Good health and wellbeing

Ensure healthy lives and promote well-being for all at all ages

Key to RAG ratings

- **GREEN:** Global or proposed UK target has been met, exceed or close to being met
- **AMBER:** Some progress or aspect of the targets met
- **RED:** Off target, poor progress, not addressed in existing policies

Prepared by The Health Foundation
Target 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

<table>
<thead>
<tr>
<th>Indicators</th>
<th>3.1.1 Maternal mortality ratio</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Applicable UK policy/ legislation | | Relevant policy documents or legislation include:

**England**

*The Government's mandate to NHS England for 2017-18* (2016): The mandate includes an objective relating to reducing the 2010 rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon after birth).


*Spotlight on Maternity (2016)*: Guidance asking organisations with maternity services to place a spotlight on maternity and make a public commitment to achieving the Government's national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030.

The *Report of the Morecambe Bay Investigation (2015)*: The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH).

**Scotland**


**Wales**

*A Strategic Vision for Maternity Services in Wales* (2011): Introduced in September 2011, the strategic vision sets out the Welsh Government’s ongoing strategy on what high-quality maternity services should look like in Wales.

**Northern Ireland**

*A Strategy for Maternity Care in Northern Ireland 2012-2018* (2012): Announced in 2012, this Strategy produced six desired outcomes with the first being ‘give every baby and family the best start in life’. A review of the strategy in 2017, from the Regulation and Quality Improvement Authority (RQIA), found ‘significant achievement’ towards the first outcome, but the Strategy had not been fully implemented and issued 19 recommendations to achieve the desired outcomes.

**UK-wide**

*MBRRACE-UK: Mothers and Babies; Reducing Risk through Audits and Confidential Enquiries across the UK.* MBRRACE-UK investigates maternal deaths in both the UK and the Republic of Ireland, issuing a report of this confidential enquiry every 3 years; the latest report was released in 2017.

*National maternity and perinatal audit (NMPA):* The NMPA is a large scale clinical audit of NHS maternity services across England, Scotland and Wales.
National SDG target

By 2025, reduce maternal mortality rate by 50% from 2010 levels*

England

In the 2017/18 Mandate to the NHS in England, the Government set an objective for NHS England to ‘work with the Department of Health and partners in a system-wide effort to achieve the national maternity ambition, to reduce the 2010 rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon after birth by 20% by 2020, demonstrating progress towards the national ambition to reduce rates by 50% by 2030’.

The Department of Health and Social Care Single Departmental Plan sets out the Department’s objective to ‘work with system partners to oversee the delivery of the Secretary of State’s ambition to halve the 2010 rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon after birth by 2025 with a 20% reduction in these rates by 2020’.

To note: The Single Departmental Plan brings forward the target date from 2030 to 2025.

*Target for England

UK commensurable indicator

As of 26 April 2018, the ONS is currently corresponding with topic experts about data for this indicator for the reporting platform.

International comparator data can be found via the World Bank statistics on maternal mortality ratio per 100,000 live births.


Baseline status/ performance

The UK meets and exceeds the global SDG target with a maternal mortality ratio of 9 per 100,000 live births in 2015. However, while the UK comfortably meets the UN target the UK ranks relatively poorly in comparison to other high-income countries. From the latest international figures, the UK ranks joint 30th in the international league tables for maternal mortality. Greece, Poland, Finland and Iceland have the lowest maternal mortality ratio of 3 per 100,000 live births in 2015.

The UK’s confidential enquiry into maternal deaths shows that the drivers of the relatively high maternal mortality in the UK compared to other high-income countries are mostly due to indirect causes of mortality. More than two thirds of maternal deaths are from physical and mental health conditions (ie mental health, cardiac disease and pre-existing health problems) and are not direct complications of pregnancy. This highlights the need to improve pre-conception and postnatal care.


The relatively high maternal mortality rates in comparison to many European countries has been a source of press attention in the UK. In England, the Government has set out an ambition to ‘halve the 2010 rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon after birth by 2025 with a 20% reduction in these rates by 2020’ (Department of Health and Social Care 2017).

Other relevant UK indicator/s
<table>
<thead>
<tr>
<th>Assessment of current state</th>
<th>RAG Rating Global Target: GREEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The UK already meets and exceeds the SDG target. However, the UK sits joint 30th in international league tables and therefore can still make significant improvements. An alternative target could be set that is more appropriate to high-income settings. A measure of severe morbidity instead of mortality might be more appropriate to assess quality of care.</td>
</tr>
</tbody>
</table>

| Notes/ disaggregation       | World Bank data (also available at the link above) suggests a drop from 277 per 100,000 in 2006 to 216 per 100,000 across the world. All OECD countries was 20 per 100,000 in 2006 and 14 in 2015. |

| Coherence issues & synergies| There are synergies between, Goal 4 – Quality education, Goal 5 – Gender equality and Goal 10 – Reduced inequalities. |

| Local to international dimensions| Through the Department for International Development (DFID) the UK Government is working to reduce the global maternal mortality rate. For example, DFID reports that it has enabled 5.6 million births to be attended by a skilled birth attendant between 2011 and 2015. |

| Trends                       | MBRRACE-UK reporting suggests that there was no change in the overall maternal death rate in the UK between 2010-12 and 2013-15. Assessors judged that improvements in care may have made a difference to the outcome for 41% of women who died, 52% of women with epilepsy and 26% of women with severe mental illness. There is a need to address indirect causes of mortality. |

| Actions needed               | The Government should continue its action into investigating how to address the key causes of maternal mortality. It is not enough to reduce absolute levels of mortality but attention needs to be paid to variation due to socio-economic, geographic and demographic differences. To achieve this, better planning and provision of pre-and post-pregnancy care is vital. A number of existing reviews have highlighted potential improvements to care. For example, the Saving Lives, Improving Mothers’ Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15 report from MBRRACE-UK highlights aspects of maternity care that could be improved (MBRRACE-UK, 2017). |
### Indicator

3.1.2 Proportion of births attended by skilled health personnel

### Applicable UK policy/legislation

Relevant policy documents or legislation include:

**England**

**The Government's mandate to NHS England for 2017-18** (2016): The mandate includes an objective relating to reducing the 2010 rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon after birth.


**Spotlight on Maternity (2016)**: Guidance asking organisations with maternity services to place a spotlight on maternity and make a public commitment to achieving the Government’s national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030.

**The Report of the Morecambe Bay Investigation (2015)**: The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH).

**Scotland**


**Wales**

**A Strategic Vision for Maternity Services in Wales** (2011): Introduced in September 2011, the strategic vision sets out the Welsh Government’s ongoing strategy on what high-quality maternity services should look like in Wales.

**Nurse Staffing Levels (Wales) Act** (2016): Introduced in full in April 2018, this Act ‘places a duty on health boards and NHS Trusts to take steps to calculate and maintain nurse staffing levels in adult acute medical and surgical inpatient wards, as well as a broader duty to consider how many nurses are necessary to provide care for patients sensitively in all settings’.

**Northern Ireland**

**A Strategy for Maternity Care in Northern Ireland 2012-2018** (2012): Announced in 2012, this Strategy produced six desired outcomes with the first being ‘give every baby and family the best start in life’. A review of the strategy in 2017 from the Regulation and Quality Improvement Authority (RIQA) found ‘significant achievement’ towards the first outcome, but found it had not been fully implemented and issued 19 recommendations to achieve the outcomes within the strategy.

**UK-wide**

**MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK.** MBRRACE-UK investigates maternal deaths in both the UK and the Republic of Ireland, issuing a report of this confidential enquiry every 3 years; the latest report was released in 2017.

### National SDG target

As above
UK commensurable indicator

The ONS is reporting on the **percentage of maternities that occurred within a medical establishment**. This indicator is being used as an approximation of the UN SDG Indicator and has not been identified in collaboration with topic experts.

Baseline status/ performance

The ONS reports that the number of maternities occurring within a medical establishment in England and Wales was 97.7 in 2016. Note, the proportion attended by skilled staff may be higher as all planned home births should be attended by midwives. However, there may be a small number of births which may be unattended as labour happened too quickly (i.e. woman on route)

The UK has close to 100% of births attended by a skilled health personnel. However, there are concerns about staffing numbers in the NHS with the Royal College of Midwives labelling the challenges to the midwife workforce in England a ‘gathering storm’ (Royal College of Midwives 2017).

In March 2018, the Secretary of State for Health and Social Care Jeremy Hunt announced plans for more than 3,000 additional midwifery training places in England over the next 4 years. This is part of the Government’s strategy to address midwife shortages in England. Additionally, there was also a commitment that a majority of mothers will be seen by the same midwife through labour, pregnancy and birth by 2021.

Other relevant UK indicator/s


Assessment of current state

RAG Rating Global Target: GREEN

The UK has close to 100% of births attended by a skilled health personnel. However, there are some concerns about recruitment and retention of the midwifery workforce.

Notes/ disaggregation

Note for clarification: Maternities occurring outside a medical establishment does not implicate the non-attendance of skilled health personnel.

Coherence issues & synergies

There are synergies between, Goal 4 – Quality education, Goal 5 – Gender equality and Goal 10 – Reduced inequalities.

Local to international dimensions

DFID reports that it enabled 5.6 million births to be attended by a skilled birth attendant between 2011 and 2015.
Trends

According to The Royal College of Midwives (RCM) demand for maternity services in England is increasing due to a rising birth rate. Extra demand is also being generated by an increase of complex births as a result of the increasing average age of mothers and rising rates of obesity. In addition, there are issues with an aging profession, retention problems and a decrease in applications to study midwifery (RCM, 2017). Data from the ONS shows that in England and Wales that the percentage of women giving birth in a medical facility has remained constant from 97.5% in 2014 to 97.7% in 2016.

The Organisational Report 2017 from the National Maternity and Perinatal Audit describes the organisation of maternity and neonatal services in Great Britain. The report found that maternity and neonatal service configuration was subject to constant change. There had also been an increase in the number of alongside midwife-led units with two-thirds of British obstetric units being co-located with an alongside midwife-led unit (68% in England, 38% in Scotland and 100% in Wales). Scotland and Wales had higher median of planned postnatal contacts than English trusts (median 4.5 in Scotland, 4 in Wales and 3 in England).

On staffing levels in the Organisational Report 2017 found that 88% of sites with an obstetric unit reported difficulties in filling obstetric middle grade rotas. They also found that only 15% of trusts and boards used models where women saw the same midwife for most care contacts in the antenatal, intrapartum and postnatal period. Though the Government (in England) has committed that this should be available for 20% of women by 2019 and the majority of women by 2021.

Actions needed

Access to skilled health personnel during births is not a priority indicator for the UK – this is more of a concern for lower income countries. However, there are workforce challenges and the Government should not be complacent about the quality of service that can be provided by the NHS system.
**Target 3.2** By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000

<table>
<thead>
<tr>
<th>Indicator</th>
<th>3.2.1 Under five-mortality rate</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td><strong>The Healthy Child Programme</strong> (2009): The Healthy Child Programme is an ongoing evidence based, integrated approach to improve the health and wellbeing of children aged 0 to 5 years. A rapid review was conducted in 2015 by PHE.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health matters: giving every child the best start in life (2016): Sets out the case for health professionals and local authorities to invest in early years services from pregnancy to age 2.</td>
<td></td>
</tr>
<tr>
<td>Scotland</td>
<td><strong>Child Health Systems Programme Pre-School (CHSP Pre-School)</strong>: This system supports the delivery of the child health programme for children aged 0 to 5 years old in Scotland.</td>
<td></td>
</tr>
<tr>
<td>Wales</td>
<td><strong>Early Years Programme</strong> (2010): This programme aims to give every child in Wales a healthy start by taking a life course approach from pregnancy to five years.</td>
<td></td>
</tr>
<tr>
<td>Northern Ireland</td>
<td><strong>Healthy Child, Healthy Future: A Framework for the Universal Child Health Promotion in Northern Ireland</strong> (2010): The Northern Irish child health promotion programme from pregnancy to 19 years which aims to ensure the best start in life for all children.</td>
<td></td>
</tr>
<tr>
<td>UK-wide</td>
<td><strong>Child vaccination programme</strong>, (2018): The child vaccination programme is the recommended vaccination programme for children to protect them from communicable diseases</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Early Years Programme</strong> (2010): This programme aims to give every child in Wales a healthy start by taking a life course approach from pregnancy to five years.</td>
<td></td>
</tr>
</tbody>
</table>

**National SDG target**

We were unable to find any domestic targets in relation to the under 5 mortality rate.

**UK commensurable indicator**

The ONS is reporting on the number of deaths per 1,000 children younger than 5 years.

National and international comparative data available from the World Bank.

**Baseline status/performance**

The ONS reports that the UK under-5 mortality rate was 4.29 in 2015. The overall trend in under 5 mortality shows a steady decline from 6.55 deaths per 1,000 children younger than 5 in 2000 to a low of 4.23 in 2014 rising to 4.29 in 2015. However, in comparison to other high-income countries (and some middle-income countries too), the UK’s performance could be improved. For example, the under 5 mortality rate in countries such as Finland and Iceland in 2015 was approximately half the UK’s at 2 per 1,000 live births (World Bank).

There are also disparities across the Devolved Administrations. The ONS reports that for 2015 the mortality rate was 5.70 per 1,000 live births for Northern Ireland, 4.24 in England, 4.15 in Wales and 3.83 in Scotland.

The UK under-5 mortality rate of 4.29 per 1,000 live births meets the target of reducing under-5 mortality to 25 per 1,000. However, the target references ending preventable deaths of children under 5 years of age by 2030.
**Other relevant UK indicator/s**
Public Health England’s Fingertips tool reports on infant mortality which is defined as the rate of death of infants aged under 1 year per 1,000 live births.

**Assessment of current state**
RAG Rating: Green – agreed during final drafting

The UK meets the numeric target but not the overall ambition to ‘end preventable mortality’.

The UK under-5 mortality rate of 4.29 per 1,000 live births meets the target of reducing under-5 mortality to 25 per 1,000. However, the target references ending preventable deaths of children under 5 years of age by 2030.

In England alone, there were 758 children under the age of 5* who had modifiable factors identified in their death reviews completed in the year ending 31 March 2017 (DfE, Child Death Reviews, 2017).


**Notes/ disaggregation**
Since 2010 the ONS has stopped using the term preventable and non-preventable deaths for child death reviews. Instead the term modifiable factors are used. A modifiable death is defined as being ‘where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.’ (Department for Education, 2014).

Factors may be judged modifiable if they could use nationally or locally achievable interventions to reduce the risks of future child deaths (Department for Education, 2017).

There is slight difference between World Bank data and ONS, but this appears to be due to rounding.

**Coherence issues & synergies**
There are synergies between the Global Goals and this target. Goal 1 – no poverty, goal 2 – zero hunger, goal 5 – gender equality, goal 10 – reduced inequalities

**Local to international dimensions**
In the 2015 Single Departmental Plan for the Department for International Development (DFID) there was an aim to ‘work to end preventable child and maternal deaths’. Additionally, there was a commitment to improve nutrition ‘for at least 50 million children under 5, women of childbearing age and adolescent girls by 2020’. This 2015 Single Departmental Plan was withdrawn in 2017 and replaced a new 2017 Plan. The aim to end to work towards ending preventable child and maternal deaths does not appear in this plan, but DFID did reach 26.3 million children under 5, women of child bearing age and adolescent girls through nutrition related interventions.

In Scotland, the Government passed the Children and Young People (Scotland) Act 2014. This Act seeks to ensure that public authorities ‘take account of children’s rights and wellbeing in fulfilling their functions’.

**Trends**
The overall trend in under 5 mortality shows a steady decline from 6.55 deaths per 1,000 children younger than 5 in 2000 to a low of 4.23 in 2014 rising to 4.29 in 2015 (ONS).

**Actions needed**
The UK Government needs to address the inequalities that have caused the divergence between the four nations in their under-five mortality rates.
### Indicator 3.2.2 Neonatal mortality rate

#### Applicable UK policy/legislation

| England | Sign up to Safety – ‘Spotlight on Maternity (2015)’ | In November 2015, the Secretary of State for Health announced a national ambition to halve the rates of still births, neonatal and maternal deaths and intrapartum brain injuries by 2030, with a 20% reduction by 2020. The Department of Health and Social Care Single Departmental Plan sets out the Department’s objective to ‘work with system partners to oversee the delivery of the Secretary of State’s ambition to halve the 2010 rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon after birth by 2025 with a 20% reduction in these rates by 2020’. |
| Scotland | Neonatal Care in Scotland: A Quality Framework (2013) | This Quality Framework defines the approach for the provision of high quality care for neonates and their families. Baby box scheme (2017): Since August 2017, all newborn babies in Scotland have been eligible to receive a baby box that includes clothes, thermometers and books in an effort to reduce infant mortality. |
| Wales | A Strategic Vision for Maternity Services in Wales (2011) | Introduced in September 2011, the strategic vision sets out the Welsh Government’s ongoing strategy on what high-quality maternity services should look like in Wales. |
| Northern Ireland | A Strategy for Maternity Care in Northern Ireland 2012-2018 (2012) | Announced in 2012, this Strategy produced six desired outcomes with the first being ‘give every baby and family the best start in life’. A review of the strategy in 2017 from the Regulation and Quality Improvement Authority (RIQA) stated that ‘significant achievement’ had been made towards the first outcome, but found it had not been fully implemented and issued 19 recommendations to achieve the outcomes within the strategy. |

#### National SDG target

In the 2017/18 Mandate to the NHS in England, the Government set an objective for NHS England to ‘work with the Department of Health and partners in a system-wide effort to achieve the national maternity ambition, to reduce the 2010 rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon after birth by 20% by 2020, demonstrating progress towards the national ambition to reduce rates by 50% by 2030’.

The Department of Health and Social Care Single Departmental Plan includes an ambition to halve the 2010 rate of stillbirths, neonatal deaths and brain injuries in babies that occur during or soon after birth by 2025 with a 20% reduction in these rates by 2020.

To note: The Single Departmental Plan brings forward the target date from 2030 to 2025.

#### UK commensurable indicator

The ONS is reporting on the number of number of deaths per 1,000 infants younger than 28 days. National and international comparative data available from the World Bank.

#### Baseline status/performance

The ONS reports that in 2015, the neonatal mortality rate per 1,000 live births was 2.6 for the UK as a whole. However, there were wide regional differences. In 2015, the rate in Northern Ireland was 4.2 deaths per 1,000 live births, 2.6 in England, 2.5 in Wales and 2.0 in Scotland. The UK ranks below a number of high income counties. For example, Japan, Iceland and Finland had a rate of 1 per 1,000 live births in 2015 (World Bank).

#### Other relevant UK indicator/s

The ONS collects data on stillbirth rates. Stillbirth is defined as an infant born after 24 or more weeks completed gestation and which did not, at any time, breathe or show signs of life. In 2016, there were 4.4 stillbirths in the UK per 1,000 total births (ONS, 2016 table 2). The highest rate of stillbirths across the four nations in 2016 was in Wales with a rate of 5.0 still births per 1,000 total births, while Northern Ireland had the lowest at 3.4 (ONS, 2016 table 2). It is also possible to disaggregate neonatal deaths into early neonatal deaths (deaths under 7 days) and late neonatal deaths (deaths between 7 and 27 days).
### Assessment of current state

**RAG Rating: Green – agreed during final drafting**

The UK meets the numeric target but not the overall ambition to ‘end preventable mortality.

The UK has already met the numeric target for neo-natal mortality. However, it has so far failed to end all preventable neo-natal deaths. In England alone in there were 384 child death reviews that were completed for children who died at an age of between 0-27 days and had modifiable factors identified in the year ending 31 March 20171 (DfE, Child Death Reviews, 2017).

In England, there is an objective to halve the number of stillbirths, neonatal deaths and brain injuries in babies that occur during or soon after birth by 2025 will be ambitious.


### Notes/ disaggregation

Neonatal mortality is defined by the [United Nations Children’s Fund](https://www.unicef.org) (UNICEF) as the probability that a child born in a specific year or period will die during the first 28 completed days of life if subject to age-specific mortality rates of that period, expressed per 1000 live births.

Since 2010 the ONS has stopped using the term preventable and non-preventable deaths for child death reviews. Instead the term modifiable factors are used. A modifiable death is defined as ‘where there are factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths (Department for Education, 2014).

There is slight difference between World Bank data and ONS, but this appears to be due to rounding.

### Coherence issues & synergies

There are synergies between the SDGs and this target. For example, Goal 1 – no poverty, goal 5 – gender equality and goal 10 – reduced inequalities.

### Local to international dimensions

In the [2015 Single Departmental Plan for the Department for International Development](https://www.gov.uk/government/publications/2015-single-departmental-plan) (DFID) there was an aim to ‘work to end preventable child and maternal deaths’. Additionally, there was a commitment to improve nutrition ‘for at least 50 million children under 5, women of childbearing age and adolescent girls by 2020’. This 2015 Single Departmental Plan was withdrawn in 2017 and replaced a new 2017 Plan. The aim to end to work towards ending preventable child and maternal deaths does not appear in this plan, but DFID did reach 26.3 million children under 5, women of child bearing age and adolescent girls through nutrition related interventions.

In Scotland, the Government passed the [Children and Young People (Scotland) Act 2014](https://www.gov.scot/acts/2014/11178). This Act seeks to ensures that public authorities ‘take account of children’s rights and wellbeing in fulfilling their functions’.

Through the delivery of all services in Wales for children and families there must be due regard for the United Nations Convention on the Rights of the Child (UNCRC).

### Trends

There was a decline in the neonatal mortality ratio from 2008 (3.2 per 1,000 live births) to 2015 (2.6 per 1,000 live births). However, between 2014-15 there was a rise in the male neonatal rate from 2.7 to 3.0 per 1,000 live births. Additionally, Northern Ireland has had a large rise in the neonatal rate between rising from 2.7 per 1,000 live births in 2012 to 4.2 per 1,000 live births in 2015 (ONS).

### Actions needed

The UK Government needs to address the inequalities that have caused the divergence between the four nations in the neo-natal mortality rate.

In Wales the relevant stats can be found at [https://statswales.gov.wales/v/C-7O](https://statswales.gov.wales/v/C-7O): in 2015 IMR = 3.7 (No. – 123); Neonatal DR = 2.5 (No. – 82); PDR = 6.5 (No. – 219)

In Wales – the UNCRC has been part of the programme in Wales since the start of devolution. See [http://gov.wales/docs/dcells/publications/150916-early-years-outcomes-framework-en.pdf](http://gov.wales/docs/dcells/publications/150916-early-years-outcomes-framework-en.pdf) for an evaluation in 2015. See above for relevant statistics.
Target 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

<table>
<thead>
<tr>
<th>Indicator</th>
<th>3.3.1 Number of new HIV infections per 1,000 uninfected population</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable UK policy/legislation</td>
<td>England</td>
<td>Health promotion for sexual and reproductive health and HIV: Strategic action plan, 2016-19 (2015) - This strategic action plan sets out PHE’s approach to ‘reversing the HIV epidemic’.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS England pre-exposure prophylaxis (PrEP) trial (2017): from September 2017, a three-year trial of PrEP provided by the NHS will be available to an estimated 10,000 people in England.</td>
</tr>
<tr>
<td></td>
<td>Wales</td>
<td>All Wales Pre-Exposure Prophylaxis (PrEP) Trial (2017): In 2017, it was announced that a 3-year study into the effectiveness of PrEP in Wales would take place from July 2017 for all where clinically appropriate.</td>
</tr>
<tr>
<td></td>
<td>Scotland</td>
<td>Sexual Health and Blood Borne Virus Framework (2011): The sexual health strategy in Scotland that includes HIV prevention. This strategy was updated in 2015, not to replace the original strategy but in order to identify emerging issues where focus is now needed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National SDG target</th>
<th>In 2014, the Joint United Nations Programme on HIV and AIDS (UNAIDS) and partners set the 90-90-90 targets. The three targets are:</th>
<th>Could a target also be to reduce the stigma around HIV/AIDS <a href="https://www.nat.org.uk/we-inform/HIV-statistics/UK-statistics">https://www.nat.org.uk/we-inform/HIV-statistics/UK-statistics</a> One third of people living with HIV in the UK have experienced discrimination.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• By 2020, 90% of all people living with HIV will know their HIV status.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UK commensurable indicator</th>
<th>The ONS reports on the number of new HIV diagnoses per 100,000 population. Alternative indicators could include measures around experience of discrimination.</th>
<th></th>
</tr>
</thead>
</table>

| Baseline status/performance | The number of new HIV diagnoses in the UK was 7.87 per 100,000 in 2016. The number of new HIV diagnoses per 100,000 population varied significantly between males and females with 12.2 males being diagnosed per 100,000 population in 2016 compared to 3.68 females. England had the highest rate at 8.49 followed by Northern Ireland 5.05, Wales 4.53 and Scotland 4.20 (ONS). | |

| Other relevant UK indicator/s | Public Health England reports data: HIV testing uptake and coverage, the prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years and rates of late HIV diagnosis (CD4 <350 cells/mm³). | |

<table>
<thead>
<tr>
<th>Assessment of current state</th>
<th>RAG Rating: Amber</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public Health England report that in the UK in 2015 87% of the estimated number of people living with HIV had been diagnosed. Of those diagnosed 96% were receiving HIV treatment and of those receiving treatment, 94% had a suppressed viral load. Public Health England note that despite advancements made towards the 90:90:90 target, further efforts are required to curb HIV transmission in the UK with areas of concern including high-levels of transmission and high rates of late HIV diagnosis.</td>
<td></td>
</tr>
</tbody>
</table>
Notes/ disaggregation
Note: given per 100,000 to ‘best reflect the UK context’.

Coherence issues & synergies
Reducing the number of new HIV infections in the UK requires further collaboration between many different sectors. Other relevant goals include: (1) No poverty, (4) Quality education, (5) Gender equality, (10) Reduced inequalities and (16) Peace, justice and strong institutions.

Local to international dimensions
The UK Government is contributing to the international dimensions of this challenge through the Department for International Development (DFID).

The UK Government has pledged to give £1.1 billion to the Global Fund between 2016-19 (UK Government, 2016). The UK is the second largest global funder of HIV prevention strategies (Letter 21 February 2017, from Rt Hon Priti Patel, concerning DFID’s work on HIV/AIDS).

At a devolved level, the availability of pre-exposure prophylaxis (PrEP) HIV drugs on the NHS varies across the four nations. PrEP is available on the NHS in Scotland while Wales has started their PrEPared Wales project. As of 1 September 2017, PrEP was available to 10,000 people in England as part of the IMPACT trial. In Northern Ireland, there is no current provision of PrEP (Terrance Higgins Trust).

Trends
Number of new HIV diagnoses per 100,000 population has decreased from 13 per 100,000 population in 2005 to 7.87 in 2016 (ONS).

Actions needed
The UK is currently not meeting the UNAIDS 90:90:90 target of 90% of people living with HIV being diagnosed with the figure standing at 87%. The UK Government and Devolved Administrations should continue to focus on reducing HIV prevalence and working with at risk groups.

According to the National AIDS Trust, one third of people living in the UK have experienced discrimination. Half of these instances involved healthcare workers. There should be more action going forward to reduce discrimination, especially from healthcare workers.

Indicators
| 3.3.2 Tuberculosis incidence per 100,000 |
| 3.3.3 Malaria incidence per 1,000 population |
| 3.3.4 Hepatitis B incidence per 100,000 population |
| 3.3.5 Number of people requiring interventions against neglected tropical diseases |

Comments

Applicable UK policy/ legislation
Due to the low rates of communicable and neglected tropical diseases within the UK we have reviewed these indicators in one section. The UK has relatively low prevalence and incidence of the diseases highlighted. However, England has relatively high rates of tuberculosis compared to other countries in Western Europe and tackling tuberculosis has been highlighted as a priority (Public Health England, 2016).

England

Collaborative Tuberculosis Strategy for England (2015-2020) - A joint strategy between NHS England and PHE working with relevant partners to reduce the burden of TB in the UK.

UK-wide

The Ross Fund: A £1 billion fund for research and development in products for infectious diseases and to strengthen delivery of new products.

Global Challenges Research Fund: A five year £1.5 billion fund to fund projects and research to tackle global challenges.
### National SDG target

Public Health England and NHS England’s joint [Collaborative Tuberculosis Strategy for England (2015-20)](https://www.england.nhs.uk/tuberculosis-strategy/) set out that it would be possible to meet the WHO’s milestone of reducing tuberculosis incidence by 50% by 2025 and to contribute to the eventual target of eliminating tuberculosis by 2050 (defined as less than 1 case per million population).

### UK commensurable indicator

The ONS is currently reporting on the following indicators:

- **Number of tuberculosis case notifications per 100,000 population**
- **New cases of malaria per 100,000 population**
- **Hepatitis B incidence per 100,000 population**

As of 27 April 2018, the ONS had not explored suitable data sources for indicator 3.3.5: Number of people requiring interventions against neglected topical diseases. ONS now have data for this indicator. See: [https://sustainabledevelopment-uk.github.io/3-3-4/](https://sustainabledevelopment-uk.github.io/3-3-4/)

### Baseline status/performance

- The ONS reports that the rate of case notifications per 100,000 population for tuberculosis was 9.6 per 100,000 in 2015. The rates per 100,000 population in Scotland, Wales and Northern Ireland for TB were 5.7, 3.7 and 3.2 respectively compared to 10.5 in England. [World Bank data](https://data.worldbank.org/indicator/SH.TUB.TBND.P2) shows the rate in England is higher than other comparator countries such as France (8 per 100,000 in 2015) or Finland (6 per 100,000).

- The ONS reports that the UK has low rates of malaria at 2.46 cases per 100,000 in 2016. Malaria does not occur naturally in the UK but travel associated infections are reported ([Public Health England, 2016](https://www.gov.uk/government/publications/annual-report-on-reportable-diseases-2016)).

- The UK has been classified as a low incidence and prevalence country for hepatitis B infection ([NICE, 2014](https://www.nice.org.uk/guidance/ta309)). The ONS report that hepatitis B incidence per 100,000 in England has reduced from 1 per 100,000 in 2008 to 0.69 in 2016. The incidence of hepatitis B varies regionally from 1.68 per 100,000 population in London to 0.49 in the South East. From autumn 2017, all babies born on or after 1 August 2017 will become eligible for a hexavalent vaccine which includes hepatitis B for their primary immunisations ([Public Health England, 2017](https://www.gov.uk/government/publications/immunisation-guidance-for-healthcare-professionals)).

The data on ONS tool shows that the UK has low rates of Hepatitis B at 0.69 per 100,000 population in 2016. The rate for males was 0.92 and for females was 0.46 per 100,000 population.

### Other relevant UK indicator/s

The Department of Health and Social Care Single Departmental Plan outlines an objective to manage the risk of a major flu or emerging infectious disease outbreak through preparedness, planning and exercises to reduce the likelihood and impact.

### Assessment of current state

**RAG Rating: AMBER**

NHS England’s [Tuberculosis Strategy for England 2015-2020](https://www.england.nhs.uk/tuberculosis-strategy/) aims to achieve a year-on-year decrease in incidence, a reduction in health inequalities and ultimately the elimination of tuberculosis as a public health problem in England. 74% of cases occur in the born abroad UK population and 85% of these cases occur among those who have lived in the UK for more than 2 years and 60% more than 6 years ([PHE, 2016](https://www.gov.uk/government/publications/annual-report-on-reportable-diseases-2016)).

### Notes/disaggregation

#### Coherence issues & synergies

Domestically, tuberculosis can be viewed as a ‘barometer of health inequalities’ ([Public Health England, 2016](https://www.gov.uk/government/publications/annual-report-on-reportable-diseases-2016)). Action to tackle risk factors relate to other Goals including: (1) No poverty (4) Quality education, (8) Decent work and economic growth, (9) Industry, innovation and infrastructure, (10) Reduced inequalities and (11) Sustainable Cities and Communities.

Diseases such as malaria may have a significant impact for UK businesses that source products from malaria prone countries. Disease outbreaks will affect resourcing along the supply chain thus affecting production. Equally employers may put workers/local populations at increased disease risk if disease prevention is not factored into business planning. As such Goal 8 Good Jobs and Economic Growth has synergies with this health goal.
### Local to international dimensions

The UK is not particularly impacted by neglected tropical diseases (NTDs) which include diseases such as leprosy (WHO, 2017). However, the UK is playing a leading role in raising the awareness of NTDs and trying to tackle them with £360 million worth of funding between 2017-2022 to reduce them further.

The Government has outlined that the UK’s support package would:

- Eradicate Guinea worm, which is transmitted through unsafe drinking water eliminate visceral leishmaniasis in Asia, a parasitic disease caused by infected sand-flies which destroy the internal organs and if left untreated is fatal prevent up to 400,000 cases of blindness caused by trachoma, the leading cause of infectious blindness in the world; and prevent tens of thousands of cases of disability caused by lymphatic filariasis, a mosquito-transmitted disease which can cause severe swelling of the lower limbs (Department of International Development, 2017).

#### Guinea Worm
- There were only 30 cases in 2 countries (Chad and Ethiopia) last year (3.5 million cases in 1986 across 26 countries), though some evidence that dogs maybe a reservoir for the disease. No medication for guinea worm, only smallpox has been eradicated before. This would be the first eradication to not use a vaccine or medicine, and the first parasitic infection to be eradicated. Not necessarily “dirty water”, it is transmitted through unsafe drinking water but not necessarily dirty. A simple filter can stop the fleas in the water that are hosts for the parasitic larvae.

### Trends

According to the ONS the number of case notifications of tuberculosis rose from 11.4 per 100,000 population in the UK in 2000 to 14.2 in 2009. However, since 2011 there has been a rapid decline in the rate of case notifications from 14.1 per 100,000 in 2011 to 9.6 case notifications in 100,000 population in 2015.

All regions have reduced the incidence of hepatitis B between 2008 and 2016. However, there are differences in the rate. London and the North West both had an incidence of hepatitis B of 1.77 per 100,000 in 2008. However, by 2016 the North West had reduced their incidence to 1.02 per 100,000 population and London made significantly less progress with the incidence of hepatitis B at 1.68 per 100,000 population.

Hepatitis B incidence in males in England was double the incidence in females (males: 0.92 per 100,000 population 2016, females: 0.46 per 100,000 population in 2016). Though this gap between males and females has narrowed since 2008, when the rates of hepatitis B was 0.6 females per 100,000 population and 1.37 males per 100,000 population.

There are also trends in the age group data for hepatitis B incidence, probably reflecting how the virus is spread:
- 0-20 years – 0.17 per 100,000 population
- 21-40 years – 1.07 per 100,000 population
- 41-60 years – 0.99 per 100,000 population
- 61+ years – 0.47 per 100,000 population

Data from the ONS shows that rates of malaria in the UK have decreased from 3.51 in 2000 to 2.46 per 100,000 in 2016. However, this rate of decline has not been uniform.

### Actions needed

While non-communicable diseases are arguably a greater challenge domestically than communicable diseases, the UK cannot be complacent. The government has additional work to do to tackle tuberculosis rates in England.

The UK Government has committed to continued investment in the Global Fund to fight AIDS, tuberculosis and malaria (DFID, 2017).
Target 3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Applicable UK policy/ legislation

**England**

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. The full list of recommendations and guidance can be found in NICE’s pathways. NICE pathways are available to all and gives guidance on treatment and best practice for a wide range of health topics. NICE also undertake clinical audits of current practice to improve care. NICE serves both the English and Welsh NHS.

The Department of Health and Social Care Single Departmental Plan outlines objectives in relation to delivering commitments in the cross-Government Obesity Plan and delivering the new tobacco control plan.

NHS Five Year Forward View (2014): a five-year strategy for the future of the NHS which called for a ‘radical upgrade in prevention and public health’.

NHS Diabetes Prevention Programme 2016-2021 (2016): this is a joint diabetes prevention initiative between the NHS, PHE and Diabetes UK to offer lifestyle interventions to those with non-diabetic hyperglycemia.


**Scotland**

Health and Social Care Delivery Plan (2016): Scotland: this delivery plan sets out how the Scottish Government will enhance health and social care services by focusing on prevention, early intervention and supported self-management in an integrated system.

Beating Cancer: Ambition and Action (2016): this strategy aims to improve the prevention, detection, diagnosis, treatment and after care for people affected by cancer.

Scotland Cancer Ambitions (Scottish Government, 2016): To improve cancer survival ‘to a level at least equivalent to other UK and European Countries’. And to stop anyone dying from breast cancer by 2050. And to reduce survival inequalities between the least and most affluent areas in Scotland.

A Healthier Future – Action and Ambitions on Diet, Activity and Healthy Weight (Scottish Government, 2017): this consultation aims to gain ideas in how to transform the food environment, for people to live healthier and more active lives and how the Scottish Government can act as leaders as well as examples of exemplary practice. The Scottish Government intends to restrict the promotion of food and drink high in fat, sugar and salt. The Scottish Government is also considering restricting price promotions on food and drinks.
Wales

**Well-being of Future Generations (Wales) Act 2015:** This Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people and communities and to tackle issues such as health inequalities.

**Public Health (Wales) Act 2017:** Making provision for a national strategy to tackle obesity as well as measures relating to tobacco and duties in relation to health impact assessments.

**Health delivery plans:** These plans are aimed at improving services by providing a reference point for relevant health groups. The plans are particularly focused on improving prevention and diagnosis, integrated and efficient care, better information, and more targeted research.

Northern Ireland

**Making Life Better – A Whole System Strategic Framework for Public Health (2013):** is the strategic framework for public health. It is designed to provide direction for policies and actions to improve the health and wellbeing of people in Northern Ireland and to reduce health inequalities.

UK-wide

**Soft Drinks Industry Levy (2018):** from 6th April 2018, a levy has been charged on the soft drinks industry that have at least 5g of sugar per 100ml of drink. In England, the funds raised from the levy will be used to encourage children to engage with physical activity and promote balanced diets. For Scotland, Wales and Northern Ireland the funding will be distributed via the Barnett Formula (UK Government, 2016).

National SDG target

The **2017/18 Mandate to the NHS in England** outlines goals to be achieved by 2020 including:

1. Measurable reduction in child obesity
2. 100,000 people supported to reduce their risk of diabetes through the NHS Diabetes Prevention Programme
   - Contribute to the reduction of preventable illness and associated hospital admissions through the implementation of tangible, preventative interventions in the NHS.
   - Through the **NHS Diabetes Prevention Programme** it is hoped by 2021 a cohort of 390,000 participants will have been recruited and 18,000 cases of diabetes will have been delayed or prevented,
   - As part of the Five Year Forward View there is a target that by 2020 in England, 57% of cancer patients will survive 10 years or more (NHS England, 2016). In 2010/11 the 10-year cancer survival rate for adults was 50% in England and Wales (Cancer Research UK, 2018).
   - **Living Well for Longer: A call to action to reduce avoidable premature mortality (2013):** this call to action sets out an ambition ‘for England to have the lowest rates of premature mortality among its European peers’.

UK commensurable indicator

The **ONS reports** on the number of deaths attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease per 100,000 population for England and Wales. We could not find comparable data for Scotland and Northern Ireland for these four non-communicable diseases.
Baseline status/performance

The ONS suggest that in England and Wales in 2015, there were 266 deaths attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease per 100,000 population. The rates for individual diseases can be found in the notes section.

Aside from ambitions to improve current outcomes there does not appear to be a concerted effort or performance monitoring of the target to reduce premature mortality by a third.

Life expectancy varies across the country with a 9-year gap for male life expectancy between 2013-15 at birth between the most and least deprived deciles in England. (Marmot Indicators Briefing, 2017)

Meanwhile the gap for health life expectancy at birth for males between England 2013-15 was even greater with a gap of 18.7 years between the most and least deprived deciles (PHE, 2017). This trend was the same for females.

Other relevant UK indicator/s

Data with differences between men, women and age groups available here

Worldwide data available here

Assessment of current state

RAG Rating: Red

Between 2013 and 2015, the number of deaths attributed to cardiovascular disease (CVD), cancer, diabetes or chronic respiratory disease in England and Wales has decreased from 270 deaths per 100,000 population to 266 (ONS). A third reduction from the 2015 baseline would be challenging without concerted action from Government to meet that target. In order to reduce premature mortality by one third a cohesive response acting beyond Goal 3 would be required.

There have been significant improvements in reducing ischemic heart diseases deaths with the male age-standardised mortality rate of deaths in England and Wales having reduced by 55.5% from 2001-2016 (ONS, 2017).

There are treatment areas that can be significantly improved such as cancer treatment with UK survival rates for cancer consistently below the EU average (http://ihe.se/wp-content/uploads/2016/08/IHE-Report_2016_4.pdf).

In 2011, the World Health Organization (WHO) set 9 global targets (WHO, 2018). The first of which was ‘a 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases’ by 2025 from a baseline in 2010.

The Richmond Group of Charities (RGC) commissioned research investigating the UK’s performance against this target. The research found that on (the then) current trends by 2025 the premature mortality rate in women would fall by 25% in women and in men by 22% (Richmond Group of Charities, 2016). While the research suggested that the UK would meet the target for women, overall it would fail to meet this target due to only a 22% reduction in the male population. Additionally, the RGC see the WHO targets as not ambitious enough ‘given the UK’s wealth and healthcare systems’.

While there are many similarities between the WHO target and the SDG target on reducing pre-mature mortality they’re not entirely comparable. The baseline for measuring progress in the WHO target is 2010, while it is 2015 in the SDGs.

There was no mention of this target within the Department of Health and Social Care’s Single Departmental Plan. While Agenda 2030 (the Government’s approach to delivering the SDGs) referenced the mortality targets that had already been met, there was no reference to target 3.4 to reduce premature mortality by a third. Further, there have been difficulties in easily accessing comparable data for Scotland and Northern Ireland for premature mortality in these specific diseases which makes progress reporting more challenging.
Notes/ disaggregation

The data presented for the mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease is the premature mortality rate – those aged between 30 and 69 years old. (ONS, 2017) The rates for individual causes of death (deaths codes are in brackets) per 100,000 population in 2015 is provided below:

- Chronic lower respiratory diseases (J40-J47) – 19.00
- Diabetes mellitus (E10-E14) – 3.52
- IX diseases of the circulatory system (I00-I99) – 82.40
- Lung diseases due to external agents (J60-J70) – 0.66
- Malignant neoplasms (C00-C97) – 156.00
- Other diseases of pleura (J90-94) – 0.08
- Other diseases of upper respiratory tract (J30-J39) – 0.05
- Other respiratory diseases principally affecting the interstitium (J80-J84) – 3.11
- Other respiratory disorders (J98) – 0.21
- Postprocedural respiratory disorders, not elsewhere classified (J95) – 0
- Respiratory failure, not elsewhere classified (J96) – 0.02
- Suppurative and necrotic conditions of lower respiratory tract (J85-J86) – 0.36

Coherence issues & synergies


Local to international dimensions

Trends

Obesity1 is a major risk factor for many non-communicable diseases including: type 2 diabetes, coronary heart disease, stroke, some cancers (breast, colon), clinical depression and many others (CDC, 2018).

Obesity rates in the UK have risen rapidly over the last two decades with adult obesity rates rising from 15% in 1993 to 27% in 2015 (NHS Digital, 2017). A further 41% of men and 31% of women were overweight2 in 2015. There are also concerns about the relationship between obesity and socio-economic inequalities. For example, in women obesity prevalence varied with household income (though not for men). 39% of women in the second lowest income quintile were obese compared with 17% of women in the highest income quintile (NHS Digital, 2016).

If obesity rates continue to rise in the UK it could make the target to reduce pre-mature mortality from non-communicable diseases by a third extremely difficult to achieve.

1 Defined as a body mass index (BMI) of 30kg/m2 or higher
2 Defined as a BMI of at least 25kg/m2 but less than 30kg/m2
A comprehensive and multi-disciplinary preventative strategy is required to reduce non-communicable diseases by a third in the UK.

It is not enough to focus on reducing absolute levels of mortality rates: it is important to focus on variation across different groups including socio-economic status. We would argue that a greater focus needs to be given to the wider determinants of health alongside consideration of broader economic and structural factors that affect health outcomes.

The Richmond Group of Charities recommend policy action around four groups of risk factors: alcohol, diet, physical activity and smoking (Richmond Group of Charities, 2016). The policy recommendations include:

- Regulation to raise the price of high strength cheap alcohol*
- Reformulation of packaged food, including portion size control
- Redesign urban environments to prioritise walking and cycling
- Increased support for smoking cessation services, particularly in hard to reach groups
- Additionally, the actions that are set out in target 3.5 are also required in meeting target 3.4.

* As noted above unit pricing is already in place for Scotland and in progress in Wales.
UKSSD — Measuring up
Appendix: Sustainable Development Goal 3

<table>
<thead>
<tr>
<th>Indicator</th>
<th>3.4.2 Suicide mortality rate</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applicable UK policy/legislation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>England</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Five Year Forward View for Mental Health (2016): this independent report made a series of recommendations on the state of mental health service provision in England. NHS England has subsequently accepted all of these recommendations and have released a plan to implement these recommendations, which includes ‘significant additional funding’ for mental health services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Scotland</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide Prevention Strategy 2013-2016 (2013): this was the Scottish Government’s flagship suicide prevention strategy. A new strategy for 2018 onwards is in the process of being written.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wales</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talk to me 2 – Suicide and self-harm prevention strategy for Wales 2015-2020 (2015): this strategy builds on the 2009 Talk to Me, national action plan by prioritizing care providers, places and people that require national and local action.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The Welsh Government hopes to target at risk groups for suicide through prevention work in these groups:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Middle aged men</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Vulnerable young people, especially those who are not in education, training or employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• People over-75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• People in prison or in custody suites and those in psychiatric care (Welsh Government, 2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Northern Ireland</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protect Life 2 – A Strategy for Suicide Prevention in the north of Ireland (2016): building off the Protect Life Strategy, this strategy is aimed at reducing suicide in Northern Ireland and to reduce the inequality in suicide rates between the most and least deprived areas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>National SDG target</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a national ambition to reduce the suicide rate by 10% by 2020/21 in England from 2016/17 levels. (NHS England, 2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Scottish Government has also said they will want to make progress towards the WHO global target 10% reduction in suicides by 2020 from 2012 or 2013 levels (Scottish Government, 2013).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern Ireland has an ambition to reduce the ‘differential suicide rates between the 20% most deprived areas and the north of Ireland average’. (Northern Irish Government, 2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The overall aims and objectives of the Welsh Government’s Talk to Me 2 Strategy is to reduce the suicide and self-harm rates in the general population and ‘promote, co-ordinate and support plans and programmes for the prevention of suicidal behaviours and self-harm at national, regional and local levels’. However, it appears there are no numerical targets in this strategy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UK commensurable indicator</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The ONS reports on the number of suicides per 100,000 population.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline status/performance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the UK, there were 10.9 suicides per 100,000 population in 2015 (ONS). There was variation across the Devolved Administrations with England having a rate of 10.1 per 100,000, Wales 13.0, Scotland 14.0 and Northern Ireland 19.3.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Other relevant UK indicator/s**

Data for suicides in the UK: 2016 registrations, available [here](http://example.com).

World Bank data is available but for 2015 shows the UK mortality rate per 100,000 population as 8.5 which is different to the ONS reporting.

---

**Assessment of current state**

RAG Rating: Red

In the UK, there were 10.9 suicides per 100,000 population in 2015 (ONS). It is not clear whether the third reduction in premature mortality is intended to apply to suicide rates. If so, it seems like this target would be very difficult to meet without a national plan to meet that specific target.

In the UK Government’s *Agenda 2030* report the Government stated their determination to improve mental health services in the UK. For example, they highlight the £1 billion of funding that will be allocated to mental healthcare in England between 2015/16 and 2020/21. However, there is not a clear reference to the SDG target.

Work and the workplace are important determinants of someone’s mental health. The ‘*Thriving at Work*’ (2017) report investigated how employers can better support the mental health of their workers. This report highlighted the importance of good work and the need to produce, implement and communicate a mental health plan at work. As well as introducing legislation that introduce core mental health standards such as increased transparency and accountability and ensure provision of tailored in-house mental health support.

---

**Notes/ disaggregation**

(ONS Suicides in the UK: 2016 registrations)

---

**Coherence issues & synergies**

Suicide is an incredibly complex challenge for the health sector to solve in isolation. The underlying causes associated with suicide attempts are equally complex and can stem from relationship breakdowns, economic instability and inequality, poor mental health, loss of partners and children, declining health, poor environment and numerous other factors (NHS Choices, 2018). Therefore, action is required across sectors and action across goals such as: (1) No poverty, (8) Decent work and economic growth, (10) Reduced inequalities may contribute to improved rates.

---

**Local to international dimensions**

**Trends**

In 2000, there were 11.9 suicides in the UK per 100,000 population and in 2015 there were 10.9 suicides per 100,000 population in the UK 2015 (ONS).

Poor mental health is a leading driver of health inequalities. For example, a 2007 study by Osborn et al., found that people with severe mental illness (SMI)* in the UK aged 18-49 years old died at a rate 3.22 greater than the control population (Osborn et al, 2007).

* The SMI category included Read and OXMIS codes for all forms of schizophrenia, schizoaffective disorder, bipolar disorder, delusional disorder, and their synonyms. All other nonorganic psychoses were also included, such as brief psychoses and unipolar depressive psychoses (Osborn et al, 2007).

**Actions needed**

Action is needed to address the regional inequalities of suicide rates across the UK and in particular attention paid to the rate in Northern Ireland which has increased between 2000 and 2015.

---

Is it worth mentioning here the Stevenson/Farmer Thriving at Work Review commissioned by the Prime Minister and completed in 2017? It highlights the issue of suicide at work and so is a good precursor to policy change. (As above there is no mention of the Sustainable Development Goal target in it)

Faith actors and leaders are increasingly stepping in to support the mental health of local community members but need support to be able to do this more effectively [https://www.mentalhealth.org.uk/sites/default/files/impact-spirituality.pdf](https://www.mentalhealth.org.uk/sites/default/files/impact-spirituality.pdf) see particularly page 21.

---
Target 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

<table>
<thead>
<tr>
<th>Indicator</th>
<th>3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable UK policy/ legislation</td>
<td>UK-wide</td>
</tr>
<tr>
<td></td>
<td>2017 Drug Strategy (UK)*: This is a partnership-based approach to tackle both drug misuse and increase the rate of individuals recovering from dependence.</td>
</tr>
<tr>
<td></td>
<td>Drug misuse and dependence: UK guidelines on clinical management (UK) 2017: These are clinical guidelines for clinicians providing treatment for people who misuse or are dependent on drugs.</td>
</tr>
<tr>
<td></td>
<td>Improving Lives: Helping Workless Families (2017): This Department for Work and Pensions report outlines a number of policies that the Government will introduce to help assist those with drug and alcohol dependencies back into work</td>
</tr>
<tr>
<td></td>
<td>England</td>
</tr>
<tr>
<td></td>
<td>Preventing drug related deaths (2016): This report investigates the causes of the rise in drug related deaths and how to prevent future deaths in England.</td>
</tr>
<tr>
<td></td>
<td>Northern Ireland</td>
</tr>
<tr>
<td></td>
<td>New Strategic Direction for Alcohol and Drugs Phase 2 2011-16 (2011): This strategy (the latest for NI) aims to reduce the harm of both alcohol and drug misuse in Northern Ireland.</td>
</tr>
<tr>
<td></td>
<td>Scotland</td>
</tr>
<tr>
<td></td>
<td>The Road to Recovery: A New Approach to Tackling Scotland’s Drug Problem (2008): This is Scotland’s current drug strategy, which put prevention at the heart of the strategy. In 2017, it was announced that a new Substance Misuse Treatment Strategy would be published in Spring 2018 (Scottish Government, 2017).</td>
</tr>
<tr>
<td></td>
<td>* The Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016, is reserved to the UK Government. The UK devolved administrations have different approaches to tackling drug and alcohol misuse and dependence. The UK devolved administrations have their own approaches to tackling drug and alcohol misuse and dependence in areas where responsibility is devolved such as healthcare and education.</td>
</tr>
</tbody>
</table>

National SDG target

The UK wide 2017 Drug Strategy sets out two main aims:

1. Reduce illicit and other harmful drug use
2. Increase the rates recovering from their dependence

However, this strategy does not appear to establish specific numeric targets.

UK commensurable indicator

As of 27 April 2018, the ONS had not explored suitable data sources for this indicator.
### Baseline status/performance

There are significant ambiguities around this indicator. For example, determining need and therefore coverage, determining effective treatment and collecting comparative data across the Devolved Administrations.

The estimated number of opiate and/or crack cocaine users (OCUs) aged 15-64 in England in 2014/15 was 300,783 (95% CI: 297,986 to 311,128). Within this group, there are an estimated 257,476 people (95% CI: 255,440 to 266,643) that use opiates and an estimated 182,828 people (95% CI: 176,675 to 190,782) that use crack cocaine (Source: Liverpool John Moores University and Glasgow Prevalence Estimation Limited, 2017).

Overall, 279,793 individuals were in contact with drug and alcohol services in 2016-17 in England; this is a 3% reduction from the previous year (288,843). The number receiving treatment for alcohol alone decreased the most (5%, 85,035 to 80,454) and the number of alcohol only clients in contact with treatment has fallen by 12% from the 91,651 peak in 2013-14 (Public Health England, 2017).

In total, 127,475 individuals exited the drug and alcohol treatment system in 2016-17, with 49% (62,500) having successfully completed their treatment free from dependence (Public Health England, 2017).

The Care Quality Commission has highlighted concerns about poor care being delivered by substance misuse providers in England. Concerns relate to inadequate risk assessments, lack of adherence to best practice guidance, poor medicines management, training deficits and failure to safeguard clients by carrying out employment checks.

### Other relevant UK indicator/s

**Assessment of current state**

RAG Rating: Amber

We have given this target an amber rating due to the lack of reference in Agenda 2030: The UK Government’s approach to delivering the Global Goals for Sustainable Development – at home and around the world. In addition, there are concerns about funding and there is variation in the application of policies across the UK.

**Notes/ disaggregation**

From 2001 to 2013, the National Treatment Agency (NTA) was responsible for treatment interventions. This has now been absorbed in to Public Health England, for England. Devolved in Scotland and Wales. Info here: http://www.nta.nhs.uk/about.aspx

**Coherence issues & synergies**

Action across a number of the goals may have an impact on substance misuse and alcohol prevalence and treatment rates including: (1) No poverty, (2) Zero hunger, (4) Quality education, (5) Gender equality, (8) Decent work and economic growth, (9) Industry, innovation and infrastructure, (10) Reduced inequalities.

**Local to international dimensions**

According to the 2017 UK Drug Strategy, the UK is ‘a global leader in tackling drug harms’. The UK Government will continue to strengthen international cooperation through control, law enforcement, policy exchange and research in tackling drug harms. The UK Government will also trying to increase access to controlled medicines for the 5.5 billion people living in countries with low or non-existent access to controlled medicines.

**Trends**

According to the Drug misuse and dependence: UK guidelines on clinical management report there is ‘an ageing cohort of those with heroin dependence in treatment’ which requires concentrated action to improve their morbidity and mortality. There has also been a recent rise in the number of people reporting stimulants or cannabis to be their main drug problem (UK Government, 2017)

**Actions needed**

The UK Government and Devolved Administrations should continue to implement their drug misuse strategies. They should continue to offer preventative services and offer outreach to at risk groups as well as continue to collaborate internationally to share best practice.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comments</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Applicable UK policy/ legislation</strong></td>
<td>UK-wide</td>
</tr>
<tr>
<td></td>
<td>• The Government’s Alcohol Strategy (2012) [UK] (Home Office): this strategy sought to reduce binge and irresponsible drinking across the UK</td>
</tr>
<tr>
<td></td>
<td>• HMRC Alcohol Strategy (2016): This strategy is focused on modernising alcohol taxes and reducing fraud related to alcohol duties.</td>
</tr>
<tr>
<td></td>
<td>• UK Chief Medical Officers’ Low Risk Drinking Guidelines (2016): this guidance outlines the latest guidelines to enable people to make informed choices about their alcohol intake.</td>
</tr>
<tr>
<td></td>
<td>• Improving Lives: Helping Workless Families (2017): This Department for Work and Pensions report outlines a number of policies that the Government will introduce to help assist those with drug and alcohol dependencies back into work</td>
</tr>
<tr>
<td>Scotland</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Alcohol (Minimum Pricing) (Scotland) Bill (2012): this Bill introduced a minimum unit price at which alcohol could be sold. The Scottish Government plans to introduce this on 1 May 2018, with a preferred price of 50p per unit of alcohol (Scottish Government, 2018). Nicola Sturgeon has been invited to join an international health taskforce (Bloomberg Taskforce on Fiscal Policy) due to work on policies such as minimum unit pricing.</td>
</tr>
<tr>
<td></td>
<td>• The Alcohol (Scotland) Act 2010 introduced into law a ban on multi-buy discounts on alcohol such as ‘three for two’.</td>
</tr>
<tr>
<td>Wales</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Public Health (Minimum Price for Alcohol) (Wales) Bill</td>
</tr>
<tr>
<td></td>
<td>• This proposed bill was at Stage 2 of the legislature process (as of 04/04/2018), but hopes to introduce a minimum unit price of alcohol.</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• New Strategic Direction for Alcohol and Drugs Phase 2 2011-16: This strategy (the latest for NI) aims to reduce the harm of both alcohol and drug misuse in Northern Ireland.</td>
</tr>
</tbody>
</table>
### National SDG target

The UK Government did not introduce numeric targets for the 2012 Alcohol Strategy but did set out 6 outcomes:

- A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others;
- A reduction in the amount of alcohol-fueled violent crime;
- A reduction in the number of adults drinking above the NHS guidelines;
- A reduction in the number of people ‘binge drinking’;
- A reduction in the number of alcohol-related deaths; and
- A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed.

### UK commensurable indicator

The ONS reports on alcohol consumption per capita in litres of pure alcohol.

### Baseline status/performance

Data from the ONS state that alcohol consumption per capita in litres of pure alcohol was 10.7 in 2015. There was a 6-year decline in alcohol consumption per capita between 2007 and 2013 from 11.8 to 10.3 litres. However, since 2013, the consumption of pure alcohol has increased to increase to 10.7 litres of pure alcohol per capita.

PHE state that sales of alcohol have increased by 42% since 1980 to 2016, with alcohol sales peaking in 2008.

PHE estimate there are currently over 10 million people drinking at levels which increase their risk of health harm in England alone. Among those aged 15 to 49 years old in England, alcohol is now the leading risk factor for ill-health, early mortality and disability and the fifth leading risk factor for ill-health across all age groups. Additionally, alcohol related harm has increased with over 1 million hospital admissions each year. Furthermore alcohol-related mortality has also increased. Liver disease has increased by 400% since 1970, which is in contrast to much of Western Europe. However, there have been significant reductions in alcohol related road traffic crashes (PHE, 2016).

The University of Sheffield has estimated there are 595,131 adults with alcohol dependence in England (with a 95% confidence interval ranging from 485,504 to 776,743) and estimate that 41.3% of adults with alcohol dependence have an intention to reduce their drinking, and that this is also typically higher in females.

Overall, 279,793 individuals were in contact with drug and alcohol services in 2016-17 in England; this is a 3% reduction from the previous year (288,843). The number receiving treatment for alcohol alone decreased the most (5%, 85,035 to 80,454) and the number of alcohol only clients in contact with treatment has fallen by 12% from the 91,651 peak in 2013-14 (Public Health England, 2017).

In total, 127,475 individuals exited the drug and alcohol treatment system in 2016-17, with 49% (62,500) having successfully completed their treatment free from dependence (Public Health England, 2017).

### Other relevant UK indicator/s

UK alcohol consumption factsheet from the Institute of Alcohol Studies from 2013 can be found here. UK data compared to other countries can be found here: http://apps.who.int/gho/data/node.sdg.3-5-viz?lang=en

### Assessment of current state

RAG Rating: Amber

We have given this target an amber rating due to the lack of reference in Agenda 2030: The UK Government’s approach to delivering the Global Goals for Sustainable Development – at home and around the world. In addition, there are concerns about funding and there is variation in the application of policies across the UK.

### Notes/ disaggregation
Coherence issues & synergies

Action across a number of the goals may have an impact on substance misuse and alcohol prevalence and treatment rates including: (1) No poverty, (2) Zero hunger, (4) Quality education, (5) Gender equality, (8) Decent work and economic growth, (9) Industry, innovation and infrastructure, (10) Reduced inequalities.

Local to international dimensions

The Scottish Government will introduce a minimum price of 50p a unit of alcohol in May 2018. This is aimed at stopping the sale of cheap, high alcohol drinks. It is hoped that this measure would reduce the number of alcohol related deaths in Scotland by 392 in the first five years and reduce hospital admissions by 8,254 cases (Scottish Government, 2017).

The Welsh Government has also submitted a Bill to the Welsh Assembly to introduce a minimum unit price (MUP) on alcohol.

In England, the Coalition Government announced plans for a UK-wide minimum unit price as part of its 2012 Alcohol Strategy. However, by July 2013 the Home Secretary Theresa May announced that the decision over when to implement Minimum Unit Pricing would be delayed ‘until we [the Government] have conclusive evidence that it will be effective’. This policy remains in review.

In Northern Ireland, the Health Minister on 3 December 2014 announced a plan to develop a policy to introduce minimum unit pricing to Northern Ireland. However, no progress has been made since then and is unlikely to be implemented soon due to the suspension of the devolved government in Northern Ireland.

Trends

According to the ONS’s Opinions and Lifestyle Survey on Adult Drinking Habits there had been a fall in the number of adults reported to have drank alcohol in the previous week from 64% in 2005 to 57% in 2016 (ONS, 2017). The largest fall in the proportion people who drank alcohol in the last week was seen in those aged between 16 to 24 years, having fallen from 60% in 2005 to 46% in 2016. While drinking in those aged 65 years and over had increased from 54 to 55% (the only age group to increase their alcohol consumption) (ONS, 2017).

Actions needed

The recommendations below are from the ‘Health First: An evidence-based alcohol strategy for the UK’ which was produced by an independent group of experts under the auspices of the Alcohol Alliance UK.

• The strategy is supported by a wide range of organisations such as: Cancer Research UK, Royal Society for Public Health and University College London. Some of the recommendations from Health First include:
  • A minimum price of at least 50p per unit of alcohol should be introduced for all alcohol sales, together with a mechanism to regularly review and revise this price.
  • At least one third of every alcohol product label should be given over to an evidence based health warning specified by an independent regulatory body.
  • The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml of blood, following Scotland which introduced this in 2014.
  • All alcohol advertising and sponsorship should be prohibited.
  • An independent body should be established to regulate alcohol promotion, including product and packaging design, in the interests of public health and community safety.
  • All health and social care professionals should be trained to routinely provide early identification and brief alcohol advice to their clients.

Why not 0% – no alcohol level is safe. This is the practice in other countries and helps to avoid the ‘just a drop more’ attitude of some drinkers.
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents

<table>
<thead>
<tr>
<th>Indicator</th>
<th>3.6.1 Death rate due to road traffic injuries</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable UK policy/ legislation</td>
<td>Working together to build a safer road system: British road safety statement (Department for Transport, UK, 2015) - adopts the safe systems approach and details short, medium and long-term actions for improving road safety. Highways England Delivery Plan 2015-2020 (Highways England, 2015) - outlines targets to reduce KSIs on the Strategic Road Network by 40% by 2020. Helping you stay safe on Britain’s roads: DVSA’s strategy for 2017 to 2022 (Department for Transport, UK) – the Driver and Vehicle Standards Agency’s 5-year strategy to improve road safety. The Road Traffic Act 1988 (Prescribed Limit) (Scotland) Regulations 2014: This Act reduced the legal alcohol drinking limit from 80mg per 100ml of blood in Scotland to 50mg per 100ml of blood.</td>
<td></td>
</tr>
</tbody>
</table>

National SDG target
In March 2017, the Government confirmed that it was not considering reinstating national road safety targets (Hansard 30 March 2017 Volume 624).

UK commensurable indicator
The ONS reports on the number of deaths due to road traffic injuries per 100,000 population. The World Bank provide international comparisons. The Department for Transport (UK) publishes an annual report on reported road casualties. 2016 data here.

Baseline status/performance
In 2016, the UK had 2.83 deaths due to road traffic injuries per 100,000 population (ONS).

Other relevant UK indicator/s

Assessment of current state
RAG Rating: Amber
In 2016, the UK had 2.83 deaths due to road traffic injuries per 100,000 population. The figure varies across the UK with Northern Ireland having the greatest number of deaths at 3.65, Scotland 3.53, Wales at 3.31 and England 2.71 deaths per 100,000 population (ONS).

After a period of considerable improvement, the number of UK road deaths has plateaued since 2012 (the 2010-14 average was 1,799) and reached a five year high in 2016 at 1,792 deaths – the rate has also plateaued at 2.83, the figure for both 2012 and 2016. Although the UK has one of the lowest road death rates in the world, there is still considerable scope for further improvement, in particular through: implementing a graduate driver licensing system (GDL) to protect young/novice drivers; mandating new and proven lifesaving vehicle technologies, such as autonomous emergency braking and intelligent speed assistance, for new cars; implementing lower national default speed limits (20mph in urban areas and 50mph in rural); and introducing an effective zero-tolerance drink-drive limit of 20mg alcohol per 100ml blood. However, indications are that the UK is unlikely to implement any of the above measures.

Notes/ disaggregation

Coherence issues & synergies
Action across other goals might have an impact including: (4) Quality education, (9) Industry, innovation and infrastructure and (11) Sustainable cities and communities.

Local to international dimensions
Scotland has introduced a lower drink driving limit than the rest of the UK. This reduced the drink driving limit to 50mg of alcohol per 100ml of blood, while in England, Wales and Northern Ireland it remains at 80mg of alcohol per 100ml of blood (gov.uk, 2018) – the highest level in the EU alongside Malta.
Trends

From 2008 to 2010 the UK dramatically improved its road death rate, from 4.28 to 3.04. However, in the following years this improvement slowed and then stalled, with the rate for 2012 and 2016 remaining at 2.83. This picture is broadly consistent across the countries of the UK with all seeing a sharp reduction followed by a stagnation, or decline, of progress. (ONS).

Actions needed

The following actions for the UK to meet this target have been suggested by Brake.

Introducing Graduated Driver Licensing:

Young drivers are disproportionately involved in road crashes in the UK – less than one in 12 license holders is under 25, yet one in five fatal and serious injury crashes involve a driver this age and often the victims are young people themselves. International best practice and a UK government commissioned report has shown that the implementation of Graduated Driver Licensing (GDL) can significantly improve road safety – the UK government report from 2013 states “The evidence is consistent and the potential public health benefits of a GDL system for new drivers are indisputable... It is estimated that a GDL system in GB would result in annual savings of 4,471 casualties and £224 million, although may range from savings of 2,236 casualties and £112 million to 8,942 casualties and £447 million depending on the effectiveness of the system. This analysis only considered drivers between 17-19 years old; a system that applied to all new drivers would be expected to achieve even greater casualty and cost savings”.

Reduction in drink-drive limit

England, Wales and Northern Ireland have the highest drink-drive limit in the EU (alongside Malta). Provisional estimates indicate that, in 2016, 240 road deaths in GB occurred where at least one driver was over the drink-drive limit. Research has shown that even small amounts of alcohol hinders reaction times and safe driving and the UK government’s own road safety campaign Think! states ‘if you’re driving, it’s better to have none for the road’. Implementing an effective zero-tolerance drink-drive limit of 20mg alcohol per 100ml blood therefore has considerable road safety potential in the UK.

Mandating new vehicle safety technologies

Autonomous Emergency Braking (AEB), Intelligent Speed Assistance (ISA), Lane Keep Assist and seat belt reminders for all seats are all technologies which can be mandated in new vehicles and which have considerable road safety potential. ISA keeps vehicles within speed limits and can therefore reduce road deaths substantially – a 2008 research report estimated that ISA could cut all road deaths by 21%.
Safer speed limits

The UK has a national default speed limit of 30mph in “built-up areas” and 60mph on single carriageways. A lowering of both these national default limits by 10mph has significant road safety potential – at present local authorities have the power to choose 20mph or 50mph, however, as these are not the default, the implementation of such measures can be prohibitively costly.

- **Urban limits:** The World Health Organization has emphasised the need for 20mph limits, stating that in areas where “motorised traffic mixes with pedestrians, cyclists, and moped riders, the speed limit must be under 30 km/h (20mph)” due the vulnerability of these road users. Public Health England also recommends the introduction of 20mph speed limits in priority areas, particularly surrounding schools, in order to prevent injuries and reduce their severity.

- **Rural limits:** A third of all road deaths in Great Britain occur on single-carriageway roads with a speed limit of 60mph and the most common crash types on these roads are all related to excessive speed: collisions at intersections, head-on collisions and running off the road. Whilst such roads can initially appear empty, they are shared spaces used by vulnerable road users including pedestrians, cyclists, and horse riders, as well as slow moving farm vehicles, livestock, wild animals, and large vehicles such as buses and quarry vehicles. In addition, such roads are often narrow, with blind bends, and no pavements or cycle paths. Therefore, due to their use by vulnerable road users and the design and condition of many rural roads, 60mph is rarely a safe speed to travel.

Segregating vulnerable road users

According to PHE’s ‘Reducing unintentional injuries on the roads among children and young people under 25’ segregated infrastructure for pedestrians and cyclists should be introduced in areas where they are not currently available in order to reduce the risk of collisions between road users and cyclists and pedestrians. There is also a need to address social inequalities with pedestrians aged 5-9 years old living in the 20% most deprived areas of England 9 times more likely to be killed or seriously injured than children living in the 20% least deprived areas of England (PHE, 2014).
**Target 3.7** By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

<table>
<thead>
<tr>
<th>Indicator</th>
<th>3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods</th>
<th>Comments</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Applicable UK policy/ legislation</th>
<th>UK-wide</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UK-wide</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abortion Act 1967:</td>
<td>The Act made abortion legal in Great Britain (but not Northern Ireland) up to 28 weeks' gestation.</td>
<td></td>
</tr>
<tr>
<td>Human Fertilisation and Embryology Act 2008:</td>
<td>Reduced the abortion limit to 24 weeks, except in cases where it was necessary to save the life of the woman, there was evidence of extreme fetal abnormality, or there was a grave risk of physical or mental injury to the woman.</td>
<td></td>
</tr>
<tr>
<td><strong>England</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and Social Care Act 2012:</td>
<td>The Act (and associated regulations) gave responsibility for sexual health services (excluding abortion) to local authorities rather than the NHS in England.</td>
<td></td>
</tr>
<tr>
<td>The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013:</td>
<td>local authorities are required to provide or secure the provision of open access sexual health services.</td>
<td></td>
</tr>
<tr>
<td>National SDG target</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>UK commensurable indicator</td>
<td>As of 27 April 2018, the ONS was corresponding with topic experts about the data for this indicator.</td>
<td></td>
</tr>
<tr>
<td>Baseline status/performance</td>
<td>The NHS in the UK offers extensive methods of family planning methods including contraception across the UK through GPs and sexual health clinics. However, access to abortion services varies across the UK.</td>
<td></td>
</tr>
</tbody>
</table>
### Assessment of current state

**RAG Rating: Amber**

The UK provides universal access to family planning services. However, there are concerns over the accessibility of contraception services from groups such as the FPA, the Advisory Group on Contraception (AGC) and the Local Government Association (LGA).

Attendance to sexual health clinics are rising in England and Wales. In 2016 there were around 2.4 million new attendances compared with 1.9 new attendances in 2012 (LGA, 2017). The LGA has expressed concern that waiting times will start to increase, while patient satisfaction experiences have decreased (LGA, 2017).

The Advisory Group on Contraception has released a report highlighting the impact that the financial pressures on local authorities and the NHS are having on contraceptive care in England. Their report found 32 local authorities closed contraceptive services in 2016/17, over a third of local authorities have reduced or plan to reduce the number of sites commissioned to deliver contraceptive services since 2015, and nearly two thirds of local authorities have made cuts to their sexual and reproductive health services between 2016/17 and 2017/8 (AGC, 2017). Additionally, in a YouGov survey commissioned by the FPA 17% of women said they found it difficult or very difficult to schedule a contraception appointment (FPA, 2017).

The legal status of abortion across the UK is different. In England, Scotland and Wales abortion has been a since 1967 if a woman is less than 24 weeks pregnant and two doctors agree that continuing the pregnancy and having a baby would be worse for physical or mental health than ending the pregnancy. In exceptional circumstances, an abortion can take place after 24 weeks if there’s a risk to life or there are serious foetal disabilities (NHS, 2018). In Northern Ireland, it is only lawful to terminate pregnancy if it is necessary to preserve the life of the women, or there is a risk of real and serious adverse effects on her physical or mental health (generally risk of loss of life), which is either long-term of permanent (Department of Health and Social Care, Social Services and Public Safety, 2016). This means that women from Northern Ireland often have to travel to other parts of the UK to have a legal abortion (Marie Stopes, 2018). The Department of Health and Social Care has an objective to fund abortions for women from Northern Ireland in England.

A Northern Irish inter-Departmental working group on termination of pregnancies in fatal fetal abnormality cases was published on the 25th April 2018. In the publications key findings, it stated that health professionals in Northern Ireland find the current situation to be professionally untenable. Explaining this finding the report said, ‘Health professionals said that, in their professional opinion, retaining the existing legal constraints would continue to place an unacceptable burden on women’s health and wellbeing’. It also stated the current legal framework in Northern Ireland ‘prevents them [health professionals] from fully meeting their duty of care to all women in this situation and therefore denies those women who wish to terminate the pregnancy, access to proper standards of health care’.

### Notes/ disaggregation

#### Coherence issues & synergies

Strengthening family planning services requires coherence across many Goals including: (4) Quality education, (5) Gender Equality, (10) Reduced inequalities, and (16) Peace, justice and strong institutions.

#### Local to international dimensions

Internationally through DFID’s work the UK government has supported 8.5 million girls and women to access modern family planning between 2015-17 (DFID, 2017). The 2017 DFID Single Departmental Plan also sets the objective for the UK to ‘continue as a global leader on sexual and reproductive health and rights and boost our support for family planning for all who want it’.

### Trends
Actions needed

According to the AGC, a group of experts of leading clinicians and advocacy groups which make policy recommendations regarding contraception needs, in England the Government should ‘strengthen and specify the national mandate to ensure that women of all ages have access to the full range of contraceptive services both through GP practices and sexual and reproductive health clinics’ and ‘ensure adequate funding is provided to local authorities and GP practices to deliver the full range of contraceptive services to women of all ages’. (AGC)

Indicator 3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group

<table>
<thead>
<tr>
<th>Applicable UK policy/ legislation</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Teenage Prevention Strategy (2000-2010): A 10-year teenage pregnancy strategy in England that used a ‘sustained, multifaceted policy intervention involving health and education agencies.’</td>
</tr>
<tr>
<td></td>
<td>Pregnancy and Parenthood in Young People Strategy 2016-2026 (2016) – the first Scottish strategy which focuses on pregnancy and parenthood in young people. This strategy looks to tackle inequality between levels of deprivation associated with many cases of pregnancy in young people and provide them with extra support.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National SDG target</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>According to the ONS the last teenage pregnancy target set in England was in 1999 which was to ‘halve the 1998 under 18 teenage pregnancy rate for England by 2010. Rates fell substantially during this period and this target was reached in 2014’. (ONS, 2016)</td>
<td></td>
</tr>
<tr>
<td>According to the Scottish Pregnancy and Parenthood in Young People Strategy the target for the Scottish Government is to ‘to drive actions that will decrease the cycle of deprivation associated with pregnancy in young people under 18’.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UK commensurable indicator</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ONS reports on the age-specific fertility rates recorded as the number of live births to women under 20 per 1,000 population in England and Wales.</td>
<td></td>
</tr>
</tbody>
</table>
The number of live births to under 20 years old per 1,000 population in England and Wales has declined from 29.3 in 2000 to 13.7 in 2016 (ONS, 2017).

The teenage live birth rate per 1,000 women under 20 in NI was 11.58 in 2012-14. This is a reduction from 15.52 in 2008-10 (Northern Irish Government, 2018).

The under 18 conception rate in England and Wales has significantly reduced over the last 50 years. In 2015, (the latest ONS figures available) the under 18 conception rate was at 21.0 conceptions per 1,000 women aged 15 to 17. This was the lowest recorded since figures began in 1969. The under 18 conception rate has declined by 55% in England and Wales since 1998 when the UK had the highest teenage pregnancy rate in Western Europe (ONS, 2017).

This decline has been rapid since 2008 where the rate fell from 40.7 in 2008 to 21.0 in 2015. The teenage pregnancy rate has declined rapidly across the country, but the rate still varies regionally. In England and Wales, the North East of England has the highest teenage conception rate at 28.0 and the South West the lowest at 16.8 in 2015. (Conceptions in England and Wales: 2015, ONS 2017).

Teenage pregnancy rates in the under 20s in Scotland continues to fall from 57.7 per 1,000 women in 2007 to 32.4 in 2015. Women from the most deprived areas under 20 had pregnancy rates 5 times higher than those in the least deprived (62.1 compared to 11.6 per 1,000 women) (Teenage Pregnancy 2015, ISD Scotland 2017).

According to the WHO, in 2012 the UK had an adolescent birth rate (per 1,000 women aged 15-19 years) of 19.3. This is higher compared to other European countries such as Germany who in 2012 had an adolescent birth rate of 7.8. (WHO, 2018).
Other relevant UK indicator/s

Public Health England’s Fingertips tool includes data on the following for England:

- Under 18s conception rate/1000
- Under 16s conception rate/1000
- Under 18s conceptions leading to abortion
- Under 18s abortions rate/1000
- Under 18s birth rate/1000

The ONS record conception statistics as all pregnancies of women resident in England and Wales which lead to one of the following outcomes:

- A maternity at which 1 or more live births or still births occur, which is registered in England and Wales
- A termination of a pregnancy by abortion under the 1967 Act, which takes place in England and Wales. Pregnancies which lead to spontaneous abortions (that is miscarriages) are not included (ONS, 2017)

The Information Services Division (ISD) in Scotland define the Scottish pregnancy rate source data as the registrations of live and stillbirths from the National Records of Scotland (NRS) with multiple births counted as one event, and the number of legal abortions notified to the Chief Medical Officer (Scotland) in accordance with the Abortion Act 1967.

- In England and Wales only about 5% of under 18 conceptions are to girls aged 14 or under and therefore the ONS excludes this group from their teenage pregnancy rate as ‘to include younger age groups in the base population would produce misleading results. The 15-17 age group is effectively treated as the ‘population at risk’.
- Scotland measures teenage pregnancy from under 20.
- Northern Ireland meanwhile only reports on the number of live births in its teenage pregnancy rate and does not include data on conceptions unlike the rest of the UK.

Assessment of current state

RAG Rating: Amber

All four nations in the UK, particularly England and Wales, have made considerable progress in reducing teenage pregnancy rates in the last twenty years. In England, this successful reduction has been largely attributed to the ‘Teenage Prevention Strategy’, which was launched in 2000.

This strategy has been described by leading academics as ‘a sustained, multifaceted policy intervention involving health and education agencies, alongside other social and educational changes, has probably contributed to a substantial and accelerating decline in conceptions in women younger than 18 years in England since the late 1990’s (Wellings, et al. 2016). The ONS say that the key factors in explaining recent reductions in the teenage pregnancy rate in England include: ‘programs invested in by successive governments (sex and relationship education, improved access to contraceptives and contraceptive publicity), a shift in aspirations of young women towards education, the perception of stigma associated with being a teenage mother’

Notes/ disaggregation

Coherence issues & synergies

There is wide scope for coherence and synergy across the Goals to reduce the teenage pregnancy rate. Particularly:

- (4) Quality education
- (5) Gender Equality
- (10) Reduced inequalities.
Local to international dimensions
Internationally through DFID’s work the UK government has supported 8.5 million girls and women to access modern family planning between 2015-17 (DFID, 2017). The 2017 DFID Single Departmental Plan also sets the objective for the UK to ‘continue as a global leader on sexual and reproductive health and rights and boost our support for family planning for all who want it’.

Trends
See above.

Actions needed
The UK has seen teenage pregnancy rates fall in recent decades due to strategies that have been holistic engaging health, education, social care and youth services. However, the UK still has one of the highest pregnancy rates in Western Europe. The UK Government should continue to promote the successful strategies that have reduced the teenage pregnancy rate so far. It should also continue to focus on reducing inequalities between the different regions of the UK.

Target 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

<table>
<thead>
<tr>
<th>Indicator</th>
<th>3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable disease and service capacity and access, among the general and the most disadvantaged)</th>
<th>Comments</th>
</tr>
</thead>
</table>

Applicable UK policy/legislation

England
- NHS Constitution for England sets out that the NHS provides a comprehensive service available to all and that access to NHS services is based on clinical need and not on ability to pay.

Scotland
- The Charter of Patient rights and responsibilities in Scotland sets out that patients have the right that NHS services received in Scotland are free of charge.

Wales
- NHS Wales states that the ‘the NHS has a key principle which is good healthcare should be available to all, regardless of wealth’.

Northern Ireland
- In Northern Ireland the national health service is referred to as HSC (Health and Social Care). The HSC is free at the point of delivery and also provides social care.

National SDG target
N/A

UK commensurable indicator
As of January 2018, the ONS had not explored suitable data sources for this indicator.

The WHO has created a Universal Health Coverage (UHC) Index that assesses the UK across a range of factors such as: Reproductive, maternal, newborn and child health; infectious diseases, non-communicable diseases, and service capacity and access (WHO, 2018).

Baseline status/performance
The UK’s score against the WHO’s UHC coverage index is 80, the maximum threshold score possible (WHO, 2018).

Other relevant UK indicator/s
Assessment of current state

RAG Rating: Green

The WHO have assessed that the UK has scored the maximum threshold value for UHC, with a score of 80. France, Canada, and Japan have all received this score too. (WHO, 2018)

The NHS in England, Scotland and Wales and the Health and Social Care service in Northern Ireland provide comprehensive coverage to all. However, there are concerns about health inequalities. Life expectancy varies across the country with a 9-year gap for male life expectancy between 2013-15 at birth between the most and least deprived deciles in England. (Marmot Indicators Briefing, 2017).

Meanwhile the gap for health life expectancy at birth for males between England 2013-15 was even greater with a gap of 18.7 years between the most and least deprived deciles (PHE, 2017). This trend was the same for females.

From the NHS Outcome Framework Health Inequalities Indicators in England, in 2016/17 there was an 8.2% difference between the least and most deprived areas in percentage of GP patient survey respondents reporting positive experiences when making an appointment to see a GP in England. This has risen from 5.3% in 2011/12.

Notes/ disaggregation

Coherence issues & synergies

To provide a universal health care system collaboration and coherence is required across many of the Goals such as (1) No poverty, (10) Reduced inequalities and (16) Peace, justice and strong institutions.
Local to international dimensions

The Devolved Administrations in Scotland, Wales and Northern Ireland have introduced policies that have led to some differences in access to health services compared to England. For example, free prescriptions have been available in Wales since 2007, Northern Ireland 2010 and Scotland 2011.

Meanwhile the current prescription charge in England is £8.60 per item. However, there are wide ranging exemptions meaning that only around 10% of prescriptions in England dispensed in the community were paid for between 2006 and 2016 (NHS Digital, 2017). Dental examinations in Scotland are also free (Scottish Dental, 2018).

NHS/Health Service dental charges are complex in the UK and differ in each of the individual countries. All four countries operate various exemptions for specific groups to access free dental treatment (The General Dental Council, 2018).

England and Wales both have a band system for NHS payments.

In England, band 1 treatments cost £20.60. This includes an examination, diagnosis and advice and if necessary it includes X-rays, a scale and polish, and planning for further treatment. Band 2 charges are £56.30 and band 3 procedures are £244.30 (NHS Choices, 2017).

In Wales, band 1 treatments cost £14.00 and that includes similar procedures to those in England. Band 2 treatments costs £44 and band 3 £190.00 (NHS Direct Wales, 2018).

In Scotland, there are no payment bands only individual treatment costs on the NHS. Patients are required to pay 80% of their NHS dental treatment, to a maximum of £384 per course of treatment. An examination is free, but two small X-rays cost £4.88 and a scale and polish cost £11.12 (Scottish Dental, 2018).

In Northern Ireland, the Health Service dental charges operates on a similar model to Scotland’s NHS charges. The charge is 80% of the dentists’ fee up to £384. However, compared to Scotland, examinations are not free and range from £6.74 for a basic to £21.20 for an extensive examination (Northern Ireland Direct, 2018).

Charges for optometry services also differ across the four nations. There are wide ranging exemptions for certain groups in all four countries. In Scotland patients between 16 and 59 years old are entitled to have a free eye examination every two years. If patients are under 16 years old or 60 years old or over, or have certain medical conditions they’re entitled to a free eye examination once a year (Scottish Government).

In England, Wales and Northern Ireland those aged between 16*-59 years old have to pay for optometrist examinations.

*16, 17 or 18 year olds and in full time education are entitled to free eye tests in England and Wales.

Trends

An increasingly ageing population and a below average increase in NHS funding has put tremendous pressures on the coverage of health services across the UK.

Actions needed

Citizens within the UK already have access to universal health coverage. However, further attention needs to be paid to equality of access to services and variation with regards the basket of benefits as financial sustainability of the health services are called in question.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Applicable UK policy/ legislation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income</td>
<td>England</td>
<td>For Wales see <a href="http://www.assembly.wales/laid%20documents/sub-ld11398-em/sub-ld11398-em-e.pdf">http://www.assembly.wales/laid%20documents/sub-ld11398-em/sub-ld11398-em-e.pdf</a> e.g. “The Social Services and Well-being (Wales) Act 2014 (the “Act”) brings together local authorities’ duties and functions in relation to improving the well-being of people who need care and support, and carers who need support. The Act provides the foundation, along with regulations and codes of practice made under it, to a statutory framework for the delivery of social care in Wales to support people of all ages as part of their families and communities.”</td>
</tr>
<tr>
<td></td>
<td>Wales</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National SDG target</td>
<td>In the 2017-19 NHS Operational Planning and Contracting Guidance, NHS England is to ‘address issues of inequalities in patients’ experience of accessing general practice, identified by local evidence, and put actions in place to resolve this.’ (<a href="http://www.england.nhs.uk/">NHS England, 2017</a>)</td>
<td></td>
</tr>
<tr>
<td>UK commensurable indicator</td>
<td>The ONS reports on average weekly household expenditure on health in GBP (£) See later sections for a detailed overview on the differences in the benefits basket across the devolved administrations. Given that Rx are free in Wales, Scotland and NI but are chargeable in England I think this should be explained in this section.</td>
<td></td>
</tr>
<tr>
<td>Baseline status/performance</td>
<td>The average weekly household expenditure on health in the UK was £7.20 in 2015. Average weekly household expenditure on health varies across age groups with the under 30 years old group paying the least at £2.50 a week, and the 65 to 74 years old group paying the most at £11.20 in 2015 (<a href="https://www.ons.gov.uk">ONS, 2018</a>). Additionally, there appears to be a correlation in health spending within socio-economic groups. According to the ONS household expenditure data, higher professional workers spend the greatest amount on health care at £11.20 a week, while intermediate workers spend £6.40 a week on health and routine workers £3.60 a week in 2015 (<a href="https://www.ons.gov.uk">ONS, 2018</a>).</td>
<td>See above re Rx charges!</td>
</tr>
<tr>
<td>Other relevant UK indicator/s</td>
<td>The WHO has produced an international comparison for this indicator by comparing the proportion of the population spending greater than 10% and 25% of household expenditure on health as a share of total household expenditure or income globally (<a href="https://www.who.int">WHO, 2018</a>).</td>
<td></td>
</tr>
</tbody>
</table>
Assessment of current state  

RAG Rating: Green

According to the WHO, in 2013 1.64% of the population were spending more than 10% of total household expenditure or income on health in the UK, while 0.48% were spending greater than 25% in 2013 (WHO, 2017). In comparison, in the USA 5% of the population spent greater than 10% of total household expenditure or income on health and 0.8% greater than 25% in 2013.

In the WHO international comparison, the UK ranks very highly on percentage of household expenditures on health. According to the ONS in 2013, the breakdown of household spending on medical goods and services was:

- 33.8% pharmaceutical products
- 19.7% therapeutic appliances and equipment (such as glasses)
- 18% hospital services
- 12% dental services
- 9.6% medical services
- 3.5% paramedical services
- 3.4% other medical products (ONS, 2015)

Pharmaceutical products are the largest source of household spending on medical goods. However, prescription charges are only implemented in England. Free prescriptions have been available in Wales since 2007, Northern Ireland 2010 and Scotland 2011. Meanwhile the current prescription charge in England is £8.60 per item. However, there are wide ranging exemptions meaning that only around 10% of prescriptions in England dispensed in the community were paid for between 2006 and 2016 (NHS Digital, 2017).

Notes/ disaggregation

Coherence issues & synergies

To provide a universal health care system collaboration and coherence is required across many of the Goals such as (1) No poverty, (10) Reduced inequalities and (16) Peace, justice and strong institutions.
Local to international dimensions

While not strictly speaking health care (as per the SDG target), the Devolved Administrations have introduced differing policies regarding the access to social care.

Provision of personal care in Scotland is free to the over-65s. However, some such as the Accounts Commission have said that the current approach to social care in Scotland is not sustainable in the long term. According to the SNP’s Programme for Government 2016-17 report, the Scottish Government plan to ‘invest £1.3 billion over the life of the Parliament from the NHS to integrated partnerships to build up social care capacity’ and deliver a ‘major programme of reform to adult social care’ in Scotland (Scottish Government, 2017). For residential care in Scotland a person will pay for their care (minus any costs for personal care) if they have assets above £26,500. With assets below £16,500 a person can receive free residential care. With assets between £26,500-16,500 weighted assistance is available.

In Wales, there has been a £70 per week limit on the amount local authorities can charge a person for the care they receive at home or within the community (Welsh Government, 2017). Since April 2017, free residential care is available to people who have less than £30,000 in capital. There is a commitment to increase the amount to £50,000 in a staged approach in Wales (Welsh Government, 2017).

In Northern Ireland, if people have capital worth over £23,250 and need care in a care home or nursing home they will have to pay in full for their care. If they have less than £14,250 they will receive this for free, and between this figure people will receive weighted assistance. (Northern Irish Government, 2017).

In England, if your capital and savings are below £14,250 you will receive free social care, if you have between £14,250 and £23,250 in capital and savings, the council will contribute towards your care. If you have capital and savings above £23,250 you will have to fund all of your own social care (Age UK, 2017).

With introduction of the Care Act 2014, the UK Government had planned to introduce a cap on social care in England, however this policy was later delayed to 2020 and has subsequently delayed further with Jackie Doyle-Price telling the House of Commons on the 7th of December 2017 that the Government ‘will not take forward the previous Government’s plans to implement a cap on care costs in 2020’ (Parliament, 2017). The Government has now announced proposals to reform for care and support for older people in England will be set out in a green paper by summer 2018 (Cabinet Office, 2017).

Trends

There has been an overall increase in spending on healthcare from £4.50 in 2001 to £7.20 in 2015, in the UK. However, there were slight decreases between 2007-2008, 2009-2010, and between 2011-2013.

Actions needed

ONS data shows that there has been an increase in average weekly household expenditure on health from £4.50 in 2001 to £7.20 in 2015. There was a slight decrease between 2006-10 from £5.80 to £5 average household expenditure on health and also from 2011 at £6.60 to 2013 at £6.20. However, data from the Living Costs and Food Survey show as a percentage of average weekly household expenditure healthcare has remained at 1% between 2001-02 to 2016/17

Citizens within the UK already have access to universal health coverage. However, further attention needs to be paid to equality of access to services and variation with regards the basket of benefits as financial sustainability of the health services are called in question.
### Target 3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

<table>
<thead>
<tr>
<th>Indicator</th>
<th>3.9.1 Mortality rate attributed to household and ambient air pollution</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applicable UK policy/ legislation</strong></td>
<td>UK Wide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>UK plan for tackling roadside nitrogen dioxide concentrations (2017): This is a strategy to reduce nitrogen dioxide (NO2) concentrations across the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northern Ireland</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Making Life Better – A Whole System Framework for Public Health 2013-2023 (Northern Ireland): Introduced in 2013 this strategic framework aims to improve public health in Northern Ireland. The framework includes measures to improve air quality by monitoring NO2 concentrations, Particulate Matter (PM10) concentrations, Benzo(a) pyrene concentrations and annual number of ozone breaches.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wales</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Well-being of Future Generations (Wales) Act 2015: Introduced in 2015, the Act introduced seven goals for Wales to meet including ‘a healthier Wales’. This goal includes indicators monitoring NO2 concentrations, PM2.5 and PM10.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scotland</td>
<td></td>
</tr>
<tr>
<td><strong>National SDG target</strong></td>
<td>There are over 20 air quality objectives affecting the UK or its individual countries. These objectives are a mixture of international and nationally set targets. These include targets for reducing NO2, PM and ozone concentrations. The full list of UK air quality standards can be found here.</td>
<td></td>
</tr>
<tr>
<td><strong>UK commensurable indicator</strong></td>
<td>The ONS reports on the percentage of adult deaths (aged 30 and over) attributable to particulate air pollution</td>
<td></td>
</tr>
<tr>
<td><strong>Baseline status/performance</strong></td>
<td>Figures from DEFRA and PHE show that deaths attributed from air pollution in England has decreased from 5.6% in 2010 to 4.72% in 2015. However, the percentage of deaths differs across the country with 5.6% of deaths in London in 2015 attributed to air pollution compared to 4.12% of deaths in the North West.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The UK Government has been criticised, internationally, for failing to adequately tackle air pollution (European Commission, 2017). London is failing to meet both EU and WHO limits for nitrogen dioxide (NO2) pollution. The Special Rapporteur to the UN reported that the UK Government had ‘violated its obligations to protect life, health and the development of children’ and ‘continues to flout its duty to ensure adequate air quality and protect the rights to life and health of its citizens’ (UN, 2017).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>According to the Royal College of Physicians (RCP) air pollution is linked to around 40,000 deaths per year in the UK. The research from the RCP also highlighted the impact of indoor sources of air pollution from many sources such as: gas cookers, cleaning products, damp and mould and cigarette smoke.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>According to research conducted at King’s College London, In London in 2010, there were an estimated 9,400 premature deaths from particulate and NO2 pollution.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additionally, from the Index of Multiple Deprivation (IMD) decile at a County and unitary authority level there is also a difference between income groups with the most deprived decile having 4.93% of deaths attributed to particulate air pollution in 2015 compared to 4.65% of deaths in the least deprived decile (Walton et al., 2015).</td>
<td></td>
</tr>
</tbody>
</table>

**Other relevant UK indicator/s**
Assessment of current state

RAG Rating: Red

While the UK performs strongly in relation to preventing deaths and illness from hazardous chemicals, water and soil pollution/contamination, air pollution is a concern.

The target to ‘substantially reduce the number of deaths and illness from air pollution and contamination’ is open to interpretation. Figures from DEFRA and PHE show that deaths attributed from air pollution in England has decreased from 5.6% in 2010 to 4.72% in 2015. However, the Government has been condemned internationally for failing to act with the European commission issuing a ‘final warning’ to the UK over breaches of legal EU air pollution limits for nitrogen in 2017.

The Institute for Public Policy Research have said that ‘fundamental’ shifts are required to reduce air pollution in London and policy is required at a European, national and local level to allow this to happen.

The Government has announced a ban of convention car sales by 2040, which could have a significant impact in reducing NO2 emissions but that ban would not be implemented before the 2030 target date of the SDGs.

According to the World Health Organization in 2012 the age-standardised mortality rate attributed to household and ambient air pollution (per 100,000) was 25.7 in the UK in 2012. This ranks the UK 47th in the world. The USA in comparison has a rate of 11.1 and France 17.2. Although this is lower than Germany who has a rate of 32.5. (WHO, 2018).

Note to reviewers: We have been debating between an amber or red RAG rating for this indicator. 3.9.2 and 3.9.3 are fine. Challenges relating to air pollution in 3.9.1 are significant.

Personally, I would say red as the government have already been criticised for this and their plans to reduce it do not fall within the SDG timeframe

Need to cross ref with SDG11 cities, SDG12 pollution
I think red would be more appropriate, as above.

Notes/ disaggregation

Coherence issues & synergies


Local to international dimensions

At a city level, the Mayor of London has made improving London’s air quality a key objective of the draft health inequalities strategy. The report highlights poor air quality is more often concentrated in poorer areas. According to the report, ‘of the more than 400 London primary schools located in areas of poor air quality four-fifths were schools in the most deprived communities’.

As part of this strategy the Mayor’s ‘key ambition is to work towards London having the best air quality of any major global city’. (Better Health for All Londoners, 2017).

In order to help reduce air pollution the Mayor of London introduced a £10 toxicity charge in 2017 for older, more polluting cars. He has also announced the introduction of an ultra-low emission zone as well as introducing low emission buses and taxis (Mayor of London, 2018).

Trends

The increasing transition of energy production to renewable sources and the expected uptake of electric car usage are positive trends in trying to reduce air pollution.
Actions needed

According to IPPR there needs to be fundamental policy changes to reduce air pollution, particularly in London.

According to DEFRA road transport is the largest source of air pollution in the UK. Therefore, radical policy changes are required to remove polluting cars from the road. IPPR recommend national policy actions such as scrappage schemes and the increasing of vehicle exercise duty on the most polluting vehicles to help transition the UK towards a low-emission car fleet.

The UK joint committee report (Environment, Food and Rural Affairs, Environmental Audit, Health and Social Care and Transport Committees) into Improving air quality published their findings on 7 March 2018. This report made a series of recommendations including:

- Place the protection of public health and the environment, rather than technical compliance or political convenience, at the centre of air quality policy.
- Develop a properly resourced national air quality support scheme available to all local authorities struggling with air pollution.
- Introduce a Clean Air Act to improve existing legislation and enshrine the right to clean air in UK law.
- Initiate a national health campaign to highlight the dangers of air pollution, including the fact that air quality can be far worse inside a vehicle than on the street. Regular motorists, children, and vulnerable groups must be informed of these risks. These groups must be provided with accurate, localised air pollution data.
- Bring forward the date by which manufacturers must end the sale of conventional petrol and diesel cars, in line with more ambitious commitments from around the world. Manufacturers of private, public and commercial vehicles should also take steps to reduce emissions from tyres and braking mechanisms, known as the ‘Oslo effect’, which is also a significant contributor to poor air quality.
- Require the automobile industry to contribute to a new clean air fund, following the ‘polluter pays’ principle, on a scale that adequately compensates for the health costs of diesel pollution.

Align climate change schemes, urban planning, public transport and fiscal incentives with air quality goals to prevent Government policy from working at cross-purposes
### Indicator

**3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)**

### Applicable UK policy/legislation


*Essential quality standards for drinking water in the European Union.*

### National SDG target

The ONS report on the number of deaths attributed to unsafe water, unsafe sanitation, and lack of hygiene per million population.

### Baseline status/performance

In 2015, the number of deaths to unsafe water, unsafe sanitation, and lack of hygiene per million population were 24.4 in England and 35.5 in Wales. For both England and Wales this rate was 25.0. There was a gender divide in the data. The female rate for England and Wales was 32.4 in 2015 compared with males at 17.5. *(ONS, 2017)*

### Other relevant UK indicator/s

For drinking water 100% of the population have at least a basic level of supply of drinking water, while 96% have access safely managed water in 2015 *(WHO/UNICEF, 2015).*

The definition for a safely managed drinking water service is ‘drinking water from an improved water source that is located on premises, available when needed and free from faecal and priority chemical contamination’. A basic water service is ‘drinking water from an improved source, provided collection time is not more than 30 minutes for a round trip, including queuing’ *(Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines, JMP 2017).*

In 2015, 97.65% of the population had safely managed sanitation services. 1.47% of the population had basic sanitation services, 0.71% limited sanitation services, 0.17% unimproved sanitation services *(JMP, 2015).* 96% of the population had access to a sewer facility, while 3% had access to latrines. *(JMP, 2015).*

The definition for a safely managed sanitation service is ‘use of improved facilities* that are not shared with other households and where excreta are safely disposed of in situ or transported and treated offsite’. The definition of a basic sanitation service ‘use of improved facilities that are not shared with other households’. Limited sanitation definition ‘use of pit latrines without a slab or platform, hanging latrines or bucket latrines’ *(Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines, JMP 2017).*

Data for hygiene provision in the UK was not available from the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation *(JMP, 2015).* The JMP base their definitions for hygiene on the availability of handwashing facilities, with soap and water *(Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines, JMP 2017).*

*Improved facilities include flush/pour flush to piped sewer systems, septic tanks or pit latrines; ventilated pit latrines, composting toilets or pit latrines with slabs.* *(Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines, JMP 2017).*

### Assessment of current state

**RAG Rating: Red**

While the UK preforms strongly in relation to preventing deaths and illness from hazardous chemicals, water and soil pollution/contamination, air pollution is a concern.

The UK has a very low mortality rate attributed to exposure to unsafe WASH services (per 100 000 population) 0.4 in 2012. Hungary has the lowest rate at 0, while European countries such as Italy, Austria and Portugal all have a rate of 0.1. *(WHO, 2018)*

We have suggested an overall RAG rating of Amber due to the concerns over current levels of air pollution rather than performance in relation to WASH services.

---

I have doubts on the accuracy of this report – may be worth omitting
<table>
<thead>
<tr>
<th>Notes/ disaggregation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coherence issues &amp; synergies</td>
</tr>
<tr>
<td>Local to international dimensions</td>
</tr>
<tr>
<td>Trends</td>
</tr>
<tr>
<td>Actions needed</td>
</tr>
</tbody>
</table>
### Sustainable Development Goal 3

#### 3.9.3 Mortality rate attributed to unintentional poisoning

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Applicable UK policy/ legislation</th>
<th>National SDG target</th>
<th>UK commensurable indicator</th>
<th>Baseline status/performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applicable UK policy/ legislation</strong></td>
<td>The UK Government has a wide range of policies to try and avoid unintentional poisoning such as packaging laws and by making certain drugs prescription only to restrict their availability for recreational use. (<a href="https://www.nhs.uk">NHS Choices, 2018</a>).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>National SDG target</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UK commensurable indicator</strong></td>
<td>The ONS reports on Number of deaths attributed to unintentional poisoning per 100,000 population.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Baseline status/performance** | In England and Wales (no data for the individual countries) in 2015 there were 11.4 deaths attributed to unintentional poisoning per 100,000 population. There is a gender divide with males having a rate of 15.5 compared with females with a rate of 7.36. ([ONS, 2015](https://www.ons.gov.uk)). | According to the data categories from the ONS UK data for the Sustainable Development Goals global indicators unintentional poisoning includes exposure to: | * Nonopioid analgesics, antipyretics and antirheumatics (1.14*)  
* Exposure to organic solvents and halogenated hydrocarbons and their vapours (0.16*)  
* Exposure to other and unspecified chemicals and noxious substances (0.42*)  
* Exposure to other and unspecified drugs, medicaments and biological substances (8.83*)  
* Exposure to other drugs acting on the autonomic nervous system (0.19*)  
* Exposure to other gases and vapours (0.66*)  
* Exposure to pesticides (0.00*) | * deaths per 100,000 population in 2015 in England and Wales. ([ONS, 2015](https://www.ons.gov.uk)). |

#### Other relevant UK indicator/s

Exposure to other and unspecified drugs, medicaments and biological substances are by far the largest source of unintentional poisonings from the data above. According to [NHS England](https://www.nhs.uk) a medication overdose 'is the most common form of poisoning in the UK'.

#### Assessment of current state

**RAG Rating: Red**

While the UK preforms strongly in relation to preventing deaths and illness from hazardous chemicals, water and soil pollution/contamination, air pollution is a concern. According to the WHO, Mauritius and Singapore have the lowest mortality rate attributed to unintentional poisoning (per 100,000 population) at 0.1, while in comparison the UK has a rate of 0.4. This is in line with many other European nation, though Germany has a rate of 0.2 ([WHO, 2018](https://www.who.int)).

We have suggested an overall RAG rating of Amber due to the concerns over current levels of air pollution rather than performance in relation to unintentional poisoning.

#### Notes/ disaggregation

We were unable to find comparable and easily accessible data for unintentional poisoning deaths in Scotland and Northern Ireland.

#### Coherence issues & synergies

Making progress in this indicator globally requires action across many of the goals including: (1) No poverty, (5) Gender equality, (6) Clean water and sanitation, (9) Industry, innovation and infrastructure, (10) reduced inequalities, and (11) Sustainable cities and communities.

#### Local to international dimensions

<table>
<thead>
<tr>
<th>Trends</th>
<th>Actions needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The UK Government already has a wide range of policies to try and avoid unintentional poisoning</td>
</tr>
</tbody>
</table>
Target 3.A Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

<table>
<thead>
<tr>
<th>Indicator</th>
<th>3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable UK policy/ legislation</td>
<td>UK Wide</td>
</tr>
</tbody>
</table>

- **The Health Act 2006**: The Act made provision for the prohibition of smoking in certain premises, places and vehicles and amended the minimum age of persons to who tobacco could be sold in England and Wales. The smoking ban took place under different legislation in Northern Ireland (Smoking (Northern Ireland) Order 2006) and in Scotland, the Smoking, Health and Social Care (Scotland) Act 2005. The ban was introduced at different stages with Scotland the first to enforce the ban on 26/03/2006, Wales 02/04/2006, Northern Ireland 30/04/2006 and 01/05/2007 in England.

- **The Standardised Packaging of Tobacco Products Regulations 2015**: The Act introduced the requirement for standard retail packaging of hand rolling tobacco and the retail packaging and appearance of cigarettes on a UK basis.

- **The Tobacco and Related Products Regulations 2016**: The regulations increased the regulatory requirements in relation to ingredients and emissions of tobacco products, increased the size of combined health warnings, regulated electronic cigarettes and prohibited certain descriptors on a UK-wide basis.

**Scotland**

- **The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016**.

**Wales**

- **Tobacco Control Action Plan 2017-2020**: This plan seeks to reduce the number of smokers in Wales to 16% by 2020, from 19% in 2016/17. Actions in the plan include: a statutory ban on smoking in hospital grounds, school grounds, public playground and outdoor care settings for children by summer 2019, encouraging the use of integrated smoking cessation services and strengthening referral pathways to smoking cessation services, particularly for groups with high smoking prevalence.
The Department of Health and Social Care policy paper *Towards a smoke-free generation: tobacco control plan for England* (2017) sets out a number of targets for England to be achieved by the end of 2022:

- Reduce the number of 15-year-olds who regularly smoke from 8% to 3% or less
- Reduce smoking among adults in England from 15.5% to 12% or less
- Reduce the inequality gap in smoking prevalence, between those in routine and manual occupations and the general population
- Reduce the prevalence of smoking in pregnancy in 10.5% to 6% or less.

In 2013, the Scottish Government announced their tobacco control strategy called ‘Creating a Tobacco-free Generation: A Tobacco Control Strategy for Scotland’. In this strategy, the Government announced a wide range of smoking prevalence targets for adults aged 16 years or older up to 2036:

- To reduce smoking prevalence in Scottish adults to 17% or less by 2016 (23% in 2011)
- To reduce smoking prevalence in Scottish adults to 27% or less by 2016 in the Scottish Index of Multiple Deprivation (SIMD) 1 group [the most deprived] (38% in 2011)
- The two 2016 targets set by the Scottish Government were not met with smoking prevalence in adults at 21% (4% higher than the target) and 32% in the SIMD 1 group (5% higher than the target). [Scottish Government, 2017]

In Wales in 2012, the Welsh Government announced their ‘Tobacco Control Delivery Plan for Wales’ (2012). In 2017, the Government announced its updated *Tobacco Control Delivery Plan for Wales 2017-2020* (2017). In the updated 2017 plan, the Government set the following targets:

- To reduce smoking prevalence from 19% in 2016/17 to 16% by 2020
- To reduce smoking prevalence in 15-16 year olds from 9% in 2013/14 to 5% by 2020
- In 2012, the original plan set an interim target to reduce smoking prevalence in adults to 20% by 2016 from 23% in 2010. This target was met early in 2015 with a 19% adult smoking prevalence rate.
- There is also a target for reductions in smoking prevalence amongst the three highest quintiles of deprivation (Welsh Index of Multiple Deprivation) to be reduced at a faster rate than quintiles one and two. In 2016/17 adult smoking prevalence was 23% in the three most deprived quintiles and 13% in the two least deprived quintiles.

See http://gov.wales/newsroom/health-and-social-services/2017/stub-out-smoking/?lang=en “Actions in the new plan include:

- Introducing a statutory ban on smoking in hospital grounds, school grounds, public playgrounds and outdoor care settings for children by summer 2019
- Helping more smokers to quit by encouraging the use of integrated smoking cessation services
- Strengthening referral pathways to smoking cessation services, particularly for groups with high smoking prevalence.”
In 2012, the Northern Irish Government announced its Ten-Year Tobacco Control Strategy for Northern Ireland (2012)

The Northern Irish targets are:

By 2020:

- Reduce the proportion of 11-16 year-old children who smoke to 3% (8%, 2012)
- Reduce the proportion of adults who smoke to 15% (24%, 2012)
- Reduce the proportion of pregnant women who smoke to 9% (15%, 2012)
- Reduce the proportion of smokers in manual groups to 20% (31%, 2012)
- To ensure that a minimum of 5% of the smoking population in Northern Ireland, accesses smoking cessation services annually.

UK commensurable indicator

The ONS reports on the percentage of population aged 16 and over who smoke cigarettes. However, data availability within the UK is limited to Great Britain for this indicator.

Baseline status/performance

Great Britain (England, Wales and Scotland) had a smoking prevalence of 16.1% in 2016 in the population aged 16 and over. Smoking prevalence is greater in the male population at 17.7% in 2016 in the 16 years and older population, compared to 14.5% in the female population. The prevalence of smoking is lowest in the 60 years and over population at 10.6% in 2016, while it is highest in the 25 to 34 years group at 23% in 2016. In 2015, the percentage of women who were pregnant who were smoking was 13.1% (ONS, 2018).

Smoking prevalence in 2015 for adults aged 18 years and above for the four countries were: Scotland 19.1%, Northern Ireland 19%, Wales 18.1%, and England 16.9% (ONS, 2017).

Research from Cancer Research UK for England shows that the prevalence of smoking in children aged 11-15 years old was 3% in 2014 (Cancer Research UK, 2018).
### Other relevant UK indicator/s

**PHE Fingertips** has over 30 smoking indicators:

- Smoking status at time of delivery (current method)
- Smoking status at time of delivery (historical method)
- 2.09i – Smoking prevalence at age 15 – current smokers (WAY surgery)
- 2.09ii – Smoking prevalence at age 15 – regular smokers (WAY survey)
- 2.09iii – Smoking prevalence at age 15 – occasional smokers (WAY survey)
- Smoking Prevalence in adults – current smokers (APS)
- Smoking prevalence in adults with serious mental illness (SMI)
- Smoking attributable mortality
- Smoking Prevalence in adults – current smokers (HIS)
- Numbers in stop smoking services
- Quit rate from stop smoking services
- Smoking prevalence – current smokers (GPPS)
- Smoking attributable hospital admissions
- Smoking Prevalence in adults in routine and manual occupations – current smokers (APS) (18-64 years)
- Smoking Prevalence in adults – ex smokers (APS)
- Smoking Prevalence in adults in routine and manual occupations – ex smokers (APS)
- Smoking Prevalence in adults in routine and manual occupations – never smoked (APS)
- Smoking Prevalence in adults – ex-smokers (IHS)
- Smoking Prevalence in adults – never smokers (IHS)
- Smoking attributable deaths from heart disease
- Smoking attributable deaths from smoke
- Potential years of life lost due to smoking related illness
- Cost per capita of smoking attributable hospital admissions
- Attitudes to smoking in 15 year olds – ‘smoking causes harm to others’ (WAY survey)
- Completeness of NS-SEC recording by Stop Smoking Services
Assessment of current state

**RAG Rating: Green**

The smoking rate has decreased from 27% of people aged 16 and over in Great Britain in 2000 (data not aggregated for Northern Ireland) to 16.1% in 2016 (ONS, 2017). However, smoking remains a leading cause of preventable death in the UK (ONS, 2017). For example, in 2015 there were an estimated 79,000 people who died from smoking related causes in England, which was 16% of all deaths (NHS Digital, 2017). Smoking prevalence in children aged 11-15 in England has also decreased from 10% in 2000 (9% male, 12% female) to 3% in 2014 (3% male, 4% female) (Cancer Research UK, 2018).

However, there are large disparities between smoking rates according to socio-economic status. For example, in Great Britain the smoking rate in routine and manual occupations prevalence is 25.7% compared to managerial and professional occupations of 10.9%, and the intermediate occupations which had a smoking prevalence of 15% for those aged 16 and above (ONS, 2017). Smoking prevalence is even higher among people who are unemployed with the smoking rate at 30.1% for those aged 16 and above in Great Britain, in 2016. Action on Smoking and Health (ASH) report that differences in smoking prevalence across the population is a major cause of health inequalities between socio-economic groups as 'smoking is the single most important driver of health inequalities'. Additionally, ASH highlight that 33% of all tobacco smoked in England is by someone with a mental health condition (ASH, 2016). According to this report, smoking rates with people living with depression and anxiety are approximately double the general population rate and for people living with schizophrenia three times greater (ASH, 2016). Furthermore, there are concerns over funding of smoking cessation services particularly in England by ASH. From 2011/12 to 2016/17 there has been a decline of more than 60% in the number of people using smoking cessation services from 816,444 to 307,507 (NHS Digital).

Internationally the UK performs well against other countries and it has managed to implement nearly all of the Framework Convention on Tobacco Control (FCTC) recommendations. These recommendations include taxes on cigarettes and a ban on tobacco advertising, The Association of European Cancer Leagues Tobacco Control Scale 2016 report ranks the UK as having the most comprehensive tobacco controls in Europe.

It has been difficult to provide an assessment for this target as the four UK countries have different domestic targets. Currently we selected a green rating due to the UK’s implementation of the FCTC recommendations and have not based the overall RAG rating on implementation of domestic targets. This could be interpreted differently.

### Notes/ disaggregation

**Coherence issues & synergies**


**Local to international dimensions**

Internationally the UK performs well against other countries and it has managed to implement nearly all of the FCTC recommendations

**Trends**

The emergence of alternative tobacco devices such as e-cigarettes and heat-not-burn (HNB) products is something that should be monitored closely. The evidence so far suggests that e-cigarettes are not undermining the decline in smoking rates and are effective smoking cessation tools being 95% less harmful than conventional cigarettes (PHE, 2015). though this is an emerging field. Waterpipe smoking (shisha) is also of concern to public health officials. While current use is low, approximately 2% of 19-24 years, it is increasingly popular with young people, especially young people from British Asian backgrounds (ADPH, 2017).

The long-term budgetary pressures on local authorities is also another area of concern. A joint report by Cancer Research UK (CRUK) and ASH highlighted that smoking cessation budgets in 2016 were cut in 59% of local authorities. The cutting of these services could undermine efforts to further reduce smoking rates.
According to the recommendations of CRUK and ASH (*Cutting Down: The Reality of Budget Cuts to Local Tobacco Control, 2016*) the UK Government should ensure smoking cuts to cessation services are stopped and reversed. Additionally, there is a need for the UK Government to tackle the variation in smoking prevalence, which according to ASH is responsible for many of the health inequalities in the population.

The UK Government should continue to plan to ratify the World Health Organisation Framework Convention on Tobacco Control (FCTC) Illicit Trade Protocol.

Target 3.B Support the research and development of vaccines and medicines for the communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

<table>
<thead>
<tr>
<th>Indicator</th>
<th>3.B.1 Proportion of the population with access to affordable medicines and vaccines on a sustainable basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable UK policy/ legislation</td>
<td>UK-wide</td>
</tr>
<tr>
<td>Childhood vaccines timeline</td>
<td>- UK-wide vaccination schedule for parents.</td>
</tr>
</tbody>
</table>
| National SDG target | • To meet the WHO's 95% target for measles, mumps and rubella (MMR) vaccination in 2 year olds [England] *(PHE, 2016)*
• 95% uptake of one dose of the MMR vaccine by 5 years of age, with a supplementary measure at 24 months. [Scotland] *(Scottish Government, 2017)* |
| UK commensurable indicator | The ONS reports on the percentage of children vaccinated by their first, second, and fifth birthday for England only *(ONS, 2017)*. |
| Baseline status/performance | England is currently failing to meet the WHO's MMR target vaccination rate of 95%. In 2015 92.3% of 2 years had received an MMR vaccine, with this percentage falling to 91.6% in 2017 *(NHS Digital, 2017)*. In Scotland, in 2015 95.4% of 2 year olds had received one dose of MMR vaccine, though this figure fell to 94.9% in 2016 *(IDS Scotland, 2017)*. Vaccination rates in Wales for 2016/17 were 95% for MMR. Wales 2016/17 - 95% MMR, 96% menC and Pn, 97% for D/T/P/Po and Hib [https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/Immunisation/percentageofimmunisationscoverageby2ndbirthdayby-localhealthboard-typeofimmunisation](https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/Immunisation/percentageofimmunisationscoverageby2ndbirthdayby-localhealthboard-typeofimmunisation) |

Other relevant UK indicator/s
Assessment of current state

RAG Rating: Green

The European Region of the World Health Organization recommends that nationally 95% of children should be immunised where possible against preventable diseases and targeted for elimination or control (WHO Europe, 2015).

The UK offers a comprehensive vaccination schedule.

The uptake of vaccines across England is high and meeting the 95% target with a few exceptions in MMR, Rotavirus and Meningococcal B (MenB) booster vaccine (ONS, 2017). The WHO has used the Diphtheria-tetanus-pertussis (DTP3) immunization coverage among 1-year-olds as an international comparison. According to the WHO, the UK has a coverage of 96% in 2015 above the 95% WHO target, but below France and Belgium who have a 98% and 99% coverage respectively (WHO, 2017).

In Wales, in 2017, uptake of all routine immunizations for children at one year of age, apart from rotavirus, exceeded 95% (NHS Wales, 2017). Northern Ireland has an immunization uptake of 95% by 5 years in primary vaccines apart from Diphtheria 4 at 92.9% between July-September and MMR second dose at 92.6% in the same quarter.

England is currently not meeting the WHO’s MMR target and since 2014 the rate has declined every year from 92.7% to 91.6% in 2017 (NHS Digital, 2017). Though in 2017, 95% of 5 year olds are vaccinated for MMR. Scotland is narrowly missing this target at 2 years old. In Wales MMR (1 dose) by 2 years was 94.9%, but by age 16 this was only 87.9%. Northern Ireland has an MMR uptake of 94.6% in the quarter of July-September 2017.

Rotavirus vaccine uptake in England was 89.6% in 2017 (the first year of available data). Uptake in Scotland, in 2017, was just below 94% (ISD Scotland, 2017). Uptake in Wales in 2017 was 93.4% by age 1 years.

The MenB booster vaccine at 24 months uptake was 91% in Scotland in 2017. However, the Scottish Government claim that uptake is expected to rise. Coverage in England for the booster dose at 18 months was 87.3% in 2017 (PHE, 2017).

Notes/ disaggregation

The WHO have internationally comparable rates of immunisation as part of their Global Health Observatory data repository. Their data puts UK vaccination rates for the following diseases as:

- DTP3 – 96%
- Haemophilus influenzae (Hib3) – 96%
- Measles, 1st dose (MCV1) – 95% 2015 (92% 2016)
- Measles 2nd dose (MCV2) – 91%
- Pneumococcal conjugate (PCV3 – 93%
- Polio – 95%
- Rotavirus – 89%

(WHO, 2018)

Coherence issues & synergies

Coherence across the Goals to increase vaccine uptake includes: (4) Quality education
Local to international dimensions
There are slight variations in vaccination rates across the four devolved administrations but not to a significant extent.

The UK is one of the largest donors of vaccines in the world through the work of DFID and its support of GAVI, the vaccine alliance (GAVI, 2018). Between 2015-16 DFID support immunised an estimated 28.7 million children, saving 475,000 lives (DFID, 2017).

Trends

Actions needed
The UK Government and devolved administrations should continue to encourage vaccination uptake to the public so that the 95% uptake is met for all vaccines.

Indicator 3.B.2 Total net official development assistance to medical research and basic health sectors

<table>
<thead>
<tr>
<th>Applicable UK policy/ legislation</th>
<th>UK-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>International Development (Official Development Assistance Target) Act 2015 (UK) – this Act created into law a legal spending requirement of 0.7% of Gross National Income to be spent on official development assistance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National SDG target</th>
<th>0.7% of Gross National Income to be spent on official development assistance (UK Government, 2015)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>UK commensurable indicator</th>
<th>The ONS reports on the net official development assistance to medical research and basic health sectors</th>
</tr>
</thead>
</table>

Baseline status/performance
In 2010 the net development assistance (ODA) to medical research and basic health sectors was £557 million. This spending then increased rapidly to £1.45 billion in 2013. However, by 2015 the net ODA to medical research and basic health sectors reduced to £961 million (DFID, 2017).

The majority of this ODA spending goes towards basic health projects (94.5% in 2013 and 90.9% in 2015) (DFID, 2017), rather than medical research spending. In 2016, health was the fourth largest source of UK bilateral ODA making up 11% of spending (DFID, 2017).

The UK Government announced in 2016 the £1 billion Ross Fund that will run across 5 years that aims to ‘develop, test and deliver a range of new products (including vaccines, drugs and diagnostics) to help combat the world’s most serious diseases in developing countries’.

Other relevant UK indicator/s

Assessment of current state
RAG Rating: Green

The UK is one of the most generous givers of international aid in the world, both in terms of actual aid given and as a percentage of GNI (Full Fact, 2017).

Notes/ disaggregation

Coherence issues & synergies
Overseas development assistance has many areas of overlap with other Goals including: (1) No poverty, (2) Zero hunger, (4) Quality education, (5) Gender equality, (6) Clean water and sanitation, (7) Affordable and clean energy, (8) Decent work and economic growth, (9) Industry, innovation and infrastructure, (10) Reduced inequalities, (11) Sustainable cities and communities (13) Climate action, (16) Peace, justice and strong institutions.

Local to international dimensions
N/A

Trends

Actions needed
The UK should continue its role as one of the leading international ODA donors and continue to consider how aid will benefit the health of its recipients.
3.C Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

<table>
<thead>
<tr>
<th>Indicator</th>
<th>3.C.1 Health worker density and distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable UK policy/ legislation</td>
<td>The Government has implemented a UK Code of Practice for international recruitment in the NHS, which is in line with the WHO's own Global Code of Practice for managing health workforce migration (NHS Employers, 2017) (WHO, 2010).</td>
</tr>
<tr>
<td>National SDG target</td>
<td></td>
</tr>
<tr>
<td>UK commensurable indicator</td>
<td>The ONS reports on the number of health workers per 1,000 population</td>
</tr>
<tr>
<td>Baseline status/performance</td>
<td>In 2015, there were 17.9 health workers per 1,000 population. The number of health workers has been increasing from 16.5 in 2011 to 19.0 in 2016. The health workforce is predominantly female, making up 75.8% of the workforce in 2016 (ONS, 2017). 12.4% of NHS staff in England are not British nationals representing 202 nationalities in total (UK Parliament, 2017). 26% of doctors are non-British nationality with 12% of doctors in NHS England reporting an Asian nationality (2/3rds of which are Indian or Pakistani) and 10% are another EU nationality. 36% of doctors gained their medical qualification outside the UK, over half of these qualified in Asia and 9% in other EU countries. There were 1,85,599 staff in NHS England in 2017. The 3 largest nationalities represented outside British in NHS England were Indian with 18,252 staff, Philippine 15,037 and Irish 13,013 (UK Parliament, 2017).</td>
</tr>
<tr>
<td>Other relevant UK indicator/s</td>
<td></td>
</tr>
<tr>
<td>Assessment of current state</td>
<td>RAG Rating: Green</td>
</tr>
<tr>
<td>Notes/ disaggregation</td>
<td>The WHO use the indicator of skilled health professionals density (per 10,000 population), 2005-15 (WHO, 2017). The UK has a score of 112.4 per 10,000 population, 2005-15. This is above the European region average of 106.4, but below France and Germany at 138.3 and 176.0 respectively (WHO, 2017).</td>
</tr>
<tr>
<td>Coherence issues &amp; synergies</td>
<td></td>
</tr>
<tr>
<td>Local to international dimensions</td>
<td>The UK through DFID has helped support the training of health workers across the world. For example, between 2011-15 DFID had supported 5.6 million births with skilled birth attendants (DFID, 2016). The NHS is a diverse workforce population that represents and relies on over 200 nationalities and immensely benefits the UK. However, there are concerns that this reliance on overseas workers by high income countries is contributing to the ‘brain drain’ effect from lower and middle-income countries (LMICs) with overseas health workers being hired by high-income countries (HICs) such as the UK. Jeremy Hunt the Secretary of State has expressed these concerns by saying in a speech ‘Is it right to import doctors from poorer countries that need them?’ (Conservative Party, 2016).</td>
</tr>
</tbody>
</table>

UKSSD — Measuring up Appendix: Sustainable Development Goal 3
The shifting demographics of the UK are increasing the demand on health services. This could mean more health workers will be required to meet this extra demand. Additionally, there are concerns about the retention of NHS staff, particularly in England. Since 2015-16 there have been more nurses leaving the NHS in England than joining, with 3,052 more nurses leaving NHS England than joining in 2016-17 (NHS Digital, 2018) (BBC News, 2018). Additionally, following the UK's decision to leave the European Union (2015-16 vs 2016-17) the number of staff joining from the EU has decreased from 5,957 to under 2,791 and the number of leavers increased from around 3,119 to 3,985. (NHS Digital, 2018). The Government has started to respond to this with NHS Employers releasing retention guidance and resources in order to address retention in the NHS (NHS Employers, 2017).

**Actions needed**

The UK Code of Practice clearly states that: ‘Any international recruitment of healthcare professionals should not prejudice the healthcare systems of developing countries. Healthcare professionals should not be actively recruited from developing countries, unless there is a government-to-government agreement to support recruitment activities’.

The UK Government should consider how to increase worker retention in the NHS, as well as reviewing workforce planning processes to ensure increasing workforce pressures do not lead to an increased reliance on workers from lower income countries and/or non-compliance with the UK Code of Practice.

### 3.D Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

#### Indicator 3.D.1 International Health Regulations (IHR) capacity and health emergency preparedness

**Applicable UK policy/ legislation**

| International Health Regulations 2005: UK National Focal Point (2013): This guidance outlines how Public Health England (PHE) is the National Focal Point for communication of events to the WHO under the International Health Regulations (IHR). |
| Global Health Strategy 2014-19 (2014): This paper sets out PHE’s Global Health Strategy which includes strengthening the IHR capacity in other nations |

**National SDG target**

The WHO assesses countries against 13 International Health Regulations (IHR) core capacities. The capacities are those required to detect, assess, notify and report events and respond to public health risks and emergencies of national and international concern. The 13 are (1) National legislation, policy and financing, (2) Coordination and National Focal Point communications, (3) Surveillance, (4) Response, (5) Preparedness, (6) Risk communication, (7) Human resources, (8) Laboratory, (9) Points of entry, (10) Zoonotic events, (11) Food safety, (12) chemical events, and (13) Radionuclear emergencies. (WHO, 2018)

**UK commensurable indicator**

As of 26 January 2018, the ONS portal did not include an indicator but a potential data source had been identified.

**Baseline status/performance**

According to the WHO’s average of 13 International Health Regulations core capacity scores the UK has a value of 89% from 2010 to 2016 (WHO, 2018). The WHO Europe Region average for 2010-2016 was 81%. According to the latest annual reporting data, the three areas the UK scored lowest in were human resources* at 40% (WHO Europe Regional average 42%), points of entry* 54% (WHO Europe Regional average 64%) and surveillance* 85% (WHO Europe Regional average 84%) (WHO, 2018). In comparison France also had an overall score of 89%, the USA 96% and Australia 100% (WHO, 2018).

* The Indicator Metadata Registry that explains how the WHO assess these values can be found here (WHO, 2018).
### Assessment of current state

**RAG Rating: Green**

The UK scores highly in these IHR assessments, however there are areas for improvement. Improving the score for human resources could be a priority for the UK Government as it was the lowest score in the report. The human resources is a relative score based on seven questions found on page 15 of the IHR Core Capacity Monitoring Framework: 2015 Questionnaire for Monitoring Progress in the Implementation of IHR Core Capacities in States Parties (IHRQ). Points of entry is assessed from questions on page 18 of the IHRQ and surveillance on page 7.

### Notes/disaggregation

People who are able to access health information are better able to help themselves to a healthier life. A third of those learning basic digital skills made fewer visits to their doctor after learning about online health resources. (Tinder foundation NHS widening digital participation programme) The Universal Health offer available in public libraries reaches 250m people across the UK. Libraries provide the tailored resources and health and wellbeing schemes for people to self-manage existing health conditions and improve health and wellbeing generally.

Health librarians working in the NHS alongside clinicians help deliver and develop healthcare and health literacy within hospitals and other healthcare facilities.

There are over 6,000 information professionals and librarians working in the health sector. Health librarians work to the Knowledge for healthcare framework and help develop and support health literacy.

### Coherence issues & synergies

To implement the IHR requires coherence across many of the Goals including: (6) Clean water and sanitation, (9) Industry, innovation and infrastructure, (12) Responsible consumption and production, (16) Peace, justice and strong institutions.

### Local to international dimensions

The UK continues to play a leading role in strengthening IHR capacity and emergency preparedness across the world. An example of this was the leading role the UK played in the West African Ebola Epidemic and the subsequent formation of a UK Public Health Rapid Support Team, that can be deployed anywhere in the world within 48 hours to tackle disease outbreaks that pose a threat to public health (PHE, 2017).

### Trends

**Actions needed**

The UK scores highly across many of the 13 IHR core capacities, but could focus on improving its score further to bring it in line with the US and Australia.