



# **NHS Outcomes Framework 2013-2014**

## **Equality analysis**

## Equality analysis

### DH INFORMATION READER BOX

<b>Policy</b>	Clinical HR / Workforce Management Planning / Performance	Commissioner Development Provider Development Improvement and Efficiency	Estates IM & T Finance Social Care / Partnership Working
<b>Document Purpose</b>	For Information		
<b>Gateway Reference</b>	18347		
<b>Title</b>	The NHS Outcomes Framework 2013-14		
<b>Author</b>	Department of Health		
<b>Publication Date</b>	<b>13 November 2012</b>		
<b>Target Audience</b>	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, GPs		
<b>Circulation List</b>	Directors of PH, Local Authority CEs, PCT PEC Chairs, PCT Cluster Chairs, NHS Trust Board Chairs, Allied Health Professionals, Communications Leads, Emergency Care Leads, Clinical Commissioning Groups		
<b>Description</b>	This an updated version of the NHS Outcomes Framework 2012/13		
<b>Cross Ref</b>	The NHS Outcomes Framework 2012/13		
<b>Superseded Docs</b>			
<b>Action Required</b>	N/A		
<b>Timing</b>	N/A		
<b>Contact Details</b>	NHS Outcomes Framework Policy Department of Health 79 Whitehall London SW1A 2NS		
<b>For Recipient's Use</b>			

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First published [Month Year]

Published to DH website, in electronic PDF format only.

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# Contents

Contents.....	4
1. Introduction .....	5
Progress made in promoting equality and reducing health inequalities.....	6
Disaggregating data by the equalities characteristics .....	6
Assessing progress in reducing health inequalities.....	8
Engagement with stakeholders .....	11
Next steps .....	11
2. Updated assessment of disaggregating the indicators.....	12
3. Supporting evidence .....	18
Domain 1 – Preventing people from dying prematurely .....	18
Domain 2- Enhancing quality of life for people with long-term conditions .....	19
Domain 3 – Helping people to recover from episodes of ill-health or following injury.....	19
Domain 4 – Ensuring that people have a positive experience of care.....	20
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm.....	21

# 1. Introduction

- 1.1. This equality analysis examines whether the updated NHS Outcomes Framework 2013-14<sup>1</sup> will affect people who share relevant protected equalities characteristics in different ways to people who do not share them.
- 1.2. The White Paper, Equity and Excellence: Liberating the NHS<sup>2</sup> set out how the improvement of healthcare outcomes for all will be the primary purpose of the NHS. This means ensuring that the accountabilities running through the system are squarely focused on the outcomes achieved for patients and not by the processes by which they are achieved.
- 1.3. The NHS Outcomes Framework reflects the vision set out in the White Paper. Its purpose is threefold:
  - To provide a national level overview of how well the NHS is performing, wherever possible in an international context;
  - To provide an accountability mechanism between the Secretary of State and the NHS Commissioning Board; and
  - To act as a catalyst throughout the NHS by encouraging a change in culture and behaviour, including a stronger focus on tackling health inequalities.
- 1.4. The indicators in the framework are structured around five domains that the NHS should be aiming to achieve:

**Domain 1:** Preventing people from dying prematurely;

**Domain 2:** Enhancing the quality of life for people with long-term conditions

**Domain 3:** Helping people to recover from episodes of ill-health or following injury

**Domain 4:** Ensuring that people have a positive experience of care; and

**Domain 5:** Treating and caring for people in a safe environment and protecting them from avoidable harm

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<sup>1</sup> [DN to be inserted once available]

<sup>2</sup> Available at:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)

## Equality analysis

- 1.5. The five domains were derived from the three part definition of quality first set out by Lord Darzi as part of the Next Stage Review . This definition that high quality care comprises: effectiveness, patient experience and safety.
- 1.6. The Coalition government has since built this definition of quality into the Health and Social Care Act 2012. The Act frames the duties placed on the Secretary of State for Health, the NHS Commissioning Board and Clinical Commissioning Groups to continuously improve the quality of care provided to patients.
- 1.7. In addition, the Secretary of State for Health has a duty, for the first time, to have regard to the need to reduce health inequalities between the people of England. The NHS Commissioning Board and Clinical Commissioning Groups also have duties as to reducing health inequalities in access to and outcomes from healthcare.

## Progress made in promoting equality and reducing health inequalities

- 1.8. Since the publication of the first NHS Outcomes Framework in December 2010 , the Department of Health has been taking forward several areas of work to make sure that promoting equality and reducing health inequalities become integral to the framework.

## Disaggregating data by the equalities characteristics

- 1.9. This work includes working with the Health and Social Care Information Centre to further explore the feasibility of disaggregating the indicators by the equality characteristics. Since December 2011, we have published disaggregations for a number of indicators, and for indicators where breakdowns are not currently available we are working with the HSCIC to explore the feasibility of providing these in the future.
- 1.10. The Department has recently published sub-national breakdowns, these include NHS providers, CCGs and local Authorities, which can be used alongside socio-economic factors to make comparisons, as well as to encourage greater transparency. The table below contains breakdowns for the following indicators:

	<b>Disaggregations published</b>
1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare	Gender
1b Life expectancy at 75	Region, Local Authority
1.1 Under 75 mortality rate from cardiovascular disease	Region, SHA, PCT, Local Authority, Age, Gender
1.2 Under 75 mortality rate from respiratory disease	Region, SHA, PCT, Local Authority, Age, Gender

## Equality analysis

1.3 Under 75 mortality rate from liver disease	Region, SHA, PCT, Local Authority, Age, Gender
1.4.i and ii) One and Five-year survival from colorectal cancer	Age, Gender
1.4.iii and iv) One and Five-year survival from breast cancer	Age
1.4.v and vi )One and Five-year survival from lung cancer	Age, Gender
1.6i – Infant mortality	Age, Gender, GOR and local authority
1.6ii – Neonatal mortality and stillbirths	Age, Gender, GOR and local authority
2.2 – Employment rate for people with long-term conditions	Age, Gender, GOR and local authority
2.3i – Hospitalisation for chronic ambulatory care sensitive conditions (adults)	Age, Gender, PCT, SHA, ethnicity and deprivation.
2.3ii – Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Age, Gender, PCT, SHA, ethnicity and deprivation.
2.5 – Employment rate for people with mental illness	Age, sex, GOR and local authority
3a – Emergency admissions for acute conditions that should not usually require hospital admission	Deprivation, Ethnicity, Local Authority, SHA, PCT, Diagnosis, Age
3b Emergency readmissions within 30 days of discharge from hospital	GOR, SHA, PCT of residence, LA, Gender , Deprivation
3.1 – Patient reported outcomes measures for elective procedures	Gender, Age, Disability, Ethnicity, Deprivation, PCT, SHA, Provider,
3.2 – Emergency admissions for children with lower respiratory tract infections	Deprivation, Ethnicity, Local Authority, SHA, PCT, Diagnosis, Age
3.6.i Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Age, Gender, Local authority, region
3.6.ii Proportion of Older People (65 and over) who were offered rehabilitation following discharge from acute or community hospital.	Age, Gender, Local authority, region

## Equality analysis

4b Patient experience of hospital care	Provider
4.1 Outpatient services	Provider
4.2 Inpatient care	Provider
4.3 A&E services	Provider
4.7 Mental health services	Provider
5a Patient safety incidents reported	Provider
5b Safety incidents involving severe harm or death	Provider
5.2 Incidence of healthcare-associated infection i MRSA bacteraemia and ii <i>C.difficile</i>	Region, Primary Care Organisation, Provider

- 1.11. An updated assessment of the availability of disaggregated data is presented in chapter 2.
- 1.12. As disaggregated data has become available, we have analysed the data by different equality dimensions, and included some of these findings in Setting Levels of Ambition for the NHS Outcomes Framework, published in July 2012. The availability and assessment of disaggregated data will play an important role in measuring progress in reducing health inequalities.

### Assessing progress in reducing health inequalities

- 1.13. The Government's Mandate to the NHS Commissioning Board asks the Board to make continuous progress against all the five domains and the outcome indicators in the NHS Outcomes Framework. The Mandate makes clear that success will be measured not only by the average level of improvement but also by progress in reducing health inequalities and unjustified variation.
- 1.14. The commitment to make progress in reducing health inequalities reinforces ongoing work to ensure that promoting equality and reducing health inequalities become an integral part of the framework. In previous iterations of the framework, we indicated that a range of metrics would be required to measure progress to cover the indicators in the framework. The first NHS Outcomes Framework explained that the Government would set 'levels of ambition' against the Framework. The Government outlined proposals for how these could be set in a public consultation on the draft mandate to the NHS Commissioning Board, published in July 2012. It also outlined options for determining the most appropriate metrics of inequality for each Domain of the Framework.

## Equality analysis

- 1.15. In light of the consultation the Department of Health has decided not to set levels of ambition. We have explained this is because although the principle of focusing on outcomes received strong support, there was criticism from some that the proposals for setting levels of ambition were too reliant upon precise technical assumptions for which the evidence base is not robust. Additionally, some were concerned that these would be perceived as local 'targets'. Instead, the mandate requires the NHS Commissioning Board to make progress on all areas of the NHS Outcomes Framework. The NHS Commissioning Board have a duty as to reducing health inequalities and will also be assessed on its progress in reducing health inequalities. This will help to ensure that reducing health inequalities will become embedded throughout the system.
- 1.16. It will be important to develop a methodology that allows the Department of Health and the NHS Commissioning Board to measure and interpret progress in each Domain and indicator taking into account existing trends in outcomes. This work will include looking at options for measuring health inequalities.
- 1.17. Exploratory work to identify available inequality metrics will continue. For some domains this work is well progressed with appropriate metrics already identified, but for some domains the options are less clear.
- 1.18. In domain 1, one approach to measuring inequality that is being considered is the Slope Index of Inequality (SII). The SII is a measure of the social gradient in an indicator, i.e. how much the indicator varies with socio-economic status or deprivation. The SII summarises social inequalities across the whole population in a single number, which represents the gap in the indicator between the best-off and worst-off within the population, based on the statistical analysis of the relation between the indicator and deprivation across the whole population.
- 1.19. For example, the SII in life expectancy at birth in England represents the range in life expectancy across England, from most to least deprived, based on statistical analysis of the relationship between life expectancy and deprivation across the whole population. A SII of 10 years indicates that life expectancy for the best-off is 10 years higher than for the worst-off in England. The higher the value of SII, the greater the inequality.
- 1.20. The SII is a better measure of the extent of inequality than simply looking at the gap between the most deprived and least deprived areas, because it also takes account of the inequalities that exist between intermediate areas and so reflects the experience of the entire population not just the extremes in terms of population.
- 1.21. This approach is also being considered as the metric for domain 2.

- 1.22. In Domain 4, the approach that is being taken is predicated on the fact that patient experience surveys are specifically designed to capture directly- reported experience of patients and service users, as opposed to qualitative measures of satisfaction or perception. All surveys used in this domain are based on simple random sampling and are conducted using the highest of professional statistical and research standards. Inequalities in outcomes attributable to NHS care can therefore be evaluated across the indicators proposed for domain 4, although it is necessary to consider the size of any confidence interval or ‘margin of error’ on survey based measures.
- 1.23. Whilst inequality is generally assessed by considering variation by socio-economic grouping or other equality characteristics, it is also possible in this domain to consider inequality in the quality of service across all patients receiving services. Whilst the quality of patient experience is reflected in the various indicators may on average be good, it is appropriate to focus on the number of patients that receive very poor experience as an aspect of inequality:
- variation in care experience is intrinsically problematic: even were 99% of the population receiving excellent care experiences, it would still be problematic were 1% receiving poor care.
  - there is no intrinsic calibration of responses in the patient surveys – and it is intuitively plausible that the benefit of moving someone from a very poor to a fair experience is greater than a move from fair to very good – justifying a focus upon the worst outcomes.
- 1.24. On this basis, work is being taken forward to define a measure of ‘very poor’ experience appropriate for each patient experience area.
- 1.25. For domains 3 and 5 - work is ongoing to explore a variety of methodologies, and is subject to the availability of disaggregated data for different indicators.
- 1.26. Additionally, domain 5 as a whole specifically addresses a cross-section of client groups through indicators which are of particular relevance to those groups. For example:
- Children – indicator 5.6 ‘Incidence of harm to children due ‘to failure to monitor’
  - Babies and women cared for by maternity services - indicator 5.5 ‘ Admission of full-term babies to neonatal care’
  - Older people indicators 5.1 ‘ Incidence of hospital-associated venous thromboembolism’ and indicator 5.3 ‘ Incidence of newly-acquired category 2,3 and 4 pressure ulcers’.

## Equality analysis

### Engagement with stakeholders

1.27. As part of the ongoing development of the framework, the Department continues to work with interested parties and experts to improve the framework.

### Next steps

1.28 Over the next twelve months, we will be focusing on the following areas:

- identification and publication of disaggregations across all indicators as appropriate – see the “P” indications in the table in Chapter 2;
- identify the health inequalities metrics for each of the five domains.

## 2. Updated assessment of disaggregating the indicators

- 2.1 The disaggregation table in this equalities analysis for the updated NHS Outcomes Framework 2013/14 has evolved from the previous table that was published alongside previous 2011/12 Framework.
- 2.2 Disaggregation options now reflect the change in the commissioning structure: the PCT/LA (Primary Care Trust/Local Authority) breakdown has been split into two: CCG (Commissioning Care Group) and LA (Local Authority). Note that fewer indicators are amenable to robust disaggregation by CCG for reason of small numbers.
- 2.3 We have in this document also adopted a stricter criterion for using a Y – as more data have now been published, we have reserved this designation for data that have already been published in a disaggregated form. “P” therefore now includes data series that will be disaggregated when published. It is intended that all the “P” series will be disaggregated in coming months.
- 2.4 Other changes reflect further investigation of the data sources that are now proposed for use, and the level of data disaggregation that can be conducted robustly. This applies particularly in Domains 3 and 5.
- 2.5 In a number of cases, we have determined that a disaggregation would be inappropriate:
  - For all indicators in Domain 1, provider breakdown is now marked Not Applicable (N/A) rather than To Be Determined (TBD), on the grounds that provider catchment populations are not defined. Simplistic disaggregation would create perverse incentives to avoid treatment of more severe cases.
  - In Domain 4, gender breakdowns are avoided on the understanding that men and women systematically rate their experience of care differently (non-comparably). Hence, the indicators are standardised for gender.

## Key

Y	Available
N	Unavailable
P	Not currently available but possible to construct
TBD	Not known / further work is required to determine if this is possible. In some instances, this depends on further development work with the indicator to determine which data source will be used. This may ultimately determine whether the disaggregated data are available.
N/A	Not applicable to this indicator
*	Starred items (i.e. Y* or P*) indicate that the breakdown should be treated with particular caution. In the case of sub-national breakdowns this is because it will not be appropriate to make comparisons between areas without risk adjustment. In other columns this is because there is concern about the reliability of some of the data or the statistical validity of this breakdown.

## Indicator details

	International comparisons	Sub-national breakdown				Equality and Inequality Strands (National Only)								
		Regional	CCG level	Local Authority	Provider	Deprivation (via postcode or area)	Socio-economic group (NSSEC)	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	
<b>1. Preventing people from dying prematurely</b>														
1a Potential Years of Life Lost (PYLL) from causes considered amenable to health care <i>i adults ii children and young people</i>	P	P*	P*	P*	N/A	P	P*	P	N	N	P	N	N	
1b Life expectancy at 75	Y	Y*	N	Y*	N/A	Y	P*	N/A	N	N	Y	N	N	
1.1 Under 75 mortality rate from cardiovascular disease	Y	Y*	Y*	Y*	N/A	P	P*	Y	N	N	Y	N	N	
1.2 Under 75 mortality rate from respiratory disease	Y*	Y*	Y*	Y*	N/A	P	P*	Y	N	N	Y	N	N	
1.3 Under 75 mortality rate from liver disease	Y	Y*	N	Y*	N/A	P	P*	Y	N	N	Y	N	N	
1.4. Under 75 mortality from cancer	Y	Y*	Y*	Y*	N/A	P	P*	P	N	N	Y	N	N	
1.4.i One-year survival for all cancers	Y*	P	P	P	N/A	P	P*	Y*	P*	N	P	N	N	
1.4.ii Five-year survival for all cancers	Y*	P	P	P	N/A	P	P*	P	P*	N	P	N	N	
1.4.iii One-year survival for breast, lung and colorectal cancer	N	P	P	P	N/A	P	P*	P	P*	N	P	N	N	
1.4.iv Five-year survival for breast, lung and colorectal cancer	N	P	P	P	N/A	P	P*	P	P*	N	P	N	N	
1.5 Under 75 mortality rate in people with serious mental illness	N	P*	P*	Y*	N/A	P	TBD	Y	P*	N	Y	N	N	

## Equality analysis

	International comparisons	Sub-national breakdown				Equality and Inequality Strands (National Only)								
		Regional	CCG level	Local Authority	Provider	Deprivation (via postcode or area)	Socio-economic group (NSSEC)	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	
1.6.i Infant mortality	Y*	Y*	N	Y*	N/A	P	Y	Y*	N	N	Y	N	N/A	
1.6.ii Neonatal mortality and stillbirths	P*	Y*	N	Y*	N/A	P	Y	P*	N	N	Y	N	N/A	
1.6.iii Five year survival for all cancers in children	Y*	N	N	N	N/A	P*	P*	P*	P*	N	Y	N	N	
1.7 Reduced premature mortality in people with learning disabilities	Possible disaggregations to be assessed once the indicator is developed													
<b>2. Improving quality of life for people with long-term conditions</b>														
2 Health related quality of life for people with long-term conditions	N	P*	P*	P*	P*	P	N	P	P*	TBD	TBD	P	TBD	
2.1 Proportion of people feeling supported to manage their condition	N	P*	P*	P*	P*	P	N	P	P*	TBD	TBD	P	TBD	
2.2 Employment of people with long-term conditions.	Y*	Y*	N	N	N	P*	P*	Y	Y	Y	Y	TBD	N	
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	Y*	Y*	Y*	Y*	Y*	Y	TBD	Y	Y*	N	Y	N	N	
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Y*	Y*	Y*	Y*	Y*	Y	TBD	Y	Y*	N	Y	N	N	
2.4 Health-related quality of life for carers	N	P*	P*	P*	P*	P	N	P	P*	TBD	TBD	P	TBD	
2.5 Employment of people with mental illness	Y*	Y*	N	N	N	P*	P*	Y	Y	Y	Y	TBD	N	
2.6i Estimating the diagnosis rate of people with dementia	Y*	P*	N	N	N	N	N	P	N	N	N	N	N	
2.6ii <i>An indicator on the effectiveness of post-diagnosis care for people with dementia in sustaining independence and improving the quality of life</i>	Possible disaggregations to be assessed once the indicator is developed													
<b>3. Helping people to recover from episodes of ill health or following injury</b>														
3a Emergency admissions for acute conditions that should not usually require hospital admission	N	Y	Y	Y	P	Y	N	Y	Y*	N	Y	N	N	
3b Emergency readmissions within 30 days of discharge from hospital	N	Y	Y	P	P	Y	N	P	P	N	Y	N	N	

## Equality analysis

	International comparisons	Sub-national breakdown				Equality and Inequality Strands (National Only)							
		Regional	CCG level	Local Authority	Provider	Deprivation (via postcode or area)	Socio-economic group (NSSEC)	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation
3.1 Number of elective procedures weighted by effectiveness i Hip replacement ii Knee replacement iii Groin hernia iv Varicose veins	N	Y	Y	N	Y	Y	N	Y	Y*	N	Y	Y	N
3.1v Number of elective procedures weighted by effectiveness - psychological therapies	Possible disaggregations to be assessed once the indicator is developed												
3.2 Emergency admissions for children with lower respiratory tract infections (LRTI)	N	Y	Y	Y	P	Y	N	Y	Y*	N	Y	N	N
3.3 An indicator on recovery from injuries and trauma	Possible disaggregations to be assessed once the indicator is developed												
3.4 An indicator on the proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months	Possible disaggregations to be assessed once the indicator is developed												
3.5.i The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 days	N	N/A	N	N	TBD	N	N	P	N	N	Y	N	N
3.5.ii The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 120 days	N	N/A	N	N	TBD	N	N	P	N	N	Y	N	N
3.6i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation/reablement services	N	Y	N	Y	N/A	N	N	Y	N	N	Y	N	N
3.6ii Proportion of older people (65 and over) who were offered rehabilitation following discharge from acute or community hospital	N	Y	N	Y	N/A	N	N	Y	N	N	Y	N	N
<b>4. Ensuring that people have a positive experience of care</b>													
4a Patient experience of primary care													
i GP services	N	Y*	N/A	Y*	Y*	TBD	N	Y	Y	Y	N/A	N	Y
ii Out of hours GP services													
iii NHS dental services													
4b Patient experience of hospital care	N	Y	Y	N	Y*	N	N	Y	Y*	TBD	N/A	N	TBD

## Equality analysis

	International comparisons	Sub-national breakdown				Equality and Inequality Strands (National Only)								
		Regional	CCG level	Local Authority	Provider	Deprivation (via postcode or area)	Socio-economic group (NSSEC)	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	
<b>4c An indicator on the Friends and Family test</b>	Possible disaggregations to be assessed once the indicator is developed													
4.1 Patient experience of outpatient services	N	Y	Y	N	Y*	N	N	Y	Y*	TBD	N/A	N	TBD	
4.2 Responsiveness to in-patients' personal needs	N	Y	Y	N	Y*	N	N	Y	Y*	TBD	N/A	N	TBD	
4.3 Patient experience of A&E services	N	Y	Y	N	Y*	N	N	P*	P*	TBD	N/A	N	TBD	
4.4i Access to GP Services	N	Y*	N/A	Y*	Y*	TBD	N	Y	Y	Y	Y	N	Y	
4.4ii Access to dental services	N	Y*	N/A	Y*	N	TBD	N	Y	Y	Y	Y	N	Y	
4.5 Women's experience of maternity services	N	P*	Y	N	P*	P*	N	P*	P*	TBD	N/A	N	TBD	
4.6 Survey of bereaved carers	N	TBD	TBD	TBD	TBD	P*	TBD	Y	TBD	TBD	Y	TBD	TBD	
4.7 Patient experience of community mental health services	N	Y	Y	N	Y*	N	N	Y	Y*	TBD	N/A	N	TBD	
<b>4.8 An indicator on children and young people's experience of healthcare</b>	Possible disaggregations to be assessed once the indicator is developed													
<b>4.9 An indicator on people's experience of integrated care</b>	Possible disaggregations to be assessed once the indicator is developed													
<b>5. Treating and caring for people in a safe environment and protecting them from avoidable harm</b>														
5a Patient safety incident reported	P*	P*	Y*	N	Y*	TBD	N	P	N	N	P	N	N	
5b Safety incidents involving severe harm or death	P*	P*	N	N	Y*	TBD	N	P	N	N	P	N	N	
<b>5c An indicator on hospital deaths attributable to problems in care</b>	Possible disaggregations to be assessed once the indicator is developed													
5.1 Incidence of hospital-related venous thromboembolism (VTE)	P*	P*	Y*	N	P*	TBD	N	Y	N	N	Y	N	N	
5.2.i Incidence of healthcare associated MRSA infection	P*	Y*	Y*	N	Y*	TBD	N	P	N	N	P	N	N	
5.2.ii Incidence of healthcare associated C. difficile infection	P*	Y*	Y*	N	Y*	TBD	N	P	N	N	P	N	N	
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers	P*	P*	N	N	P*	TBD	N	N	N	N	N	N	N	
5.4 Incidence of medication errors causing serious harm	P*	P*	N	N	Y*	TBD	N	P	N	N	P	N	N	

## Equality analysis

	International comparisons	Sub-national breakdown				Equality and Inequality Strands (National Only)							
		Regional	CCG level	Local Authority	Provider	Deprivation (via postcode or area)	Socio-economic group (NSSEC)	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation
5.5 Admission of full-term babies to neonatal care	P*	P*	N	N	P*	TBD	TBD	N	N	N	N	TBD	N
5.6 Incidence of harm to children due to 'failure to monitor'	N	N	N	N	N	N	N	N/A	N	N	N	N	N

## 3. Supporting evidence

- 3.1. A small number of changes have been made to the indicator set in the NHS Outcomes Framework. This chapter provides a summary of the impact that these changes may have on promoting equality and reducing inequalities.

### Domain 1 – Preventing people from dying prematurely

#### Cancer survival indicators

- 3.2. New placeholder indicators for cancer survival have been included in the updated framework. This was in response to concerns that the existing indicators did not include rarer cancers and could not be broken down to Clinical Commissioning Group level.
- 3.3. The new indicators are based on existing datasets, which have already been assessed in the previous two equality analyses for 2011/12 and 2012/13<sup>3</sup>.

#### Reducing premature mortality in people with a learning disability

- 3.4. Since the publication of the NHS Outcomes Framework 2012/13, work has continued to develop the placeholder indicator to reduce premature mortality in people with a learning disability. A definition for this indicator has now been identified as “Excess under 60 mortality rate in adults with a learning disability”.
- 3.5. For some people with a learning disability, there is physiological cause of the disability that itself leads to earlier death. The indicator itself is designed to focus upon those that die early for other reasons – causes that may be avoidable through better care. (There is evidence that even those with a learning disability without a physical cause are dying at a younger ages than those without a learning disability).<sup>4</sup> The rationale for selecting an age cut-off of under 60 years is to exclude deaths at older ages, where the cause of death is more likely to be unavoidably linked to the cause of the disability itself, and therefore to ensure that the indicator is better focused upon those dying from causes that are avoidable through better care.

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<sup>3</sup> Available at:

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_122955.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122955.pdf) and [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_131722.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131722.pdf)

<sup>4</sup> G. Glover and M. Ayub, How people with learning disabilities die. The Learning Disabilities Observatory. June 2010

## Domain 2- Enhancing quality of life for people with long-term conditions

### Dementia

- 3.6. In this domain, the 'placeholder' indicator **2.6 Enhancing the quality of life for people with dementia** has been updated and extended. Since the publication of last year's framework, the Prime Minister announced a 'dementia challenge' focused on boosting diagnosis rates and supporting and improving treatment for people with dementia. The 'PM Challenge' included a commitment that the Department would develop a two part indicator for the NHS Outcomes Framework. For 2013/14, therefore the framework will include an indicator which measures diagnosis rate for people with dementia, there being evidence that receiving early diagnosis is an important outcome for people living with dementia, enabling them to better cope with their condition.
- 3.7. In developing the second part of this indicator, we will draw upon the existing equality analyses on dementia compiled by the Department of Health. Dementia affects people from all backgrounds and across the full range of the equality characteristics. People with dementia can suffer from stigma and discrimination and difficulties in accessing services. In particular, the challenge of living well with dementia can be significant in for people also living with other conditions<sup>5</sup>.

## Domain 3 – Helping people to recover from episodes of ill-health or following injury

### Psychological therapies

- 3.8. The Department is committed to ensuring that mental health is on a par with physical health, and close the health gap between people with mental health problems. To strengthen the mental health indicators in the framework, and in recognition that depression and anxiety disorders is estimated to affect 17% of the population, a new indicator is under development . The indicator will measure the response to depression and anxiety disorders through the delivery of the Improving Access to Psychological therapies programme.
- 3.9. The IAPT programme collects data on six equality items. These are: age, gender, ethnicity, religion, sexual orientation and disability. An application has been made to the Information Standards Board to include the three remaining protected equality characteristics - gender reassignment; pregnancy/maternity and marriage/civil partnership. If approved these additional items will be included in the IAPT data standard from summer 2013.

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<sup>5</sup> Available at [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_128519](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128519)

- 3.10. The IAPT Data Standard has been mandated from April 2012 and data is returned monthly to the Health and Social Care Information Centre (HSCIC). Data for quarter 1 (April to June) will be published on the HSCIC website on 27th November. These first reports will include data quality checks and measurement against key quality standards including the number of referrals entering treatment by age, gender, ethnicity and disability. The Programme is working closely with the HSCIC to develop further these reports

## Domain 4 – Ensuring that people have a positive experience of care

### The Friends and Family test

- 3.11. The new overarching indicator is based on the Friends and Family test (FFT). The FFT is a new requirement from April 2013 to collect and publish results of a question all NHS trusts will ask patients about their experience of NHS services. It will be important to ensure that the FFT is designed in a way that enables maximum participation, and is implemented in a way that avoids indirect discrimination against particular groups.
- 3.12. As part of this development work, it will be important to recognise the challenges in surveying hard to reach groups. For example, research indicates a fundamental lack of source material to even begin the most basic analysis of the needs of some of hard to reach groups<sup>6</sup>.
- 3.13. Since FFT is specifically concerned with the experience of patients who have used NHS services, rather than of the population as a whole, exclusion from healthcare in a general sense is not something that can be mitigated for. However, it is important that in designing the FFT, that any members of hard to reach communities who have used NHS services are given the opportunity to feed back, ideally in a way that matches their preferences and lifestyle.
- 3.14. Other equality considerations will need to be considered, for example, older people are much less likely to respond online, women generally give more positive feedback, and some BME groups tend to respond over a longer timeframe than the general population. The best way to mitigate for these differences is to allow for a plurality of feedback mechanisms to be used in any given survey.

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<sup>6</sup> Wilkinson S, Stockl A, et al (2009). 'Surveying hard to reach groups – Final Report'. University of East Anglia.

## Integration of care

- 3.15. In January 2012, the NHS Future Forum highlighted the importance of the integration of care: “Integration is a vitally important aspect of the experience of health and social care for millions of people. It has perhaps the greatest relevance for the most vulnerable and those with the most complex and long term needs.” [Insert reference].
- 3.16. Work aimed at advancing a methodology for capturing people's experience of integrated care is currently underway. Once available, this will inform the development of outcome measures for the NHS , Public Health and Adult Social Care outcomes frameworks. A full equality assessment will be completed once a measure has been identified

## Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

- 3.17. Recent research published in the BMJ estimated the number of preventable deaths due to problems with care in English hospitals<sup>7</sup>. This evidence prompted the Department to analyse the number of incidents recorded under indicator 5b *Safety incidence involving severe harm or death* and its sub-indicator 5.4 *Safety incidents of type medication involving severe harm or death*) which seriously understated the burden of harm from problems with care. These indicators are retained to monitor level of recording of safety incidents, but need to be complemented by a much more robust estimate of harm done.
- 3.18. This new overarching indicator focuses on preventable deaths within a hospital setting. Consideration will need to be given to various age groups, for example, older people are more likely to occupy hospital beds and make up a large share of hospital admittances, and this is reflected in the mean age of both the male and female sample used to estimate the number of preventable deaths (76.7 and 78.8 years respectively). There is no clear evidence of a gender effect within this study as the sample of 1000 deaths is fairly evenly split between the sexes (54% and 46%).

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<sup>7</sup> Hogan H, Healy F, Neale G, et al (2012). ‘Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study’. *BMJ Qual Saf*. doi:10.1136/bmjqs-2012-001159