed at six weeks of age)	22) Infant mortality
10.	Obese children	Prevalence of obesity in children aged under 11 years	Obese children	Percentage of children aged 2 to 10 years who are obese (Children aged 2 to 10 are classified as obese if their Body Mass Iindex score lies above the 95th percentile of the United Kingdom reference curves)	11) Physically active children
11.	Physically active children	Schoolchildren – definition to be agreed	Physically active children (PE and school sport)	Percentage of pupils in school sport partnership Schools who spend a minimum of two hours in a typical week on high-quality PE and school sport	10) Obese children

Table 5.1 – The definitions of the local authority health profiles indicator set and the national trend data – continued

No.	LHP indicator	LHP definition	National trend indicator	National trend definition	Example related indicators
12.	Teenage pregnancy (under 18)	Conception rates per 1,000 female population aged 15 to 17	Teenage pregnancy (under 18)	As LHP	22) Infant mortality
The way we live					
13.	People who smoke	Regional data from Health Survey for England, lower tier authorities based on synthetic estimate of the percentage of adults who smoke	People who smoke	Percentage of adults (ages 16 and over) who smoke cigarettes	18) Life expectancy 19) Deaths – smoking 20) Early death – CVD 21) Early death – Cancer
14.	Binge drinking	Regional data from Health Survey for England, lower tier authorities based on synthetic estimate of the percentage of adults binge drinking	(a) Drinking (b) Binge drinking	(a) Percentage of adults (ages 16 and over) drinking more than four units (for males) or three units (for females) of alcohol on at least one day in the previous week (b) Percentage of adults (ages 16 and over) drinking more than eight units (for males) or six units (for females) of alcohol on at least one day in the previous week	18) Life expectancy 26) Alcohol related hospital stays
15.	Healthy eating	Regional data from Health Survey for England, lower tier authorities based on synthetic estimate of the percentage of adults who eat five or more portions of vegetables per day	Healthy eating	Percentage of adults (ages 16 and over) consuming five or more portions of fruit and vegetables per day	10) Obese children 17) Obese adults
16.	Physically active adults	Adults – definition to be agreed	Physically active adults	Percentage of adults (ages 16 and over) achieving a minimum of five days a week of 30 minutes or more moderate-intensity activity	11) Physically active children 17) Obese adults 20) Early death – CVD 18) Healthy life expectancy
17.	Obese adults	Regional data from Health Survey for England, lower tier authorities based on synthetic estimate of the percentage of adults who are obese	Obese adults	Percentage of adults (ages 16 and over) who are obese (Body Mass Index > 30)	10) Obese children 11) Physically active children 15) Healthy eating 16) Physically active adults

Table 5.1 – The definitions of the local authority health profiles indicator set and the national trend data – continued

No.	LHP indicator	LHP definition	National trend indicator	National trend definition	Example related indicators
How long we live, and what we die of					
18.	Life expectancy	Life expectancy at birth	Life expectancy	As LHP	13) People who smoke 17) Obese adults 16) Physically active adults 19) Deaths – smoking 20) Early death – circulatory diseases 21) Early death – Cancer 22) Infant mortality 23) Road injuries and deaths 25) Suicide
19.	Deaths – smoking	Av. annual deaths due to smoking-related causes (aged 35 and over) expressed as a no. and directly age-standardised rate per 100,000 population of all ages	Deaths from smoking	Mortality from smoking-related causes (ages 35 and over) – directly age-standardised rate per 100,000 European Standard Population of all ages	13) People who smoke 18) Life expectancy 20) Early death – circulatory diseases 21) Early death – Cancer
20.	Early deaths – heart disease and stroke	Mortality from all circulatory disease (ICD10 I00-I99) Directly age-standardised rates, persons under 75, per 100,000 European Standard population	Early deaths – circulatory diseases	As LHP	13) People who smoke 15) Healthy eating 17) Obese adults 18) Life expectancy
21.	Early deaths – cancer	Mortality from all cancers (ICD10 C00-C97) Directly age-standardized rates, persons under 75, per 100,000 European standard population	Early deaths – cancer	As LHP	13) People who smoke 14) Binge drinking 15) Healthy eating 18) Life expectancy
22.	Infant deaths (under one year)	The number of infant deaths (less than one year old) per 1,000 live births	Infant deaths (under one year)	As LHP	1) Deprivation 4) Children in poverty 3) Poor quality housing 8) Smoking In pregnancy 9) Breastfeeding
23.	Road injuries and deaths	Number of people killed or seriously injured in RTAs per 100 million vehicle kilometres	Road injuries and deaths	As LHP	14) Binge drinking 18) Life expectancy 18) Healthy life expectancy 26) Alcohol related hospital stays

Table 5.1– The definitions of the local authority health profiles indicator set and the national trend data – continued

No.	LHP indicator	LHP definition	National trend indicator	National trend definition	Example related indicators
Health and ill health in communities					
24.	Feeling 'in poor health'	Directly age-standardised percentage of household residents who reported their health over the previous 12 months as having been 'not good'	Feeling 'in poor health'	Percentage of adults (ages 16 and over) who reported their general health as being 'very bad or bad' (based on Health Survey for England general health categories)	18) Life expectancy 18) Healthy life expectancy
25.	Mental health treatment	Prevalence rate of patients on practice register of people with severe long-term mental health problems who require and have agreed to regular follow-up (rate per 1,000 population)	Mental health treatment (Suicide rates)	Mortality from suicide and undetermined injury (ICD10: X60-X84, Y10-Y34 excl. Y33.9) – directly age-standardised rate per 100,000 European standard population	14) Binge drinking 18) Life expectancy 18) Healthy life expectancy 24) Feeling in poor health 25) Suicide
26.	Alcohol related hospital stays	Directly standardised rate for persons who were admitted at least once in year for alcohol-related condition (ICD10: F10, I42.6, K70, K73, K74, X45) rate per 100,000 pop/year	Alcohol related hospital stays	As LHP	14) Binge drinking 18) Healthy life expectancy 24) Feeling in poor health 25) Suicide
27.	Drug misuse treatment	Number of resident persons aged 15 to 44 in contact with drug treatment services per 100,000 resident population aged 15 to 44 years	Drug misuse treatment (a) numbers in treatment (b) retained in treatment	(a) Number of drug users in contact with drug treatment services (b) Percentage of clients discharged from drug treatment who had remained in treatment for 12 weeks or more	6) Violent crime 14) Binge drinking 18) Life expectancy 18) Healthy life expectancy 24) Feeling in poor health 25) Mental health treatment 26) Alcohol-related hospital stays
28.	People with diabetes	Prevalence – number of patients who have a GP diagnosis of diabetes as a proportion of total list size (%)	People with diabetes	Percentage of adults (ages 16 and over) who reported having doctor-diagnosed diabetes	10) Obese children 11) Physically active children 15) Healthy eating 16) Physically active adults 17) Obese adults 18) Life expectancy 18) Healthy life expectancy 20) Early death – circulator diseases
29.	Children's tooth decay	Mean number of decayed, missing or filled teeth in five year-old children	Children's tooth decay	As LHP	15) Healthy eating

Table 5.1 – The definitions of the local authority health profiles indicator set and the national trend data – continued

No.	LHP indicator	LHP definition	National trend indicator	National trend definition	Example related indicators
30.	Sexually transmitted infections	Gonorrhoea – Rate of new gonococcal diagnoses per 100,000 population	Sexually transmitted infections (a) gonorrhoea (b) chlamydia	(a) Rate of new diagnoses of gonorrhoea per 100,000 population (b) Rate of new diagnoses of chlamydia per 100,000 population	12) Teenage pregnancy 24) Feeling in poor health

See **Appendix 2** for rationale for the local health profile indicator selection.
See **Appendix 3** for rationale for the national trend data selection.

Appendix 2 – Rationale for the Selection of Indicators for the Local Health Profiles (LHP) (Presented in Table 1.1)

Blue rows = LHP 'GAP' indicator, where local authority data are not available

No.	LHP indicator	LHP definition	LHP rationale
Our communities			
1.	Deprivation	Number and percentage of people living in the most deprived national quintile of Lower Super Output Areas	This indicator is a measure of deprivation. Deprivation has an important impact on the health of an area as those living in deprived areas typically have worse health than those living in non-deprived areas. Although deprivation scores are widely used and understood by professionals, this indicator attempts to quantify the number/percentage of a population living in deprived circumstances. This derivation is not commonly used but may be more readily understood by the lay public. Neighbourhood renewal is targeted on areas of high need and deprivation measures support this process.
2.	Air quality	Combined air quality indicator based on the addition of four indices (Nitrogen Dioxide, Particulates, Sulphur Dioxide, Benzene)	This is a measure of air quality. The Committee on the Medical Effects of Air Pollutants advised in 1998 that air pollution was responsible for up to 25,000 deaths each year. It supports delivery of a PSA target for the Department for Environment, Food and Rural Affairs and Department for Transport. Traffic, industrial pollution, and global warming are all relevant factors that could be influenced.
3.	Poor-quality housing	Percentage of local authority dwellings that fall below the 'Decent Homes Standard'	This indicator measures the proportion of local authority owned dwellings that fall below the 'Decent Homes Standard'. It does not include a measure of the standard of privately owned housing, and local authorities that have undertaken large-scale voluntary transfer (LSVT) of housing stock are no longer required to submit data. However, the measure is consistent with the policy thrust of the DCLG. Epidemiological surveys have shown strong associations between housing and health but have been unable to show causal links.
4.	Children in poverty	Number and percentage of children under 16 living in 'low income households' (Child Poverty Index)	This indicator is a measure of childhood deprivation. Tackling inequalities in childhood is the most cost-effective intervention for reducing health inequalities both in childhood and later life. This measure supports *Choosing Health* and *Programme for Action*, and delivery of the cross-Departmental PSA target. Note that the LHP indicator is based on a different source (and slightly different definition) from the national survey data used to monitor the child poverty PSA target and related national indicators (such as in Opportunity for All), as robust, local-level data are not available from the national survey.
5.	GCSE achievement (five A*–C)	Percentage of 15-year-old pupils in schools maintained by LEAs achieving five or more A*–C GCSE grades	This indicator measures the level of GCSE achievement in the area. Educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources. These are related to health and health inequalities. This indicator relates to the DfES PSA target 10, which is to raise standards in schools and colleges so that: By 2008, 60% of those aged 15 achieve the equivalent of five GCSEs at grades A*–C; and in all schools at least 20% of pupils achieve this standard by 2004, rising to 25% by 2006 and 30% by 2008.
6.	Violent crime	Violent offences recorded per 1,000 population	Violent offences is considered to be the best indicator for headline use because of its close association with alcohol consumption and particularly binge drinking. Alcohol is a major contributor to violence.
7.	Older people supported at home	Older people aged 65 or over helped to live at home (per 1,000 population aged 65 or over)	The White Paper *Modernising Social Services* sets out the Government's aims to promote the independence and social participation of Social Services users. Supporting people in their own homes is a key part of this agenda. This indicator covers people receiving any amount of care. Providing care in the home can prevent or postpone a person needing more intensive care packages or residential care.

Blue rows = LHP 'GAP' indicator, where local authority data are not available

No.	LHP indicator	LHP definition	LHP rationale
Giving children and young people a healthy start			
8.	Smoking in pregnancy	Proportion of women who continue to smoke throughout pregnancy	Smoking during pregnancy harms both the mother and the unborn child, and is closely related to health inequalities between those in need and the most advantaged. Smoking in pregnancy causes adverse health outcomes, including an increased risk of miscarriage, reduced birthweight and perinatal death.
9.	Breastfeeding	Breastfeeding at six weeks	There is clear evidence that breastfeeding has positive health benefits for both mother and baby in the short- and longer-term. Breast milk provides all the nutrients that a baby needs for healthy growth and development in the first months of life. Breastfeeding has an important contribution to make towards meeting the target to reduce infant mortality and health inequalities.
10.	Obese children	Prevalence of obesity in children under 11 years	Obesity increases the risk of heart disease, cancer and diabetes. Obesity costs the NHS over £1 billion per year and society as a whole up to £3.5 billion per year. There has been a persistent rising trend in childhood obesity over the last decade.
11.	Physically active children	Schoolchildren – definition to be agreed	All children, whatever their circumstances, should be able to participate in and enjoy PE and school sport. Regular participation, both within and beyond the school day, can reduce obesity, improve fitness levels and, by improving concentration and self-esteem, help improve attendance, behaviour and attainment.
12.	Teenage pregnancy (under 18)	Conception rates per 1,000 female population aged 15–17	This indicator measures the level of teenage conceptions in the area. Teenage conceptions are an important public health target. There is a national target of a 50% reduction by 2010 (intermediate target 15% reduction by 2004). Teenage conception targets feature in the performance ratings for PCTs and in the Priorities and Planning Framework 2003–06. This indicator supports *Choosing Health* and *Programme for Action*.
The way we live			
13.	People who smoke	Synthetic estimate of the percentage of adults who smoke[1]	Smoking is a major cause of ill health and mortality as it has been linked to respiratory illness, cancer and coronary heart disease. Smoking not only affects the smoker, as 17,000 children under the age of five are admitted to hospital every year with illnesses resulting from passive smoking. 1 The figures for regions are direct estimates from the Health Survey for England. Data for lower tier authorities (district councils, unitary authorities and London boroughs) are based on synthetic (modelled) estimates of the prevalence because there is insufficient sample size at this level.
14.	Binge drinking	Synthetic estimate of the percentage of adults binge drinking[1]	The annual cost of alcohol misuse includes: • 360,000 incidents of domestic violence (around a third) which are linked to alcohol misuse • over 30,000 hospital admissions for alcohol dependence syndrome • up to 22,000 deaths per annum. 1 The figures for regions are direct estimates from the Health Survey for England. Data for lower tier authorities (district councils, unitary authorities and London boroughs) are based on synthetic (modelled) estimates of the prevalence because there is insufficient sample size at this level.
15.	Healthy eating	Synthetic estimate of the percentage of adults who eat five or more portions of vegetables per day[1]	This indicates how many people are eating a healthy diet. Up to a third of deaths from cancer (including colorectal, gastric and possibly some breast cancer) may be due to unhealthy diets. Five-a-day fruit and vegetable consumption is seen as the second most important cancer prevention strategy after reducing smoking. This measure supports local delivery plans, LAAs, PSA targets and DH standards. It is relevant to delivering key national priorities (CHD/Cancer NSFs, *Choosing Health*, PSAs, Health and Social Care Standards, *Programme for Action*). It is an existing indicator (HPI, Programme for Action). Evidence cited in *Five A Day Health Benefits* (DH). 1 The figures for regions are direct estimates from the Health Survey for England. Data for lower tier authorities (district councils, unitary authorities and London boroughs) are based on synthetic (modelled) estimates of the prevalence because there is insufficient sample size at this level.

Blue rows = LHP 'GAP' indicator, where local authority data are not available

No.	LHP indicator	LHP definition	LHP rationale
16.	Physically active adults	Adults – definition to be agreed	People who have a physically active lifestyle are at approximately half the risk of developing coronary heart disease (CHD) compared with those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon cancer, and with improved mental health. In older adults, physical activity is associated with increased functional capacities. (*HDA evidence briefing summary*).
17.	Obese adults	Synthetic estimate of the percentage of adults who are obese[1]	Obesity decreases life expectancy by up to nine years and increases the risk of heart disease, cancer and diabetes. Obesity costs the NHS over £1 billion per year and society as a whole up to £3.5 billion per year 1 The figures for regions are direct estimates from the Health Survey for England. Data for lower tier authorities (district councils, unitary authorities and London boroughs) are based on synthetic (modelled) estimates of the prevalence because there is insufficient sample size at this level.
How long we live, and what we die of			
18	Life expectancy	Life expectancy at birth	This indicator measures average life expectancy at birth. Average life expectancy is determined by mortality at all ages. Therefore, the range of influences on life expectancy is vast and includes all those influences on health at each age. All of the health determinants will have an impact on life expectancy. Average life expectancy is therefore a good summary indicator of the health status of the population. The Department of Health 2004 PSA targets include increasing average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women, and to reduce health inequalities by 10% by 2010 as measured by life expectancy at birth (PSA priority 1).
19.	Deaths from smoking	Av. annual deaths due to smoking-related causes (aged 35 and over) expressed as a no. and directly standardised rate per 100,000 population of all ages	Smoking is the UK's single greatest cause of preventable illness and early death. Smoking is a priority area in *Choosing Health*.
20.	Early deaths – circulatory diseases	Mortality from all circulatory disease (ICD10 I00-I99) Directly age-standardised rates, persons under 75, per 100,000 European standard population	Circulatory disease accounts for 40% of all deaths (30% under 75). There are significant inequalities, with deaths from circulatory disease over 25% higher in the North West than in the South East of England. The measure supports *Choosing Health*, *Programme for Action* and the NSF for Coronary Heart Disease. This is a PSA target for the Department of Health and an indicator in the Basket of Indicators, LDP, and Area Profiles.
21.	Early deaths – cancer	Mortality from all cancers (ICD10 C00-C97) Directly age-standardised rates, persons under 75, per 100,000 European standard population	Cancer is amongst the three leading causes of death in the UK. It accounts for 26% all deaths. Inequalities exist in cancer rates between the most deprived areas and the most affluent. This measure supports delivery of the Department of Health PSA targets and LDP, and is relevant to *Saving Lives: Our Healthier Nation*, *Choosing Health*, Cancer NSF and *Programme for Action*.

Blue rows = LHP 'GAP' indicator, where local authority data are not available

No.	LHP indicator	LHP definition	LHP rationale
22.	Infant deaths (under one year)	The number of infant deaths (less than one year old) per 1,000 live births	This indicator measures the level of infant deaths in the area. It is also used as a general indicator of the health of children and the rest of the population. There is a national health inequalities target for infant mortality, which aims for a reduction in the gap between the infant mortality rate in the routine and manual socio-economic group and the population as a whole. However, this target is difficult to monitor at local level as the number of infant deaths in any given local authority or primary care trust (PCT) among a particular socio-economic group is very small and subject to random fluctuations from year to year. Therefore we have chosen to include overall infant mortality as an indicator. There are wide inequalities in infant mortality rates by local authority in England and monitoring these inequalities is essential to understanding trends in inequalities in infant mortality.
23.	Road injuries and deaths	Number of people killed or seriously injured in RTAs per 100 million vehicle kilometres	Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups. For children and for men aged 20 to 64 years, mortality rates for motor vehicle traffic accidents are higher in lower socio-economic groups. For instance, there would be 600 fewer deaths in men aged 20 to 64 years from motor vehicle traffic accidents each year if all men had the same death rates as those in social classes I and II combined. One of the Department for Transport's PSA targets is to reduce the number of people killed or seriously injured by 40%, and the number of children killed or seriously injured by 50% by 2010 compared with the baseline of 1994–98. This measure supports *Saving Lives* and the delivery of the Department for Transport and Department of Health PSA and Best Value.
Health and ill health in communities			
24.	Feeling 'in poor health'	Directly age-standardised percentage of household residents who reported their health over the previous 12 months as having been 'not good'	This indicator measures the percentage of the population who rate their health as 'not good'. Evidence suggests that a self-reported single-item measure of health has good predictive validity of mortality and health care utilisation.
25.	Mental health treatment	Prevalence rate of patients on practice register of people with severe long-term mental health problems who require and have agreed to regular follow-up (rate per 1,000 population)	This measures the proportion of people in an area who have severe mental health problems that are being followed up in primary care. Mental health problems are a major cause of ill-health, disability and mortality, and people with mental health problems are at increased risk of premature death. Increased risk of mental health problems is associated with a number of social and health inequalities such as socio-economic, family and housing circumstances, ethnicity and country of origin. Improving mental health is identified as a priority in both *Choosing Health* and *Our Healthier Nation*.
26.	Alcohol related hospital stays	Directly standardised rate for persons who were admitted at least once in year for alcohol-related condition (ICD10: F10, I42.6, K70, K73, K74, X45) rate per 100,000 pop/year	This indicator measures the rate of hospital admissions that are attributable directly to alcohol (e.g. cirrhosis). Alcohol is a major cause of avoidable hospital admissions. However, admissions attributable to alcohol reflect the impact on health services. The short-term effects of interventions aimed at reducing misuse of alcohol are better monitored using more proximate measures (i.e. alcohol intake, surveys of drinking habits etc). However, it is important to be able to demonstrate that successful interventions ultimately impact on health, both in the short term (e.g. alcohol-related accidents) and longer term.

Blue rows = LHP 'GAP' indicator, where local authority data are not available

No.	LHP indicator	LHP definition	LHP rationale
27.	Drug misuse treatment	Number of resident persons aged 15 to 44 in contact with drug treatment services per 100,000 resident population aged 15 to 44 years	This indicator measures the number of drug users in contact with treatment services. Ideally we would use the numbers in treatment as a proportion of estimated number of drug users in an area to assess the quality of local service provision. Currently, up-to-date prevalence figures are unavailable; however they are imminently expected from the Home Office. Once these have been reviewed, it may be possible to update the indicator to represent the proportion of problem drug users in treatment.
28.	People with diabetes	Prevalence – number of patients who have a GP diagnosis of diabetes as a proportion of total list size (%)	This measures the proportion of people in an area who are on primary care diabetes registers. The burden of diabetes falls disproportionately on members of minority ethnic groups, older people and the poor. If badly controlled, it can lead to blindness, coronary heart disease (CHD) and stroke, renal disease and lower limb amputations. As the most significant modifiable risk factor for Type 2 diabetes, action to tackle overweight and obesity will need to be central to local prevention strategies. Establishing good control of diabetes, including obesity management, will also contribute to better outcomes, reducing inequalities and the number of people with CHD.
29.	Children's tooth decay	Mean number of decayed, missing or filled teeth in five-year-old children	Dental caries (tooth decay) and periodontal (gum) disease are the most common dental pathologies in the UK. Tooth decay has become less common over the past two decades, but is still a significant health and social problem. It results in destruction of the crowns of teeth and frequently leads to pain and infection. Gum disease can begin as inflammation (gingivitis) during childhood. However, it may have developed by middle-age, leading to severe damage to segments of bone supporting teeth. Dental disease is more common in deprived, compared with affluent, communities. It is a good indicator of overall child health and diet. This indicator supports *Choosing Health*, the NSF and LAAs. It is an existing indicator in the Basket of Indicators.
30.	Sexually transmitted infections	Gonorrhoea – Rate of new gonococcal diagnoses per 100,000 population	This indicates rates of infection and access to sexual health services and information. The White Paper *Choosing Health* identifies sexual health as one of the key national priorities for action. The number of new diagnoses of gonorrhoea is currently one of the better indicators of population sexual health. Local delivery plans require monitoring of gonorrhoea, new diagnosis rates and demonstration of a reduction from 2002.

Appendix 3 – Rationale for the Selection of Indicators for the Health Profile of England (Presented in Table 1.3)

No.	Indicator	National trend definition	National trend rationale
Our communities			
1.	Deprivation (employment)	Percentage of working age people in employment (Working age is defined as 16 to 59 for women and 16 to 64 for men)	This indicator relates to the Department for Work and Pensions and HM Treasury joint PSA target on employment. It is also an Opportunity for All and a UK Government Sustainable Development indicator. It is included as an alternative indicator of deprivation, because the local health profiles deprivation indicator is not a useful measure at national level.
2.	Air quality (a) PM10 (Urban background) (b) PM10 (Roadside) (c) Ozone (Urban background) (d) Ozone (Rural)	Annual levels of particulate matter (PM10) and ozone For PM10, annual level is the annual mean concentration (micrograms per cubic metre). For ozone, annual level is the annual mean of the daily maximum eight hour running mean concentration (micro grams per cubic metre) Urban background sites include suburban, urban background, urban centre and urban industrial monitoring sites. Roadside sites include kerbside and roadside monitoring sites. Rural sites include remote and rural monitoring sites	This is part of the indicator on air quality and health in the UK Government Sustainable Development Strategy.
3.	Poor quality housing (a) social sector (b) vulnerable private sector	(a) Percentage of social sector dwellings that fall below the 'Decent Homes Standard' (b) Percentage of vulnerable private sector households living in homes that fall below the 'Decent Homes Standard' (vulnerable households are households in receipt of at least one of the principal means-tested or disability related benefits)	This indicator relates to the Department for Communities and Local Government PSA target on housing quality. It is also a UK Government Sustainable Development indicator. The indicator is based on national data available from a national survey.
4.	Children in poverty (a) before housing costs (b) after housing costs	Percentage of children in England living in households with relative low income (below 60% of Great Britain median income in each year), before and after housing costs (A child is an individual aged under 16, or an unmarried 16- to 18-year old on a course up to and including A level standard)	This is an Opportunity for All and a UK Government Sustainable Development indicator. It relates to the Department for Work and Pensions and HM Treasury joint PSA target on child poverty. The indicator is based on national data available from a national survey.
5.	GCSE achievement (five A*–C)	Percentage of pupils aged 15 at the start of the academic year achieving five or more GCSE grades A*–C (or equivalent) in all schools in England	This indicator relates to the Department for Education and Skills PSA target on GCSE achievement. It is also an Opportunity for All indicator. The indicator covers all schools in England, and is not restricted to schools maintained by LEAs.

No.	Indicator	National trend definition	National trend rationale
6.	(a) Violent crime (b) Overall crime	(a) British Crime Survey violent crime victimisation rate per 10,000 adults (b) Number of incidents of crime (all British Crime Survey crime) Indicators cover crime against adults (ages 16 and over) living in private households. British Crime Survey violent crime includes common assault, wounding, robbery and snatch theft (homicide is not included).	This indicator is based on national data available from a national survey. For the crime types it covers, the British Crime Survey can provide a better reflection of the true extent of crime at national level than police-recorded crime figures because it includes crimes that are not reported to the police and crimes that are not recorded by them. It also gives a better indication of trends in crime over time because it is unaffected by changes in levels of reporting to the police and in police recording practices. The number of incidents of crime (all British Crime Survey crime) relates to the Home Office PSA target on crime.
7.	Older people supported at home (a) any service (b) intensive home care	(a) Older people aged 65 or over helped to live at home (receiving any community-based service) per 1,000 population aged 65 or over (b) Number of older people aged 65 and over supported intensively to live at home as a percentage of the total being supported by social services intensively at home or in residential care	This indicator relates to the Department of Health PSA target on supporting older people at home, which has two parts. Part (a) is the same as the local health profiles indicator.
Giving children and young people a healthy start			
8.	Smoking in pregnancy	Percentage of mothers who continue to smoke throughout pregnancy	This indicator is included in the local health profiles. For the national trends, the indicator is based on national data available from a national survey (the Infant Feeding Survey). The indicator relates to the White Paper *Smoking Kills* target on smoking during pregnancy, and is an Opportunity for All indicator.
9.	Breastfeeding	Prevalence of breastfeeding at six weeks (percentage of babies who are being breastfed at six weeks of age)	This indicator is included in the local health profiles. For the national trends, the indicator is based on national data available from a national survey (the Infant Feeding Survey).
10.	Obese children	Percentage of children aged 2 to 10 years who are obese (Children aged 2 to 10 are classified as obese if their Body Mass Index score lies above the 95th percentile of the United Kingdom reference curves.)	This indicator relates to the Department of Health, Department for Education and Skills, and Department for Culture, Media and Sport joint PSA target on child obesity. It is also an Opportunity for All and a UK Government Sustainable Development indicator. It is included in the local health profiles. For the national trends, the indicator is based on national data available from a national survey (the Health Survey for England).
11.	Physically active children (PE and school sport)	Percentage of pupils in school sport partnership schools who spend a minimum of two hours in a typical week on high-quality PE and school sport	This indicator relates to the Department for Education and Skills and Department for Culture, Media and Sport joint PSA target on PE and school sport.

No.	Indicator	National trend definition	National trend rationale
12.	Teenage pregnancy (under 18)	Under 18-conception rate per 1,000 female population aged 15 to 17	This indicator is included in the local health profiles. It relates to the Department of Health and Department for Education and Skills joint PSA target on teenage pregnancy. It is also an Opportunity for All indicator.
13.	People who smoke	Percentage of adults (ages 16 and over) who smoke cigarettes	This indicator relates to the Department of Health PSA target on smoking prevalence. It is also an Opportunity for All and a UK Government Sustainable Development indicator. The indicator is based on national data available from the national survey used to monitor the PSA target (the General Household Survey), and covers all adults.
The way we live			
14.	(a) Drinking (b) Binge drinking	(a) Percentage of adults (ages 16 and over) drinking more than four units (for males) or three units (for females) of alcohol on at least one day in the previous week (b) Percentage of adults (ages 16 and over) drinking more than eight units (for males) or six units (for females) of alcohol on at least one day in the previous week	Part (b) of this indicator is included in the local health profiles on 'binge' drinking, and part (a) relates to the recommended daily guidelines for sensible drinking. For the national trends, the indicator is based on national data available from the General Household Survey.
15.	Healthy eating	Percentage of adults (ages 16 and over) consuming five or more portions of fruit and vegetables per day	This indicator is included in the local health profiles. It is also a UK Government Sustainable Development indicator. For the national trends, the indicator is based on national data available from a national survey (the Health Survey for England).
16.	Physically active adults	Percentage of adults (ages 16 and over) achieving a minimum of five days a week of 30 minutes or more moderate-intensity activity	For the national trends, this indicator relates to the guidelines on recommended adult physical activity levels. It is based on national data available from a national survey (the Health Survey for England).
17.	Obese adults	Percentage of adults (ages 16 and over) who are obese (Body Mass Index > 30)	This indicator is included in the local health profiles. For the national trends, the indicator is based on national data available from a national survey (the Health Survey for England).
How long we live, and what we die of			
18.	Life expectancy	Life expectancy at birth	This indicator relates to the Department of Health PSA target on overall life expectancy. It is included in the local health profiles.
19.	Deaths from smoking	Mortality from smoking-related causes (ages 35 and over) – directly age-standardised rate per 100,000 European standard population of all ages	This indicator is included in the local health profiles.
20.	Early deaths – circulatory diseases	Mortality from all circulatory disease (ICD10: I00-I99) – directly age-standardised rate, persons under 75, per 100,000 European standard population	This indicator is included in the local health profiles. It relates to the Department of Health PSA target on circulatory disease mortality, and is a UK Government Sustainable Development indicator.

No.	Indicator	National trend definition	National trend rationale
21.	Early deaths – cancer	Mortality from all cancers (ICD10: C00-C97) – directly age-standardised rate, persons under 75, per 100,000 European standard population	This indicator is included in the local health profiles. It relates to the Department of Health PSA target on cancer mortality, and is a UK Sustainable Development indicator.
22.	Infant deaths (under one year)	Number of infant deaths (less than one year old) per 1,000 live births	This indicator is included in the local health profiles.
23.	Road injuries and deaths	Number of people killed or seriously injured in road traffic accidents per 100 million vehicle kilometres	This indicator is included in the local health profiles. The indicator is a rate. The Department for Transport has a PSA target to reduce the number of people killed or seriously injured in road traffic accidents.
Health and ill health in communities			
24.	Feeling 'in poor health'	Percentage of adults (ages 16 and over) who reported their general health as being 'very bad or bad' (based on Health Survey for England general health categories)	This indicator is included in the local health profiles. For the national trends, the indicator is based on national data available from a national survey (the Health Survey for England), and uses the Health Survey for England general health categories.
25.	Mental health treatment (Suicide rates)	Mortality from suicide and undetermined injury (ICD10: X60-X84, Y10-Y34 excl. Y33.9) – directly age-standardised rate per 100,000 European standard population	This indicator relates to the Department of Health PSA target on suicide. It is also a UK Sustainable Development indicator.
26.	Alcohol related hospital stays	Directly standardised rate for persons who were admitted at least once in year for alcohol-related conditions (ICD10: F10, I42.6, K70, K73, K74, X45) – rate per 100,000 European standard population	This indicator is included in the local health profiles.
27.	Drug misuse treatment (a) numbers in treatment (b) retained in treatment	(a) Number of drug users in contact with drug treatment services (b) Percentage of clients discharged from drug treatment who had remained in treatment for 12 weeks or more	This indicator relates to the Department of Health PSA target on drug misuse treatment.
28.	People with diabetes	Percentage of adults (ages 16 and over) who reported having doctor-diagnosed diabetes	This indicator is included in the local health profiles. For the national trends, the indicator is based on national data available from a national survey (the Health Survey for England).
29.	Children's tooth decay	Mean number of decayed, missing or filled teeth per child in five-year-old children	This indicator is included in the local health profiles.
30.	Sexually transmitted infections (a) gonorrhoea (b) chlamydia	(a) Rate of new diagnoses of gonorrhoea per 100,000 population (b) Rate of new diagnoses of chlamydia per 100,000 population	Part (a) of this indicator (on gonorrhoea) is included in the local health profiles. Part (b) on chlamydia is included in the national trends as genital chlamydia trachomatis is the most common sexually transmitted infection (STI) in England.

Appendix 4 – Signposts to Selected Key Websites

This appendix signposts web links to sources of further information and data. Each signpost is numbered, and it is these numbers that appear in the style of 'references' throughout the *Health Profile of England.*

1. GENERAL LINKS

101. Association of Public Health Observatories

Gateway to sites for PHOs for Ireland, Scotland, Wales and the nine English regions.
www.apho.org.uk/apho/

102. Department of Health

Government health information
www.dh.gov.uk/Home/fs/en

103. Healthcare Commission

The Healthcare Commission promotes improvement in the quality of the NHS and independent healthcare. It has a wide range of responsibilities, all aimed at improving the quality of healthcare. It has a statutory duty to assess the performance of healthcare organisations, award annual performance ratings for the NHS and co-ordinate reviews of healthcare by others. Through its site, you can find out more about what it does and the difference it will make to patients and the public.
www.healthcarecommission.org.uk/Homepage/fs/en

104. Health Protection Agency

The Health Protection Agency's role is to provide an integrated approach to protecting UK public health through the provision of support and advice to the NHS, local authorities, emergency services, other arms length bodies, the Department of Health and the devolved administrations. The Agency was established as a special health authority in 2003. In addition to the Agency's role in reducing the dangers to health from infections, and chemical and radiation hazards, it also provides support to, and works in partnership with, others who also have health protection responsibilities, and advises, through the Department of Health, all government departments and devolved administrations throughout the UK. In England, it provides the local health protection services which in the rest of the UK are delivered by the three other lead health protection bodies: the National Public Health Service Wales; Health Protection Scotland (HPS); and the Department of Health, Social Services and Public Safety, Northern Ireland. The Agency works closely with all these organisations.
www.hpa.org.uk/default.htm

105. Information Centre for Health and Social Care (IC)

The 'IC' works to co-ordinate and streamline the collection and sharing of data about health and adult social care. It provides an important service to front-line healthcare staff by reducing the time they spend on data collection, allowing them more time to concentrate on providing care to patients. To improve accessibility, the IC will be a focus for everyone who needs information, including patients, clinicians and regulators such as Monitor and the Healthcare Commission.
www.ic.nhs.uk/

106. National Statistics – Office for National Statistics

Gateway for quality-assured Government statistics covering the United Kingdom.
www.statistics.gov.uk/

107. Organisation for Economic Co-operation and Development (OECD)

The OECD groups 30 member countries sharing a commitment to democratic government and the market economy. With active relationships with some 70 other countries, NGOs and civil society, it has a global reach. Best known for its publications and its statistics, its work covers economic and social issues from macroeconomics, to trade, education, development and science and innovation.
www.oecd.org/home/

The OECD statistics portal can be found at
www.oecd.org/statsportal/0,2639,en_2825_293564_1_1_1_1_1,00.html

108. Public Health Information and Intelligence Strategy

Chaired by Professor Bernard Crump, a task force advised on the initial development of an information and intelligence strategy to support the delivery of Choosing Health policy objectives.
www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/ChoosingHealth/ChoosingHealthArticle/fs/en?CONTENT_ID=4117185&chk=4omPuB

109. World Health Organization (WHO) (European Office)

The World Health Organization (WHO) is the United Nation's specialised agency for health. WHO's objective is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This is a key site of data relating to the countries of Europe, mostly national level data.
www.euro.who.int/

110 to 200 not allocated

2. DATASET LINKS

201. Audit Commission – Area Profiles

Area profiling will be particularly helpful to councils and their partners in Local Strategic Partnerships (LSPs) and to central government and national agencies.
www.areaprofiles.audit-commission.gov.uk/(cyx3id55p4gp4h55ivispq35)/StaticPage.aspx?info=25&menu=56

202. Hospital Episodes Statistics (HES)

HES is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.
www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=537

203. National Centre for Health Outcomes Development (NCHOD) – Public Health Common Data Set

This is a one-stop source of all information on health outcomes generated by NCHOD. It includes comparative data for 700 health and local government organisations in England, plus advice on how to measure health and the impact of health care.
Version limited to users of the NHSNet: nww.nchod.nhs.uk/

General version (some data restricted to prevent the potential identification of individual cases).
www.nchod.nhs.uk/

204. National Statistics – Health Statistics Quarterly

Health Statistics Quarterly is the web presence of digest of health statistics published quarterly by ONS. Contains regular data and special reports.
www.statistics.gov.uk/StatBase/Product.asp?vlnk=6725&Pos=&ColRank=1&Rank=422

205. National Statistics – Neighbourhood Statistics

Local information down to small area level, by area or subject
www.neighbourhood.statistics.gov.uk/dissemination/home.do

206. World Health Organization – Health For All Database

A range of health-related data covering all countries across Europe.
www.euro.who.int/hfadb

207 to 300 not allocated

3. INDICATOR SETS

301. Health Profiles

The family of health profile products comprises – the *Health Profile of England*, 386 local health profiles (of local authority areas) and an associated website and web-based tool. The local health profile reports have been produced by the Association of Public Health Observatories, and there has been close liaison in the development of the local and national profiles.
www.communityhealthprofiles.info/index.php

302. Health Poverty Index (HPI)

The NHS Plan (2000) stated that 'no injustice is greater than the inequalities in health which scar our nation' and proposed a number of developments to combat this situation. One of these was the production of a Health Poverty Index (HPI). Following the publication of the NHS Plan, the Department of Health (DH) commissioned a scoping project to develop the HPI concept, involving a major consultation and a series of discussions within the DH and between the DH and other bodies charged with tackling the issue of health inequalities.

Work on the initial HPI development was funded by the DH. The Information Centre has now taken the lead on progressing the HPI. Work is being taken forward by the School of Geography and Geosciences, University of St Andrews, the Social Disadvantage Research Centre (SDRC) of the Department of Social Policy and Social Work at the University of Oxford and the South East Public Health Observatory (SEPHO).
www.hpi.org.uk

303. Local Basket of Indicators (LBOI)

The London Health Observatory has developed this indicator set. The purpose of the LBOI is to support local action and priority-setting to tackle health inequalities and it is aimed at the NHS, local authorities, Local Strategic Partnerships and partner organisations such as the voluntary, community and private sectors.
www.lho.org.uk/HEALTH_INEQUALITIES/BasketOfIndicators.aspx

304. Opportunity for All

Opportunity for All is the annual government report about tackling poverty and social exclusion. It sets out the Government's current strategy and measures its effectiveness against established and challenging indicators of progress.

Maintained on the Department for Work and Pensions website www.dwp.gov.uk/ofa/

305. Public Service Agreements (PSAs) – including Department of Health PSA

These associated indicators and targets are intended to detail progress on the Government's Public Service Agreements (PSA). Each target represents a step-change in the level of quality of a specific service, or an improvement in the lives of people across the UK. The Department of Health targets represent efforts to transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities.

Maintained on the Treasury website
www.hm-treasury.gov.uk/spending_review/spend_sr04/psa/spend_sr04_psaindex.cfm

306. Social Services Performance Assessment Framework Indicators (Commission for Social Care Inspection)

The Commission for Social Care Inspection (CSCI) registers, inspects and reports on social care services in England.
www.csci.org.uk/care_professional/information_for_councils/paf.aspx

307. Sustainable Development

The UK Government, Scottish Executive, Welsh Assembly Government and the Northern Ireland Administration have agreed upon a set of shared UK principles that provide a basis for sustainable development policy in the UK. The UK has four priority areas for immediate action, shared across the UK. These are: Sustainable Consumption and Production, Climate Change and Energy, Natural Resource Protection and Environmental Enhancement, and Sustainable Communities.

To support the Strategy, there is now a suite of 68 national sustainable development indicators. These include 20 UK Framework Indicators. In addition there are indicators, targets and performance measures in the individual strategies for the UK Government, Scotland, Wales and Northern Ireland. The remaining 48 indicators in the Strategy highlight additional priorities relevant to the UK Government Strategy.

Maintained on the Sustainable Development website
www.sustainable-development.gov.uk/index.asp

308 to 400 not allocated

4. PUBLICATIONS/REPORTS

401. Alcohol Harm Reduction Strategy for England

Produced by The Prime Minister's Strategy Unit, the *Alcohol Harm Reduction Strategy for England* puts joint action at the heart of a series of measures which aim to: tackle alcohol-related disorder in town and city centres, improve treatment and support for people with alcohol problems, clamp down on irresponsible promotions by the industry and provide better information to consumers about the dangers of alcohol misuse.
www.strategy.gov.uk/work_areas/alcohol_misuse/index.asp

402. British Crime Survey 2005/06

The British Crime Survey (BCS) is a very important source of information about levels of crime and public attitudes to crime and other Home Office issues.
www.homeoffice.gov.uk/rds/crimeew0506.html

403. Census 2001 – National Statistics

The Census is a survey of all people and households in the country. It provides essential information from national to neighbourhood level for government, business and the citizen.
www.statistics.gov.uk/census2001/census2001.asp

404. Chief Medical Officer's Annual Report on the state of the public health

The Chief Medical Officer's Annual Report identifies major health challenges requiring immediate action, and describes progress in addressing issues featured in previous reports.
www.dh.gov.uk/annualreports

405. Choosing Health: Making healthy choices easier (White Paper – 2004)

This White Paper sets out the key principles for supporting the public to make healthier and more informed choices in regards to their health. The Government will provide information and practical support to get people motivated and improve emotional well-being and access to services so that healthy choices are easier to make.
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5Cor

406. Choosing Health Progress Report (May 2006)

Progress report, May 2006, on the *Choosing Health* commitments and the joint contributions of all the departments involved
www.dh.gov.uk/choosinghealth

407. Delivering Choosing Health: making healthier choices easier

This delivery plan highlights how the DH and the NHS, within the framework of government policies, will help more people make more healthy choices and reduce health inequalities. It outlines clearly the priorities for delivery at national, regional and local levels and what will be done by whom and when. It brings into one place all of the actions on the *Choosing Health* White Paper commitments, alongside related Public Service Agreements and local targets to improve health.
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4105355&chk=gFTjxL

408. Department of Health Departmental Report

This report provides Parliament and the public with an account of how the Department of Health has spent the resources allocated to it, as well as its future spending plans. It also describes DH policies and programmes and gives a breakdown of spending within these programmes.
www.dh.gov.uk/annualreports

409. English House Condition Survey (to 2004)

The information collected by the English House Condition Survey (EHCS) is the main source of information on the condition and energy efficiency of housing in England. The survey builds a picture of all types of housing, whether owner-occupied or owned by local authorities, housing associations or private landlords.
www.communities.gov.uk/index.asp?id=1155269

410. Family Resources Survey (to 2004/05)

The Family Resources Survey collects information on the incomes and circumstances of private households in the United Kingdom (or Great Britain before 2002-03).
www.dwp.gov.uk/asd/frs/

411. General Household Survey 2004

The General Household Survey (GHS) is an inter-departmental, multi-purpose continuous survey carried out by the ONS, collecting information on a range of topics from people living in private households in Great Britain. The survey has run continuously since 1971, except for breaks in 1997/08 (when the survey was reviewed) and 1999/2000 when the survey was redeveloped.
www.statistics.gov.uk/StatBase/Product.asp?vlnk=5756

412. Health Reform in England: Update and next steps (2005)

This document describes the elements of reforms to the healthcare system and how they are expected to interact, resulting in better patient services and value for taxpayers' money. It sets a framework for taking forward the implementation and further development of reforms.
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4124723&chk=y2qlXE

413. Health Survey for England 2003 and 2004

The Health Survey for England (HSE) comprises a series of annual surveys beginning in 1991. The series is part of an overall programme of surveys commissioned by the DH and designed to provide regular information on various aspects of the nation's health. All surveys have covered the adult population aged 16 and over living in private households in England. Children have been included in every year since 1995.
www.dh.gov.uk/healthsurvey

414. Infant Feeding Survey 2005: Early Results

The 2005 Infant Feeding Survey is the seventh national survey of infant feeding practices carried out. Surveys have been conducted every five years since 1975.
www.ic.nhs.uk/pubs/breastfeed2005/ifsreport/file

415. Informing healthier choices: Information and intelligence for healthy populations

The Information and Intelligence Strategy supports wider health priorities such as action on health inequalities, health protection and effective commissioning of health and well-being. It aims to improve the availability and quality of health information and intelligence across England and to increase its use to support population health improvement, health protection and work on care standards and quality. The strategy will support the delivery of *Choosing Health* and the 2006 White Paper *Our health, our care, our say: a new direction for community services* by making information and knowledge available to local communities to inform their decisions.
www.dh.gov.uk/Consultations/ClosedConsultations/ClosedConsultationsArticle/fs/en?CONTENT_ID=4135308&chk=JUbu1h

416. Our health, our care, our say: a new direction for community services (White Paper – 2006)

This White Paper sets a new direction for the whole health and social care system. It confirms the vision set out in the Department of Health Green Paper on social care for adults, *Independence, Well-being and Choice*. There will be a radical and sustained shift in the way in which services are delivered, ensuring that they are more personalised and that they fit into people's busy lives.
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127453&chk=NXIecj

417. PE, School Sport and Club Links (PESSCL) 2004/05 School Sport Survey

The national PE, School Sport and Club Links Strategy was launched in October 2002. The Department for Education and Skills and the Department for Culture, Media and Sport have come together to jointly lead the strategy. Its overall objective – a Public Service Agreement target shared by the two departments – is to enhance the take-up of sporting opportunities by 5 to 16 year-olds.
www.teachernet.gov.uk/docbank/index.cfm?id=9045

418. Road Casualties Great Britain annual report 2004

Road accident statistics play a leading part in the Government's Road Safety Strategy and in monitoring its targets for the number of road deaths and injuries by 2010. The Road Casualties Great Britain annual report provides detailed analyses of road casualties and reports on trends in relation to casualty reduction targets.
www.dft.gov.uk/stellent/groups/dft_transstats/documents/page/dft_transstats_041303.hcsp

419. Saving Lives: Our Healthier Nation (White Paper – 1999)

This White Paper set out the Government's action plan for tackling poor health by improving the health of everyone, and of the worst off in particular. It set tough but attainable targets in priority areas. The document provides 10 tips for better health and is divided into three sections. 'Our healthier nation' looks at a new approach to saving lives and at the aims and advances in public health. It also discusses individuals and health and tackling the wider causes of ill-health within communities. 'Saving lives' deals with the specific issues of cancer, coronary heart disease and stroke, accidents, and mental health. It also looks at wider issues such as sexual health, tackling drug and alcohol problems, communicable disease, genetics and improving ethnic minorities' health. 'Making it work' discusses progress and partnership as well as standards and success.
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4118614&chk=IpHfou

420. Securing good health for the whole population: Final report – February 2004

In April 2003, the Prime Minister, the Chancellor and the Secretary of State for Health asked Derek Wanless, ex-Group Chief Executive of NatWest, to provide an update of the challenges in implementing the fully engaged scenario set out in his report on long-term health trends. This report provides an update of the challenges in implementing the fully engaged scenario set out in the 2002 Wanless report on long-term health trends.
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4074426&chk=c4gJvj

421. Securing Our Future Health: Taking a Long-term View – an independent review by Derek Wanless (2002)

This is the first-ever evidence-based assessment of the long-term resource requirements for the NHS.
www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless03_index.cfm

422. Drug use, smoking and drinking among young people in England in 2005

This is the latest in a series of surveys of secondary school pupils which provides the national estimates of the proportion of young people aged 11 to 15 who smoke, drink alcohol or take illegal drugs. The first survey in the series, carried out in 1982, provided estimates of the proportion of pupils who smoked and described their smoking behaviour. Similar surveys were carried out to monitor trends in the prevalence of cigarette smoking every two years until 1998, and annually since then. Questions on alcohol consumption were included for the first time in the 1988 survey, and the 1998 survey was the first to include questions on the prevalence of drug use.
www.ic.nhs.uk/pubs/drugsmokedrinkyoungeng2005/finalreport.pdf/file

423. Smoking Kills (White Paper on tobacco – 1998)

This White Paper announced the Government's concerted plan of action to stop people smoking. It presented a series of measures for reducing smoking among young people, new cessation services for adults and action on smoking among pregnant women. It then outlined proposals for abolishing tobacco advertising and promotion, altering public attitudes, preventing tobacco smuggling and supporting research. It described further proposals for working in partnership with businesses to restrict smoking in public places, places of work, and government offices, and for working with other governments at European and global levels.
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4006684&chk=AqVFgM

424. Tackling Health Inequalities: Status report on the Programme for Action (2005)

The status report provides a review of developments against the data since the publication of the *Programme for Action* in 2003. It considers progress against the Public Service Agreement (PSA) inequalities target, the national headline indicators and against government commitments. The report highlights the challenging nature of the health inequalities PSA target for 2010.
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4117696&chk=OXFbWI

425 and upwards not allocated

Acknowledgements

The Public Health Information and Intelligence Task Force – formed as part of the implementation of *Choosing Health* under the chairmanship of Professor Bernard Crump – played a central role in the planning and development of this document. We are grateful to all members of the Task Force; however particular thanks for advice and guidance are due to the members of the sub-group set up to oversee this work. Thanks are also due to the Project Team overseeing the development of local health profiles, with whom we collaborated closely to ensure consistency between the two projects.

A document such as the *Health Profile of England* reflects substantial input from a large number of individuals and organisations. Limited space precludes naming all concerned. We wish however to acknowledge the substantial contribution of many analysts and policy colleagues within the Department of Health and across several other government departments, without whom it would have been impossible to compile this report. Other organisations, including the Office for National Statistics, the Information Centre for Health and Social Care, the Association of Public Health Observatories (and the constituent observatories), the Health Protection Agency and the National Centre for Health Outcomes Development have readily provided assistance, advice and/or data, for which we are very grateful.

Central Health Monitoring Unit, Health Improvement Directorate
and
Public Health Statistics Team, Standards and Quality Analytic Team
Department of Health
October 2006

276621 1p 2k Oct06 (WYN)
Produced by COI for the Department of Health

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