

Child School Health Profile 2014

Indicator Guide: District Profile

This document presents metadata including the definitions and sources of data for the district versions of School Health Profiles 2014 created by Leicestershire County Council's Public Health team.

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Child Residence Map

Indicator	Map of Child Residence
How is this indicator actually defined?	The population of children attending the schools in the district of interest are grouped into quartiles based on the highest to lowest counts of children living in middle super output areas (MSOAs).
Why is this included?	It is important to understand the catchment area population that attend the schools in the district of interest. Cross district travelling is common and is highlighted by the maps.
Who does it measure?	All children attending schools in the district of interest
When does it measure?	Leicestershire: May 2014 Rutland: January 2014
How is it measured?	Counts
Where does the data come from?	School census populations are sourced from the local authority school census team
How accurate is the data?	The data is of very high quality as they are drawn from a 100% scan of administrative records and as a result are not subject to any sampling error. Comprehensive validation checks are undertaken.
Are there any caveats?	MSOAs were ranked from highest counts of children residing in each area to the lowest. Only the MSOAs with the top 95% counts of the child population have been included in the analysis.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	N/A

Age Profile

Indicator	Population Pyramid of Age Profile
How is this indicator actually defined?	Percentage of child population by age and gender compared to Leicestershire average.
Why is this included?	Understanding the age of children will help to identify the level and type of need. A younger population will have different needs to those children of an older age.

Who does it measure?	All children attending schools in the district of interest
When does it measure?	Leicestershire: May 2014 Rutland: January 2014
How is it measured?	Percentage
Where does the data come from?	School census populations are sourced from the local authority school census team
How accurate is the data?	The data is of very high quality as they are drawn from a 100% scan of administrative records and as a result are not subject to any sampling error. Comprehensive validation checks are undertaken.
Are there any caveats?	N/A
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	N/A

Income Deprivation Affecting Children Index Chart

Indicator	Income Deprivation Affecting Children Index Chart (IDACI)
How is this indicator actually defined?	The school census population attending schools in each district are grouped into quintiles by their degree of income deprivation affecting children based on their resident location. The percentage of children that live in each quintile is displayed. Quintile 1 is the most deprived and quintile 5 is the least deprived.
Why is this included?	The difference in deprivation between areas is a major determinant of health inequality in the United Kingdom. Many studies and analyses have demonstrated the association of increasingly poor health with increasing deprivation. If deprivation inequalities decrease, health inequalities are likely to decrease also.
Who does it measure?	All children attending schools in the district of interest
When does it measure?	School census - Leicestershire: May 2014 Rutland: January 2014 The English Indices of Deprivation 2010
How is it measured?	Percentage
Where does the data come from?	School census populations are sourced from the local authority school census team. The English Indices of Deprivation 2010 are sourced from the Department of Communities and Local Government.
How accurate is the data?	The data used to calculate the IDACI score is from the time-point 2008 so may not reflect the state of population at the current time. However, the data is of very high quality it is drawn from a 100% scan of administrative records and as a result is not subject to any sampling error. Comprehensive validation checks are undertaken.
Are there any caveats?	N/A
Are particular tests needed such as standardisation, significance tests, or statistical	N/A

process control to test the meaning of the data and the variation they show?

Mode of Transportation to School

Indicator	Mode of Transportation to School Chart
How is this indicator actually defined?	Percentage of the school census population attending schools in this area by method of transportation to school.
Why is this included?	Regular physical activity is an important part of a healthy lifestyle. Making physical activity a priority and encouraging good habits in children from an early age is important and can help them develop the skills they need to continue being active throughout their lives. Walking or cycling to school can be a great way to incorporate physical activity into a child's daily life.
Who does it measure?	All children attending schools in the district of interest
When does it measure?	2013
How is it measured?	Percentage
Where does the data come from?	Transport department, Leicestershire County Council
How accurate is the data?	Whilst the numbers of schools returning some data has been consistent to the previous year, the accuracy of the mode of travel dataset cannot be guaranteed within every school return as it relies on parents updating any changes to schools. Any changes would then have to be updated on the relevant (non-mandatory) field in the database.
Are there any caveats?	N/A
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	N/A

Key Figures Table

Indicator	Key Figures
How is this indicator actually defined?	Key indicators taken from the school census dataset.
Why is this included?	This is included to present the demographics of the children attending these schools in the district.
Who does it measure?	All children attending schools in the district of interest
When does it measure?	Leicestershire: May 2014 Rutland: January 2014
How is it	Percentage

measured?	
Where does the data come from?	School census populations are sourced from the local authority school census team
How accurate is the data?	The data are of very high quality as they are drawn from a 100% scan of administrative records and as a result are not subject to any sampling error. Comprehensive validation checks are undertaken.
Are there any caveats?	N/A
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	N/A

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Map of GCSE Achieved

Indicator	Map of GCSE Achieved (5A*-C including. English and Maths)
How is this indicator actually defined?	Percentage of pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) or equivalent, percentage of pupils at end of Key Stage 4 in schools maintained by the Local Authority at the end of the academic year based on area of residence.
Why is this included?	Educational attainment is influenced by both the quality of education children receive and their family socio-economic circumstances. 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.
Who does it measure?	All children resident in the district of interest
When does it measure?	Academic year 2012-2013
How is it measured?	Percentage
Where does the data come from?	Department of Education: https://www.gov.uk/government/publications/neighbourhood-statistics-in-england-academic-year-2012-to-2013
How accurate is the data?	This indicator only contains data for maintained schools; therefore it excludes pupils educated in private schools.
Are there any caveats?	The data for this indicator are based on the local authority of pupil residence. The Child Health Profiles mirrors this definition but the Health Profiles contain data for this indicator is based on the local authority of school location. It is important to bear this in mind when examining this indicator in the different profiles.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they	N/A

show?

Achievement Throughout School Journey

Indicator	<ul style="list-style-type: none">Percentage of pupils achieving a good level of development at the end of receptionPercentage pupils achieving the expected level in reading, writing and maths at the end of Key Stage 2Percentage of pupils achieving 5 or more A*-C grades at GCSE or equivalent including English and Mathematics GCSEs
How is this indicator actually defined?	<ul style="list-style-type: none">Children defined as having reached a good level of development at the end of the Early Years Foundation Stage Profile (EYFS) as a percentage of all eligible childrenChildren defined as having reached the expected level in reading, writing and maths at the end of the Key Stage 2 as a percentage of all eligible childrenPercentage of pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) or equivalent, percentage of pupils at end of Key Stage 4 in schools maintained by the Local Authority at the end of the academic year based on area of residence.
Why is this included?	Educational attainment is influenced by both the quality of education children receive and their family socio-economic circumstances. 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.
Who does it measure?	All children resident in the district of interest
When does it measure?	Academic year 2012-2013
How is it measured?	Percentage
Where does the data come from?	Department of Education: https://www.gov.uk/government/publications/neighbourhood-statistics-in-england-academic-year-2012-to-2013
How accurate is the data?	This indicator only contains data for maintained schools; therefore it excludes pupils educated in private schools.
Are there any caveats?	The data for this indicator are based on the local authority of pupil residence. The Public Health Outcomes Framework (PHOF) contains data for the EYFS and GCSE indicator, but is based on the local authority of school location. There will therefore be some differences between the two profiles in results for this indicator.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	N/A

Reception Children: Percentage Overweight (including Obese)

Indicator	Reception Children: Percentage Overweight (including Obese)
How is this indicator actually defined?	Proportion of children aged 4-5 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

Why is this included?	<p>The UK is experiencing an epidemic of obesity affecting both adults and children. The Health Survey for England (HSE) found that among boys and girls aged 2 to 15, the proportion of children who were classified as obese increased from 11.7 per cent in 1995 to 16.0 per cent in 2010, peaking at 18.9 per cent in 2004.</p> <p>There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.</p> <p>The National Institute of Health and Clinical Excellence have produced guidelines to tackle obesity in adults and children - Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. Available at http://guidance.nice.org.uk/CG43.</p>
Who does it measure?	Children in Reception (age 4-5)
When does it measure?	2006/07 – 2008/09 to 2010/11 - 2012/13
How is it measured?	Percentage
Where does the data come from?	<p>Aggregated data is taken from Public Health Outcomes Framework: http://www.phoutcomes.info</p> <p>Raw data from Health and Social Care Information Centre, National Child Measurement Programme</p>
How accurate is the data?	<p>The published NCMP data do not include children in the Independent sector and special schools; therefore, coverage of school children aged 4-5 years is not complete. Further issues concerning data quality can found in the data quality statement. http://www.hscic.gov.uk/catalogue/PUB09283</p> <p>Data have been aggregated at Local Authority (LA) level on the basis of school postcode and may differ from data aggregated on the basis of child postcode.</p>
Are there any caveats?	<p>There is the potential for error in the collection, collation and interpretation of the data (bias may be introduced due to poor response rates and selective opt out of larger children which it is not possible to control for).</p> <p>Further information is available in the NCMP Analysis Guidance documents published by the Obesity Knowledge and Intelligence in Public Health England. http://www.noo.org.uk/NCMP/analytical_guidance</p>
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	N/A

Year 6 Children: Percentage Overweight (including Obese)

Indicator	Year 6 Children: Percentage Overweight (including Obese)
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How is this indicator actually defined?	Proportion of children aged 10-11 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.
Why is this included?	<p>The UK is experiencing an epidemic of obesity affecting both adults and children. The Health Survey for England (HSE) found that among boys and girls aged 2 to 15, the proportion of children who were classified as obese increased from 11.7 per cent in 1995 to 16.0 per cent in 2010, peaking at 18.9 per cent in 2004.</p> <p>There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.</p> <p>The National Institute of Health and Clinical Excellence have produced guidelines to tackle obesity in adults and children - Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. Available at http://guidance.nice.org.uk/CG43.</p>
Who does it measure?	Children in Year 6 (age 10-11)
When does it measure?	2006/07 – 2008/09 to 2010/11 - 2012/13
How is it measured?	Percentage
Where does the data come from?	<p>Aggregated data is taken from Public Health Outcomes Framework: http://www.phoutcomes.info</p> <p>Raw data from Health and Social Care Information Centre, National Child Measurement Programme</p>
How accurate is the data?	<p>The published NCMP data do not include children in the Independent sector and special schools; therefore, coverage of school children aged 10-11 years is not complete. Further issues concerning data quality can found in the data quality statement. http://www.hscic.gov.uk/catalogue/PUB09283</p> <p>Data have been aggregated at Local Authority (LA) level on the basis of school postcode and may differ from data aggregated on the basis of child postcode.</p>
Are there any caveats?	<p>There is the potential for error in the collection, collation and interpretation of the data (bias may be introduced due to poor response rates and selective opt out of larger children which it is not possible to control for).</p> <p>Further information is available in the NCMP Analysis Guidance documents published by the Obesity Knowledge and Intelligence in Public Health England. http://www.noo.org.uk/NCMP/analytical_guidance</p>
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	N/A

Teenage Pregnancy (under 18) Chart

Indicator	Teenage Pregnancy (under 18) Chart
How is this indicator actually defined?	Under-18 conception rate per 1,000 females aged 15-17
Why is this included?	<p>Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. And while for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.</p> <p>Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.</p>
Who does it measure?	Females aged 15-17 who conceive
When does it measure?	2001-03 to 2010-12
How is it measured?	Rate per 1,000 females aged 15-17
Where does the data come from?	Aggregated data is taken from Public Health Outcomes Framework: http://www.phoutcomes.info Raw data from Office of National Statistics
How accurate is the data?	Data relating to legal abortions and births is collated through mandatory reporting processes and is of sound data quality.
Are there any caveats?	The date of conception is estimated using recorded gestation for abortions and stillbirths, and assuming 38 weeks gestation for live births. A woman's age at conception is calculated as the number of complete years between her date of birth and the date she conceived. The postcode of the woman's address at time of birth or abortion is used to determine geographical area of residence at time of conception. Only about 5% of under 18 conceptions are to girls aged 14 or under and to include younger age groups in the base population would produce misleading results. The 15-17 age group is effectively treated as population at risk.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	N/A

Teenage Pregnancy (under 18) Ward Level Map

Indicator	Teenage Pregnancy (under 18) Ward Level Map
How is this	Significance of Under-18 conception rate per 1,000 females aged 15-17 at ward level compared

indicator actually defined?	to the England average.
Why is this included?	<p>Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. And while for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.</p> <p>Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.</p>
Who does it measure?	Females aged 15-17 who conceive
When does it measure?	2009-11
How is it measured?	Rate per 1,000 females aged 15-17 at ward level
Where does the data come from?	Ward level data from Office of National Statistics
How accurate is the data?	Data relating to legal abortions and births is collated through mandatory reporting processes and is of sound data quality.
Are there any caveats?	The date of conception is estimated using recorded gestation for abortions and stillbirths, and assuming 38 weeks gestation for live births. A woman's age at conception is calculated as the number of complete years between her date of birth and the date she conceived. The postcode of the woman's address at time of birth or abortion is used to determine geographical area of residence at time of conception. Only about 5% of under 18 conceptions are to girls aged 14 or under and to include younger age groups in the base population would produce misleading results. The 15-17 age group is effectively treated as population at risk.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	<p>Wards are blue or red when the figure is statistically significantly lower or higher than the England average, based on the 95% confidence intervals of the figure compared to the England value.</p> <p>Wards are green when there is no significant difference and yellow when the numbers are suppressed.</p>

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1. Children in poverty indicator

Indicator Number	1
How is this indicator actually defined?	Percentage of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income) for under 16s only
Definition of numerator	Number of children aged under 16 living in families in receipt of Child Tax Credit whose reported income is less than 60 per cent of the median income or in receipt of Income Support or (Income-

	Based) Job Seeker's Allowance.
Definition of denominator	Number of children aged under 16 for whom Child Benefit was received in each local authority.
Why is this included?	<p>Child poverty is an important issue for public health. Inclusion of this indicator emphasises its importance.</p> <p>The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.</p> <p>'A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives' sets out the Government's approach to tackling poverty for this Parliament and up to 2020. This strategy meets the requirements set out in the Child Poverty Act 2010, focuses on improving the life chances of the most disadvantaged children, and sits alongside the Government's broader strategy to improve social mobility.</p>
When does it measure?	2011
How is it measured?	Percentage
Where does the data come from?	<p>Aggregated data is taken from Public Health Outcomes Framework: http://www.phoutcomes.info</p> <p>Raw data collected from HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics)</p> <p>http://www.hmrc.gov.uk/stats/personal-tax-credits/child_poverty.htm</p> <p>http://www.hmrc.gov.uk/stats/child_benefit/geographical.htm</p>
How accurate is the data?	The data are of very high quality as they are drawn from a 100% scan of administrative records and as a result are not subject to any sampling error. Comprehensive validation checks are undertaken.
Are there any caveats?	<p>For National Statistics data on child poverty at regional level, please refer to the Department of Work and Pensions' Households Below Average Income publication which uses the relative child poverty measure as set out in the Child Poverty Act 2010. The small area estimates are not directly comparable with the national figures.</p> <p>N.B. Data for Isles of Scilly is not presented, but its data are included in the values for England.</p>
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

2. GSCE achieved indicator

Indicator Number	2
How is this indicator actually defined?	Pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) or equivalent, percentage of pupils at end of Key Stage 4 in schools maintained by the Local Authority, at the end of the academic year 2012/13, persons.
Definition of numerator	Number of pupils at the end of Key Stage 4 at the end of the academic year 2012/13 achieving 5 or more GCSEs, including English and Maths, at grades A*-C or equivalent in schools maintained by the Local Authority. The numerator will include achievements by these pupils in previous academic years.
Definition of denominator	Number of pupils at the end of Key Stage 4 at the end of the academic year 2012/13 in schools maintained by the Local Authority.

Why is this included?	Educational attainment is influenced by both the quality of education children receive and their family's socio-economic circumstances. 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.
When does it measure?	2012/13
How is it measured?	Proportions expressed as percentage of pupils.
Where does the data come from?	Aggregated data is taken from Health Profiles: http://www.apho.org.uk/default.aspx?RID=49802 Raw data from collected and collated by the Department for Education.
How accurate is the data?	This indicator only contains data for maintained schools; therefore it excludes pupils educated in private schools.
Are there any caveats?	Data are aggregated on the basis of the Local Authority District of school location.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

3. Pupil absence indicator

Indicator Number	3
How is this indicator actually defined?	Percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence).
Definition of numerator	The number of sessions missed due to overall absence
Definition of denominator	The total number of possible school sessions
Why is this included?	Parents of children of compulsory school age (aged 5 to 15 at the start of the school year) are required to ensure that they receive a suitable education by regular attendance at school or otherwise. Educational attainment is influenced by both the quality of education they receive and their family socio-economic circumstances. 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.
When does it measure?	2011/12
How is it measured?	The number of half day sessions missed due to overall absence, expressed as a percentage of the total number of possible sessions.
Where does the data come from?	Aggregated data is taken from Public Health Outcomes Framework: http://www.phoutcomes.info Raw data taken from the School Census: https://www.gov.uk/government/collections/statistics-pupil-absence , Pupil absence in schools in England for the appropriate academic year, the

	'underlying data' zip file link, the data will be within the 'school_location_UD.csv' file.
How accurate is the data?	Data are based on state funded primary and secondary (including maintained primary and secondary schools and city technology colleges and academies) and special schools. Data are based on the geographical location of the school.
Are there any caveats?	Information relating to pupil absence counts the number of enrolments rather than the number of pupils. From September 2011 the way schools record attendance and absence for dually registered pupils changed. Attendance code D (Dual registered at another educational establishment) is no longer counted in the School Census as an attendance. Each school now only records the attendance and absence for the sessions a pupil is required to attend at their school, previously each school recorded all absence. This change affects a relatively small number of pupils and has only a marginal effect on absence rates. Data relate to 2.5 terms of the 2011/12 academic year. Year on year comparisons of local authority data may be affected due to schools converting to academies. Indicator is based on data returned as part of the School Census. It does not include data which has been submitted by local authorities or schools outside of the School Census Collection. Data does not include those children not registered at a school. N.B. Data for the City of London is not presented, but its data are included in the values for England.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

4. Fast food outlets indicator

Indicator Number	4
How is this indicator actually defined?	Crude rate of fast food outlets per 100,000 population, 2011
Definition of numerator	The number of fast food outlets in each local authority
Definition of denominator	ONS mid year population estimates
Why is this included?	People generally have easy access to cheap, highly palatable and energy-dense food frequently lacking in nutritional value - such as fast food. Research into the link between food availability and obesity is still relatively undeveloped.
When does it measure?	2011
How is it measured?	Rate of fast food outlets per 100,000 persons
Where does the data come from?	Aggregated data is taken from National Obesity Observatory: https://www.noo.org.uk/visualisation Raw data taken from the Ordnance Survey and Office of National Statistics (ONS): http://www.ordnancesurvey.co.uk/oswebsite/products/points-of-interest/index.html http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/mid-2011--2011-census-based-/index.html

How accurate is the data?	Data is based on 2011. Number of fast food outlets may have altered.
Are there any caveats?	N.B. Data for the City of London is not presented due to its extreme difference of geographical and population make-up, but its data is included in the values for England.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

5. Injured on the road indicator

Indicator Number	5
How is this indicator actually defined?	Children aged under 16 years injured on the roads of the area, crude rate per 100,000 resident population.
Definition of numerator	The number of children (aged under 16) injured on the roads of the area in 2010. The indicator is based on casualties who incur injury on the public highway (including footways) in which at least one road vehicle or a vehicle in collision with a pedestrian is involved and which becomes known to the police within 30 days of its occurrence. The vehicle need not be moving and accidents involving stationary vehicles and pedestrians or other road users are included. One accident may give rise to more than one casualty.
Definition of denominator	Census based mid-year resident population (under 16 years) estimate for the year 2010.
Why is this included?	<p>To help reduce road traffic collisions which are a major cause of preventable death and serious injury.</p> <p>One of the Department of Transport's PSA targets was 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 1994-8.</p> <p>The public health strategy 'Healthy Lives, Healthy People' (2010) reiterated the need to reduce road injuries in children and address the "strong social and regional variations". Reports relating to the earlier cross-government 'Staying Safe' strategy such as the 'Staying Safe: Action Plan' (2008) and 'Accident Prevention Amongst Children and Young People - A Priority Review' (2009) address child road safety issues in more detail.</p> <p>However, the Department for Transport's 'Strategic Framework for Road Safety' launched 11 May draws together and updates the wide-ranging issues that will need to be addressed to reduce road casualties. The strategy also drops over-arching national targets in favour of a new proposed 'Road Safety Outcomes Framework' that will complement the measure included in Health Profiles.</p> <p>The Department of Health's public health strategy 'Healthy lives, healthy people: Improving outcomes and supporting transparency' (2012) also highlights the importance of reducing casualties and serious injuries on England's roads.</p> <p>The need for safer roads is also linked to the recent public health strategy, and existing government-backed initiatives, to increase 'active travel' and physical activity.</p>
When does it measure?	2010

How is it measured?	Rates: numbers per 100,000 resident population aged under 16.
Where does the data come from?	Aggregated data is taken from Chimat: http://www.chimat.org.uk/ Raw data from Department for Transport and Office of National Statistics (ONS).
How accurate is the data?	Data quality varies as there are differences between police forces in procedures for recording, collecting and collating.
Are there any caveats?	Not all road casualties are reported to police. Areas with low resident populations but which have high inflows of people or traffic may have artificially high rates because the at-risk resident population is not an accurate measure of exposure to transport. This is likely to affect the results for employment centres and sparsely populated rural areas which have high numbers of visitors or through traffic.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

6. Low birth weight indicator

Indicator Number	6
How is this indicator actually defined?	Live births with a recorded birth weight under 2500g and a gestational age of at least 37 complete weeks as a percentage of all live births with recorded birth weight and a gestational age of at least 37 complete weeks.
Definition of numerator	Number of live births at term (≥ 37 gestation weeks) with low birth weight ($<2500g$)
Definition of denominator	Number of live births at term (≥ 37 weeks) with recorded birth weight
Why is this included?	Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low birth weight births could indicate lifestyle issues of the mothers and/or issues with the maternity services.
When does it measure?	2011
How is it measured?	Percentage
Where does the data come from?	Aggregated data is taken from Public Health Outcomes Framework: http://www.phoutcomes.info Raw data from Office of National Statistics (ONS). ONS publishes data at national level, in the context of infant mortality. Local authority level data are available on request from cim@ons.gsi.gov.uk .
How accurate is the data?	ONS has linked birth registrations with NHS birth notification records to allow reporting by gestational age and birth weight. With 99.4% of records linked successfully, completeness of this dataset is very good.

Are there any caveats?	Not all births are recorded with a valid birth weight and gestational age. There may be regional variations in the completeness of these fields.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

7. Starting breastfeeding indicator

Indicator Number	7
How is this indicator actually defined?	Percentage of mothers who put their baby to the breast in the first 48 hours after delivery per 100 maternities where breast feeding initiation status is recorded.
Definition of numerator	Number of mothers who put their baby to the breast in the first 48 hours after delivery
Definition of denominator	Number of maternities
Why is this included?	Breast milk provides the ideal nutrition for infants in the first stages of life. There is evidence that babies who are breast fed experience lower levels of gastro-intestinal and respiratory infection. Observational studies have shown that breastfeeding is associated with lower levels of child obesity. Benefits to the mother include a faster return to pre-pregnancy weight and possibly lower risk of breast and ovarian cancer (BMA Board of Science, 2009)
When does it measure?	2012/13
How is it measured?	Percentage: Number of women who initiate breast feeding per 100 maternities where breast feeding initiation status is recorded.
Where does the data come from?	Aggregated data is taken from Health Profiles: http://www.apho.org.uk/default.aspx?RID=49802 Raw data from Department of Health (DH), Integrated Performance Monitoring Return
How accurate is the data?	A Local Authority (LA) will not have an estimate of prevalence if the data quality in any of its component PCTs did not meet any of the DH data quality validation tests which can be found contained in each quarterly report and the component PCT or PCTs made up more than 5% of the LA's maternities. In addition the England totals do not equal the sum of the Local Authorities as all of the suppressed values have been included in the England figure. There may however be a difference between the England total quarterly values and the LA derived value given the different refresh timeframes.
Are there any caveats?	The indicator is based on observation and is therefore susceptible to measurement bias. The denominator in the Public Health Outcomes Framework (PHOF) implicitly assumes that all patients whose breastfeeding initiation status is unknown did not initiate breastfeeding. This will result in an underestimate of the percentage of mothers initiating breastfeeding.
Are particular tests needed such as standardisation, significance tests, or statistical	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

process control to test the meaning of the data and the variation they show?

8. Smoking in pregnancy indicator

Indicator Number	8
How is this indicator actually defined?	Number of women who currently smoke at time of delivery per 100 maternities where smoking status is recorded
Definition of numerator	Number of women who currently smoke at time of delivery
Definition of denominator	Number of maternities where smoking status is recorded
Why is this included?	Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes. Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to secondhand smoke by the infant.
Who does it measure?	Women giving birth in 2012/13 whose smoking at time of delivery status is recorded.
When does it measure?	2012/13
How is it measured?	Percentage: Number of women who smoke at time of delivery per 100 maternities where smoking status is recorded
Where does the data come from?	Aggregated data is taken from Health Profiles: http://www.apho.org.uk/default.aspx?RID=49802 Raw data from Health and Social Care Information Centre's return on Smoking Status At Time of delivery (SATOD). Year end outturn position supplied by the Department of Health. Weighted by the number of births by LA-PCT, extracted from the ONS 2011 birth file and cross-referenced with Feb 2013 postcode file.
How accurate is the data?	A Local Authority (LA) will not have an estimate of prevalence if the data quality in any of its component PCTs did not meet any of the DH data quality validation tests which can be found contained in each quarterly report and the component PCT or PCTs made up more than 5% of the LA's maternities. In addition the England totals do not equal the sum of the Local Authorities as all of the suppressed values have been included in the England figure. There may however be a difference between the England total quarterly values and the LA derived value given the different refresh timeframes.
Are there any caveats?	The indicator is based on observation and is therefore susceptible to measurement bias. These data are collected by acute trusts that provide maternity services and were then sent to former PCTs on a commissioner basis. PCT level data are then converted to LA level using birth weighting. If there were several LAs within one PCT they will all have the same prevalence, thereby masking any variation in prevalence which may exist within that PCT. Where local authorities crossed PCT boundaries, the local authority estimate is a weighted average of the PCT indicator values. Where a local authority was within a single PCT's boundary, the local authority value presented is the value from the PCT. The denominator in the Public Health Outcomes Framework (PHOF) implicitly assumes that all patients whose smoking status is unknown are non smokers. This will result in an underestimate of the percent of mothers who are smokers at time of delivery.
Are particular tests	The data point is green or red when the figure in a district is statistically significantly better or

needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.
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9. Tooth decay in five year olds indicator

Indicator Number	9
How is this indicator actually defined?	Mean severity of tooth decay in children aged five years based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted decayed/missing/filled teeth (d3mft)
Definition of numerator	Total number of obviously decayed, missing (due to decay) and filled teeth in five year old children in an area.
Definition of denominator	Total number of examined five year old children in area.
Why is this included?	<p>Tooth decay is a predominantly preventable disease. Significant levels remain (28% of five-year-old children have observable decay), resulting in pain, sleep loss, time off school and, in some cases, treatment under general anaesthetic.</p> <p>Inclusion of this indicator in the Public Health Outcomes Framework will encourage local authorities to focus on and prioritise oral health and oral health improvement initiatives to reduce tooth decay.</p>
When does it measure?	2012
How is it measured?	Mean severity of tooth decay per child
Where does the data come from?	<p>Aggregated data is taken from Health Profiles: http://www.apho.org.uk/default.aspx?RID=49802</p> <p>Raw data from National Dental Epidemiology Programme for England, Oral Health Survey of five year old children, 2012. http://www.nwph.net/dentalhealth/</p>
How accurate is the data?	The sampling frame is children attending mainstream schools; therefore it excludes pupils educated in private schools. For a child to participate in the survey, a positive consent is required following the guidance by the Department of Health. There is potential for consent bias to impact upon the validity of results. Investigation into factors related to consent returns may be indicated again and this will be carried out by the Public Health England using the raw data. The process requires that all children approached for consent are entered into the database along with their home postcode and consent return status. The provision of consent, refusal or non- provision needs to be recorded.
Are there any caveats?	Local Authorities (LAs) are not included if all or part of the LA area did not take part in the survey or if the number examined was too small (less than 30) for a robust estimate. Data for Leicestershire districts or Rutland is not affected.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

of the data and the variation they show?

10. Excess weight in reception indicator

Indicator Number	10
How is this indicator actually defined?	Proportion of children aged 4-5 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.
Definition of numerator	Number of children in Reception (aged 4-5 years) classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.
Definition of denominator	Number of children in Reception (aged 4-5 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.
Why is this included?	<p>The UK is experiencing an epidemic of obesity affecting both adults and children. The Health Survey for England (HSE) found that among boys and girls aged 2 to 15, the proportion of children who were classified as obese increased from 11.7 per cent in 1995 to 16.0 per cent in 2010, peaking at 18.9 per cent in 2004.</p> <p>There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.</p> <p>The National Institute of Health and Clinical Excellence have produced guidelines to tackle obesity in adults and children - Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. Available at http://guidance.nice.org.uk/CG43.</p>
When does it measure?	2012/13
How is it measured?	Percentage
Where does the data come from?	Aggregated data is taken from Public Health Outcomes Framework: http://www.phoutcomes.info Raw data from Health and Social Care Information Centre, National Child Measurement Programme
How accurate is the data?	<p>The published NCMP data do not include children in the Independent sector and special schools; therefore, coverage of school children aged 4-5 years is not complete. Further issues concerning data quality can found in the data quality statement. http://www.hscic.gov.uk/catalogue/PUB09283</p> <p>Data have been aggregated at Local Authority (LA) level on the basis of school postcode and may differ from data aggregated on the basis of child postcode.</p>
Are there any caveats?	There is the potential for error in the collection, collation and interpretation of the data (bias may be introduced due to poor response rates and selective opt out of larger children which it is not possible to control for).

	Further information is available in the NCMP Analysis Guidance documents published by the Obesity Knowledge and Intelligence in Public Health England. http://www.noo.org.uk/NCMP/analytical_guidance
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

11. Excess weight in Year 6 indicator

Indicator Number	10
How is this indicator actually defined?	Proportion of children aged 10-11 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.
Definition of numerator	Number of children in Year 6 classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.
Definition of denominator	Number of children in Year 6 (aged 10-11 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.
Why is this included?	<p>The UK is experiencing an epidemic of obesity affecting both adults and children. The Health Survey for England (HSE) found that among boys and girls aged 2 to 15, the proportion of children who were classified as obese increased from 11.7 per cent in 1995 to 16.0 per cent in 2010, peaking at 18.9 per cent in 2004.</p> <p>There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.</p> <p>The National Institute of Health and Clinical Excellence have produced guidelines to tackle obesity in adults and children - Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. Available at http://guidance.nice.org.uk/CG43.</p>
When does it measure?	2012/13
How is it measured?	Percentage
Where does the data come from?	Aggregated data is taken from Public Health Outcomes Framework: http://www.phoutcomes.info Raw data from Health and Social Care Information Centre, National Child Measurement Programme
How accurate is the data?	The published NCMP data do not include children in the Independent sector and special schools; therefore, coverage of school children aged 10-11 years is not complete. Further issues concerning data quality can found in the data quality statement.

	<p>http://www.hscic.gov.uk/catalogue/PUB09283</p> <p>Data have been aggregated at Local Authority (LA) level on the basis of school postcode and may differ from data aggregated on the basis of child postcode.</p>
Are there any caveats?	<p>There is the potential for error in the collection, collation and interpretation of the data (bias may be introduced due to poor response rates and selective opt out of larger children which it is not possible to control for).</p> <p>Further information is available in the NCMP Analysis Guidance documents published by the Obesity Knowledge and Intelligence in Public Health England. http://www.noo.org.uk/NCMP/analytical_guidance</p>
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	<p>The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.</p>

12. Teenage pregnancy indicator

Indicator Number	12
How is this indicator actually defined?	Under-18 conception rate per 1,000 females aged 15-17, 2012.
Definition of numerator	Number of pregnancies that occur to women aged under 18, that result in either one or more live or still births or a legal abortion under the Abortion Act 1967.
Definition of denominator	Number of women aged 15-17 living in the area
Why is this included?	<p>Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. And while for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.</p> <p>Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.</p>
When does it measure?	2012
How is it measured?	Rate per 1,000 females aged 15-17
Where does the data come from?	<p>Aggregated data is taken from Public Health Outcomes Framework: http://www.phoutcomes.info</p> <p>Raw data from Office for National Statistics</p>

How accurate is the data?	Data relating to legal abortions and births is collated through mandatory reporting processes and is of sound data quality.
Are there any caveats?	The date of conception is estimated using recorded gestation for abortions and stillbirths, and assuming 38 weeks gestation for live births. A woman's age at conception is calculated as the number of complete years between her date of birth and the date she conceived. The postcode of the woman's address at time of birth or abortion is used to determine geographical area of residence at time of conception. Only about 5% of under 18 conceptions are to girls aged 14 or under and to include younger age groups in the base population would produce misleading results. The 15-17 age group is effectively treated as population at risk.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

13. Infant deaths indicator

Indicator Number	13
How is this indicator actually defined?	Rate of deaths in infants aged under 1 year per 1,000 live births
Definition of numerator	The number of infant deaths aged under 1 year that occurred in the relevant period.
Definition of denominator	The number of live births that occurred in the relevant period.
Why is this included?	Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn.
Who does it measure?	Infants aged less than 1 year.
When does it measure?	2010-12
How is it measured?	Rates: numbers per 1,000 live births.
Where does the data come from?	Aggregated data is taken from Public Health Outcomes Framework: http://www.phoutcomes.info Raw data from Office for National Statistics (ONS)
How accurate is the data?	Data on births and deaths are considered to be complete and robust.
Are there any caveats?	Live births were assigned to geographical areas by ONS using the postcode of mother's usual residence and the National Statistics Postcode Directory (NSPD).
Are particular tests needed such as standardisation, significance tests, or statistical	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

process control to test the meaning of the data and the variation they show?

14. Hospital stays for gastroenteritis indicator

Indicator Number	14
How is this indicator actually defined?	Emergency hospital admission for gastroenteritis, indirectly age-sex standardised rate, under 5 years, 2011/12, persons
Definition of numerator	Number of emergency admission inpatient spells for children (age under 5) for gastroenteritis (ICD10 codes: A02.0, A04.-, A05.9, A07.2, A08.0, A08.1, A08.3, A08.4, A08.5, A09, K52.0, K52.1, K52.2, K52.8, K52.9)
Definition of denominator	Census based mid-year resident population (under 5 years) estimate for the year 2011.
Why is this included?	To draw attention to the burden of potentially avoidable hospital admissions due to gastroenteritis, where a majority may be able to be managed in primary care.
When does it measure?	2011/12
How is it measured?	Indirectly age-sex standardised rate per 100,000 population
Where does the data come from?	Collection and collation from Hospital Episodes Statistics (HES) via the Health and Social Care Information Centre. Population statistics are taken from the Office of National Statistics (ONS).
How accurate is the data?	HES data and ONS population statistics are considered to be complete and robust.
Are there any caveats?	There may be variation between Trusts in the way hospital admissions are coded. Routine data do not allow for all of these aspects to be identified and removed from the indicator, however, this may be done through local audit. N.B. Where the observed total number of hospital admissions is less than 5, the rates have been suppressed for confidentiality reasons.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

15. Hospital stays for lower respiratory tract infections indicator

Indicator Number	15
How is this indicator actually defined?	Emergency hospital admission for lower respiratory tract infections, indirectly age-sex standardised rate, under 16 years, 2011/12, persons

Definition of numerator	Number of emergency admission inpatient spells for children (age under 16) for lower respiratory tract infections (ICD10 codes: J10.0, J11.0, J11.1, J12.-, J13, J14, J15.-, J16.-, J18.0, J18.1, J18.9, J21.-)
Definition of denominator	Census based mid-year resident population (under 16 years) estimate for the year 2011.
Why is this included?	To draw attention to the burden of potentially avoidable hospital admissions due to lower respiratory tract infections, where a majority may be able to be managed in primary care.
When does it measure?	2011/12
How is it measured?	Indirectly age-sex standardised rate per 100,000 population
Where does the data come from?	Collection and collation from Hospital Episodes Statistics (HES) via the Health and Social Care Information Centre. Population statistics are taken from the Office of National Statistics (ONS).
How accurate is the data?	HES data and ONS population statistics are considered to be complete and robust.
Are there any caveats?	There may be variation between Trusts in the way hospital admissions are coded. Routine data do not allow for all of these aspects to be identified and removed from the indicator, however, this may be done through local audit. N.B. Where the observed total number of hospital admissions is less than 5, the rates have been suppressed for confidentiality reasons.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

16. Hospital stays for asthma

Indicator Number	16
How is this indicator actually defined?	Emergency hospital admission for asthma, indirectly age-sex standardised rate, under 16 years, 2011/12, persons
Definition of numerator	Number of emergency admission inpatient spells for children (age under 16) for asthma (ICD10 codes: J45.- and J46.-)
Definition of denominator	Census based mid-year resident population (under 16 years) estimate for the year 2011.
Why is this included?	Asthma is the commonest long-term medical condition in childhood. Emergency admissions should be avoided whenever possible. Unplanned hospitalisation for asthma, diabetes and epilepsy in children and young people under 19 years is a national quality indicator in the NHS Outcomes Framework.
When does it measure?	2011/12

How is it measured?	Indirectly age-sex standardised rate per 100,000 population
Where does the data come from?	Collection and collation from Hospital Episodes Statistics (HES) via the Health and Social Care Information Centre. Population statistics are taken from the Office of National Statistics (ONS).
How accurate is the data?	HES data and ONS population statistics are considered to be complete and robust.
Are there any caveats?	There may be variation between Trusts in the way hospital admissions are coded. Routine data do not allow for all of these aspects to be identified and removed from the indicator, however, this may be done through local audit.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

17. Hospital stays for falls

Indicator Number	17
How is this indicator actually defined?	Rate of hospital admissions in 2008/09 to 2010/11 due to falls based on an ICD 10 code of S00 to S99 or T00 to T79 in the primary diagnosis position and an ICD 10 code of W00 to W19 in the 1st secondary position and where age of child between 5 and 16 years per 100,000 population
Definition of numerator	Number of hospital admissions in 2008/09 to 2010/11 due to falls based on an ICD code of S00 to S99 or T00 to T79 in the primary diagnosis position and an ICD code of W00 to W19 in the 1st secondary position and where age of child between 5 and 16 years.
Definition of denominator	Total of mid-year population estimate 2008 to 2010 for age band
Why is this included?	To draw attention to the burden of potentially avoidable hospital admissions due to falls, regardless of cause.
When does it measure?	2008/09-2010/11
How is it measured?	Crude rate: numbers of cases per hundred thousand populations.
Where does the data come from?	Collection and collation from Hospital Episodes Statistics (HES) via the Health and Social Care Information Centre. Population statistics are taken from the Office of National Statistics (ONS).
How accurate is the data?	HES data and ONS population statistics are considered to be complete and robust.
Are there any caveats?	There may be variation between Trusts in the way hospital admissions are coded. Routine data do not allow for all of these aspects to be identified and removed from the indicator, however, this may be done through local audit.
Are particular tests	The data point is green or red when the figure in a district is statistically significantly better or

needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.
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18. Hospital stays for tooth extraction

Indicator Number	18
How is this indicator actually defined?	Number of Finished Consultant Episodes (FCEs) for children and adolescents aged 0 to 19 in England admitted to hospital for extraction during 2012/13 by lower tier local authority (LA) of residence, (surgical removal or simple extraction of tooth)
Definition of numerator	Number of Finished Consultant Episodes (FCEs) for children and adolescents aged 0 to 19 admitted to hospital for extraction (surgical removal or simple extraction of tooth)
Definition of denominator	Children aged 0-19 years, ONS mid year population estimates, 2011
Why is this included?	Attempts to reduce the number of admissions to hospital for the extraction of teeth is a priority and one that needs to address several areas, which include: engagement of primary and secondary care providers; establishment of clear acceptance criteria and triage of referrals; provision of training and support for primary care teams in the management of caries among children in acute and chronic stages; commissioning and implementation of oral health improvement interventions with the local authority; and clear agreement about provision of support for families before and after hospital admission in an effort to avoid repeat admissions in the future.
When does it measure?	2012/13
How is it measured?	Crude rate: numbers of cases per hundred thousand populations.
Where does the data come from?	Collection and collation from Hospital Episodes Statistics (HES) via the Health and Social Care Information Centre. Population statistics are taken from the Office of National Statistics (ONS).
How accurate is the data?	HES data and ONS population statistics are considered to be complete and robust.
Are there any caveats?	There may be variation between Trusts in the way hospital admissions are coded. Routine data do not allow for all of these aspects to be identified and removed from the indicator, however, this may be done through local audit. The vast majority of teeth extracted will have been removed because of decay. In some instances the data are an underestimate of the number of admissions, as the Community Dental Service may provide the extraction service in hospital premises but the episodes may not be included in hospital data recording.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

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19. Hospital stays for alcohol related harm

Indicator Number	19
How is this indicator actually defined?	Persons admitted to hospital due to alcohol specific conditions, crude rate per 100,000 population aged under 18 years. Alcohol specific conditions are those that are wholly related to alcohol.
Definition of numerator	The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause. See LAPE user guide for further details http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf
Definition of denominator	Children aged 0-17 years, ONS mid year population estimates
Why is this included?	Alcohol misuse at any age has health and social consequences. Alcohol misuse in young people is a major contributor to criminal and antisocial behaviour. Although evidence suggests that the number of teenagers who drink has decreased in recent years, the amount drunk by young people who do drink has increased.
Who does it measure?	All persons, aged under 18 years
When does it measure?	2010/11 - 2012/13
How is it measured?	Crude rate: numbers of cases per hundred thousand populations.
Where does the data come from?	Collection and collation from Hospital Episodes Statistics (HES) via the Health and Social Care Information Centre. Population statistics are taken from the Office of National Statistics (ONS).
How accurate is the data?	HES data and ONS population statistics are considered to be complete and robust.
Are there any caveats?	There may be variation between Trusts in the way hospital admissions are coded. Routine data do not allow for all of these aspects to be identified and removed from the indicator, however, this may be done through local audit.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

20. Hospital stays for mental health conditions

Indicator Number	20
How is this indicator actually defined?	Under 18s admitted to hospital with mental health conditions per 100,000 population, 2010-2012

Definition of numerator	Children aged under 18 years admitted to hospital due to a mental health condition
Definition of denominator	Children aged 0-17 years, ONS mid year population estimates
Why is this included?	One in ten children aged 5-16 years has a clinically diagnosable mental health problem and, of adults with long-term mental health problems, half will have experienced their first symptoms before the age of 14. Self-harming and substance abuse are known to be much more common in children and young people with mental health disorders – with ten per cent of 15-16 year olds having self-harmed. Failure to treat mental health disorders in children can have a devastating impact on their future, resulting in reduced job and life expectations.
When does it measure?	2010-2012
How is it measured?	Crude rate: numbers of cases per hundred thousand populations.
Where does the data come from?	Collection and collation from Hospital Episodes Statistics (HES) via the Health and Social Care Information Centre. Population statistics are taken from the Office of National Statistics (ONS).
How accurate is the data?	HES data and ONS population statistics are considered to be complete and robust.
Are there any caveats?	There may be variation between Trusts in the way hospital admissions are coded. Routine data do not allow for all of these aspects to be identified and removed from the indicator, however, this may be done through local audit.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

21. Hospital stays for self-harm indicator

Indicator Number	21
How is this indicator actually defined?	Under 18s admitted to hospital with a primary diagnosis of self-harm per 100,000 population, 2010-2012
Definition of numerator	Children aged under 18 years admitted to hospital due to self harm diagnosis
Definition of denominator	Children aged 0-17 years, ONS mid year population estimates
Why is this included?	Hospital admissions for self-harm in children have increased in recent years, with admissions for young women being much higher than admissions for young men. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment.
Who does it measure?	All persons, aged under 18 years
When does it measure?	2010-2012

How is it measured?	Crude rate: numbers of cases per hundred thousand populations.
Where does the data come from?	Collection and collation from Hospital Episodes Statistics (HES) via the Health and Social Care Information Centre. Population statistics are taken from the Office of National Statistics (ONS).
How accurate is the data?	HES data and ONS population statistics are considered to be complete and robust.
Are there any caveats?	There may be variation between Trusts in the way hospital admissions are coded. Routine data do not allow for all of these aspects to be identified and removed from the indicator, however, this may be done through local audit.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

22. Unintentional and deliberate injuries indicator

Indicator Number	22
How is this indicator actually defined?	Emergency hospital admissions for unintentional and deliberate injuries (ICD 10 codes V01-Y98 excluding X33-X39 and X52) in children aged 0-17 years. Crude rate per 10,000 population aged 0-17 years.
Definition of numerator	Emergency hospital admissions for unintentional and deliberate injuries (ICD 10 codes V01-Y98 excluding X33-X39 and X52) in children aged 0-17 years
Definition of denominator	Children aged 0-17 years, ONS mid year population estimates
Why is this included?	The aim of this indicator is to measure hospital admissions by injury type, which will include both unintentional and deliberate injury to children and young people. Given that some hospital admissions with an external cause of injury will be elective admissions, including some for follow-up treatment after an earlier emergency admission, the indicator is restricted to counting only emergency admissions. Some children and young people may have more than one emergency admission with an external cause of injury within a time period.
Who does it measure?	All persons, aged 0-17 years
When does it measure?	2011/12
How is it measured?	Crude rate: numbers of cases per ten thousand populations.
Where does the data come from?	Aggregated data is taken from VIPER profiles: http://www.eviper.org.uk/ Raw data collected and collated from Hospital Episodes Statistics (HES) via the Health and Social Care Information Centre. Population statistics are taken from the Office of National Statistics (ONS).

How accurate is the data?	HES data and ONS population statistics are considered to be complete and robust.
Are there any caveats?	Hospital admission data can be coded differently in different parts of the country. In some cases details of the patient's residence are insufficient to allocate the patient to a particular area and in other cases the patient has no fixed abode. These cases are not included in the England value. Rates generated using numerator data below 6 are omitted.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.

23. Unintentional deaths

Indicator Number	23
How is this indicator actually defined?	The rate of unintentional mortalities for 100,000 population aged 0 to 24 for the years 2001 to 2010
Definition of numerator	The number of unintentional mortalities for persons aged 0 to 24 for the years 2001 to 2010 (pooled). Unintentional mortalities were considered to be those with ICD-10 codes of V01 to X59 and Y85 to Y86.
Definition of denominator	Total population aged 0 to 24 years from 2001 to 2010 (pooled)
Why is this included?	In 2010 almost 1,600 people aged 0 to 24 died in England and Wales. Most deaths were unintentional which means they are often predictable and preventable.
When does it measure?	2001-10
How is it measured?	Crude rate: numbers of cases per hundred thousand populations.
Where does the data come from?	Office of National Statistics (ONS) mortality data files.
How accurate is the data?	ONS mortality and population statistics are considered to be complete and robust.
Are there any caveats?	The underlying cause is selected by ONS from the cause of death information recorded on the death certificate. Information on the cause of death is reliant on what the certifier (doctor or coroner) chooses to put on the death certificate.
Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	The data point is green or red when the figure in a district is statistically significantly better or worse respectively than the England average, based on the 95% confidence intervals of the figure compared to the England value. England value has been treated as an exact reference value rather than as an estimate.