

**NHS OUTCOMES FRAMEWORK 2011/12**  
**EQUALITIES IMPACT ASSESSMENT**

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## 1. Introduction

- 1.1 *Equity and Excellence: Liberating the NHS*<sup>1</sup> set out a vision of the NHS that achieves amongst the best outcomes of any health service in the world. To achieve this, it outlined two major shifts:
- a move away from centrally-driven process targets which get in the way of patient care; and
  - a relentless focus on outcomes and the quality standards that deliver them.
- 1.2 On 19 July, the Department of Health, published *Transparency in Outcomes - a framework for the NHS*<sup>2</sup>. This explained how an NHS Outcomes Framework would be developed to provide that national accountability for the outcomes that the NHS delivers between both the Secretary of State for Health and Parliament, and between the Secretary of State for Health and the NHS Commissioning Board. The framework would not only be a mechanism to hold the NHS to account, but would also act as a catalyst to drive quality improvement and delivery of better outcomes across the system by encouraging a change in culture and behaviour, including a renewed focus on tackling inequalities in outcomes.
- 1.3 The consultation document put forward proposals for a framework and sought views on the structure, and core principles that should underpin the development of the framework as well as the more specific outcome indicators that should be included under each domain. We are now publishing the first NHS Outcomes Framework<sup>3</sup>, which follows the structure proposed in the consultation:
- **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 people have a positive experience of care
  - **Domain 5:** Treating and caring for people in a safe environment and protecting them from avoidable harm

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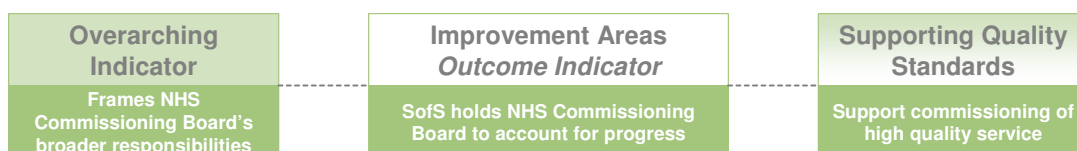
<sup>1</sup> *Equity and Excellence: Liberating the NHS* is available at [www.dh.gov.uk](http://www.dh.gov.uk)

<sup>2</sup> *Transparency in Outcomes – a framework for the NHS* is available at [www.dh.gov.uk](http://www.dh.gov.uk)

<sup>3</sup> *Transparency in Outcomes – NHS Outcomes Framework 2011-12 - NHS* is available at [www.dh.gov.uk](http://www.dh.gov.uk)

1.4 Each of the five domains follow the same structure as set out below:

Figure 1 – Structure of each domain in the NHS Outcomes Framework



- a single or small set of **overarching indicator(s)**, allowing the Secretary of State to track the progress of the NHS as a whole in delivering outcomes in the domain;
- a small set of **improvement areas** identified where the NHS Commissioning Board will be tasked with delivering quality improvement and where it can be measured; and
- a supporting suite of **NICE Quality Standards** setting out what high quality care looks like for a particular pathway of care.

1.5 This Equality Impact Assessment (EqIA) examines the potential impact that the NHS Outcomes Framework may have on the protected equalities strands. One of the underpinning principles in developing the NHS Outcomes Framework is the need to promote equalities and reduce inequalities of health outcomes. To encourage this, the outcome indicators, as far as possible, will have been chosen with consideration of where data can be disaggregated by equalities characteristics and by geography so that outcomes for disadvantaged groups can be measured.

### **Consultation process**

1.6 The consultation ran between 19 July and 11 October 2010. The Department of Health received 773 responses to the consultation, which were used alongside rigorous analysis, to help determine the selection of the final outcome indicators for the first NHS Outcomes Framework. An extensive stakeholder engagement process was undertaken – full details of the events are listed at **Annex A**. The consultation responses and feedback from the stakeholder events has helped to inform the development of the EqIA.

## 2. Relevance to equality and diversity

### Why is this relevant?

- 2.1 The NHS Outcomes Framework will provide the mechanism through which the Secretary for State for Health holds the NHS Commissioning Board to account for the outcomes it secures for patients through its role in overseeing the commissioning process and the allocation of the NHS budget. It has been designed to provide an indication of the overall progress of the NHS, wherever possible, in an international context. It will be for the NHS Commissioning Board to determine how best to deliver improvements by working with GP consortia and making use of the various tools and levers it will have at its disposal.
- 2.2 For example, it will commission NICE to develop Quality Standards to define the quality of care necessary to deliver the desired outcomes in the NHS Outcomes Framework. Drawing on these Quality Standards, the NHS Commissioning Board will produce a Commissioning Outcomes Framework, which it will use to hold GP commissioning consortia to account and to pay consortia for delivering outcomes through commissioning. Linked to this, a quality premium will reward consortia for the improvement in outcomes that they achieve and for the effectiveness with which they manage their resources.
- 2.3 The NHS Outcomes Framework has the potential to have a significant impact on the incentives within the NHS, and how the NHS focuses its resources. As with any accountability structure, there may be a risk that it will incentivise behaviours that are inequitable, or disadvantage some groups, but there is also an opportunity for it to incentivise greater equity and reduce health inequalities.

### Covering the needs of all groups

- 2.4 The NHS Outcomes Framework has been designed with the specific aim of ensuring that it includes a balanced set of outcomes across the breadth of NHS treatment responsibilities, including the specific needs of different groups. Five outcome goals or domains are defined that aim to provide a complete description of the NHS' responsibilities; overarching indicators have been chosen to cover these aims as completely as possible; and improvement areas have been selected based on robust evidence of where there is the potential to significantly improve outcomes based on analysis of the needs of groups who risk being disadvantaged.

### **Specifically addressing equalities and inequalities**

- 2.5 Nonetheless, if the NHS is asked only to improve overall outcomes at a national level then there may be a risk that not all groups are treated equally. For example, the NHS Commissioning Board could choose to target its resources on groups of people for which it gets the greatest return in terms of improved outcomes. In terms of equalities, this could mean that some groups are disadvantaged. In terms of inequalities, the groups with the worst outcomes are not necessarily the groups in which the greatest gains can be made for the lowest cost - in particular, they may be hard to reach. In short: national-level improvement goals alone may not prevent discrimination and may not narrow inequalities.
- 2.6 The NHS Commissioning Board and Secretary of State for Health will negotiate levels of ambition for the indicators in the NHS Outcomes Framework once the Board is in place in shadow form. The Secretary of State for Health and the NHS Commissioning Board will use a set of principles to underpin the negotiations as to what the levels and pace of delivery should be. One of these principles will consider the variation and inequalities in health outcome indicators, taking account of equalities characteristics, disadvantage and where people live.
- 2.7 Health inequalities will be monitored where possible, and if any issues are identified then the NHS Commissioning Board and Secretary of State may wish to agree a related level of ambition for improvement in outcomes for that group. *The NHS Outcomes Framework 2011/12* makes clear where the indicators chosen allow outcomes for different groups to be measured. The Department of Health recognises that more needs to be done to improve the number of indicators that can be disaggregated.

### 3. Summary of evidence

- 3.1 This section provides a summary of the challenges and opportunities relevant to each of the five domains, when considering the promotion of health in health outcomes and when trying to reduce health inequalities.

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

- 3.2 There is a clear socio-economic gradient in the overarching mortality outcomes in this domain. Men and women living in the most deprived areas have the highest rates of amenable mortality and mortality from all its component causes, and the lowest life expectancy at birth and at 65.
- 3.3 Generally, mortality rates in childhood are low with the exception of children under 1 year. After childhood, mortality rates increase as we get older. Relative survival rates for major cancers get worse with age at diagnosis even when the higher mortality from other causes in older people is allowed for.
- 3.4 There is paradoxical evidence relating to mortality rates in women. Women in England can expect to live longer than men but evidence from international comparisons indicates that the difference in life expectancy between men and women is even greater in the EU than in the UK. Men's life expectancy in the UK is around the same as the (pre-2004) EU15 average, while women's life expectancy in the UK is lower even than the EU27 average including the new Eastern European members.
- 3.5 There is a lack of information about ethnicity, religion or belief, sexual orientation or disability in mortality data as this information is not recorded on death certificates. However there is evidence that people with learning disabilities and people diagnosed with serious mental illness are much more likely to die from causes amenable to health care.
- 3.6 There is mixed evidence on inequalities in amenable mortality in certain ethnic groups, for example people of Black and Black British - Caribbean origin have a low prevalence of Coronary Heart Disease (CHD) compared with the white population, although they have much higher prevalence of and mortality from hypertension and stroke. People from black and minority ethnic (BME) groups are at a lower risk overall from cancer than the white population, but this may be partly explained by the younger age profile of BME groups.

- 3.7 There is a risk that older people (aged 75+) are disadvantaged by the selection of ‘mortality amenable to healthcare’ as an overarching indicator for this domain. This is because mortality amenable to healthcare by definition is capped at age 75, due to multiple morbidities and the consequent difficulties in ascribing cause of death to those aged 75 years and above. Considering all deaths above a particular age as ‘not premature’ discriminates against older people who still lead healthy and fulfilling lives. To mitigate this risk, ‘Life Expectancy at 75’ will be used as a companion indicator to amenable mortality.
- 3.8 Because deaths from causes considered amenable to healthcare are largely dominated by adults, there is a risk that children will be neglected. To mitigate this risk, outcomes have been selected that specifically relate to periods of childhood where the risk of death is highest: infant mortality and perinatal mortality (including stillbirths).

## **Domain 2: Enhancing Quality of Life for people with Long-term conditions**

- 3.9 The overarching indicator for domain 2 is ‘**health-related quality of life for people with long-term conditions**’. Analysis of health-related quality of life scores from the EQ-5D<sup>4</sup> (reported in the Health Survey for England) suggests that people from unskilled manual, semi-skilled manual and skilled manual jobs have poorer health states than people in management or professional jobs. There is also some variation in reported quality of life between different ethnic groups. There is an expected differential in terms of age with older people reporting a lower quality of life than younger people.
- 3.10 Improvement areas have been selected to take into account generic outcomes that would be important to any person with a long-term condition. In addition, specific improvement areas have been selected for people with mental illness and for carers.
- 3.11 **Ensuring people feel supported to manage their condition** - This will be measured using the GP Patient survey. Analysis of the care planning questions from the GP Patient Survey<sup>5</sup> has shown that people from more deprived groups, ethnic minority populations, minority religious groups, gay lesbian and bisexual groups, younger patients in poorer health states and patients with psychological or emotional problems tend to report feeling less supported.

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<sup>4</sup> EQ-5D<sup>TM</sup> is a trademark of the EuroQol Group. Further details can be found on their website: <http://www.euroqol.org>

<sup>5</sup> GP Patient Survey, Q3+Q4, 2009/2010.



- 3.12 **Improving functional ability in people with long-term conditions** – as measured by the employment of people with long-term conditions. While the data is not readily available for this indicator, previous research can be drawn on to look at inequalities for this indicator. Minority ethnicity and long-term ill-health are associated with greatly reduced chances of employment for both men and women<sup>6</sup>. Rates of employment were substantially lower for those from Pakistani, Bangladeshi and Ghanaian communities studied than among comparable White British men and women. Employment rate for women with a long-term condition has been found to be slightly lower than for men with a long-term condition.
- 3.13 **Reducing time spent in hospital by people with long-term conditions** – the indicators proposed for this improvement area are ‘Unplanned hospitalisation for chronic ambulatory care sensitive conditions for adults’ and ‘Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19 year olds’. These indicators reflect how well the NHS manages the condition(s) by looking at unnecessary admissions.
- 3.14 Basic analysis of hospital admission data from 2009-10<sup>7</sup> suggests that people from some ethnic groups have a higher rate of emergency admissions than people from the White British majority. People aged over 85 are significantly more likely to have an emergency admission than someone in their 20s, 30s or 40s. However, this is not surprising as older people are the largest users of hospital services. As they are the major driver of the overall rate, it is vital to look at emergency admissions for children and adults to ensure that other groups are not neglected.
- 3.15 The specific improvement areas that have been selected for carers and people with mental illness are **enhancing health-related quality of life for carers** and **employment of people with mental illness**. Data on carer’s quality of life is not readily available at present and little previous research exists. However, research is available on the proportion of adults in contact with secondary mental health services in employment. People in contact with mental health services have an unacceptably low employment rate, which is the lowest among any disability group. Estimates suggest that between 86%-90% of people with mental health conditions not in employment actually would like to be.

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<sup>6</sup> Long-term ill-health, poverty and ethnicity, Joseph Rowntree Foundation, 2007. This report can be accessed at the following website: <http://www.jrf.org.uk/publications/long-term-ill-health-poverty-and-ethnicity>

<sup>7</sup> Hospital Activity Data (Hospital Episode Statistics – HES), 2009-10

3.16 Black and ethnic minority mental health patients are less likely to use employment services and less likely to gain employment than their White counterparts<sup>8</sup>. In terms of gender, female mental health users are more likely to be in paid work than male service users, 26% of women versus 16% of men<sup>9</sup>

**Domain 3: Helping people to recover from episodes of illness or following injury**

3.17 This domain looks at reducing the number of people who are admitted to hospital for conditions that should usually be managed without hospital care. It appears that disadvantaged groups (in terms of socio-economic status) are more likely to be admitted to hospital for these conditions.

3.18 The other overarching indicator for this domain looks at readmission to hospital. Greater levels of deprivation are linked to higher chances of readmission. Older people are more likely to be readmitted, and the total number of admissions for this age group is much higher. As such they are the major driver of the overall rate. The NHS will need to ensure that other groups are not neglected by monitoring rates for children and adults, not just the overall rate.

3.19 The improvement areas have been chosen to ensure that the main causes of emergency care in all age groups are covered. However, there are more improvement areas for older people than for other groups. This may be appropriate, as older people need more healthcare, but when the NHS Outcomes Framework is reviewed in the future it will be important to ensure that improvement areas for children in particular are retained. There appears to be no bias towards one gender or the other in the areas selected.

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<sup>8</sup> Evening the odds, Employment support, mental health and Black and minority ethnic communities, Sainsbury Centre for Mental Health, 2010

<sup>9</sup> Improving the employment rates of people using secondary mental health services: A regional strategy for the North West, North West Regional Employment Team, 2008.

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

- 3.20 The NHS National Patient Survey Programme and the GP Patient Survey build on an approach that was originally pioneered by Picker/Commonwealth Program in the USA<sup>10</sup>. This approach focuses on service specific issues which are important to patients, and which can help clinicians and managers easily identify specific service issues for improvement. Questions are designed to keep the subjective element to a minimum, so avoiding some of the problems commonly associated with questions that ask patients to provide an overall rating or level of satisfaction. However it has to be recognised that a patient's assessment of the services they have received will reflect to some degree their expectations and previous experiences.
- 3.21 A diverse range of indicators have been chosen for domain 4 to reflect a wide range of patient experiences in a number of different settings. The size of the questionnaire samples mean they are representative and reflect the views of a cross section of NHS users. In particular the GP patient survey is currently the second largest data collection exercise in England after the census.
- 3.22 Variations in reported experience of patients by demographic subgroups are evident in the survey data. However this is a complex area and various factors should be considered. It is acknowledged that perception, expectations and what is important to patients varies greatly depending on the patient and various other factors. Therefore variations in experience reported could genuinely reflect real inter-group differences in the quality of service received, or could reflect differences across groups in subjective factors such as expectations or perceptions, or some combination of these factors. Variations are not across the board, but show complex patterns, varying question by question, and also across settings.
- 3.23 The Healthcare Commission (now the Care Quality Commission) have previously carried out analysis to investigate differences in reported patient experiences across groups including age, gender, health, and ethnicity. This was based on 2004/05 surveys from the following settings: mental health, primary care, emergency departments and outpatients.<sup>11</sup>. They found that trusts need to improve the quality of services provided to

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<sup>10</sup> Bruster, S., Jarman, B., Bosanquet, Weston D., Erens, R. and Delbanco, T (1994) National survey of hospital patients, *British Medical Journal*, 309, 1542-1546

<sup>11</sup> Variations in the experiences of patients using the NHS services in England (Analysis of 2004/05 surveys) [http://www.cqc.org.uk/publications.cfm?search\\_string=variations&widCall1=customDocManager.search\\_do\\_2&cl\\_id=2&top\\_parent=4513&tax\\_child=4759&tax\\_grand\\_child=](http://www.cqc.org.uk/publications.cfm?search_string=variations&widCall1=customDocManager.search_do_2&cl_id=2&top_parent=4513&tax_child=4759&tax_grand_child=)

those patients who are very unwell or admitted to hospital on an emergency basis, residents of deprived areas and people of minority ethnic origin.

- 3.24 Domain 4 of the NHS Outcome Framework will continue to improve the overall patient experience but also permit the drilling down of the experience of particular groups who may merit particular patient experience improvement programmes.

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

- 3.25 Ensuring the safety of everyone who comes into contact with health services is one of the most important challenges facing healthcare, with up to 10% of patients experiencing some kind of patient safety incident. There is little evidence to show that the vulnerability faced by different groups actually leads to an increased risk of harm - this premise is largely assumed. However, there are particular groups who may be more vulnerable in a healthcare setting, and it is thought that this vulnerability could well result in a less safe service being delivered to them.
- 3.26 The patient safety outcomes and indicators suggested for the NHS Outcomes Framework should lead to safer services for all patients; however, there is scope for some equality groups to benefit more than others.

### **OTHER ISSUES**

#### **Staff/Workforce**

- 3.27 The NHS Outcomes Framework is aimed at the whole population, and we would expect NHS staff to receive the same benefits as the rest of the population, and not to be disproportionately affected. The successful delivery of improved health outcomes will be dependant on a fully engaged and motivated workforce. Evidence suggests that there is a relationship between staff health and well-being and performance on areas such as patient satisfaction.<sup>12</sup>

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<sup>12</sup> NHS Health and Well-being – Final Report, November 2009

## **Human Rights**

- 3.27 Due regard has been taken to the principles of Fairness, Respect, Equality, Dignity and Autonomy, as out in the Human Rights Act 1998 in the development of the NHS Outcomes Framework. For example, Article 2 - The Right to Life, is captured across all the domains, but has resonance in *Domain 5: Treating and Caring for people in a Safe Environment*.
- 3.28 This domain seeks to help patients understand the risk of their condition as well as the risks associated with particular treatments and procedures. Alongside this, is the expectation that the NHS will provide timely care, without causing or contributing to additional unacceptable harm or injury in the process. A culture that promotes reporting of safety incidents will allow an organisation to increase the likelihood of reducing harmful incidents by giving it a richer understanding of how to deliver safer care. This enables organisations to learn from incident reports and make tangible changes that improve safety and the public's confidence in the organisation.

## **Recommended Actions**

- 3.29 The list below sets out the actions that the Department of Health will take forward to ensure the NHS Outcomes Framework is equitable.
- one of the underpinning principles in developing the NHS Outcomes Framework has been the need to promote equality and reduce inequalities in outcomes from healthcare;
  - The Department of Health and the NHS Commissioning Board will use a set of principles when negotiating levels of ambition for the NHS Outcomes. One of these principles will focus on the variation and inequalities in health outcome indicators, taking account of equalities characteristics, disadvantage and where people live. The framework will help the NHS Commissioning Board play its full part in promoting equality in line with the Equality Act 2010;
  - over time, we will work to improve data collections so that more indicators can be disaggregated by equality characteristics and geography. This will help to improve coverage of disadvantaged groups; and
  - to explore and commission additional research for areas to where there is little data available.

### **Equalities and inequalities for specific indicators**

- 3.30 The rest of the document looks in turn at each of the indicators included in the NHS Outcomes Framework and identifies which can be disaggregated by the different equalities protected characteristics.
- 3.31 Where data is available, outcomes for different groups are compared and any disparities identified. Health inequalities between the least and most deprived are also assessed, where data is available. Both may warrant consideration when agreeing levels of ambition.

## 4. Evidence base

- 4.1 This chapter provides supporting evidence for the Equality Impact Assessment for *Transparency in Outcomes - a framework for the NHS*. It should be read in parallel with the main body of the EqIA and seen largely as contextual information to the arguments made there, in particular that any improvement (or indeed deterioration) in equality will be brought about not simply by the inclusion of these indicators in the NHS Outcomes Framework, but by the action of the NHS Commissioning Board and the NHS locally.
- 4.2 Taking each domain in turn, this document gives an overview of any inequalities that exist in the outcomes included in the first NHS Outcomes Framework, and highlights any risks and opportunities relating to specific indicators.

## **DOMAIN 1 – Preventing people from dying prematurely**

### **SUMMARY OF INDICATORS**

#### **Underlying principles**

- **People should not die early where medical intervention could make a difference.** A key function of the NHS is to stop people from dying at a point where medical intervention could prevent that death. Many such deaths occur before old age. However, the definition of ‘premature’ death, while often referring to deaths under age of 75, is not hard and fast, and many people live healthy lives at much older ages.
- **Focus on what the NHS can do.** Not all deaths can be avoided by the provision of healthcare alone, so the NHS needs to be clear about where it can and should improve outcomes, and what level of contribution it can make, acknowledging areas where it will need to work with partners to deliver the outcomes that matter most to patients.
- **Overarching indicators**
  - 1a Mortality from causes considered amenable to health care
  - 1b Life expectancy at 75

#### **Improvement areas**

- **Reducing premature mortality from the major causes of death**
  - 1.1 Under 75 mortality rate from cardiovascular disease
  - 1.2 Under 75 mortality rate from respiratory disease
  - 1.3 Under 75 mortality rate from liver disease
  - 1.4 Cancer survival
    - i) One- and ii) five-year survival from colorectal cancer
    - iii) One- and iv) five-year survival from breast cancer
    - v) One- and vi) five-year survival from lung cancer
- **Reducing premature death in people with serious mental illness**
  - 1.5 Premature mortality in people with serious mental illness
- **Reducing deaths in babies and young children**
  - 1.6.i Infant mortality
  - 1.6.ii Perinatal mortality (including stillbirths)



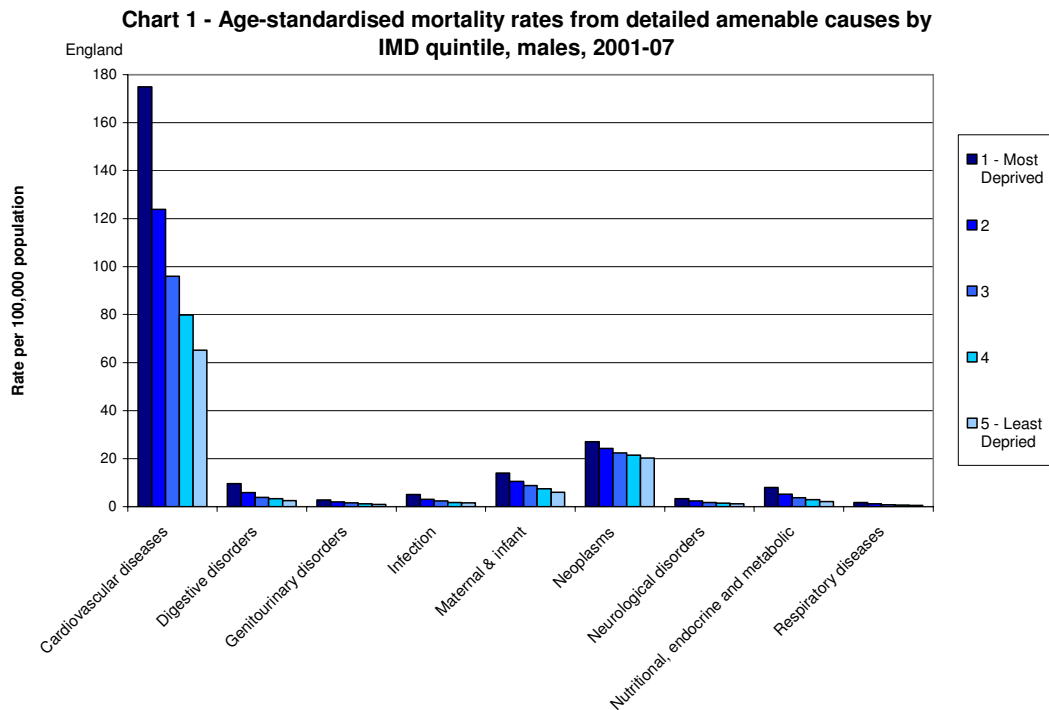
## Evidence

All indicators (overarching and for each improvement area) are examined together under this domain

### Socio-economic group

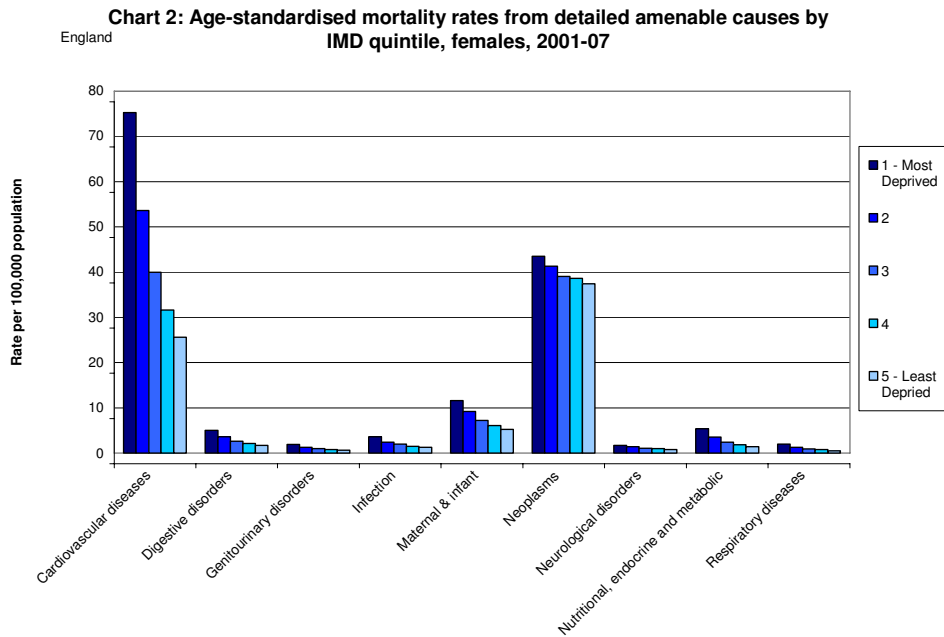
4.3 There is clear evidence to show that lower socio-economic groups have higher amenable mortality. Work carried out by Office of National Statistics (ONS) on behalf of DH Inequalities Unit on inequalities in amenable mortality (ONS definition)<sup>13</sup> shows a clear gradient by IMD deprivation quintile for all the components of amenable mortality, both for males and females:

Figure 2



<sup>13</sup> Trends in Avoidable Mortality, Health Statistics Quarterly No 34, ONS, 2007  
<http://www.statistics.gov.uk/articles/hsq/HS34Q-Mortality.pdf>

Figure 3



4.4 Life expectancy at 65 also shows a clear socio-economic gradient<sup>14</sup>:

Figure 4

**Table 2: Life expectancy, healthy life expectancy and disability free life expectancy at 65: by deprivation quintile and sex, 2003**  
(Source: *Pensions Trends* Chapter 3, 2010, ONS)

England	Years					
	Life expectancy		Healthy life expectancy		Disability-free life expectancy	
	Men	Women	Men	Women	Men	Women
Index of Multiple Deprivation 2004 (quintile)						
1 - Least deprived	18.2	20.8	15.0	17.2	12.0	13.4
2	17.4	20.2	13.9	15.7	11.0	12.7
3	16.8	19.6	13.0	15.3	10.4	12.4
4	15.8	18.9	11.5	13.8	9.0	10.4
5 - Most deprived	14.6	17.8	9.5	12.3	7.5	9.4

<sup>14</sup> ONS Pension Trends 2010

<http://www.statistics.gov.uk/cci/nugget.asp?id=1913>

- 4.6 Cancer survival rates are worse for deprived groups across a wide range of cancers. For example for breast cancer there is a 7.6% difference in 5-year survival between the most affluent and the most deprived groups. For colon cancer the figure is 4.3%.<sup>15</sup>
- 4.7 The 2006 Confidential Enquiry into Maternal and Child Health (CEMACH) perinatal mortality figures showed that babies born to women living in the most deprived areas were 1.7 times more likely to be stillborn or to die shortly after birth than babies born to women in the least deprived areas.<sup>16</sup>
- 4.8 For breast and cervical cancer screening coverage is generally lower in more deprived parts of the country and London.<sup>17</sup>

### **Ethnicity**

- 4.9 Detailed amenable mortality data for England is not readily available by ethnic group. However there is evidence to show that mortality from some of its constituent causes is higher in certain ethnic groups:
- South Asians, particularly Bangladeshis and Pakistanis, have significantly higher CHD prevalence and mortality than the general population<sup>18</sup>
  - Although people of Black and Black British origin have a low prevalence of CHD compared with the white population, they have much higher prevalence of and mortality from hypertension and stroke.<sup>19</sup>
  - A study in New Zealand by Martin Tobias et al showed that amenable mortality in 1996-2006 varied across ethnic groups, with Maori amenable mortality rates around three times and Pacific people's rates around two times the corresponding non-Maori or non-Pacific people's rates in both sexes. Asian peoples on the other hand had amenable mortality rates around half those of non-Asian people.<sup>20</sup>

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<sup>15</sup> Coleman M et al., Cancer Survival Trends in England and Wales, 1971-1995: Deprivation and NHS Regions. London, The Stationery Office, 1999

<sup>16</sup> NICE guidelines for pregnant women with complex social factors  
<http://guidance.nice.org.uk/nicemedia/live/11814/42412/42412.pdf>

<sup>17</sup> Information Centre, Breast and Cervical Screening Programmes, England

<sup>18</sup> The epidemic of coronary heart disease in South Asian populations: causes and consequences, Kiran C R Patel, Raj S Bhopal, 2004  
<http://www.sahf.org.uk/uploads/docs/files/21.pdf>

<sup>19</sup> Ethnicity and cardiovascular risk: variations in people of African ancestry and South Asian origin, FP Cappuccio, 1997

<http://www2.warwick.ac.uk/fac/med/staff/cappuccio/publications/jhumhypert97ethnicity.pdf>

<sup>20</sup> Saving Lives: Amenable Mortality in New Zealand 1996-2006, Martin Tobias et al., 2010

- While people from black and minority ethnic (BME) groups are at a lower risk overall from cancer than the white population, there is an increased risk of certain cancers in the Asian and Black ethnic groups. Asian and black women have lower survival than the white ethnic group for females diagnosed with breast cancer aged under 65 years. The lower number of cancer deaths overall among BME groups may partly be explained by the younger age profile of BME groups.<sup>21</sup>
- The Care Quality Commission (CQC) Maternity Patient Survey in 2007 found that women of Asian and Black origin are less likely to have their first booking appointment with a midwife within 12 weeks of pregnancy and were less likely to have a scan at 20 weeks. These are key risk factors for Infant and Perinatal Mortality and maternal death.<sup>22</sup>
- Infant mortality rates are higher among some ethnic groups than others, with Pakistani and Black and Black British - Caribbean babies being twice as likely to die in their first year compared to White British or Bangladeshi babies<sup>23</sup>
- A review by the Equality and Human Rights Commission in 2009 found that gypsies and travellers had an infant mortality rate that was three times higher than in the rest of the population.<sup>24</sup> High rates of maternal death during pregnancy and shortly after childbirth have also been reported by Parry et al, 2004.<sup>25</sup>
- The rate of stillbirth in babies born to women with a black ethnicity (African, Caribbean or other) was 2.3 times higher than the rate among babies born to women of white ethnicity. The neonatal death rate was twice as high for babies born to women of black ethnicity compared with babies born to women with white ethnicity. Similarly, the stillbirth rate and neonatal death rate for babies born to women of Asian ethnicity were 2.0 and 1.8 times higher, respectively, compared with those for babies born to women of white ethnicity.<sup>26</sup>

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<sup>21</sup> Cancer Incidence and Survival By Major Ethnic Group, England, 2002 – 2006  
[http://info.cancerresearchuk.org/prod\\_consump/groups/cr\\_common/@nre/@sta/documents/generalcontent/crukmg\\_1000ast-2749.pdf](http://info.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@sta/documents/generalcontent/crukmg_1000ast-2749.pdf)

<sup>22</sup> Women's experiences of maternity care in the NHS in England, Healthcare Commission, 2007  
[http://www.cqc.org.uk/\\_db/\\_documents/Maternity\\_services\\_survey\\_report.pdf](http://www.cqc.org.uk/_db/_documents/Maternity_services_survey_report.pdf)

<sup>23</sup> 'How fair is Britain? The First Triennial Review' Equality and Human Rights Commission 2010  
<http://www.equalityhumanrights.com/key-projects/triennial-review/>

<sup>24</sup> Inequalities experienced by gypsy and traveller communities: a review, Equality and Human Rights Commission, 2009  
[http://www.equalityhumanrights.com/uploaded\\_files/research/12inequalities\\_experienced\\_by\\_gypsy\\_and\\_traveller\\_communities\\_a\\_review.pdf](http://www.equalityhumanrights.com/uploaded_files/research/12inequalities_experienced_by_gypsy_and_traveller_communities_a_review.pdf)

<sup>25</sup> The Health Status of Gypsies & Travellers in England, University of Sheffield, 2004  
<http://www.sheffield.ac.uk/content/1/c6/02/55/71/GT%20report%20summary.pdf>

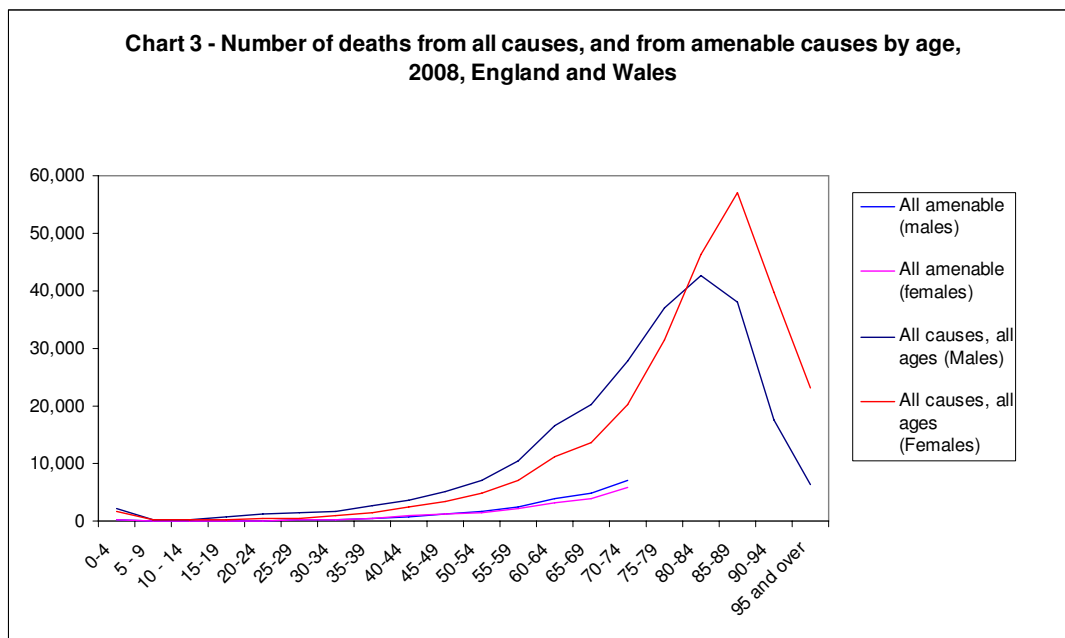
<sup>26</sup> NICE guidelines for pregnant women with complex social factors

## Age

4.10 Amenable mortality is by definition capped at age 75. Deaths under 75 are chosen largely because of the difficulty of ascribing cause of death in 75+ age groups where there are often multiple morbidities. For this reason Life Expectancy at 75 is proposed as a companion indicator to amenable mortality.

4.11 As the chart below shows, there is also a gender dimension to the age distribution of death. While 42 % of all male deaths in 2008 occurred before the age of 75, only 26% of female deaths did.

Figure 5



4.12 Relative survival rates for the major cancers decrease with increasing age at diagnosis, even when the higher mortality from other causes in older people is allowed for:<sup>27</sup>

<sup>27</sup> Cancer Research UK  
<http://info.cancerresearch.org/cancerstats/survival/age/>

Figure 6

**Five-year relative survival, by site and age at diagnosis, England and Wales, 1996-1999 followed up to the end of 2001**

Cancer Type	Sex	Age at diagnosis					
		15-39	40-49	50-59	60-69	70-79	80-99
		%	%	%	%	%	%
Breast	women	76	82	85	82	74	58
	men	61	54	50	50	47	40
Colon	women	58	54	54	52	48	39
	men	54	55	54	52	47	34
Rectum	women	60	61	62	58	49	36
	men	21	9	9	7	5	2
Lung	women	28	13	11	8	4	1

4.13 As death rates are so much higher in older age groups child deaths are at risk of being masked by the amenable mortality indicator. This is why two of the improvement area indicators for this domain are concerned with babies and children: infant mortality and perinatal mortality.

4.14 In 2009 the infant and perinatal mortality rates were highest in lower socio-economic groups, in babies born to mothers under 20, single mothers and mothers born in Pakistan or the Caribbean.<sup>28</sup>

### Disability

4.15 Detailed mortality data for England is not readily available by disability group. However, there is evidence that disability impacts on the length and quality of life, and can adversely affect access to services:

- Access to services can be difficult for people with a physical, cognitive or sensory impairment unless special measures are put in place
- There is low uptake of both breast and cervical cancer screening amongst disabled people:
  - Only 19% of learning disabled women have cervical smears, compared to 77% in the general population

<sup>28</sup> Infant and perinatal mortality in England and Wales by social and biological factors, 2008, Office for National Statistics  
<http://www.statistics.gov.uk/pdfdir/hsqsb0509.pdf>

- Access to mobile breast screening units is difficult for physically disabled women, but alternative arrangements are in place at static units
- The lack of inclusion of disability in routine recording makes it difficult to measure equity of access and treatment for disabled people, and presence of a disability is not recorded on death certificates so it is not possible to break down ONS mortality data by disability.
- People with learning disabilities:
  - are three times more likely to die from respiratory disease
  - have a higher risk of ischemic heart disease than the general population and this is the second most common cause of death in people with learning disabilities
  - are 58 times more likely to die before the age of 50 than the general population.
- People with a diagnosis of Serious Mental Illness (SMI) are twice as likely to die from coronary heart disease and four times as likely to die from respiratory disease as the general population<sup>29</sup> and schizophrenics are more than four times as likely to die from infectious diseases<sup>30</sup>. Rates of diabetes and hypertension are also high.<sup>31</sup> Clients with SMI sometimes find it difficult to engage with primary care services, which results in them not accessing routine health checks. This domain will include an indicator on amenable mortality in people with serious mental illness to address this inequality directly.

## Gender

4.16 There are particular issues around risk factors and mortality for both men and women:

- Women can expect to live longer than men (see figure 6 above).
- Although women live longer than men, they also spend more years in sub-optimal health on average, males in England spend 59.1 years in good health and 15.9 years in poor health; for women the corresponding figures are 61.4 years and 18.6 years.

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<sup>29</sup> DH Choosing Health, 2006

<sup>30</sup> Harris, E.C., Barraclough, B.(1998) Excess mortality of mental disorder. *The British Journal of Psychiatry*; 173: 11-53.

<sup>31</sup> The Sainsbury Centre for Mental Health (2001) *Physical Health of the Severe and Enduring Mentally Ill*.  
[http://www.centreformentalhealth.org.uk/pdfs/gp\\_training\\_pack.pdf](http://www.centreformentalhealth.org.uk/pdfs/gp_training_pack.pdf)

- For both males and females life expectancy at 75 has been increasing in recent decades, but the gap between males and females has decreased slightly over the last fifteen years.

Figure 7

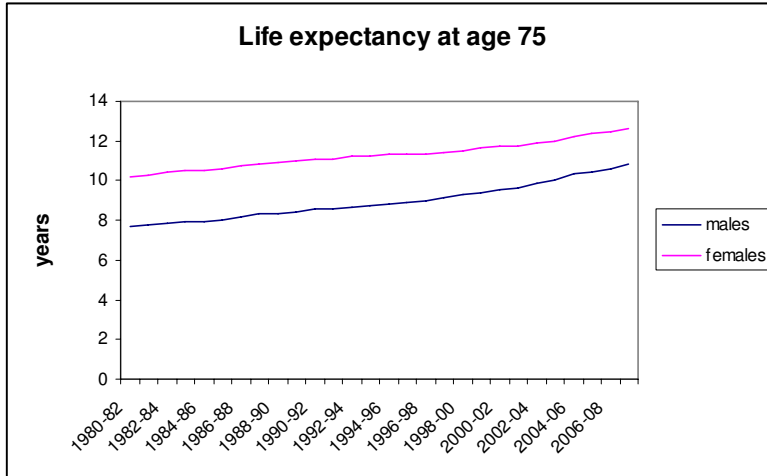
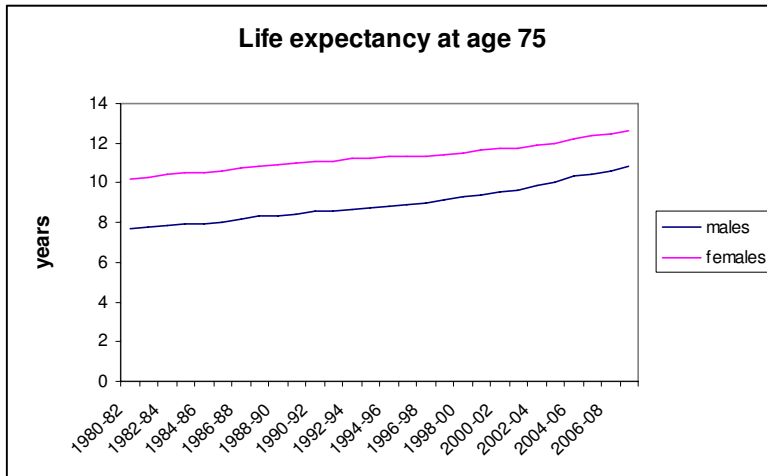


Figure 8

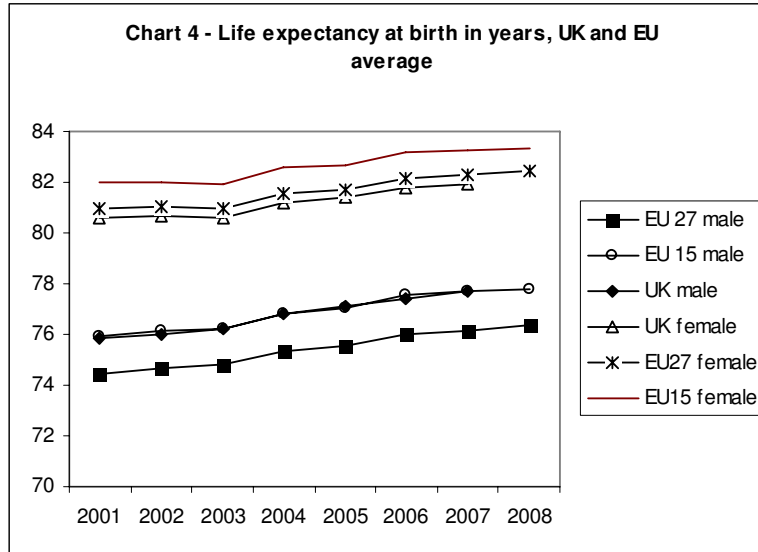


4.17 It will be important to make sure that the gender differences noted above do not lead to perverse incentives to focus care more on men for the following reasons:

- There is evidence from international comparisons that women in all countries live on average longer than men, and the difference in life expectancy between men and women is even greater in the EU than in the UK: men's life expectancy in the UK is around the same as the EU15 average, while women's life expectancy in the UK is lower even than the EU27 average which includes the new Eastern European EU members (see figure 9 below).



Figure 9

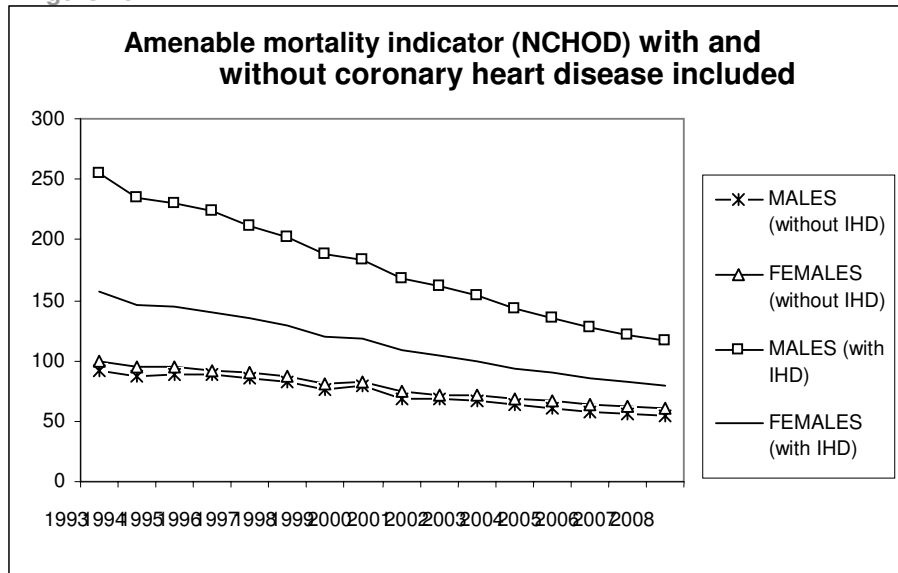


- The gender difference in life expectancy is greatest in deprived areas.
- Some cancers are gender specific. For most cancers which affect both men and women, such as lung cancer, age standardised survival rates are somewhat higher in women.<sup>32</sup> However mortality from lung cancer in UK women is higher than the EU15 average, while for men it is lower. This may be related to UK women's relatively higher smoking levels.
- Men are more vulnerable to cardiovascular disease than women, and at a younger age, and are also diagnosed with the majority of cancers.
- Because the death rate from coronary heart disease (CHD) is very different for men and for women, the extent to which this condition is included in any definition of amenable mortality has a large impact on the difference in the amenable mortality rate between men and women. For example, NCHOD<sup>33</sup> publishes data for two versions of an amenable mortality indicator – one includes CHD as a condition amenable to healthcare and the other does not (see figure 10 below).

<sup>32</sup> Gender differences in lung cancer: Have we really come a long way, baby? Olak & Colson, 2004

<sup>33</sup> Mortality from causes considered amenable to health care, NCHOD  
<http://nww.nchod.nhs.uk/>

Figure 10



4.18 When all deaths from CHD are included there are far more male amenable deaths. When CHD is excluded there are slightly more female amenable deaths. The Nolte & McKee definition used in figure 5 includes half of deaths from CHD.

### Religion or Belief

4.19 In general there is little available evidence on the links between specific religions or beliefs and amenable mortality beyond that relating to race. There are some issues around cancer screening and certain religions:

- Uptake of routine invitations for breast screening is lower amongst Muslim women than among women in the general population possibly due to fear of a male carrying out the mammogram; and
- In the first phase of the bowel screening programme overall population uptake was 62% but only 32% for Muslims.

### Sexual orientation

4.20 There is currently limited data availability on sexual orientation issues. From the General Household survey, fewer people living in same sex couples had used hospital services in the past year than in the population as a whole, however this is likely to reflect the age profile of those in same sex couples.

4.21 A study of mortality among over 8,000 Danish men and women in same-sex marriage concluded that despite recent marked reduction in mortality among gay men, Danish men and women in same-sex marriages still have mortality rates that exceed those of the general population. However the excess mortality is restricted to the first few years after a marriage, possibly reflecting pre-existing illness at the time of marriage.<sup>34</sup>

### **Gender-reassignment**

4.22 There is little evidence available to determine whether the mortality rate from amenable causes in the transgender population is different from the rate in the population as a whole. Available evidence shows:

- 35% of the transgender population report having made at least one suicide attempt. However, the Gender Identity Research and Education Society (GIRES) are not aware of any data that indicate high mortality among severely gender dysphoric people from successful suicide attempts.<sup>35</sup>
- A report of the use of cross-sex hormones in the context of gender re-assignment in a hospital in Netherlands from 1995 to 2006 in over 3000 (2236 male-to-female and 876 female-to-male transsexuals) reveals that the mortality rate from cancer and coronary heart disease was not higher than in a comparison group.<sup>36</sup>

### **Marital status (marriage/civil partnership)**

4.23 There is evidence to show that single men and to a lesser extent single women have higher mortality rates than married men and women<sup>37</sup> and that single people have a greater risk of dying after surgery<sup>38</sup>. Further study is needed to investigate the reasons for this. It is known that these outcomes are likely to be highly influenced by economic factors, and some studies have shown that stress associated with marital separation affects the body's immune system and its ability to fend off disease.<sup>39</sup>

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<sup>34</sup> Mortality among men and women in same-sex marriage: a national cohort study of 8333 Danes, *Am J Public Health*. 2009 Jan;99(1):133-7. Epub 2008

<sup>35</sup> Gender Variance in the UK, Gender Identity Research and Education Society, 2009

<sup>36</sup> Long-term treatment of transsexuals with cross-sex hormones: extensive personal experience. Gooren LJ, Giltay EJ, Bunck MC, *J Clin Endocrinol Metab*. 2008 Jan;93(1):19-25.

<sup>37</sup> Ross et al, 1990

<sup>38</sup> Goodwin et al, 1987

<sup>39</sup> Decreased cancer survival in individuals separated at time of diagnosis, *Cancer* 1 November 2009 Volume 115, Issue 21

4.24 Infant and perinatal rates are highest among sole registered births and births outside marriage registered jointly by both parents living at different addresses<sup>40</sup>.

### **Missing Information**

- ethnic group
- social class
- religion or belief
- sexual orientation
- transgender; and
- marital status

4.25 Data in relation to mortality rates for the equality strands listed above are not available routinely as it is not recorded on death certificates. Until this information is available an assessment of amenable mortality rates in these groups could be done through detailed investigation of a sample of deaths where the cause was considered 'amenable', if there were reliable estimates of numbers in the relevant populations. Mortality data are available by low level geographical area so deprivation of area where the death occurred can be used as a proxy for socio-economic group.

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<sup>40</sup> Infant and perinatal mortality in England and Wales by social and biological factors, 2008, Office for National Statistics

## **DOMAIN 2 – Enhancing quality of life for people with long-term conditions**

### **SUMMARY OF INDICATORS**

#### **Underlying principles**

- **Treating the individual.** Patients do not see themselves as a condition; they see themselves as people who have one or more long-term condition. It is therefore proposed to take a general view of the needs of and desired outcomes for those with long-term conditions both mental and physical.
- **Functional and episodic outcomes.** The framework should focus on the outcomes that are important to those living with long-term conditions. These relate to the debilitating effect the conditions can have on their lives, such as preventing them from being physically active, working or living independently. The importance of acute episodes that can develop into long-term conditions is also recognised, and that good management of the condition can reduce their frequency and severity.
- **Meeting the needs of all age groups.** People with long-term conditions of different ages have different needs, particularly in relation to functional outcomes that they want to achieve. As such it is proposed to separately identify appropriate functional outcomes for children, adults and older people.

#### **Overarching indicators**

- **2 Health-related quality of life for people with long-term conditions**

#### **Improvement areas**

- **Ensuring people feel supported to manage their condition**  
2.1 Proportion of people feeling supported to manage their condition.
- **Improving functional ability in people with long-term conditions**  
2.2 Employment of people with long-term conditions
- **Reducing time spent in hospital by people with long-term conditions**  
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions  
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
- **Enhancing quality of life for carers**  
2.4 Health-related quality of life for carers
- **Enhancing quality of life for people with mental illness**  
2.5 Employment of people with mental illness

## **Evidence**

### **Overarching indicator**

<b><i>Health - related quality of life for people with long-term conditions</i></b>
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4.26 Data on mean EQ-5D<sup>41</sup> scores for people with a long-standing illness is only available for four of the equality strands - social economic group, ethnicity, age and gender. The data comes from the Health Survey for England (HSE) which is a series of annual surveys designed to measure health and health related behaviours of adults and children, in England. The HSE takes a representative sample of the population in England at different time points, as opposed to following the same individuals over time (i.e. panel data). As the sample composition and size is different every year, comparable time series of the data is unavailable. We will address this by developing a case-mix adjustment method and applying this to the data.

4.27 The EQ-5D is a validated direct measure of health status or health-related quality of life that is used internationally. It asks individuals a set of five questions, and based on the answers to these a score from - 0.594 (poor health) to 1.000 (good health) is calculated.

### **Socio-economic group**

4.28 Respondents in unskilled manual, semi-skilled manual and skilled manual jobs tend to have poorer health states than people in management or professional jobs, an EQ-5D score of 0.66-0.70 versus 0.85-0.88. Figure 11 below shows these scores from the 2008 Health Survey for England for respondents with a long-standing illness and a valid response to the EQ-5D. To note is the small number of observations for some categories (e.g. employers - large establishments) which should be treated with caution when trying to infer a trend in the scores.

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<sup>41</sup> EQ-5D™ is a trademark of the EuroQol Group. Further details can be found on their website: <http://www.euroqol.org>

**For respondents with:**

- \* Health Survey for England 2008
- \* Long-standing illness
- \* Valid EQ-5D score (i.e. completed it)
- \* Valid response to EQ-5D Q3 ('Usual Activities')

Figure 11

Socio-economic	Mean EQ-5D	Observations
employers - large establishments	0.696	3
managers - large establishments	0.813	342
employers - small establishments	0.656	107
managers - small establishments	0.793	248
professional - self-employed	0.853	53
professional - employees	0.883	214
intermediate non-manual ancillary	0.799	1,006
intermediate non-manual foremen	0.782	208
junior non-manual	0.737	1,208
personal service	0.723	454
foremen and supervisors - manual	0.704	249
skilled manual	0.695	526
semi - skilled manual	0.663	718
unskilled manual	0.657	298
own account (other than professional)	0.764	363
farmers - employers and managers	0.818	8
farmers - own account	0.858	9
agricultural	0.713	31
armed forces	0.788	15
inadequately described/not stated	0.508	7

**Ethnicity**

4.29 The mean EQ-5D score for Asian-British respondents with a long-standing illness is 0.66 compared to 0.74 for White-British respondents suggesting that Asian-British respondents are in a poorer health state than White-British respondents (as measured by the EQ-5D). Mixed black and white Caribbean scored 0.76 and Black or Black British – Caribbean scored 0.73. These scores would suggest that these groups have a similar health state level to White-British respondents. However, it is important to note the small number of observations for some categories which should be treated with caution when trying to infer a trend in the scores

Figure 12

Ethnic origin	Mean EQ-5D	Observations
white - british	0.743	5,971
mixed - white and black caribbean	0.758	68
asian or asian british - indian	0.664	216
black or black british - caribbean	0.731	95

## Age

4.30 Older respondents are more likely to have lower EQ-5D health state score than younger respondents, with people aged 16-24 having a score of 0.86 and 75+ years having a score of 0.66.

Figure 13

Age (10 year bands)	Mean EQ-5D	Observations
16-24	0.863	345
25-34	0.833	566
35-44	0.791	837
45-54	0.743	995
55-64	0.728	1,384
65-74	0.709	1,169
75+	0.657	1,057

## Gender

4.31 Men have a slightly lower EQ-5D score than women with a score of 0.77 versus a score of 0.72 respectively.

Figure 14

Sex	Mean EQ-5D	Observations
men	0.765	2,756
women	0.721	3,597

## Disability

4.32 Data on disability is not currently collected on the EQ-5D HSE but some general points need to be taken into account. The publication, Disability equality within healthcare, BMA, 2007, reports that disabled people experience various negative health inequalities compared to those who are not disabled. These health inequalities are demonstrated by a greater risk of certain conditions, an increased likelihood of having major health problems, lower and shorter survival rates after diagnosis and even lower life expectancy rates.

4.33 People with learning difficulties have higher rates of respiratory disease at 19.8% than the remaining population (15.5%).

4.34 People with learning disabilities are more likely to be obese. The rate of obesity in all those with their body mass index (BMI) recorded was 28.3% in people with a learning disability as compared to 20.4% for the remaining population.



### **Missing Information**

- Religion or Belief
- Sexual orientation
- Gender-reassignment
- Marital status (marriage/civil partnership)

4.35 The intended introduction of the EQ-5D and associated case-mix adjustment questions into the GP Patient Survey would allow some of these missing information fields to be collected.

### **Improvement Areas**

#### ***Ensuring people feel supported to manage their conditions***

- Proportion of people feeling supported to manage their condition.

4.36 One of proposed improvement areas for this domain is the 'Percentage of people with long-term conditions feeling supported to manage their condition. This is a question from the GP Patient Survey.

4.37 Previous DH analyses, September 2010, of the care planning questions from the GP Patient Survey (Quarters 3 & 4 2009/10) has found evidence that some demographic groups feel less supported to manage their condition. Lower levels of support are reported by non-white populations, younger patients, patients in poorer health states and patients with psychological or emotional problems.

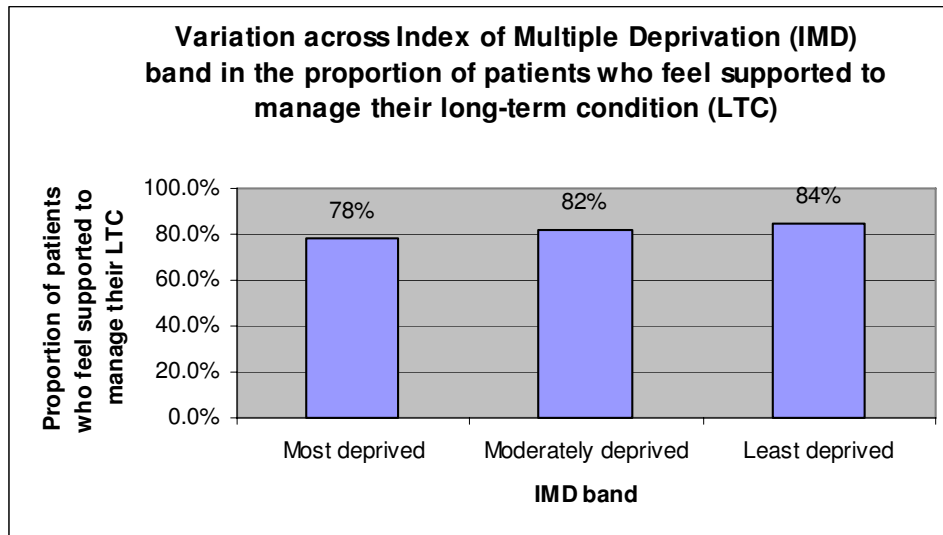
4.38 Although the GP Patient Survey has collected data since 2007, as questions asked have been different between some years, there is no extensive time series available. Trend analysis is only available for the years 2008/09 and 2009/10. As previous DH analysis has not found much variation between years, it has not been included in this analysis.

4.39 Data from the GP Patient Survey have been weighted for the age and gender of respondents. Weighting adjusts the survey data to account for potential age and gender differences between the profile of all eligible patients in a practice and the patients who actually complete a questionnaire. By applying weights, the results for a practice will more accurately reflect the views of the practice population. In order to apply weights, the actual demographic profile of the practice list has to be known; the available data currently contains age and gender of registered patients but does not contain any information about ethnicity.

## Socio-economic Status

4.40 People in the more deprived groups are less likely to feel supported to manage their long-term condition. 78% of people in the most deprived grouping reported feeling supported to manage their condition compared to 84% in the least deprived grouping.

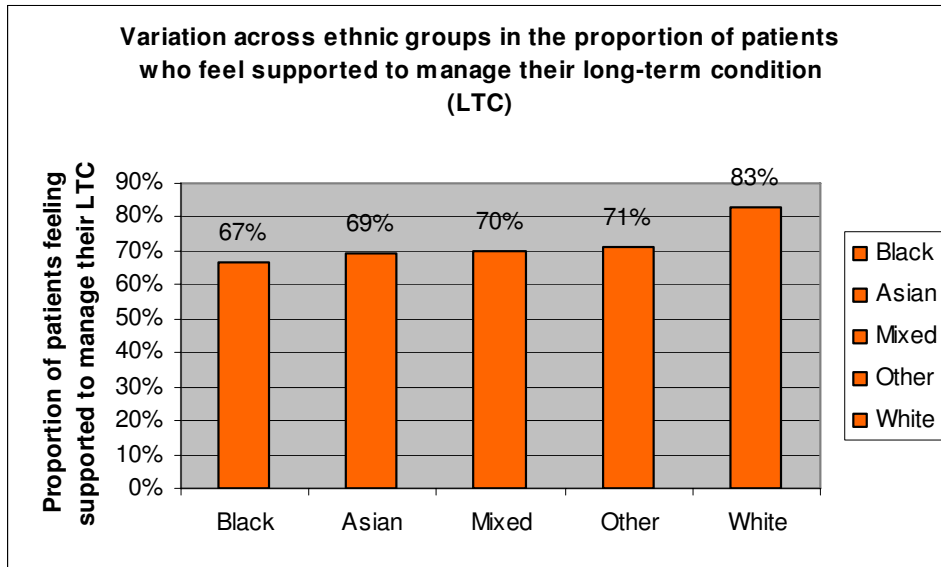
Figure 15



## Ethnicity

4.41 Non-white populations reported lower levels of support, with Black and Black British- caribbean populations reporting the lowest support at 67% and white populations at 83%.

Figure 16



### Age

4.42 Younger patients with long-term conditions reported lower levels of support than older patients with 71% of the 18-24 year olds and 88% of 85and over year olds feeling supported.

### Gender

4.43 There was no significant difference between men and women in how supported they feel to manage their condition.

### Religion or belief

4.44 There is some variation across religion and belief in the proportion of patients who feel supported to mange their condition, with only 67% of Muslims saying they feel supported compared to the highest rate of 83% of Christians.

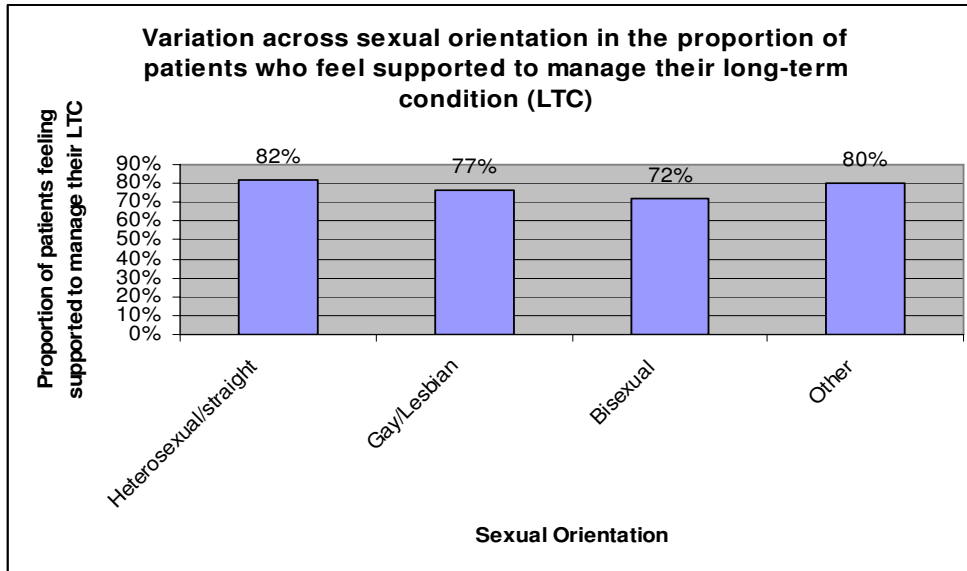
### Disability

4.45 Patients with psychological or emotional problems report the lowest levels of support.

### Sexual orientation

4.46 Gay/Lesbian, Bisexual and Other sexual orientation patients report feeling lower levels of support than Heterosexual/Straight patients.

Figure 17



### Missing Information

- Gender-reassignment
- Marital status (marriage/civil partnership)

### ***Improving functional ability in people with long-term conditions***

- Employment of people with long-term conditions

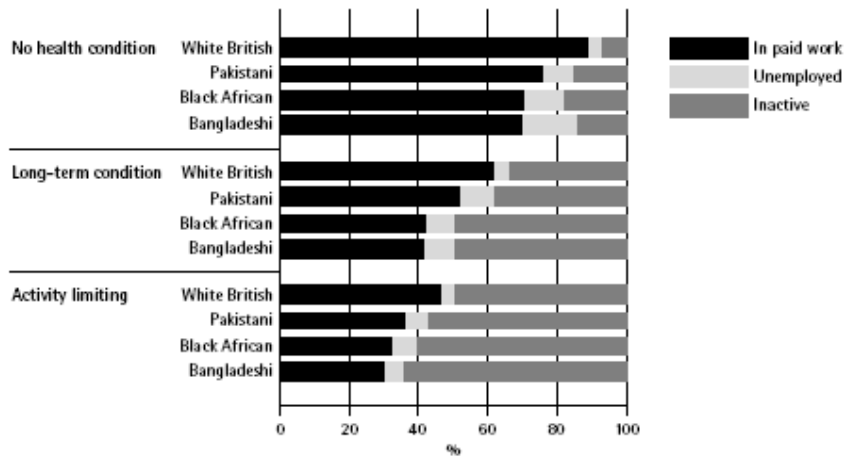
4.47 The above indicator measures the extent to which people with long-term conditions are able to live as normal a life as possible by looking at their levels of employment. It links in well with other Government department policies. The indicator still needs to be developed. The data, while collected through the Labour Force Survey, are not readily available in the appropriate format as this indicator requires ascertaining the number of people with long-term conditions who are in work and comparing it to employment in the general population.

### **Ethnicity**

4.48 A report, *Long-term ill-health, poverty and ethnicity*, by the Joseph Rowntree Foundation, 2007, found that both minority ethnicity and long-term ill health are associated with greatly reduced chances of employment for both men and women.

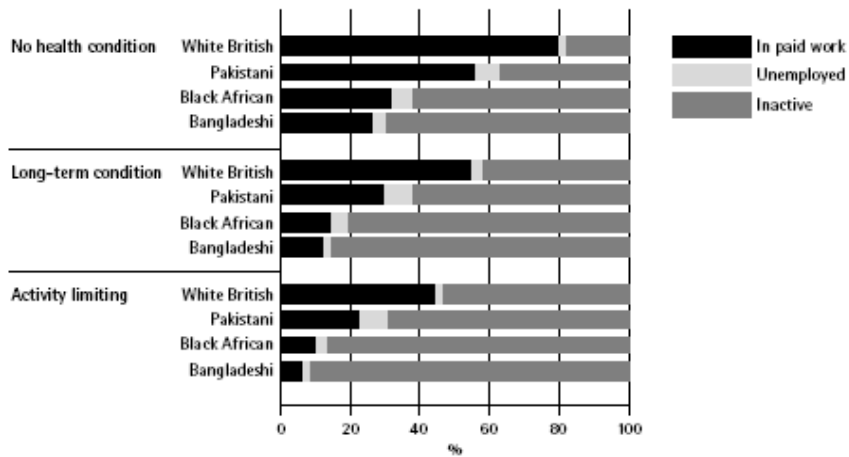
- 4.49 Respondents with long-term conditions expressed a commitment to paid work and appreciation of its benefits, above and beyond income. However, there was variation in the extent to which paid work was seen as a possibility or priority
- 4.50 The effect of long-term ill health in reducing chances of employment was similar across ethnic groups. However, older Bangladeshis and Pakistanis appeared to be more accepting than white English or Ghanaians of their limited prospects of paid work. Younger people and men often found it harder than older people and women to accept alternatives to paid work. Commitment to employment was positive for some, but for others it conflicted with their health needs or undermined other important roles (such as child-rearing).
- 4.51 Rates of employment were substantially lower for those from three ethnic minority groups studied than among comparable White British men and women.
- 4.52 Risks of unemployment were significantly higher for Pakistani and Black African women compared with their White British counterparts.
- 4.53 Respondents reported various barriers to employment: their inability following ill health to return to former types of employment (particularly work that was physically demanding); the demands of hospital appointments and the experience of chronic pain; employers' inflexibility; and for those with mental health conditions, stigma and discrimination.
- 4.54 Pay was also affected both by having an activity-limiting health condition and by ethnicity. Pay deficits were particularly large for working Bangladeshi men. Both Bangladeshi men and White British men (and to a lesser extent, White British women) experienced lower pay if they had a long-term health condition.
- 4.55 Penalties due to ethnicity were found for men and for Pakistani women regardless of health status, and Bangladeshi and Black African women without a long-term health condition were also penalised. However, the highly selected group of Bangladeshi and Black African working women with an activity-limiting condition were not disadvantaged in pay compared with White British women.

Figure 18: Employment, unemployment and economic inactivity by ethnic group and health status: men



Notes: Proportions are adjusted by person weights.  
Source: LFS, pooled quarters, 2002-05

Figure 19: Employment, unemployment and economic inactivity by ethnic group and health status: women



Notes: Proportions are adjusted by person weights.  
Source: LFS, pooled quarters, 2002-05

## Gender

4.56 The *Long-term ill-health, poverty and ethnicity*<sup>42</sup> report also found that the employment rate for women with a long-term condition was slightly lower than for men with a long-term condition.

4.57 Another report, *Health, disability, caring and employment, Longitudinal analysis*<sup>43</sup>, found some notable differences in work activity by gender and that were not specifically linked to health. For example, men were more likely than women to have been working across a two-year period (61 per cent compared with 46 per cent) but men who had an limiting health condition across two years were only slightly more likely to remain active than women. Men were no more likely than women to return to work after a period of having a limiting health condition (six per cent).<sup>44</sup>

## Age

4.58 Older people were more accepting of their limited prospects of paid work. Younger people and men often found it harder than older people and women to accept alternatives to paid work. Commitment to employment was positive for some, but for others it conflicted with their health needs or undermined other important roles (such as child-rearing) (*Long-term ill health, poverty and ethnicity*, 2007).

## Missing information

- Socio-economic status
- Sexual orientation
- Religion
- Disability

### **Reducing time spent in hospital by people with long-term conditions**

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Adults)
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19 year olds.

<sup>42</sup> Joseph Rowntree Foundation, 2007

<sup>43</sup> DWP, 2007

<sup>44</sup> *Health, disability, caring and employment, Longitudinal analysis*, Adele Atkinson, Andrea Finney and Stephen McKay, 2007

- 4.43 The definition of the first indicator is still in development and therefore the exact conditions that this measure will include are not confirmed. There are at least three definitions currently in use that assess aspects of this outcome. The Department of Health aims to develop an indicator that looks at emergency admissions for all long-term conditions where optimum management can be achieved in the community.
- 4.44 Therefore, data are not readily available for this indicator as yet. However, a proxy indicator can be used to illustrate the status of this indicator, as well as the indicator for children with regards to analysing inequalities: emergency admissions usually managed in primary care (published by NCHOD). This indicator only includes asthma and diabetes as long-term conditions. The indicator for the outcomes framework aims to include a broader range of conditions.

### **Ethnicity**

- 4.45 Basic analysis of this data suggests that people from some ethnic minority groups have a higher rate of emergency admissions than people from the White British majority. In 2007, indirectly standardised rate of the number of unplanned admissions for the White British group for was 127.1 compared to 684.1 for any other Black background (highest). The lowest rate was 26.1 for the Chinese group.
- 4.46 Indeed, a recent study by the University of Edinburgh, 2010<sup>45</sup> found that people with asthma from ethnic minority groups are more likely to need hospital treatment than white patients. They found that Asian patients were three times more likely, and black people twice as likely to receive hospital treatment. This looked at 22,350 people from 1981 to 2002. The differences could be due to asthma severity, lack of awareness or poor access to primary health.

### **Age**

- 4.47 People aged over 85 were nearly 10 times more likely to have an emergency admission than someone in their 20s, 30s or 40s. However, at most, 40 per cent of the increased number of emergency admissions can be explained by the effects of population aging (Trends in emergency admissions in England 2004–2009: is greater efficiency breeding inefficiency, Nuffield Trust, 2010). Higher admission rates for older age groups is not surprising as they are the largest users of hospital services.

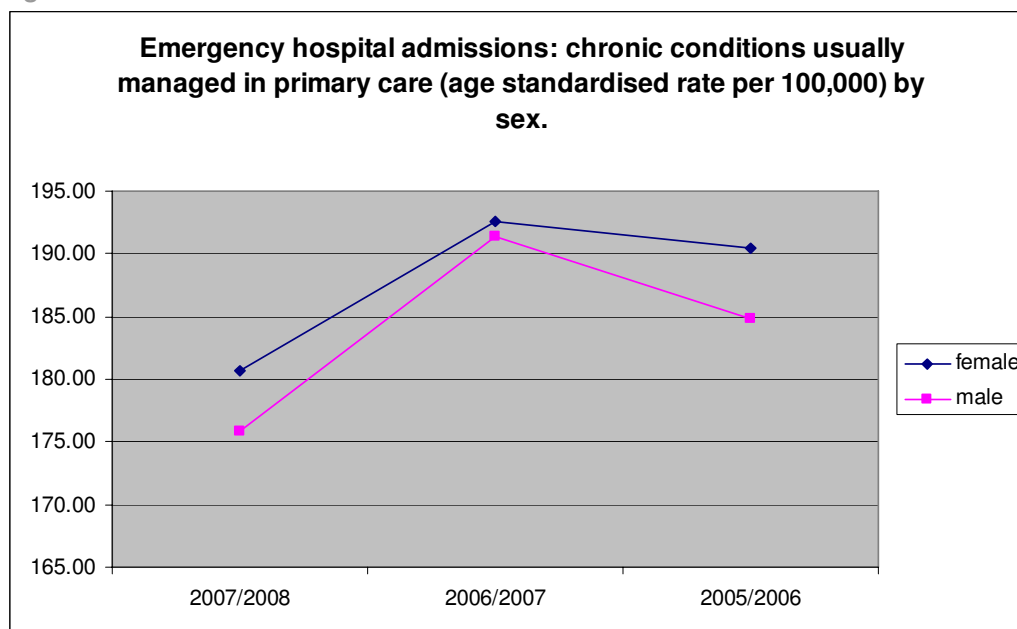
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<sup>45</sup> Netuveli G *et al*, Ethnic variations in the UK asthma frequency, morbidity and health service use: A systematic review and meta analysis. *Lancet* 2005 (365); 312-317



## Gender

Figure 21



4.48 Figure 21 shows the latest years of published data for this indicator, for males and females. The rate was slightly higher for females than for males, for the three years. However, the differences are quite small.

### Missing information

- Socio-economic status
- Sexual orientation
- Marital status
- Disability
- Gender re-assignment

### **Enhancing quality of life for carers**

- Health-related quality of life for carers

4.49 This indicator is under development and is dependent on whether the GPPS continues and includes EQ-5D. There is already a question on caring responsibilities in the survey. This indicator would have to be developed once the data collection is confirmed. As such, there is no data to analyse for this indicator and also there is very little existing information on

inequalities for carers. Therefore there is missing information for all equality strands.

### **Enhancing quality of life for people with mental illness**

- Employment of people with mental illness

4.50 The indicator still needs to be developed. The data while collected through the Labour Force Survey, are not readily available in the appropriate format as the indicator requires ascertaining the number of people with mental illness who are in work and comparing it to employment in the general population.

4.51 Adults with mental health problems are one of the most excluded groups in society. Although many want to work, fewer than a quarter actually do.

4.52 Latest data suggest that people in contact with secondary mental health services have an unacceptably low employment rate, which is the lowest amongst any disability group. Whilst authoritative data is not available, estimates have been made of the employment rate for this group. The NHS Information Centre (IC) estimates that only 3.4% of those on the Care Programme Approach (CPA) are in employment over 16 hours. (The CPA is co-ordinated Health and Social care provision for mental health service users with complex needs. People on the programme are those considered most at risk or who require a higher level of care co-ordination). However, the figure above is likely to be an underestimate due to data issues. Data from the Labour Force Survey estimates the rate of employment for people with mental health conditions excluding depression (a broader definition than that of the IC) at between 10-16%.

4.53 However, estimates suggest that between 86-90% of people with mental health conditions not in employment actually would like to work. Indeed, there is clear evidence that good work is beneficial for a person's well-being and lack of work is detrimental to health and well-being. Re-employment leads to improvement in health and well-being; further unemployment leads to deterioration in health and well-being, (Work, Recovery and Inclusion, Employment support for people in contact with secondary mental health services, HM Government, 2009).

## **Socio-economic status**

4.54 There is no evidence looking at socio-economic status and employment rate amongst users of secondary mental health care services. However, a few general points should be noted. A report produced by MIND (2008) states that poverty can be both a determinant and consequence of mental illness:

- People with a mental health problem are more likely to live on lower than average incomes;
- Over 75% are reliant on welfare benefits;
- 1 in 4 people with a mental health problem also report being in debt compared to 1 in 11 of the general population.
- Unemployment rates could be as high as 75%

## **Deprivation**

4.55 Deprivation can either influence the prevalence of mental illness or impact on its severity, including the likelihood of relapse. The follow up study to 'Psychiatric morbidity among adults living in private households 2010 also found that people who were of lower socio-economic status were less likely to recover from common mental disorder, as were the long term sick and disabled and those who were not employed at the time of both interviews, (Mental Health Needs Assessment for Adults of Working Age, (16 to 64 years of age), Hillingdon PCT, NHS, 2008).

## **Social exclusion and mental health: Current situation and future directions**

4.56 The relationship between social exclusion and mental ill-health is complex: many of the elements of "exclusion" (poor educational levels, unemployment, low income, poor housing, lack of social networks, neighbourhood deprivation) can be both causal factors and consequences of mental ill-health in different circumstances. In addition there are groups of the population that are often regarded as excluded from society.

4.57 An important example is adults aged 16-64 in the general population with common mental disorders. The national surveys of psychiatric morbidity in Britain show that this group, compared with those without mental ill-health, were more likely to be, separated or divorced, to have no formal educational qualifications, to be unemployed, and to rent rather than own their accommodation. However, the most significant differences relate to social participation. Adults with neurotic disorders, compared with other people, were more likely to have small primary support groups, express a severe lack of social support, and participate in fewer leisure activities. The situation is even worse for people diagnosed with significant mental illness;

these are among the most 'excluded' in society. At best 15% of people of working age with long-term mental health problems are working, and joblessness is far lower than in any other group of disabled people. Their lack of social networks is often exacerbated by discrimination and profound loss of social status, (Mental Health Needs Assessment for Adults of Working Age, (16 to 64 years of age), Hillingdon PCT, NHS, 2008).

## **Ethnicity**

- 4.58 The following evidence is from the briefing report, Evening the odds, employment support, mental health and Black and minority ethnic communities, Sainsbury Centre for Mental Health, 2010.
- 4.59 Black and ethnic minority mental health patients are less likely to use employment services and less likely to gain employment than their White counterparts.
- 4.60 Currently 63% of Black and ethnic minority people are in employment compared to 72% of all White people, with research showing that since 2005, rates of employment amongst Black and ethnic minority people remains about 10%, lower than the national average.
- 4.61 The employment rate for Bangladeshi people is about 23% lower than for the White population, with men more likely to be employed than women. There is a similar pattern in the Pakistani population but Indians have a higher rate of employment, currently about 6% lower than White people and a greater proportion of Indian women are in employment.
- 4.62 Most people with mental health problems can and would like to work. However, they face barriers getting and keeping jobs and it seems that ethnic minorities have more difficulty overcoming these barriers. Mental health and employment services need to be able to respond positively to this challenge and offer targeted support where it is needed.
- 4.63 The Sainsbury Centre briefing found that almost two thirds of the people from Black and Black British communities had been employed before using mental health services, with 39% educated to graduate and post graduate level. However, no-one amongst those surveyed was employed at the time the study was being carried out, despite evidence of high educational attainment among Black and Black British groups.

4.64 The paper points out that former mental health patients from Black and Black British communities have the qualifications and will to get paid employment but barriers which range from low expectations of mental health staff, lack of resources, systemic racism and the stigma of mental illness are hindering this.

### **Gender**

4.65 Female mental health service users are more likely to be in paid work than male service users, 26% of women versus 16% of men. (Improving the employment rates of people using secondary mental health services, 2008).

### **Missing information**

- Age.
- Sexual orientation
- Disability
- Religion
- Marital status
- Gender re-assignment

## **DOMAIN 3 – Helping people to recover from episodes of ill health or following injury**

### **Summary of indicators**

#### **Underlying principles**

The high-level aim of this domain can be broken down into two parts:

- preventing conditions from becoming more serious
- helping people to recover from illness or injury

The overarching indicators have been selected to reflect these two aims.

The improvement areas have been selected to cover the causes of ill health or injury that are most important to each age group. In order to identify these causes, the consultation document looked at which led to the greatest number of bed days in children, adults and older people. The results showed that fractures were the largest cause in each age group; bronchiolitis was the second largest cause in children; stroke was the second largest cause in adults and older people. The improvement areas set out below cover the top two causes for each age group, and an additional indicator on helping older people to recover their independence has been included as this was identified as a key issue for this age group.

#### **Overarching indicators**

- **3a Emergency admissions for acute conditions that should not usually require hospital admission**
- **3b Emergency re-admissions with 28 days of discharge from hospital**

#### **Improvement areas**

- **Improving outcomes from planned procedures**  
3.1 Patient Reported Outcomes Measures (PROMs) for elective procedures
- **Preventing lower respiratory tract infections (LRTI) in children from becoming serious**  
3.2 Emergency admissions for children with LTRI
- **Improving recovery from injury and trauma**  
3.3 *An indicator needs to be developed.*
- **Improving recovery from stroke**  
3.4 *An indicator needs to be developed.*
- **Improving recovery from fragility fractures**  
3.5 The proportion of patients recovering to their previous levels of mobility/ walking ability at i 30 days and ii 120 days
- **Helping older people to recover their independence after illness or injury**  
3.6 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services.

## Evidence

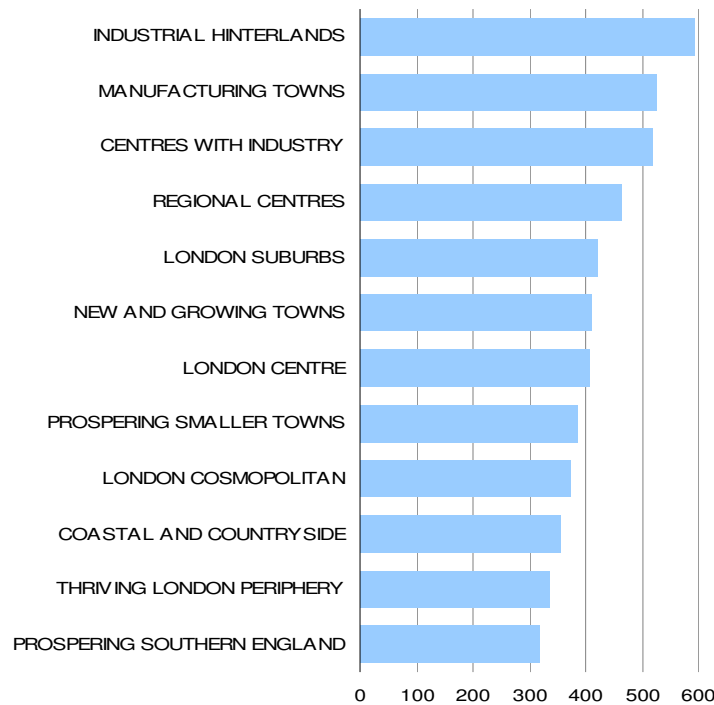
### Overarching Indicators

#### ***Emergency admissions for acute conditions that should not usually require hospital admission***

##### **Socio-economic group**

4.66 Figure 22 shows a breakdown of this indicator by ONS area classification (a breakdown by an explicit deprivation index was not available). This breakdown has been chosen as it is provided by NCHOD, and gives a broad indication of deprivation<sup>46</sup>. While no explicit analysis of deprivation has been undertaken here, it seems from figure 21 that the areas with higher admission rates from these conditions tend to be the more deprived areas.

**Figure 22: Emergency hospital admissions: acute conditions usually managed in primary care (age standardised rate per 100,000 by ONS area classification)**



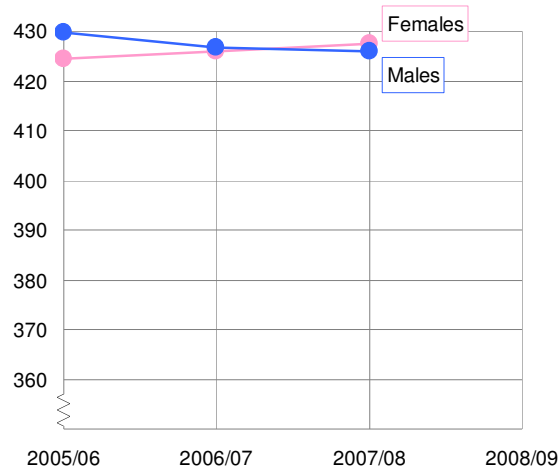
<sup>46</sup> An analysis of a similar classification can be found here: <http://www.statistics.gov.uk/articles/RegionalTrends/RT41-Article6.pdf>. No analysis of this exact classification has been identified.

## Gender

4.67 Figure 23 shows the last years of published data for this indicator, for males and females. While the rate was slightly higher for females than for males, this was only the case for 2007/08. In the preceding years the reverse was true, and the rate appears to be increasing for females while it decreases for males.

4.68 However, the differences are very small. In 2005/06 the rate for males was 1.2% higher than the rate for females; in 2007/08 the rate for females was 0.4% higher. These differences are of the order of 1000 admissions, when the total admissions for these causes are around 200,000.

**Figure 23: Emergency hospital admissions: acute conditions usually managed in primary care (age standardised rate per 100,000) by sex**





## Age and ethnic group

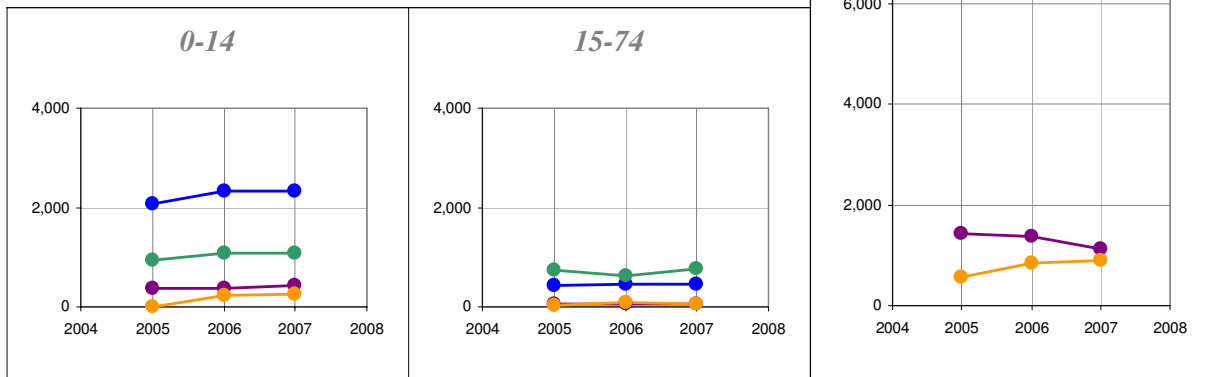
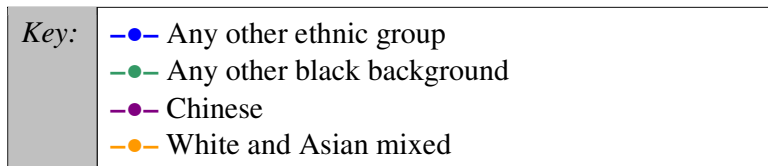
Figure 24 shows how the number of emergency hospital admissions for conditions usually managed in primary care varies between different age and ethnic groups.

The most striking fact is that older people experience far higher numbers of these admissions. This is also unsurprising, as they are the largest users of hospital services. However, there is also much greater variation between the highest and lowest rates for ethnic groups: the highest is nearly 20 times the lowest, compared with less than ten for children and adults.

There is significant variation between ethnic groups. Figure 3 shows two of the highest and two of the lowest for each age group: for children and older people the highest is “other ethnic group” and the lowest “white and Asian mixed”; for adults the highest is “any other black background” and the lowest “chinese”.

As an admissions indicator, this relates primarily to older people; and there is significant inequality between ethnic groups in relation to this indicator.

**Figure 24: Emergency hospital admissions: acute conditions usually managed in primary care (age and sex standardised rate per 100,000) by age and ethnic group**



## Missing Information

No data has been identified for the following areas:

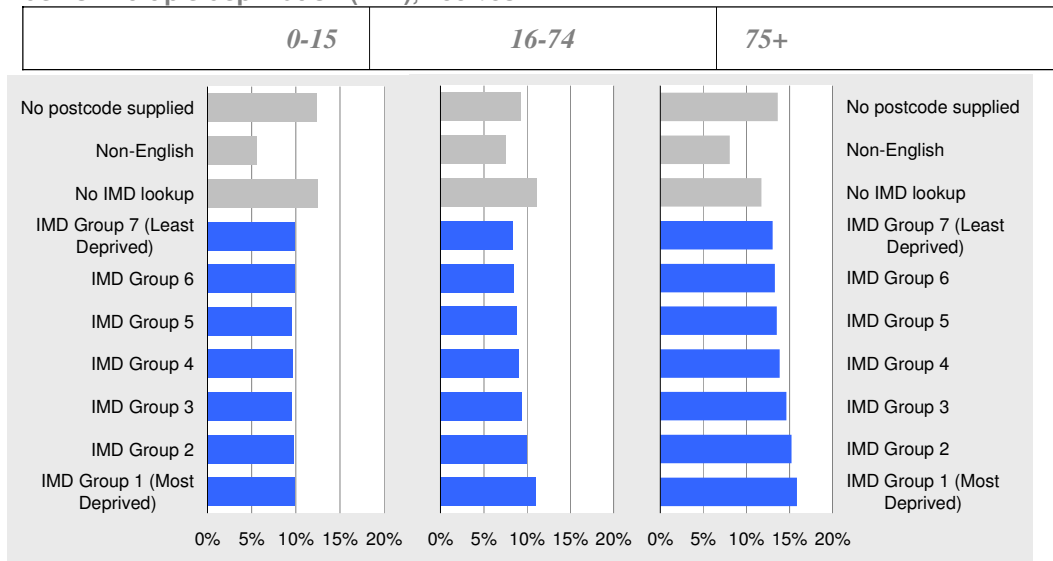
- Religion or Belief
- Sexual orientation
- Gender-reassignment
- Marital status (marriage/civil partnership)

## ***Emergency readmissions within 28 days of discharge from hospital***

### **Socio-economic group**

4.69 Figure 25 gives a breakdown of this indicator by index of multiple deprivation (IMD). For adults and older people there is a clear pattern: greater deprivation is linked with a higher rate of emergency readmissions. However, as with the difference between males and females, this pattern is not seen in children, where emergency readmission rates are the same for all levels of deprivation.

**Figure 25: Emergency readmissions to hospital within 28 days of discharge, by age and index of multiple deprivation (IMD), 2007/08**



### **Age and gender**

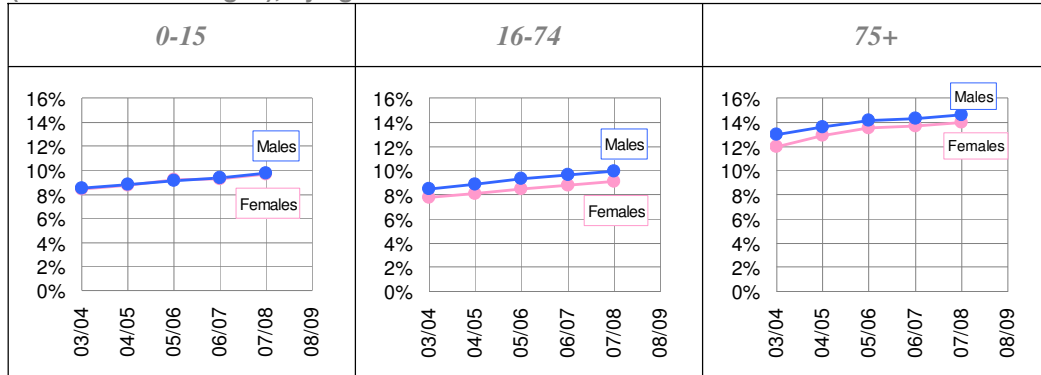
4.94 Figure 26 presents the latest five years' data for this indicator, split by sex and age. For all age groups, for males and females, the number of emergency readmissions is rising.

4.95 Over 75s are significantly more likely to be readmitted in this way than other age groups. As over 75s are also more likely to be in hospital in the first place, they will account for a large proportion of all readmissions.

4.96 In general, males are slightly more likely to be readmitted than females, but there is no difference between the sexes in those aged 0-15.

4.97 To improve its score on this indicator the NHS is likely to have to focus on older people. To avoid others, in particular children, being overlooked, it may be helpful to monitor this indicator separately for different age groups – as set out in figure 4.

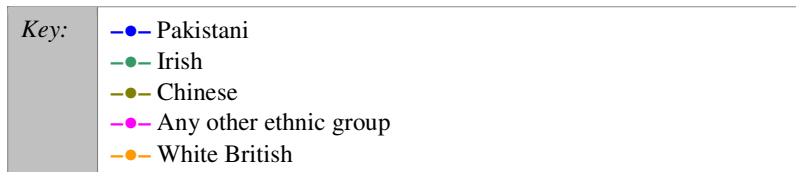
**Figure 26: Emergency readmissions to hospital within 28 days of discharge (as a % of discharges), by age and sex**

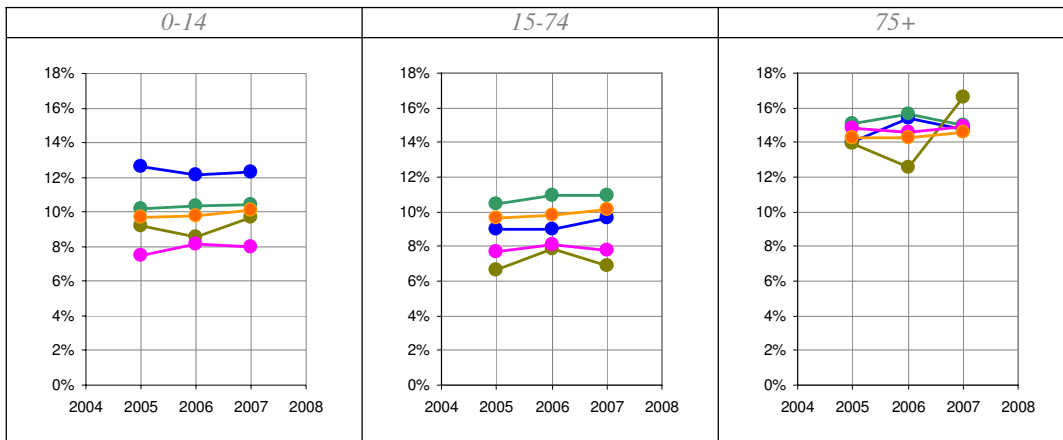


**Ethnic group**

4.98 Figure 27 shows emergency readmission rates for selected ethnic groups, broadly including those with the highest and lowest rates for each age group, as well as the majority group (white British). While there is some variation between ethnic groups, the order is not consistent across different age groups, and no one ethnic group has noticeably high readmission rates for all age groups. This confused picture in part reflects the difficulty in interpreting readmission rates, which has led to the Department deciding to investigate this indicator further before it is used for accountability.

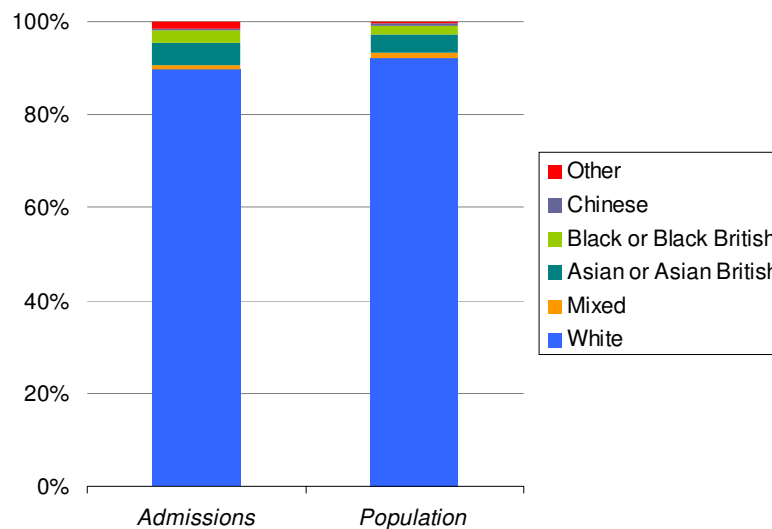
**Figure 27: Emergency readmissions to hospital within 28 days of discharge (as a % of discharges), by age and ethnic group**





4.99 Figure 28 shows the proportion of all hospital admissions attributable to different ethnic groups (this is a complete set of ethnic groups taken at a higher level of aggregation than in previous charts) and compares this with a population breakdown from the 2001 census. It is apparent that minority ethnic groups account for a higher proportion of hospital admissions than they do of the population. An indicator focusing on all hospital admissions (as this one does) will, in broad terms, have a slightly increased focus on minority ethnic groups when compared to a population-level indicator.

**Figure 28: proportion of hospital admissions and total population size by ethnic group**



4.100 There is variation between ethnic groups on this proxy outcome measure, but no ethnic groups are noticeably worse off across all age groups. As such we cannot identify obvious inequality on this measure, which in part reflect the difficulty in its interpretation. Hospital admissions per head are higher among minority ethnic groups, so focusing on an admissions-based indicator may lead to increased focus on the health of these groups.

### **Missing Information**

There is currently no information on the following areas:

- Religion or Belief
- Sexual orientation
- Gender-reassignment
- Marital status (marriage/civil partnership)

## Improvement areas

**All improvement areas and associated indicators are examined together under this domain**

4.101 Figure 29 identifies the age group, gender and race that is most affected (in terms of prevalence and hospital episodes) by the conditions to which the proposed improvement area indicators for this domain relate, and how much more affected this group is. Data was taken from the National Quality Board's (NQB) clinical prioritisation work, which does not include data for all relevant areas.

**Figure 29: prevalence estimates and hospital episodes for clinical areas proposed as improvement areas (from the NQB's clinical prioritisation work; original sources: GPRD and HES)**

	Prevalence (from primary care data)				Hospital Episodes per 100,000					
	Most affected age group vs. overall		Most affected sex vs. overall		Most affected age group vs. overall		Most affected sex vs. overall		Most affected ethnic group vs. overall (excluding unknown and "Other")	
Hip replacement										
Knee replacement										
Hernia	75+	+192%	Male	+34%	75+	+148%	Male	+36%	P-Any other Black background	+130%
Varicose veins	75+	+207%	Female	+34%	55-74	+71%	Female	+25%	C-Any other White background	+34%
Respiratory diseases in children										
Stroke	75+	+509%	Male	+5%	75+	+659%	Female	+3%	P-Any other Black background	+54%
Falls					75+	+588%	Female	+17%	P-Any other Black background	+17%
Hip fractures	75+	+455%	Female	+16%	75+	+929%	Female	+44%	A-British (White)	+12%
Rehab in older people										

## **Race**

- 4.102 The number of the proposed improvement areas focus on conditions that are most common in those whose ethnic group is classified as “any other black background” (hernia, stroke and falls). Ethnic minority groups in general have worse health outcomes, so focusing on these indicators could help to address these equalities issues.
- 4.103 However, some areas do not focus on minority groups, for example hip fractures. The ethnic group that has the highest rate of hospital admissions for hip fracture is “white British”. As these rates are not age standardised and hip fractures are much more common in older people, this result may be caused by demographics. However, it should be noted that focusing on older people does mean focusing on groups with a higher proportion of older people, which tend to be the least disadvantaged (at least in terms of life expectancy).

## **Age**

- 4.104 Most of these conditions are more prevalent in older people. This would be expected, as older people in general have poorer health, but it is essential that the overall set covers the issues that are most important to adults and children as well. Stroke is included, which was identified in the consultation document as one of the key areas for adults, while “respiratory diseases for children” clearly focuses on children – but there is a noticeable bias towards indicators for older people.
- 4.105 The proposed set of improvement areas does serve all ages, but care must be taken to ensure that it does not disproportionately focus on older people.

## **Gender**

- 4.106 The areas where data exists are a mix of those which focus more on men (hernia), those focusing more on women (varicose veins, falls, hip fractures) and those focusing equally on both (stroke).

## **Missing Information**

There is currently no information on the following areas:

- Socio-economic group
- Religion or Belief
- Sexual orientation
- Gender-reassignment
- Marital status (marriage/civil partnership)

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

### **SUMMARY OF INDICATORS**

#### **Underlying principles**

- **to reflect the experience of patients** . For over a decade it has been seen as important to collect information on the experiences of patients and to act on any shortcoming identified. The patient experience survey programme is robust and reproducible questionnaire based methodology to gauge the quality of care in a range of setting. The survey results can be used locally to identify particular areas which may need management action and nationally to gauge the overall change in patient assessments of care they have received.

#### **Overarching indicators**

- **4a Patient experience of primary care**
- **4b Patient experience of hospital care**

#### **Improvement areas**

- **Improving people's experience of outpatient services**  
4.1 Patient experience of outpatient services
- **Improving hospitals' responsiveness to personal needs**  
4.2 Responsiveness to in-patients' personal needs
- **Improving people's experience of accident and emergency services**  
4.3 Patient experience of A&E services
- **Improving access to primary care services**  
4.4 Access to i) GP services and ii) dental services
- **Improving women and their families' experience of maternity services**  
4.5 Women's experience of maternity services
- **Improving the experience of care for people at the end of their life**  
4.6 Survey of bereaved carers
- **Improving experience of healthcare for people with mental health illness**  
4.7 Patient experience of community mental health services
- **Improving children and young people's experience of healthcare**  
4.8 *An indicator needs to be developed*



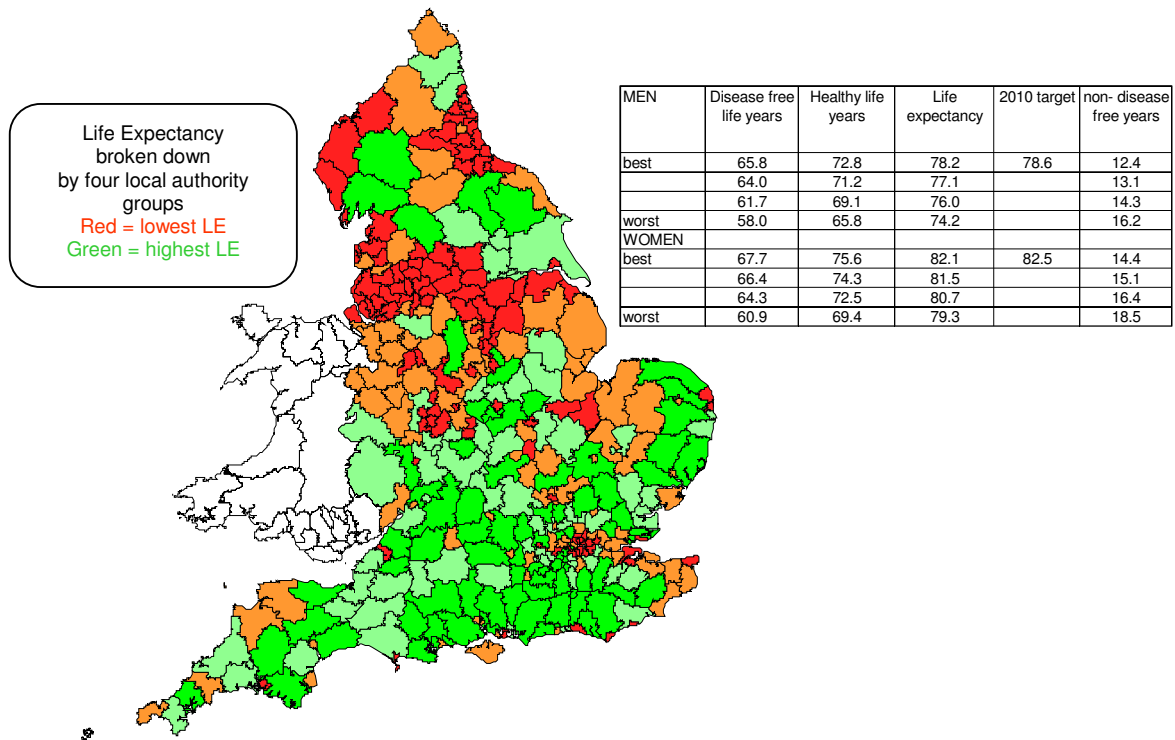
## Evidence

All indicators (overarching and for each improvement area) are examined together under this domain

### Socio-economic group

4.107 Despite the many advances in healthcare and the resultant improvement in average life expectancy the variation of how long we live is not dissimilar to the pattern first observed in the Victorian era. Poor life expectancy shows a distinct north south divide and tends to be focused on the old manufacturing regions. The traditional classification of socio-economic group of a family by the work done by the male head of the household tends to be less useful with modern family configurations and most people living for many years in retirement.

Figure 30: Local authorities grouped by average life expectancy<sup>47</sup>



<sup>47</sup> <http://www.statistics.gov.uk/life-expectancy/default.asp>; National Statistics Online - Product

4.108 The economic association with health inequalities has recently confirmed by the Marmot review<sup>48</sup>. Poor economic achievement is linked to low educational attainment, including limited literacy and communications skills. This may lead to the possibility of sampling bias in the patient experience surveys where those who might benefit the most from an improved patient experience might be the least able to communicate their needs.

4.109 However in the GP survey people who live in areas of higher multiple deprivation are less likely to feel supported to manage their Long-Term Condition. 78% of people in the most deprived area reported feeling supported to manage their condition compared to 84% in the least deprived areas. This result is in line with what we would expect and suggests that if there is a sampling bias due to communication skills then this may reduce the magnitude of the measure but in this case does not make the result invalid.

### Race

4.110 The in-patient survey sampled the 4.5 million patients aged 16+ who spend at least one night in hospital but excludes maternity and mental health specialties.

4.111 The age / sex / ethnicity of this group of patients are as follows as a percentage of all patients included in the in-patient survey.

Figure 31: Source HES 2008/09 – DH analysis

	Female						Male					
	White	mixed	Asian or Asian British	Black or Black British	Chinese	other	White	mixed	Asian or Asian British	Black or Black British	Chinese	other
16-44	22.3%	0.4%	2.5%	1.6%	0.2%	0.8%	9.1%	0.1%	0.8%	0.4%	0.0%	0.3%
45-64	10.3%	0.1%	0.5%	0.3%	0.0%	0.2%	10.4%	0.1%	0.5%	0.2%	0.0%	0.2%
65-84	14.1%	0.0%	0.4%	0.2%	0.0%	0.1%	13.5%	0.0%	0.5%	0.2%	0.0%	0.1%
85+	6.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total 16+	<b>52.8%</b>	<b>0.5%</b>	<b>3.5%</b>	<b>2.2%</b>	<b>0.2%</b>	<b>1.1%</b>	<b>36.0%</b>	<b>0.2%</b>	<b>1.8%</b>	<b>0.9%</b>	<b>0.1%</b>	<b>0.7%</b>

<sup>48</sup> <http://www.marmotreview.org/>

4.112 The higher female ratio of hospital usage is concentrated in the 16-44 and 85+ age bands. There seems to be very little difference between the ages 45-84. The higher hospital used between 16-44 may be explained through gynaecological procedures whereas the higher rate at 85+ will reflect the longer life expectancy of women compared to men.

4.113 Looking at the ethnicity percentage breakdown in the in-patient survey compared to the general UK population estimates from the 2001 census we find the following values:

Figure 32: Source HES 2008/09 – DH analysis

	White	Mixed	Asian or Asian British	Black or Black British	Chinese	all other
in-patients 16+ 2008/09	88.8%	0.8%	5.3%	3.1%	0.3%	1.7%
UK population 2001	92.0%	0.4%	4.0%	2.0%	0.4%	0.4%

4.114 The Department of Health published ‘Report on the self reported experience of patients from black and minority ethnic groups’ in June 2009<sup>49</sup>. This included analysis based on 2008/09 inpatient, 2008/09 emergency department, 2007/08 primary care services and 2007/08 community mental health surveys.

4.115 Results show a range of variations between black and minority ethnic (BME) groups compared to white british respondents. Where differences were found, most were negative, indicating that BME groups are less likely to report a positive experience. However many areas showed no difference with some showing a positive difference.

4.116 BME groups tended to be less positive about questions relating to ‘access and waiting’ or to ‘better information more choice’.

<sup>49</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH\\_100467](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_100467)

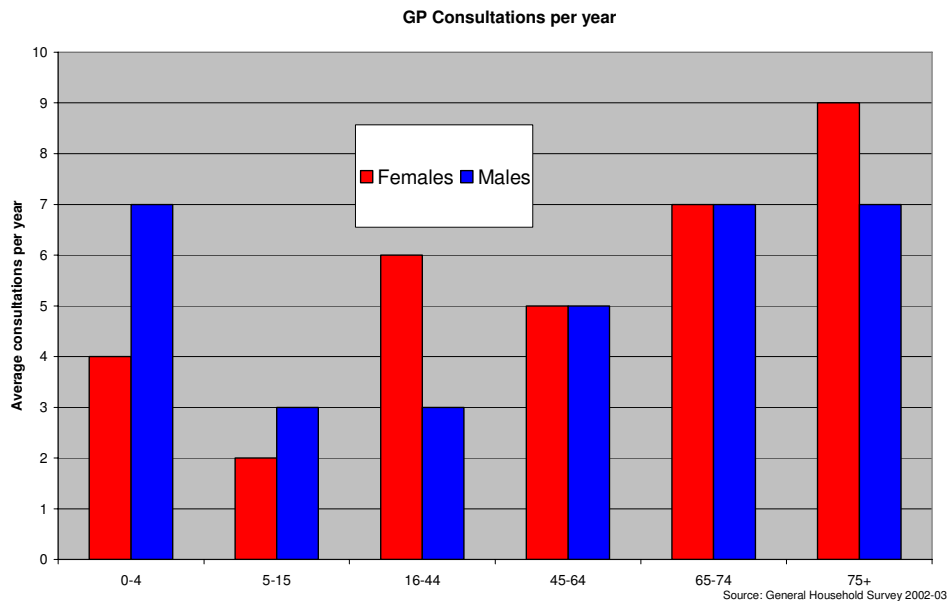
4.117 The earlier Healthcare Commission analysis also found that patients from black and minority ethnic groups were more likely to report negative experiences than white patients. In particular, patients from minority ethnic groups were more likely than white patients to report that doctors and nurses talked in front of them as if they were not there and that they were not as involved in decisions about their care and treatment as they would have liked.

4.118 As illustrated in figure 15, non-white populations with long term conditions reported lower levels of support in the GP survey, with Black and Black British-caribbean populations reporting the lowest support at 67% and white populations at 83%.

### Age

4.119 Many risk factors for poor health, such as obesity, hypertension, disability and poverty increase with age:

Figure 33: Average number of GP consultations per year by sex and age



- 4.120 The prevalence of most acute and chronic diseases increases with age including cancer, cardiovascular disease, diabetes, suicide, and dementia. Older people also often suffer co-morbidities. The proportion of people with a long-term illness or disability that restricts their daily activities increases with age. About 3.5 million people aged 65+ have a limiting longstanding illness or disability.
- 4.121 This reflects the fact that 36 per cent of people aged 65 used hospital services in the last year, compared to 23 per cent of adults aged under 65. Despite this, there were still significantly more people aged under 65 being referred to hospital care (6.7 million people aged 16-64 versus 2.6 million aged 65+).
- 4.122 And when older people used care, they did so more intensely – despite people aged 65+ accounting for 16 per cent of the population, they used 27 per cent of all outpatient first attendances, 36 per cent of all inpatient episodes and 64 per cent of all emergency bed days.
- 4.123 Younger patients with long-term conditions reported lower levels of support in the GP survey compared to older patients with 71% of the 18-24 year olds and 88% of 85and over year olds feeling supported.
- 4.124 In the in-patient survey older patients were consistently more likely to report positive experiences of health services than younger patients. For example, patients who were older were more likely to say that they were listened to, were treated with respect and dignity, had enough time to discuss their condition and treatment and had a say in decisions about their care.
- 4.125 The Office of the Deputy Prime Minister's Social Exclusion Report '*A Sure Start to Later Life: Ending Inequalities for Older People*' highlighted that ethnic minorities (across all ages) are more likely to be in poor general health, particularly those from Pakistani and Bangladeshi communities. The report also stated the Policy Research Institute on Ageing and Ethnicity has commented that 'Black and minority elders do not enjoy the same quality of life of their peers, continue to have many unmet needs, from care to quality of life issues, which reduce their potential for participation...'

4.126 Risk factors and disease patterns vary between ethnic groups, for example:

- South Asians, particularly Bangladeshis and Pakistanis, have significantly higher CHD prevalence and mortality than the general population.
- Although people of Black and Black British origin have a low prevalence of CHD compared with the white population, they have much higher prevalence of and mortality from hypertension and stroke.

4.127 South Asians (particularly Pakistanis and Bangladeshis) and people of Black and Black British origin have a 3-6 fold higher prevalence of Type 2 diabetes. The quality of care is reportedly inadequate for Asian and Black and Black British patients, with poor compliance caused by inadequate information leading to patients' lack of knowledge about disease management.

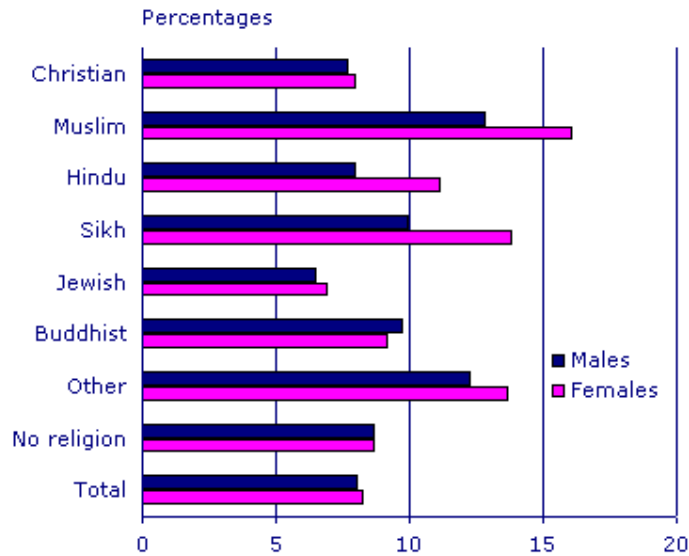
4.128 The GP registered population sampling system used by the GP survey will not over sample those with higher usage of primary care due to higher than average usage. However those who are infrequent visitors to their GP and other primary medical services may be under sampled.

### **Gender**

4.129 In general gender does not appear to be a significant factor in determining the experiences of patients in the NHS. Women responded more positively than men to some questions; the reverse was also true.

## Religion or Belief

Figure 34: Age standardised 'not good' health rates: by religion and sex, April 2001, GB<sup>50</sup>

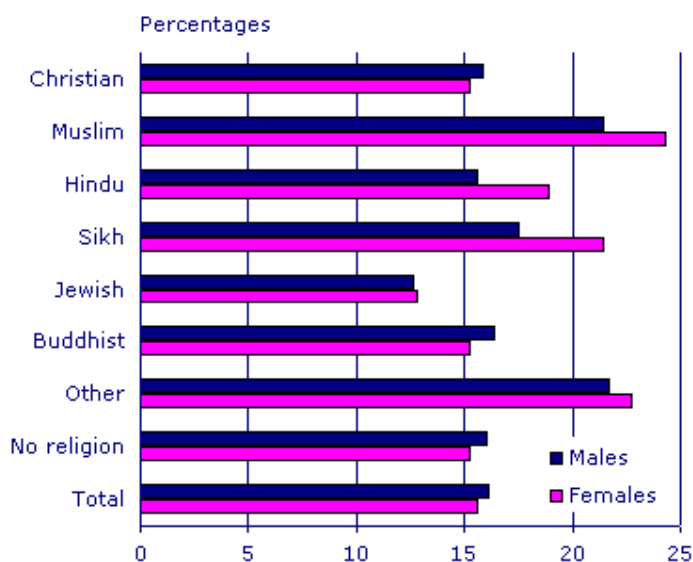


4.130 If the different age structures of the religious groups are not taken into account, Christian and Jewish groups have the highest proportion of people saying their health was “not good”. This is a direct result of the older age profiles within each group.

4.131 Muslim males and females in Great Britain had the highest rates of reported ill health in 2001 once age is standardised.

<sup>50</sup> <http://www.statistics.gov.uk/cci/nugget.asp?id=959>

Figure 35: Age standardised limiting long-term illness or disability rates: by religion and sex, April 2001, GB



4.132 In 2001 the highest overall rates of disability were found among Christian and Jewish groups. However, once age was taken into account, Jewish people had the lowest rates of disability (13 per cent for both males and females). Christians had the second lowest age-standardised rates, at 16 per cent for males and 15 per cent for females respectively.

4.133 After taking account of the different age structures of the groups, Muslims had the highest rates of disability. Almost a quarter of Muslim females (24 per cent) had a disability, as did one in five (21 per cent) Muslim males.

4.134 In the GP survey There is some variation across religion and belief in the proportion of patients who feel supported to manage their condition, with only 67% of Muslims saying they feel supported compared to the highest rate of 83% of Christians.

### Disability

4.135 Patients with a disability are more likely to respond negatively than those without a disability in the hospital based surveys.

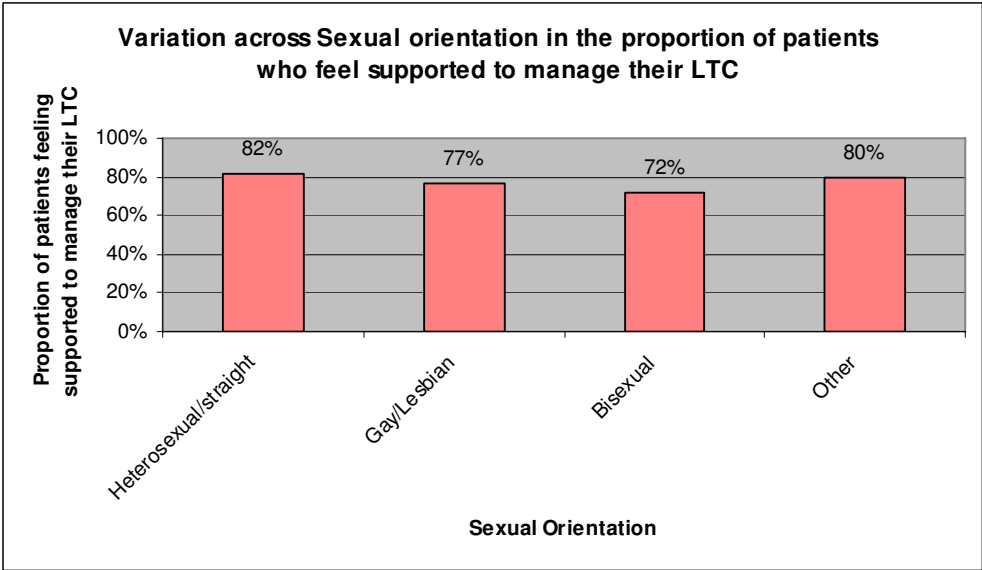
4.136 In the GP survey patients with psychological or emotional problems report the lowest levels of support.



**Sexual orientation**

4.137 In the GP survey Gay/Lesbian, Bisexual and Other sexual orientation patients report feeling lower levels of support than Heterosexual/Straight patients.

Figure 36



**Missing Information**

- Gender-reassignment
- Marital status (marriage/civil partnership)

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

### **SUMMARY OF INDICATORS**

#### **Underlying principles**

- **Protecting people from further harm.** Patients understand the risk of their condition as well as the risks associated with particular treatments and procedures. But, they rightly expect the NHS to provide them with care when they need it, without causing or contributing to additional unacceptable harm or injury in the process
- **An open and honest culture** NHS staff should be empowered to expose failings in care. A culture that promotes reporting of safety incidents will allow an organisation to increase the likelihood of reducing the number of harmful incidents by giving it a richer understanding of how to deliver safe care.
- **Learning from mistakes** – Reporting harmful incidents will not by itself prevent further similar incidents happening. Organisations must be able to learn from incident reports and make tangible changes that improve safety and the public's confidence in the organisation.

#### **Overarching indicators**

##### **Three part patient safety measure consisting of:**

- **5a Patient safety incident reporting**
- **5b Severity of harm; and**
- **5c Number of similar incidents**

#### **Improvement areas**

- **Reducing the incidence of avoidable harm**
  - 5.1 Incidence of hospital-related venous thromboembolism (VTE)
  - 5.2 Incidence of health care associated infection
    - i) MRSA,
    - ii) *C. difficile*
  - 5.3 Incidence of newly-acquired category 3 and 4 pressure ulcers
  - 5.4 Incidence of medication errors causing serious harm
- **Improving the safety of maternity services**
  - 5.5 Admission of full-term babies to neonatal care
- **Delivering safe care to children in acute settings**
  - 5.6 Incidence of harm due to 'failure to monitor'

## **Evidence**

**All indicators (overarching and for each improvement area) are examined together under this domain**

### **Race/ Ethnicity**

- 4.138 There is conflicting evidence on the link between safety and ethnicity. Some research suggests that as a whole, the likelihood of experiencing a patient safety incident does not consistently vary with ethnic background (Shimada et al, 2008<sup>51</sup>). Counter-evidence suggesting there may be a link exists (Coffey et al, 2005<sup>52</sup>), but relates to evidence about healthcare access in the US health system, rather than in the state-funded NHS.

### **Socio-economic group**

- 4.139 The evidence of the impact on socio-economic groups on the rate of errors in healthcare is similar in many ways to that on ethnicity. Research suggests for some types of error, people on lower incomes are at greater risk, but conversely for some error types lower income groups may be at lower risk (Coffey et al, 2005). The research relates to the US healthcare system and it is debatable whether the same issues apply in the state-funded NHS.

### **Disability**

#### ***Learning disabilities and mental health***

- 4.140 It is suggested that other vulnerable groups also carry a disproportionate risk of being harmed because of an inability to understand what treatment is being provided to them (e.g. the very young, those with learning disabilities or mental health problems (NPSA, 2004<sup>53</sup>)), or because of being physically physical vulnerable (people with physical disabilities or those who are about to give birth).

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<sup>51</sup> Shimada SL, Montez-Rath ME, Loveland SA, Zhao S, Kressin NR, Rosen AK, 2008, *Racial disparities in patient safety indicator (PSI) rates in the Veterans Health Administration* Advances in Patient Safety: New Directions and Alternative Approaches (Vol.1: Assessment)  
[http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=aps2v1&part=advances-shimada\\_65](http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=aps2v1&part=advances-shimada_65)

<sup>52</sup> Coffey RM, Andrews RM, Moy E, 2005, *Racial, Ethnic and Socioeconomic Disparities in Estimates of AHRQ Patient Safety Indicators*, Medical Care:43(3) – pp I-48 – I-57

<sup>53</sup> National Patient Safety Agency, 2004, *Understanding the patient safety issues for people with learning disabilities*

4.141 Such issues were brought into sharp focus following a number of fatal cases among people with learning disabilities as highlighted in a 2007 Mencap report.<sup>54</sup> In an earlier 2004 report, the National Patient Safety Agency (NPSA) had highlighted the following risks as priorities for addressing:

- *Inappropriate use of physical intervention*
- *Vulnerability in general hospitals (possibly leading to harm)* – approximately 26% of people with learning disability/difficulty are admitted to general hospitals every year compared to 14% of the general population
- *Swallowing difficulties* – which if not appropriately addressed can be life threatening for people with learning disability/difficulty, leading to poor nutritional status, dehydration and aspiration leading to chest infections. Respiratory disease was “a leading cause of death in 52% of adults with learning disability compared with 15% of males and 17% of females in the general population.”
- *Lack of accessible information* – which can lead to harm if a person with a learning disability cannot understand their illness and relevant treatments
- *Illness or disease being mis- or un-diagnose*

4.142 As outlined earlier, the patient safety outcomes measures suggested for the NHS Outcomes Framework should lead to safer services for all patients by improving the culture of addressing safety in the NHS; the equality issues highlighted may mean that there is scope for some equalities groups to benefit more than others.

### **Age**

4.143 Older people are particularly vulnerable anyway because they often have co-morbidities; they are physically frailer; their treatment usually depends on the taking of medications (often several); and their personal autonomy can be severely reduced in an unfamiliar setting (particularly a care home setting). Loss of confidence and autonomy could mean that older people are less able to identify the things they can do to mitigate harm being caused to them; they may also have difficulty understanding risks when healthcare staff communicate them.

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<sup>54</sup> Mencap, 2007, *Death by indifference*

## **Gender**

4.144 There is no evidence to suggest any unequal impact of tackling patient safety on people of different gender

## **Religion or Belief**

4.145 There is relatively little data relating to religion/belief and no evidence to suggest any unequal impact of tackling patient safety on people of different religions/beliefs.

## **Sexual orientation**

4.146 There is relatively little data relating to sexual orientation and no evidence to suggest any unequal impact of tackling patient safety on people of different sexual orientation.

## **Gender-reassignment**

4.147 There is little data relating to gender-reassignment and no evidence to suggest any unequal impact of tackling patient safety on people of different sexual orientation.

## **Marital status (marriage/civil partnership)**

4.148 There is no evidence to suggest any unequal impact of tackling patient safety on people of different marital status.

## **Missing Information**

4.149 As highlighted earlier, there are a number of equality strands where data is relatively light, notably on the following:

- religion/belief
- sexual orientation
- gender-reassignment
- marital status (marriage/civil partnership)

## Annex - NHS Outcomes Framework – consultation and engagements events grid

Date	Event
21 July	Presentation at the Third Sector Sounding Board
26 July	Ministerial visit and engagement event -NHS East Midlands SHA
26 July	Ministerial visit and engagement event - NHS South Central SHA
26 July	Presentation at the National Stakeholder Forum
29 July	Presentation at the SHA Directors of Finance
03 August	Presentation at Transforming Community Service - Service User Advisory Group
03 August	Presentation at Respiratory Disease Stakeholder Group
31 August	Amenable mortality workshop with analytical experts
01 September	Ministerial visit and engagement event - NHS London SHA
01 September	Ministerial visit and engagement event - NHS South East Coast
01 September	Physiological Measurement Stakeholder meeting
02 September	Ministerial visit and engagement event - NHS Yorkshire and Humber
02 September	SHA Medical Directors meeting
07 September	Regional Voices workshop - North West
07 September	Presentation at Foundation Trust Clinical leads
07 September	Presentation and workshop - Professional Bodies Quality meeting
08 September	Regional Voices workshop –South East
08 September	Workshop at NHS Confederation White Paper event
09 September	Ministerial visit and engagement event - NHS South West SHA
09 September	Regional Voices workshop - West Midlands
09 September	Diabetes Stakeholder meeting
10 September	Regional Voices workshop - London
13 September	Ministerial visit and engagement event - NHS East of England SHA
13 September	Ministerial visit and engagement event - NHS West Midlands SHA
14 September	Regional Voices workshop – South West
14 September	National Clinical Audit leads
15 September	Ministerial visit and engagement event - NHS North East
15 September	Healthcare Science Professional Bodies meeting
16 September	SHA Directors of performance
17 September	Ministerial visit and engagement event - North West
20 September	Regional Voices workshop- Yorkshire & Humber
22 September	Regional Voices workshop - North east
22 September	Neurological Stakeholders meeting
22 September	CNO Business meeting (London)
23 September	Regional Voices workshop - East Midlands
23 September	CNO Business meeting (Leeds)
23 September	DH Board meeting
24 September	Regional Voices workshop - South Central
28 September	SHA Quality Leads meeting
30 September	Equalities White Paper Engagement event
30 September	Respiratory Outcomes meeting
04 October	Vascular programme Voluntary Sector Stakeholders event
05 October	SHA Senior Lead Scientist event