



Public Health Outcome Framework (PHOF) Summary

Outcome Title: Mortality from respiratory disease

Context

The Public Health Outcomes Framework (PHOF) 'Healthy lives, healthy people: Improving outcomes and supporting transparency' sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected. The framework concentrates on two high-level outcomes to be achieved across the public health system, and groups further indicators into four 'domains' that cover the full spectrum of public health. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life.

Definitions

4.07i - Under 75 mortality rate from respiratory disease

Number of deaths from respiratory diseases (classified by underlying cause of death recorded as ICD codes J00-J99) registered in the respective calendar years, in people aged under 75.

4.07ii - Under 75 mortality rate from respiratory disease considered preventable

Number of deaths that are considered preventable from respiratory disease (classified by underlying cause of death recorded as ICD codes J09-J11, J40-J44) registered in the respective calendar years, in people aged under 75.

Counts of deaths for years up to and including 2010 have been adjusted where needed to take account of the ICD-10 coding change introduced in 2011. The detailed guidance on the implementation is available at <http://www.apho.org.uk/resource/item.aspx?RID=126245>.

Why is respiratory disease an issue?

Respiratory disease is one of the top causes of death in England in under 75s and smoking is the major cause of chronic obstructive pulmonary disease (COPD), one of the major respiratory diseases. This indicator will focus public health attention on the prevention of smoking and other environmental factors that contribute to people getting respiratory disease.

Mortality from respiratory disease which has been considered to be preventable has also been included as an indicator. The basic concept of preventable mortality is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense. Preventable mortality overlaps with, but is not the same as 'amenable' mortality, which includes causes of deaths which could potentially be avoided through good quality healthcare. Preventable mortality and amenable mortality are the two components of 'avoidable' mortality, as defined by the Office for National Statistics in April 2012.

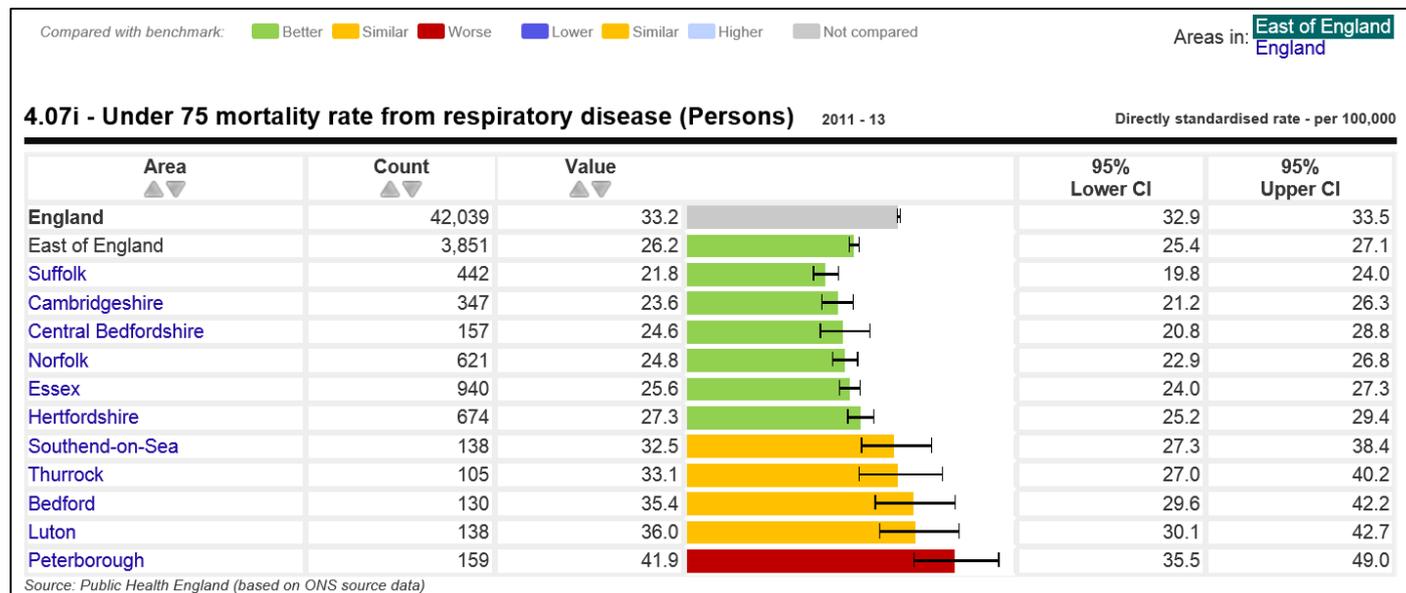
The inclusion of these indicators (alongside other indicators in the Public Health and NHS Outcomes Frameworks) reinforces the Government's commitment to reducing avoidable deaths through public health policy and interventions and sends out a clear signal that prevention of respiratory disease is just as important as treatment.

What does the evidence show?

Norfolk performs well for mortality from respiratory disease when compared with other areas in the East of England. The rate of mortality from respiratory disease in under 75 year olds per 100,000 people is significantly better in Norfolk (24.8) compared with England (33.2).

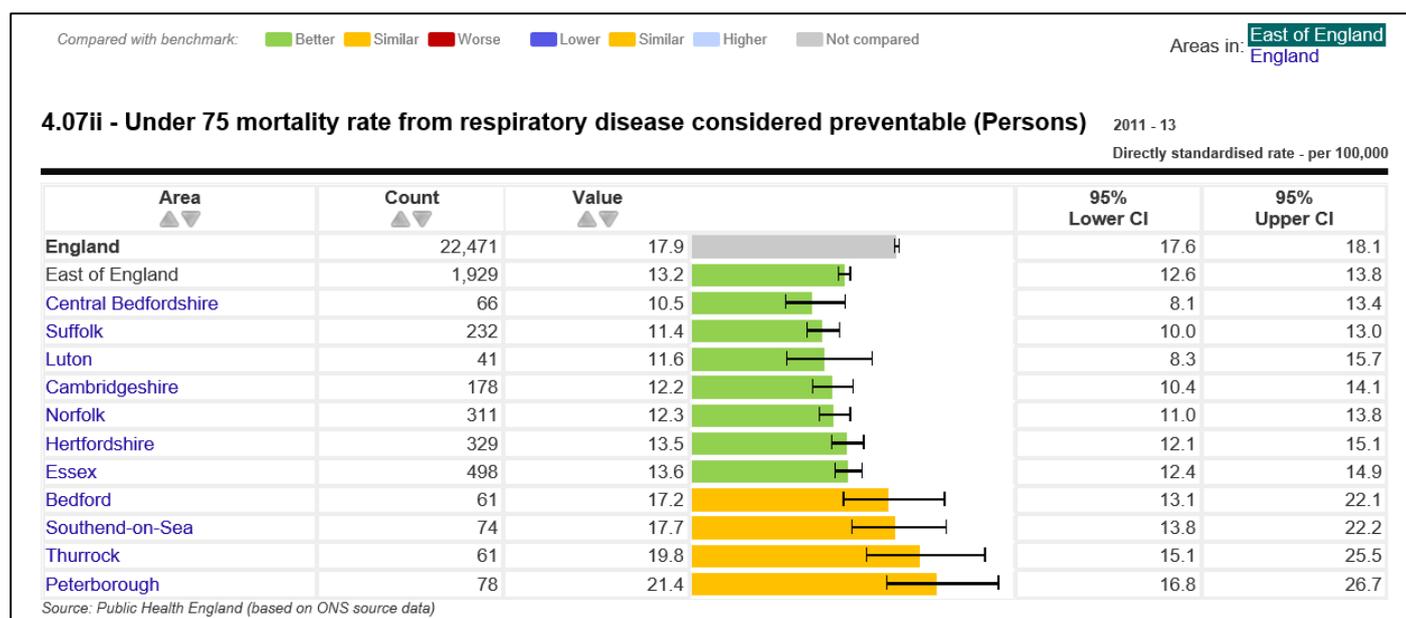
Peterborough is the only authority area in the East of England which has a significantly higher rate of mortality from respiratory disease (41.9) than the national average.

Figure 1: Under 75 mortality rate from respiratory disease (all persons), East of England areas. 2011-2013



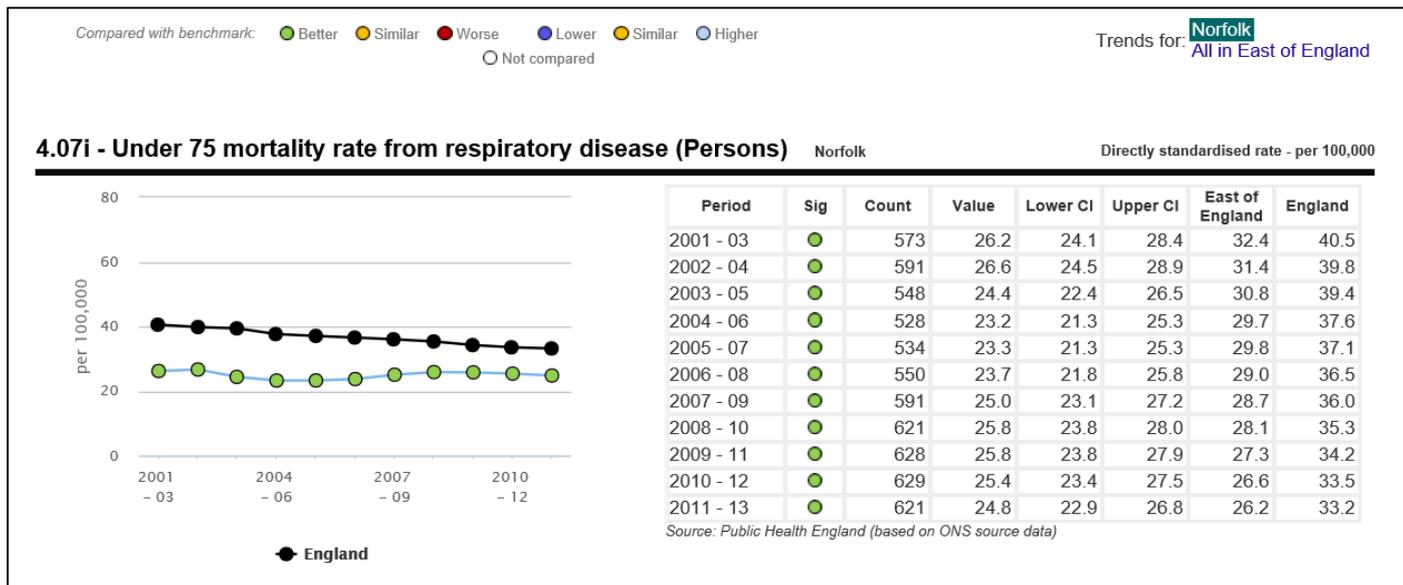
No authority area in the East of England has a significantly higher mortality rate from respiratory disease considered preventable than the national average. Seven authorities including Norfolk have a significantly lower rate of preventable deaths from respiratory disease compared to the national average (Figure 2).

Figure 2: Under 75 mortality rate from respiratory disease considered preventable (all persons), East of England areas. 2011-2013



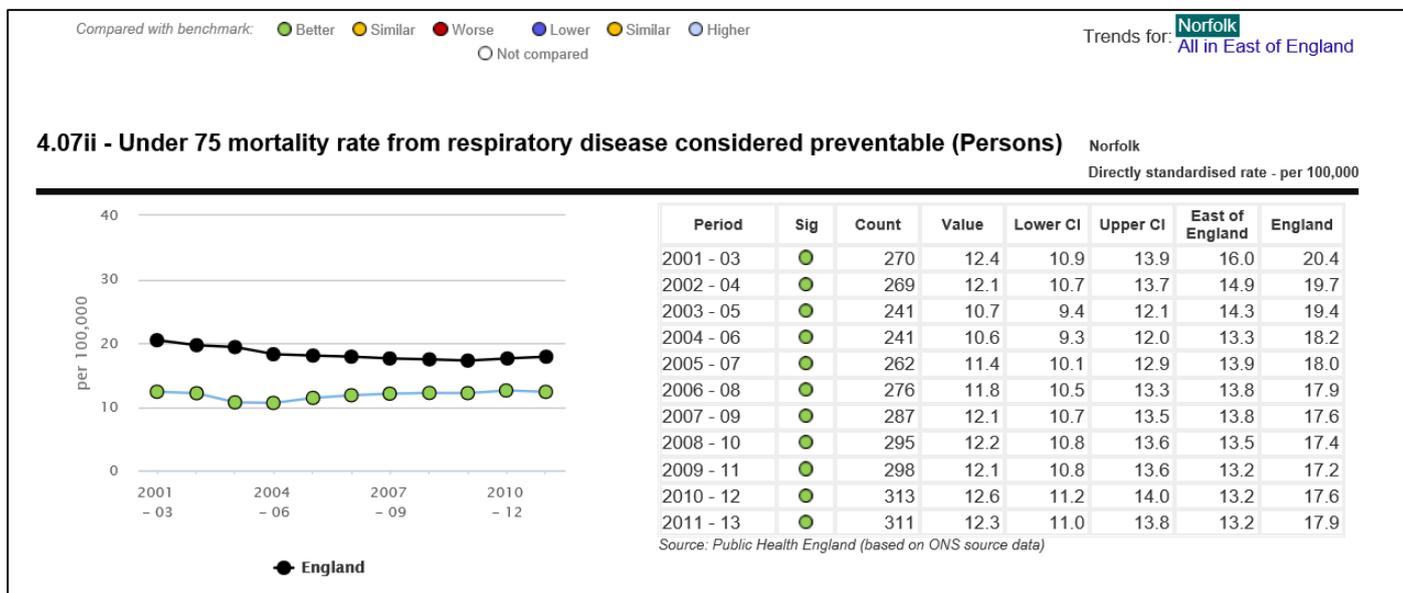
In Norfolk the mortality rate from respiratory disease for people below the age of 75 has been significantly below the national average since 2001-03. These rates have been steadily decreasing nationally but Norfolk has not made the same progress (**Figure 3**).

Figure 3: Under 75 mortality rate from respiratory disease (all persons), Norfolk. 2001-03 to 2010-12



Similarly, the mortality rate from preventable respiratory disease for people below the age of 75 has been significantly below the national average since 2001-03, but the rates have not decreased by the same amount as the England average over the same time period.

Figure 4: Under 75 mortality rate from respiratory disease considered preventable (all persons), Norfolk. 2001-03 to 2010-12



What can we do to reduce prevalence?

An outcome improvement strategy was published for COPD (National Institute for Health and Care Excellence¹) and for asthma (National Institute for Health and Care Excellence²), encompassing the National Institute for Health and Clinical Excellence guidelines for each of these as well as the outcomes strategy and the Public Health Outcomes Frameworks (Department of Health, 2012)³.

These documents outline the following key outcomes and priority actions:

- To improve the respiratory health and well-being of all communities and minimise inequalities between communities.
- To reduce the number of people who develop COPD by ensuring they are aware of the importance of good lung health and well-being, as well as risk factors.
- To reduce the number of people with COPD who die prematurely through a proactive approach to early identification, diagnosis and intervention.
- To enhance quality of life for people with COPD across all social groups, with a positive experience of care and support right through to the end of life.
- To ensure people with COPD receive safe and effective care, which minimises progression, enhances recovery and promotes independence.
- To ensure that people with asthma are free of symptoms due to prompt diagnosis, shared decision-making and on-going support and teaching regarding self-management.

Local actions to address the issue

The latest COPD needs assessment for Norfolk⁴ provides further breakdown of groups affected by COPD as well as the following local recommendations:

- There is a need for further investigation and data integration for Norwich CCG, as the mortality figures/trends for males do not match the prevalence.
- There is a need for further detailed review of the impact of the rise in migrant workers and people from countries which have smoking prevalence rates considerably higher than the UK. The implications of this on the delivery of future respiratory services need to be explored.
- It is difficult to examine potential inequity in certain population groups e.g. those defined by ethnicity, physical health and mental health owing to a lack of information.

¹ NICE Chronic Obstructive Pulmonary Disease Quality Standard: <http://www.nice.org.uk/guidance/QS10>

² NICE Asthma Quality Standard: <http://www.nice.org.uk/guidance/qs25>

³ <http://www.slough.gov.uk/council/strategies-plans-and-policies/respiratory-disease.aspx>

⁴ Latest needs assessment for COPD in Norfolk (2013), available:
<http://www.norfolkinsight.org.uk/resource/view?resourceId=808>

For more information on this subject

Public Health Outcomes Framework:

<http://www.phoutcomes.info/>

NICE Chronic Obstructive Pulmonary Disease Quality Standard:

<http://www.nice.org.uk/guidance/QS10>

NICE Asthma Quality Standard:

<http://www.nice.org.uk/guidance/qs25>

Department of Health Outcomes Strategy for Chronic Obstructive Pulmonary Disease COPD and Asthma in England:

<https://www.gov.uk/government/publications/an-outcomes-strategy-for-people-with-chronic-obstructive-pulmonary-disease-copd-and-asthma-in-england>

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Additional PHOF summaries are available on Norfolk Insight JSNA Page:

<http://www.norfolkinsight.org.uk/jsna/phoutcomes#summary>



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