hscic Health & Social Care Information Centre

NHS Outcomes Framework

England, May 2016: Quarterly Publication

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This product may be of interest to members of the public, provider managers, commissioning managers, clinicians and patients to support the understanding of health-related outcomes at local level and across the health and care system.

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This is a National Statistics publication

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods; and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

Find out more about the Code of Practice for Official Statistics at https://www.statisticsauthority.gov.uk/monitoring-and-assessment/code-of-practice/

Executive Summary

This quarterly report provides information about the NHS Outcomes Framework (NHS OF) indicators which have been updated in the May 2016 release. Full details of the new time periods and breakdowns available for each indicator can be found in the appendix at the end of this report.

The NHS OF is a set of indicators developed by the Department of Health to measure the health outcomes and health inequalities of adults and children in England. The indicators:

- Provide a national overview of how well the NHS is performing
- Provide an accountability mechanism between the Secretary of State for Health and NHS England
- Improve quality throughout the NHS by encouraging a change in culture and behaviour focused on health outcomes not process

The framework does not set out how outcomes should be delivered, it is for NHS England to determine how best to deliver improvements.

The data used to calculate NHS OF indicators come from a variety of sources such as the Office for National Statistics (ONS) and the Department for Communities and Local Government (DCLG). When new source data become available, the indicators are updated and published by the Health and Social Care Information Centre (HSCIC) in quarterly releases. Each release includes a commentary report and revised data files for indicators with new source data.

Data files for all indicators in the NHS OF can be found on our Indicator Portal at the link below. The files include national indicator values and other relevant disaggregations such as age and local authorities. The files contain both the latest data and historical data for time series analysis. The Indicator Portal also includes data quality statements and detailed background information for each of the indicators. All documents can be accessed from the bottom left of the portal website under *NHS Outcomes Framework* by selecting the domain and indicator of interest.

HSCIC Indicator Portal: https://indicators.hscic.gov.uk

A dashboard of all the latest indicator values, a schedule of future updates to NHS OF indicators and further information about the framework can be found using the above link and selecting the *NHS OF summary dashboard and useful links* page from the left hand side.

Queries and feedback about this publication

The Health and Social Care Information Centre welcomes all queries and feedback relating to any aspect of this publication. If you have any queries or feedback, please let us know using the following contact details.

HSCIC website: http://www.hscic.gov.uk/haveyoursay
Email: enquiries@hscic.gov.uk
Telephone: 0300 303 5678
Twitter: @hscic

Updates in this release

The May 2016 release includes one new indicator, new data points for eight indicators and some presentational changes.

The following indicator is being published for the first time:

- 2.7 Health-related quality of life for people with three or more long-term conditions

The indicators with new data points are listed below:

- 1c Neonatal mortality and stillbirths (formerly indicator 1.6.ii)
- 1.4.i One-year survival from all cancers
- 1.4.ii Five-year survival from all cancers
- 1.6.i Infant mortality
- 2.2 Employment of people with long-term conditions
- 2.5.i Employment of people with mental illness (formerly indicator 2.5)
- 4.6 Bereaved carers' views on the quality of care in the last 3 months of life
- 5.6 Patient safety incidents reported (formerly indicators 5a, 5b and 5.4)

There are three data files with presentational changes. The deprivation quintile labels have been re-ordered for the following indicators to align them with the rest of the framework. Quintile 1 is now the most deprived rather than the least deprived:

- 3.5.i Hip fracture: Proportion of patients recovering to their previous levels of mobility / walking ability at 30 days
- 3.5.ii Hip fracture: Proportion of patients recovering to their previous levels of mobility / walking ability at 120 days

A new column has been added to the below data file to show the names as well as the codes for the provider breakdown:

- 4.1 Patient experience of outpatient services

Where possible, historic deprivation data in the NHS OF indicators will be revised using the latest Index of Multiple Deprivation (IMD) published in 2015. This will be done in stages at the same time as new data points are released. Deprivation data has been re-stated for the below indicators in this release. The scale of the changes is discussed in the *IMD 2015 Updates* section of the *Introduction* chapter.

- 1c Neonatal mortality and stillbirths (formerly indicator 1.6.ii)
- 1.6.i Infant mortality

Key findings

The following table provides a summary of the NHS OF indicators with new national data points in this release.

Figure 1: Key Findings

Indicator title	Latest data available	Indicator value	Unit	Change over latest time period	Change over last five years	Latest findings
1c Neonatal mortality and stillbirths	2014	7.1	per 1,000 births	Not Tested - Improved	Not Tested - Improved	Values generally improving over time, value reduced from 9.4 in 2003.
1.4.i One-year survival from all cancers	2014	70.2	%	Not Tested - Similar	Not Tested - Improved	Very small increases each year, from 59.2 per cent in 1996. Yearly rate of increase has grown over time.
1.4.ii Five-year survival from all cancers	2014	49.6	%	Not Tested - Similar	Not Tested - Improved	Similar trends to one-year cancer survival. Very small increases each year, from 41.4 per cent in 1996 and yearly rate of increase has grown over time.
1.6.i Infant mortality	2014	3.6	per 1,000 live births	Not Tested - Improved	Not Tested - Improved	Rate improving gradually over time, has decreased from 5.7 in 1999.
2.2 Employment of people with long-term conditions	Oct-Dec 15	13.8	% gap	Not Tested - Improved	Not Tested - Deteriorated	The gap decreased between 2007 and 2010 but has increased since then. Lowest value was 11.2 in Q1 2010.
2.5.i Employment of people with mental illness	Oct-Dec 15	34.7	% gap	Not Tested - Improved	Not Tested - Improved	The gap has been generally decreasing since Q2 2011 when the indicator was at 43.1 per cent.
2.7 Health-related quality of life for people with three or more long-term conditions	Jul14-Mar15	0.470	mean EQ-5D score	Not Tested - Similar	No data	Small improvement between 11/12 and 12/13 but mean score has remained similar since then.
4.6 Bereaved carers' views on the quality of care in the last 3 months of life	2015	74.9	% scoring outstanding, excellent or good	Not Tested - Similar	Not Tested - Similar	Little change over the five year time series, indicator value was 76.0 in 2010/11.
5.6 Patient safety incidents reported	Oct-Dec 15	863.4	per 100,000 population	Interpret With Caution	Interpret With Caution	Overall, indicator has been increasing over the 11-year time series. This should be interpreted with caution; it could mean more incidents are being reported rather than more are occurring.

Further information about the change categories can be found in the *Describing change over time* section on page 10.

Introduction

This commentary provides information about the NHS Outcomes Framework and the indicators which have been updated in the May 2016 release.

Report structure

This *Introduction* chapter contains information about what is included in this report, background information about the framework and some important information about the data in this release.

The *Executive Summary* section gives a brief overview of the NHS OF and the new information that has become available in the present release.

The *Key Findings* table summarises the new national indicator values updated in this release and provides a summary of the trends for each. The *Commentary* chapter expands on this and provides more detailed analysis on some of the updated indicators.

This publication has an *Appendix* which includes full details about the time periods and breakdowns added to the indicator data files in this release.

Framework background

The NHS Outcomes Framework is a set of indicators which were developed by the Department of Health (DH) in December 2010, following publication of the *Equity and Excellence: Liberating the NHS*[1] white paper, which outlined the Government's intention to shift the NHS from a focus on process targets to a focus on measuring health outcomes.

The indicators are selected by the DH in collaboration with stakeholders. For the very first framework, the government put forward a set of proposals in the public consultation *Transparency in Outcomes – a framework for the NHS*[2]. The consultation set out how an NHS Outcomes Framework might be developed and sought the views of those working in the NHS, Strategic Health Authorities, Primary Care Trusts, Local Authorities, patients and members of the public about how this might be achieved. The feedback from that consultation was used to create the first framework.

The indicators included in the framework are reviewed annually to ensure that they continue to reflect the current landscape of the health and care system and the many challenges that the system faces.

In autumn 2014, the DH ran a further consultation[3] to determine how the NHS Outcomes Framework could be improved. It was recognised that since it was first published in 2010, there had been several developments in both the NHS and the wider health and social care system. These developments are reflected in the 2015/16 framework, which came into effect as of April 2015. A summary of the changes made in 2015/16 can be found on the Indicator Portal by using the below link and selecting the *NHS OF summary dashboard and useful links* page from the left hand side list.

HSCIC Indicator Portal: https://indicators.hscic.gov.uk

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf
[2] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/consultations/liveconsultations/DH_117583
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/

The 2016/17 NHS OF has recently been published by DH and there are no changes from 2015/16. A list of the current indicators can also be found on the summary dashboard page of the Indicator Portal.

Once DH decide which indicators are to be included, they work with the HSCIC to develop a methodology and source the appropriate data sets. This process is currently managed through the Indicator Methodology and Assurance Service (IMAS) which was set up to strengthen confidence in health and social care indicators. The IMAS process involves completing a detailed application form which is reviewed by panels of experts against a set of criteria. Once the indicators are approved, they are published by the HSCIC in the appropriate quarterly release. Indicators are re-assessed at suitable intervals to ensure that they remain relevant and robust.

For more details about this process please see the IMAS website at the below link:
http://www.hscic.gov.uk/article/1674/Indicator-Assurance-Service

Details about the types of people who use the NHS OF indicators can be found in our Users and Uses Statement on the NHS OF home page at the following link: http://www.hscic.gov.uk/nhsof

Framework structure

The framework is structured around the outcome domains shown below, which set out the high-level national objectives for the NHS. The key focus is around improving health outcomes and reducing health inequalities.

Domain 1 - Preventing people from dying prematurely
This domain captures how successful the NHS is in reducing the number of avoidable deaths.

Domain 2 - Enhancing quality of life for people with long-term conditions
This domain captures how successfully the NHS is supporting people with long-term conditions to live as normal a life as possible.

Domain 3 - Helping people to recover from episodes of ill health or following injury
This domain captures how people recover from ill health or injury and wherever possible how it can be prevented.

Domain 4 - Ensuring that people have a positive experience of care
This domain looks at the importance of providing a positive experience of care for patients, service users and carers.

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm
This domain explores patient safety and its importance in terms of quality of care to deliver better health outcomes.

Notes on this release

Describing change over time

Descriptions of change in the summary dashboard, key findings and commentary sections of this report follow a prescribed set of guidelines. There are two ways in which change is measured, depending on whether confidence intervals are currently available for the data.

Confidence intervals show the range of values within which the true indicator value is expected to lie. They are used when the true value of something is uncertain because of random variation in the world around us. Narrow confidence intervals show that the indicator value is precise, wider confidence intervals show that the indicator is less precise. For example, because of the relative sizes of the underlying populations, an indicator at England level will be more precise than a local value, i.e. the effect of random variation is greater when considering a smaller population.

When considering change over time we look at whether confidence intervals overlap from the starting period to the current period. If confidence intervals overlap this could be due to natural variation rather than a true change in the direction of the indicator.

If indicators are described as 'Tested', the change over time has been statistically tested by looking at confidence intervals. These changes are classed as 'Statistically Similar' where confidence intervals overlap, and where they don't, the change is categorised as 'Significantly Improved' or 'Significantly Deteriorated'.

Where indicators are described as 'Not Tested', indicator data are available but do not currently have confidence intervals. 'Not Tested' changes are classed as 'Similar' if the percentage change is between -2 and +2 (inclusive) and either 'Improved' or 'Deteriorated' if not.

The 'No Data' category is used in the key findings where the indicator is in development or the time series has not yet reached five years.

Index of Multiple Deprivation (IMD) 2015 updates

Many of the deprivation breakdowns in the NHS OF are calculated by using Index of Multiple Deprivation (IMD) data[4] from the Department of Communities and Local Government (DCLG). The IMD is a composite score for each Lower Super Output Area (LSOA) in England, derived from 37 different measures of deprivation. LSOAs relate to small geographical areas with populations of roughly 1,000 to 3,000 people which can be allocated to a deprivation quintile or decile in order to monitor the difference in health outcomes between the more and less deprived areas of the country.

The IMD data are usually refreshed every three years. The HSCIC update the indicator data where possible, each time a new IMD version is released, applying the latest IMD to all years of indicator data to ensure a consistent time series. New IMD data were released in 2015 and this has been used to revise the deprivation figures for all previously published years for the following indicators in this release:

[4] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

- 1c Neonatal mortality and stillbirths (formerly indicator 1.6.ii)
- 1.6.i Infant mortality

This update affects the counts of births, counts of deaths and indicator values in the deprivation breakdowns for these indicators but not the overall yearly totals. The following tables describe these changes in more detail. There were both positive and negative changes in equal proportions so to simplify the tables, the findings are based on the absolute value of change, i.e. they show the size but not the direction. The analysis takes account of data for all previously published years, covering data from 1999 to 2013 inclusive.

Figure 2 describes the differences between the previous and current deprivation values for indicator 1c. It shows that for the live births, stillbirths and neonatal deaths columns, the vast majority of deprivation values have changed. This has not affected the indicator value in all cases; 31 per cent remain unchanged. For the majority of indicator values that did change, the difference equated to between 0 and 5 per cent of the previous value.

The patterns of change are slightly different for each of the columns in the data file. The scale of change was small (between 0 and 2 per cent) for the majority of values from the live births column. For the stillbirth values, the changes were predominantly small to medium in size, increasing or decreasing between 0 and 5 per cent. The neonatal death changes were also predominantly small to medium but also had a more substantial proportion (16 per cent) of larger changes, of between 5 and 12 per cent. This reflects the relative sizes of the groups, i.e. there are many more live births than still births, and more still births than neonatal deaths.

Figure 2: Neonatal mortality and stillbirths (NHS Outcomes Framework Indicator 1c)
Changes in deprivation values as a result of IMD 2015 updates

Indicator	Percentage of deprivation values	Indicator value column	Live births column	Stillbirths column	Neonatal deaths column
1c	With no changes	31	0	1	7
	With changes between 0 and 2 per cent	39	87	47	39
	With changes between 2 and 5 per cent	28	13	41	39
	With changes between 5 and 12 per cent	3	0	11	16

Source: February 2016 indicator 1c data file, May 2016 indicator 1c data file
Columns might not add up to 100 per cent due to rounding

Figure 3 shows that the patterns of change for indicator 1.6.i, which are very similar to those seen for indicator 1c. The live births columns are the same for both indicators and therefore the changes for the column presented in this indicator are identical to those described above.

For the 1.6.i indicator column, the majority of values changed by between 0 and 5 per cent following the update. However, there were also substantial proportions of values with larger changes (13 per cent of values) or no change at all (21 per cent of values). The infant deaths column changes were predominantly small to medium in size but they also had a substantial proportion (17 per cent) of larger changes.

Figure 3: Infant mortality (NHS Outcomes Framework Indicator 1.6.i)
Changes in deprivation values as a result of IMD 2015 updates

Indicator	Percentage of deprivation values	Indicator value column	Live births column	Infant deaths column
1.6.i	With no changes	21	0	1
	With changes between 0 and 2 per cent	20	87	41
	With changes between 2 and 5 per cent	45	13	40
	With changes between 5 and 12 per cent	13	0	17

Source: February 2016 indicator 1.6.i data file, May 2016 indicator 1.6.i data file
Columns might not add up to 100 per cent due to rounding

Commentary

The following sections provide more detailed commentary on some of the indicators updated in this release. The following indicators are included:

- 1c Neonatal mortality and stillbirths (formerly indicator 1.6.ii)
- 1.4.i One-year survival from all cancers
- 1.4.ii Five-year survival from all cancers
- 1.6.i Infant mortality
- 2.2 Employment of people with long-term conditions
- 2.5.i Employment of people with mental illness (formerly indicator 2.5)
- 2.7 Health-related quality of life for people with three or more long-term conditions
- 4.6 Bereaved carers' views on the quality of care in the last 3 months of life

Domain overviews are also included in this section to give additional background information about the indicators included in this commentary.

Domain 1 - Overview

Domain 1 of the framework focusses on preventing people from dying prematurely. The indicators in this area monitor how successful the NHS has been in achieving this objective and look at different areas which may have contributed to progress.

This area is important for two reasons: The rates of premature death in England are worse than those in many other European countries for diseases like cancer, heart and liver disease[5]. Also, there are significant inequalities between different communities and groups within England for both overall life expectancy and the quality of health people can expect towards the end of their life[5].

Some of the indicators in this area relate to all types of the diseases and other indicators relate to just the diseases considered amenable to healthcare. 'Amenable' in this context relates to premature deaths that should not occur in most cases in the presence of timely and effective healthcare.

The NHS can contribute to improving outcomes for people with both amenable and non-amenable diseases, and therefore to improvements in all of the domain 1 indicators. However, the relative contributions of healthcare, prevention activity and other external factors in delivering improvements to health outcomes are difficult to disentangle. The types of activities that can contribute are discussed below.

Healthcare contribution

The NHS contributes to improvements in domain 1 indicators through prompt diagnosis and effective management of conditions and treatments. They can help to prevent or slow the process of chronic conditions and encourage healthy behaviours and uptake of screening or vaccination.

[5] https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-1/

Public health and social care contribution

Prevention, early identification and management of risk factors including cholesterol, blood pressure, diabetes, chronic kidney disease and transient ischemic attack interventions can affect domain 1 indicators. Smoking, lack of physical activity, diet, salt and alcohol consumption, obesity, vaccination rates and the quality of care people receive will also have an influence.

Other contributions

The predominant external driver of outcomes in domain 1 is the incidence of the diseases themselves and incidence is greatly affected by demographic and environmental effects. For this reason, it is important to consider the impact of factors external to healthcare, public health and social care organisations when reviewing the progress of these indicators.

The World Health Organisation state that:

Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health.

The NHS has a responsibility to work with public health and social care services to improve outcomes for current patients by improving health behaviours, but it must be recognised that the full benefit of many such interventions will not be apparent in mortality data for many years or even decades.

Indicators 1c and 1.6.i - Neonatal mortality and stillbirths, Infant mortality

Indicator 1c is an overarching indicator in domain 1 of the framework and measures the rate of neonatal mortality and stillbirths per 1,000 births in England. It has been selected to ensure focus on this age group since it is not covered anywhere else within the framework. A baby is considered stillborn when it is born after 24 or more weeks' gestation and which did not, at any time, breathe or show signs of life. Neonatal mortality refers to deaths that occur in live-born babies under 28 days old.

Reducing deaths in babies under one year of age and reducing the gap between the richest and poorest groups are part of the government's strategy for public health[6]. The government has also recently announced an ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50 per cent by 2030[7].

Indicator 1.6.i measures the rate of infant mortality per 1,000 live births in England and has been selected to ensure sufficient focus on this age group. Infant mortality covers deaths of babies under one year old. This includes the neonatal deaths included in indicator 1c, but excludes stillbirths and also includes post-neonatal deaths (those aged more than 28 days but less than 1 year).

These indicators are updated with 2014 data in this publication. Both the numerator and denominator values are sourced from the Office for National Statistics (ONS) Childhood

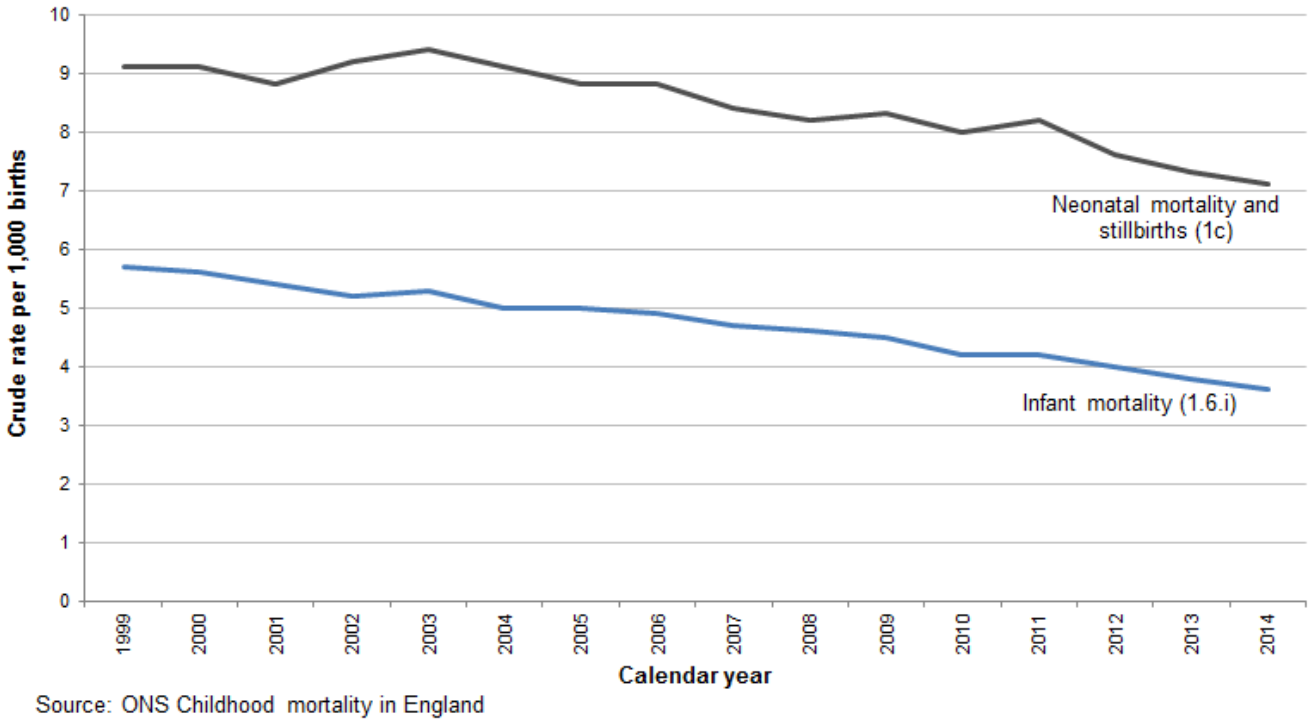
[6] https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england
[7] https://www.gov.uk/government/news/new-ambition-to-halve-rate-of-stillbirths-and-infant-deaths

Mortality publication[8]. This is a National Statistics publication and is therefore considered to be of good quality.

Deaths under one year of age are considered a key international indicator of a country's population health and quality of health care services. The infant mortality rate is particularly important for monitoring outcomes for high risk groups such as pre-term babies and growth restricted babies.

Historically, infant mortality claimed a considerable percentage of children born, but rates have significantly declined in the UK mainly due to improvements in basic health care and technological advances. Many post-neonatal deaths occur because of improvements in neonatal care postponing deaths, which might otherwise have occurred earlier.

Figure 4: Neonatal mortality and stillbirths and infant mortality (NHS Outcomes Framework indicators 1c and 1.6.i)
Crude rate per 1,000 births (1.6.i live births only), 1999 to 2014



Source: ONS Childhood mortality in England

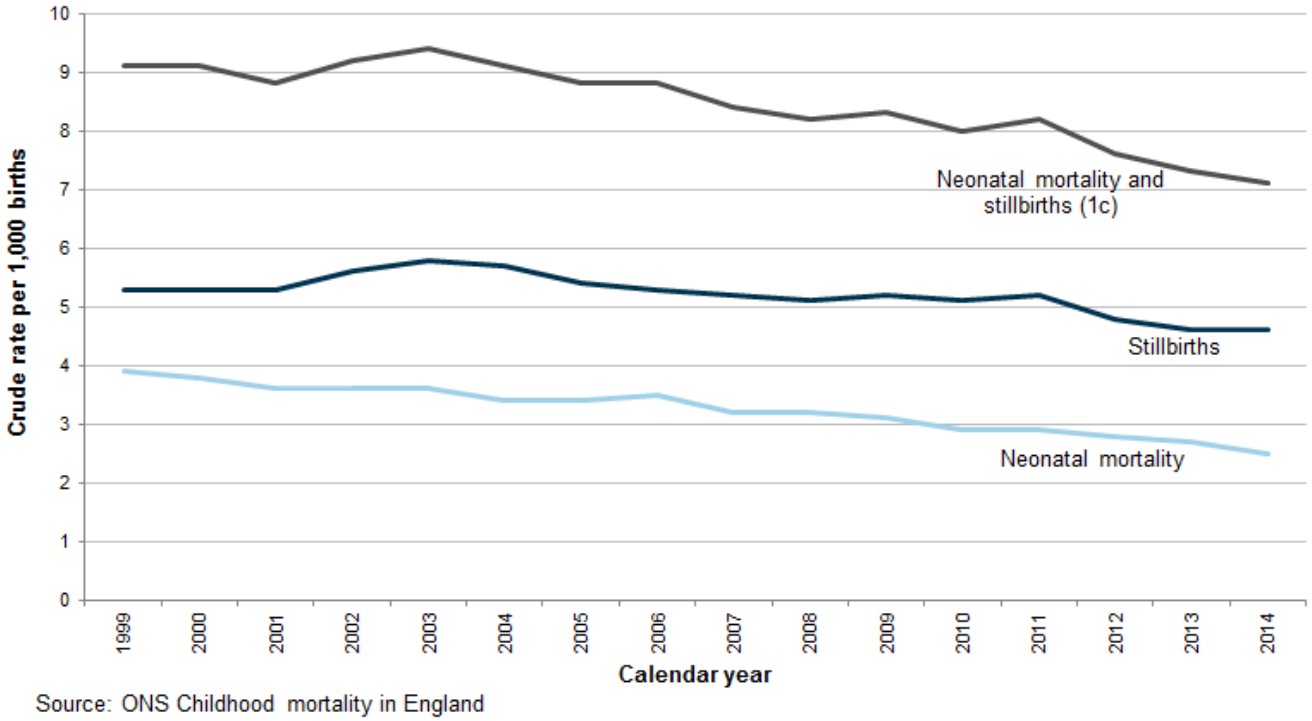
Figure 4 shows the national rates for the two indicators. Neonatal mortality and stillbirth values (Indicator 1c) have generally improved over time, falling from 9.4 per 1,000 births in 2003 to 7.1 in 2014. The infant mortality rate (Indicator 1.6.i) has also improved gradually over time from 5.7 per 1,000 live births at the start of the time series in 1999 to 3.6 in 2014, which equates to 2,391 infant deaths from 661,496 live births. Although there is a clear downward trend, confidence intervals are not currently produced for these indicators so we cannot test whether this fall is statistically significant.

The latest data show that the neonatal death and stillbirth rate fell by 2.7 per cent between 2013 and 2014 (from 7.3 per 1,000 births to 7.1) and the infant mortality rate fell by 5.3 per cent (from 3.8 deaths per 1,000 live births to 3.6) over the same time period.

[8] http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/childmortalitystatisticschildhoodinfantandperinatalchildhoodinfantandperinatalmortalityinenglandandwales

Neonatal deaths are a subset of infant deaths and they have made up between 66 and 71 per cent of infant deaths over the course of the time series. This means that the two indicators will generally see similar trends depending on the effect of post-neonatal deaths on indicator 1.6.i and stillbirths on indicator 1c. Figure 5 shows the individual stillbirth and neonatal death rates together with the combined rate (indicator value) between1999 and 2014 to look at the trends for the individual rates:

Figure 5: Neonatal mortality and stillbirths (NHS Outcomes Framework indicator 1c)
Crude rate per 1,000 births, 1999 to 2014

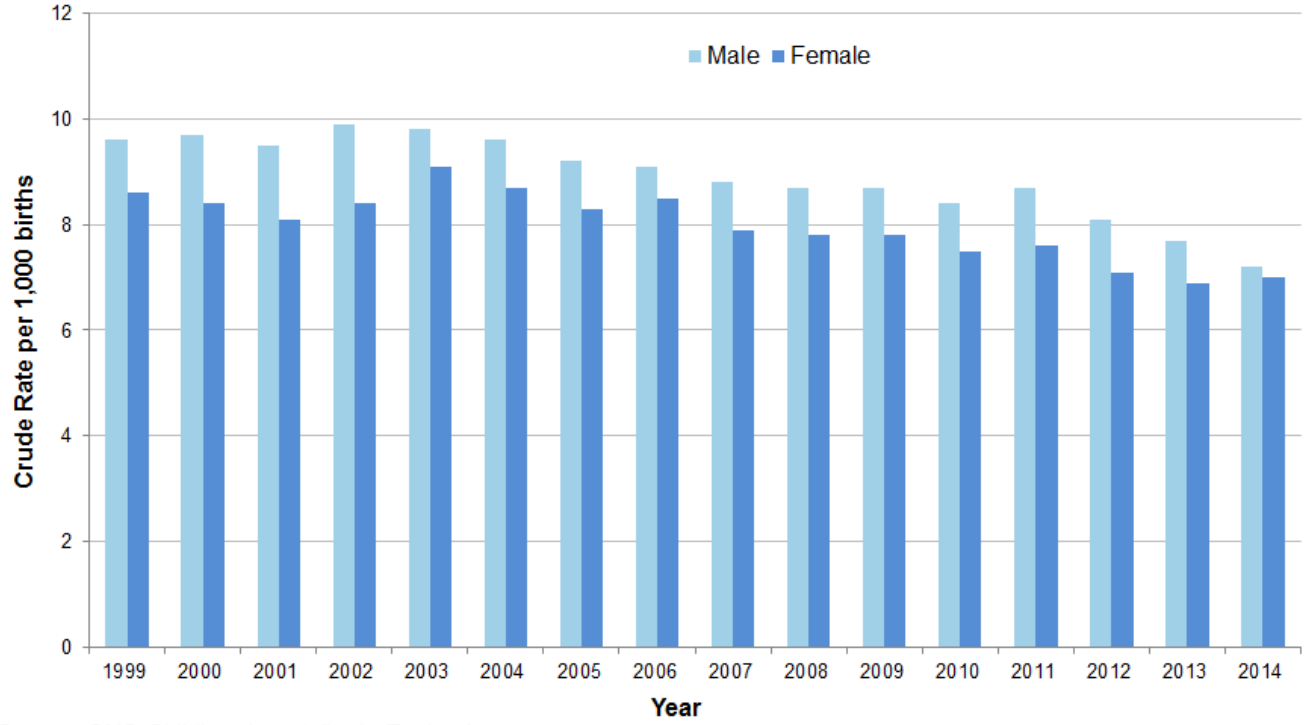


Source: ONS Childhood mortality in England

The rate of stillbirths per 1,000 births remained relatively stable between 1999 and 2011 but has fallen slightly since then. Over the course of the time series, the rate has fallen from 5.3 stillbirths per 1,000 births in 1999 to 4.6 in 2014 (a fall of 13.2 per cent). This equates to 3,047 stillbirths in 2014. The rate of neonatal deaths has fallen consistently throughout the time series from 3.9 neonatal deaths per 1,000 births in 1999 to 2.5 in 2014 (a fall of 35.9 per cent). This equates to 1,679 neonatal deaths in 2014. These trends in the individual rates suggest that falls in neonatal deaths have been the main driver in the reduction of the overall rate for indicator 1c. It may also suggest that the number of stillbirths is linked more strongly to the overall number of births than the number of neonatal deaths and infant deaths are.

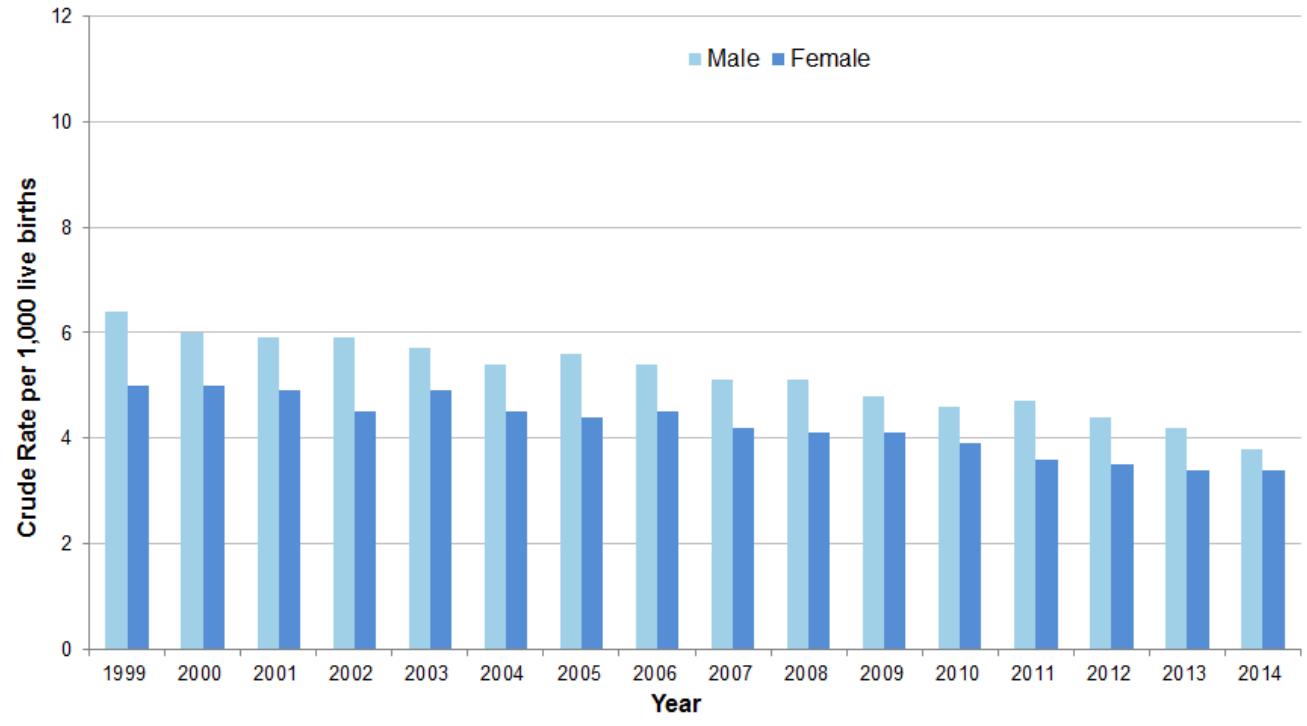
For both indicators male infants have had higher mortality/stillbirth rates than female infants in all years of the time series as shown in the following charts.

Figure 6: Neonatal mortality and stillbirths (NHS Outcomes Framework indicator 1c)
Crude rate per 1,000 births by gender, 1999 to 2014



Source: ONS Childhood mortality in England

Figure 7: Infant mortality (NHS Outcomes Framework indicator 1.6.i)
Crude rate per 1,000 live births by gender, 1999 to 2014

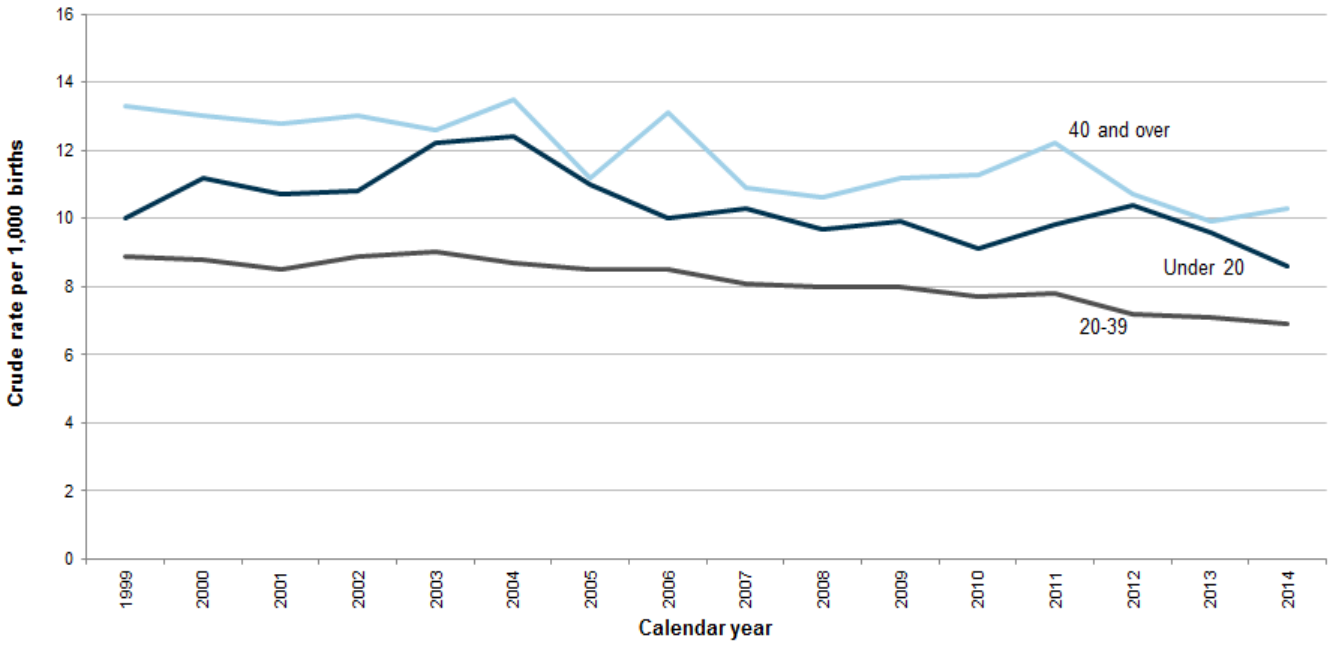


Source: ONS Childhood mortality in England

For both of these indicators, the gap between the male and female mortality rates reached its lowest level in the time series in 2014. This was driven by large falls in the rates for males between 2013 and 2014. The neonatal deaths and stillbirths rate for males fell from 7.7 per 1,000 births in 2013 to 7.2 in 2014, a fall of 6.5 per cent, which suggests an improving outcome.

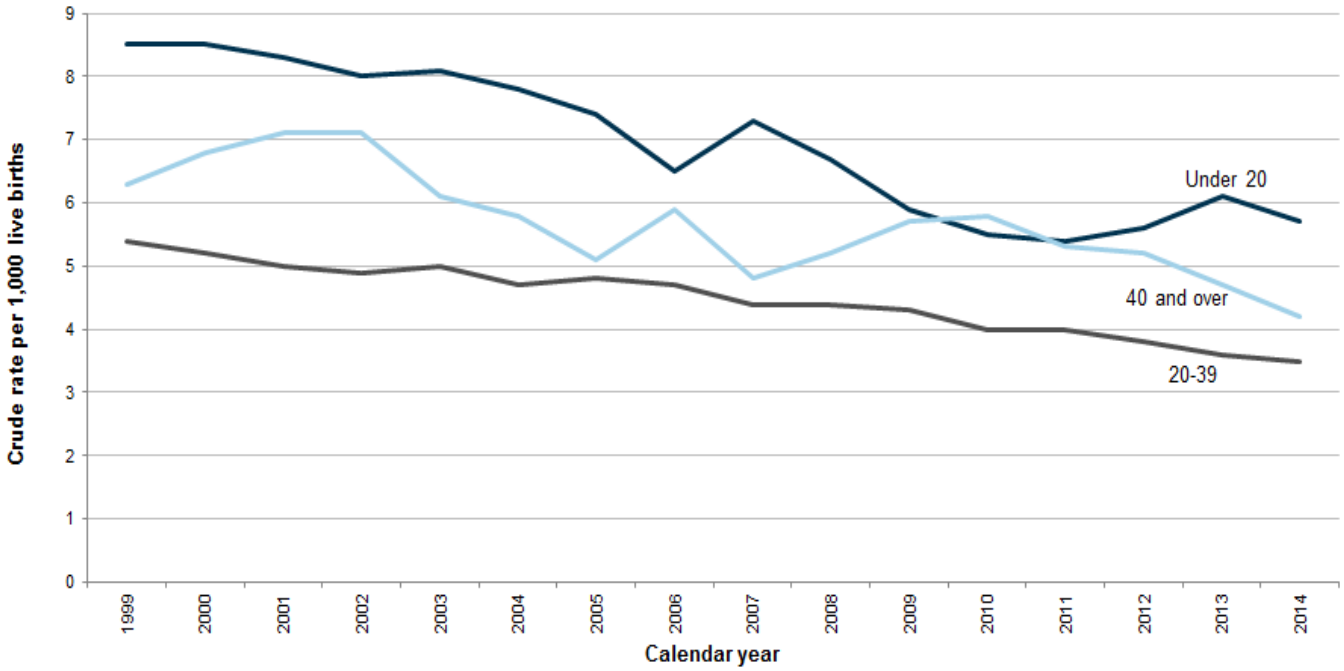
The infant mortality rate for males fell from 4.2 per 1,000 live births to 3.8 over the same time period, a fall of 9.5 per cent which also suggests an improving outcome. In 2014, both female rates remained similar to 2013. The relatively low number of deaths and absence of confidence intervals means this change should be interpreted with caution as natural variation may have an effect. Outcomes also vary by age of mother, figures 8 and 9 compare the rates for both indicators by the age of the babies' mother.

Figure 8: Neonatal mortality and stillbirths (NHS Outcomes Framework indicator 1c)
Crude rate per 1,000 births by age of mother, 1999 to 2014



Source: ONS Childhood mortality in England

Figure 9: Infant mortality (NHS Outcomes Framework indicator 1.6.i)
Crude rate per 1,000 live births by age of mother, 1999 to 2014



Source: ONS Childhood mortality in England

The fall in rates nationally between 2013 and 2014 can also be partly explained by falls in certain maternal age groups in the latest year. Mothers under 20 saw the rate of neonatal deaths and stillbirths fall by 10.4 per cent between 2013 and 2014 and mothers aged between 20 and 39 also saw a 2.8 per cent decrease over the same period.

For mothers aged 40 or over, the neonatal and stillbirth mortality rate fell to its lowest level in the time series in 2013 but saw the rate increase by 4.0 per cent between 2013 and 2014, which suggests a deterioration in outcomes for this group.

All age groups saw a fall in the infant mortality rate between 2013 and 2014, with the under 20 maternal age group seeing the first fall in the rate since 2011. This group still had the highest infant mortality rate with 5.7 infant deaths per 1,000 live births.

As both indicators measure crude rates which are not standardised, care should be taken when comparing different regions or local authorities rates against each other as these may have different demographics meaning like for like comparisons are inappropriate.

As has been shown, age of mother and gender of infant have significant impacts on infant and neonatal mortality and stillbirth likelihood. The proportion of women and infants is likely to vary by region and even more so by local authority, therefore comparisons between these groups should be made with caution. Areas with a high proportion of younger mothers for example, should not be compared with areas with an even distribution of mothers in each age group.

Factors that are not analysed here, either because the data is unavailable or the analysis is unfeasible, such as length of gestation, weight of infant and multiple pregnancy are also known to be significant risk factors for infant and neonatal mortality and stillbirth likelihood.

Indicators 1.4.i and 1.4.ii - One-year and five-year survival from all cancers

Indicator 1.4.i and 1.4.ii are improvement areas in domain 1 of the framework, which measure the one-year and five-year survival rate from all cancers. The survival rate is the percentage of those diagnosed with cancer in a given calendar year, who are still alive one or five years after diagnosis. The calculation of the rate takes into account the background mortality that patients would have experienced if they had not had cancer to give an estimated probability of survival from cancer alone.

Only 23 per cent of cancer deaths are considered amenable[9] and these indicators recognise that the NHS has a responsibility not just to reduce the incidence of cancer but also to prevent people from dying of cancer once they have been diagnosed with the condition.

These indicators are updated with data for patients diagnosed in 2013 for indicator 1.4.i and patients diagnosed in 2009 for indicator 1.4.ii in this publication. The survival rates are sourced directly from the Office for National Statistics (ONS)[10] Index of cancer survival for Clinical Commissioning Groups publication. This publication has been designated as National Statistics and is therefore considered to be of good quality.

The national level survival rates for indicators 1.4.i and 1.4.ii are for adults aged 15 to 99. Children aged 0 to 14 are covered in indicator 1.6.ii, five-year survival from all cancers in

[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385751/NHS_Outcomes_Tech_Appendix.pdf

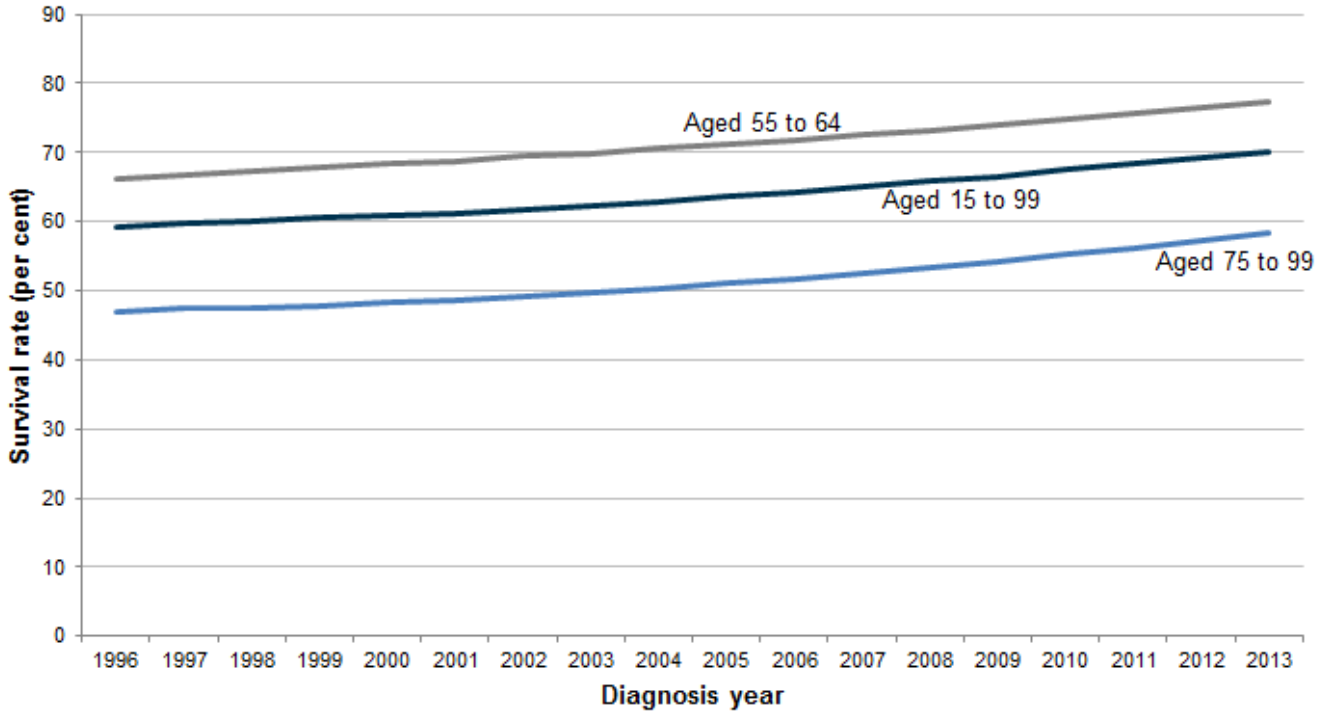
[10] http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/table01to091yearcancersurvivalbyclinicalcommissioninggroupsinenglandwithprecisionestimates

children. Survival rates for the age groups 55 to 64 and 75 to 99 are also published in the indicator data files in order that differences in survival can be seen between them. If consecutive age groups without an age gap between them had been chosen it may be difficult to see if there was a real difference between survival for different age groups.

At national level, one-year survival from all cancers (indicator 1.4.i) has seen very small increases each year, from 59.2 per cent in 1996 to 70.2 per cent in 2013 with the yearly rate of increase growing over time. Five-year survival has seen similar trends to one-year cancer survival, increasing from 41.4 per cent in 1996 to 49.6 per cent in 2009, with the yearly rate of increase also growing over time. Confidence intervals are not available for these estimates so the significance of this change cannot be determined. Despite this, we can say for both indicators that the increases in survival rates over the last five years for which data is available suggests an improving outcome.

Figures 10 and 11 show the one-year and five-year survival rates at national level and for the selected age groups between 1996 and 2013.

Figure 10: One-year survival from all cancers (NHS Outcomes Framework indicator 1.4.i)
Cancer survival rate (per cent) by selected age groups, 1996 to 2013 (year of diagnosis)

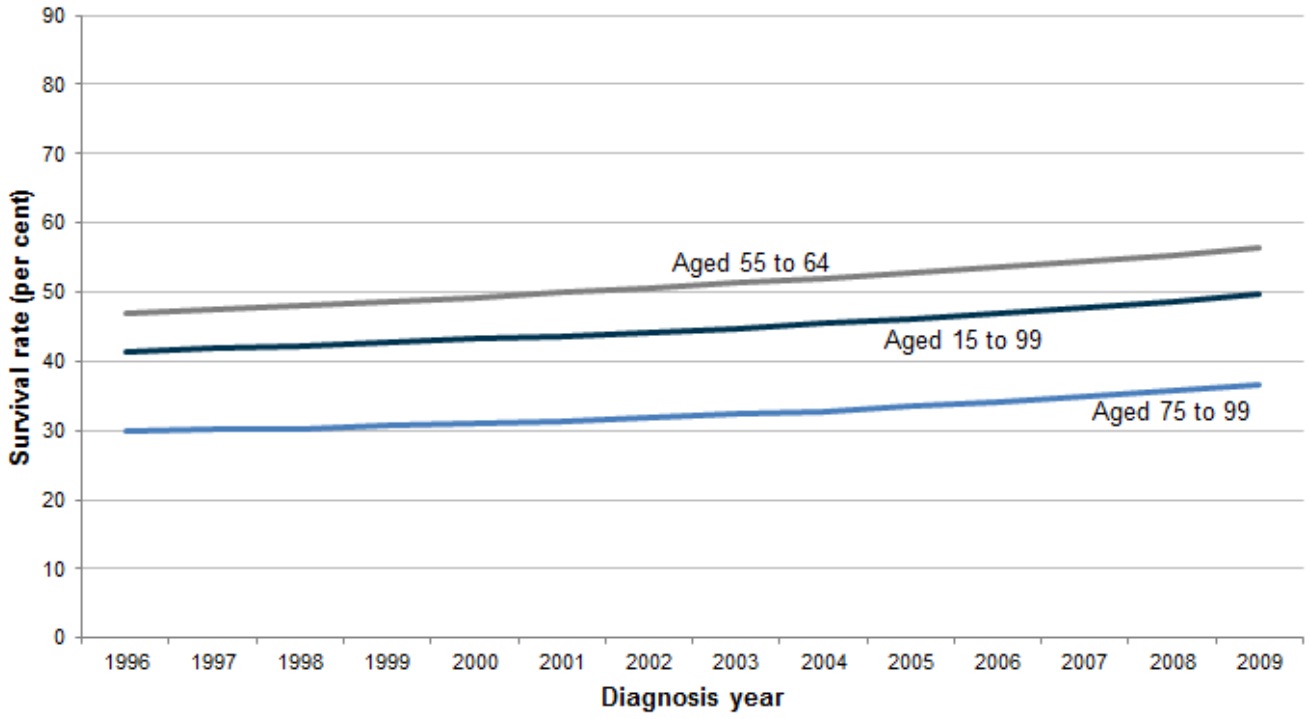


Source: Office for National Statistics (ONS) Index of cancer survival for Clinical Commissioning Groups in England

All of the selected age groups have seen a similar increase in survival rates over the eighteen years of the time series with a greater year on year increase in more recent years. Annual increases of between 0.4 and 0.5 percentage points were usually seen in the earlier years of the time series, between 1997 and 2001. Annual increases of at least 0.8 percentage points have been seen for the 15 to 99 and 75 to 99 age groups in each year since 2007, with increases of at least 0.7 percentage points seen in each year since 2007 for the 55 to 64 age group.

For those diagnosed in 2013, the one-year survival rate was 70.2 per cent for those aged 15 to 99, 77.3 per cent for those aged 55 to 64, and 58.4 per cent for those aged 75 to 99.

Figure 11: Five-year survival from all cancers (NHS Outcomes Framework indicator 1.4.ii)
Cancer survival rate (per cent) by selected age groups, 1996 to 2009 (year of diagnosis)



Source: Office for National Statistics (ONS) Index of cancer survival for Clinical Commissioning Groups in England

As with one-year survival, five-year survival rates have seen similar upward trends for all three selected age groups over the course of the time series. The 15 to 99 age group saw the five-year survival rate increase from 41.4 per cent in 1996 to 49.6 per cent in 2009, an increase of 19.8 per cent. Over the same time period the 55 to 64 age group saw the five-year survival rate increase by 20.5 per cent and the 75 to 99 age group saw a 22.0 per cent increase.

All three age groups have seen large enough increases over the latest five years' worth of data to suggest an improving outcome.

Despite the long-term improving outcomes for one-year and five-year survival there remains concern that there is a gap between survival rates in England and the European average. The Department of Health identified cancer as a specific improvement area for preventing people dying prematurely in the National Strategy (announced in 2011)[11]. In 2015 a new five-year cancer strategy for England was developed by the Independent Cancer Task Force[12]. This sets out recommendations for how the NHS can improve cancer outcomes for patients. The new strategy is being reviewed by government bodies.

Domain 2 - Overview

Domain 2 of the NHS Outcomes Framework seeks to capture how successfully the NHS is supporting people with long-term conditions to live as normal a life as possible. A long-term condition is any condition that cannot, at present, be cured but can be controlled by medication

[11] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371
[12] https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

and/or therapy. This includes any condition that people live with over a period of time whether it is a physical or mental condition, or is associated with a disability.

NHS England estimates that 15.4 million people in England (over a quarter of the population) have a long-term condition, and an increasing number of these have multiple conditions. The number of people with three or more long-term conditions is expected to increase from 1.9 million in 2008 to 2.9 million in 2018. People with long-term conditions use a significant proportion of health care services and the cost of care accounts for 70 per cent of hospital and primary care budgets in England[13].

The NHS supports people with long-term conditions to be as independent and healthy as possible by helping them to get the skills to manage their own health, agreeing care plans that are based on their personal needs and making sure their care is well coordinated.

Indicators 2.2 and 2.5.i - Employment of people with long-term conditions and with mental illness

Background

Indicators 2.2 and 2.5.i measure the difference in employment rate between the general population and people with long-term conditions (LTCs) or a mental illness respectively. They were selected for the framework based on the analysis of evidence and of responses from the initial framework consultation[14]. The analysis showed that one of the outcomes that mattered most to people with long-term conditions was their level of functional ability, i.e. their ability to live as normal a life as possible. Looking at levels of employment is one way to measure this.

All figures for these indicators are estimated based on results from the quarterly Labour Force Survey (LFS) which is managed by the Office for National Statistics (ONS)[15]. The LFS publication has been designated as National Statistics and is therefore considered to be of good quality. The figures used in these indicators relate to adults aged 16-64 living in England.

Long-term conditions are described in the survey as 'any physical or mental health conditions or illnesses that will last or is expected to last for 12 months or more'. These respondents can have multiple LTCs and the conditions they have can vary in severity. The majority of this group are still able to participate in employment.

The mental illness group are made up of respondents who said they had one or more of: depression, bad nerves, anxiety, learning difficulties, mental illness, a phobia or nervous disorder. These individuals are a subset of the LTC group.

Long-term conditions and mental illnesses are based on individuals' own assessments and do not have to be medically diagnosed.

The latest indicator data estimates that there were 9.9 million people with long-term conditions in quarter 4 (Q4) 2015 and of these, 2.8 million people (28.6 per cent) had a mental illness. These groups make up a substantial proportion of the working age population. The latest data estimate that 28.9 out of every 100 working age people have an LTC, and 8.2 out of every 100 working age people have a mental illness. The rate has been increasing for the mental illness

[13] http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/
[14] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/consultations/liveconsultations/DH_117583
[15] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes

group from 4.8 out of every 100 people in Q1 2007 while the LTC rate has remained similar (28.3 out of every 100 in Q1 2007).

Although the data estimate that the proportion of working age people with mental illnesses has increased, it is difficult to determine whether more people have an illness or more people are reporting an illness. Reporting could have increased if more people are able to recognise they have a mental illness or if more people feel able to talk about their mental illness.

Latest indicator data

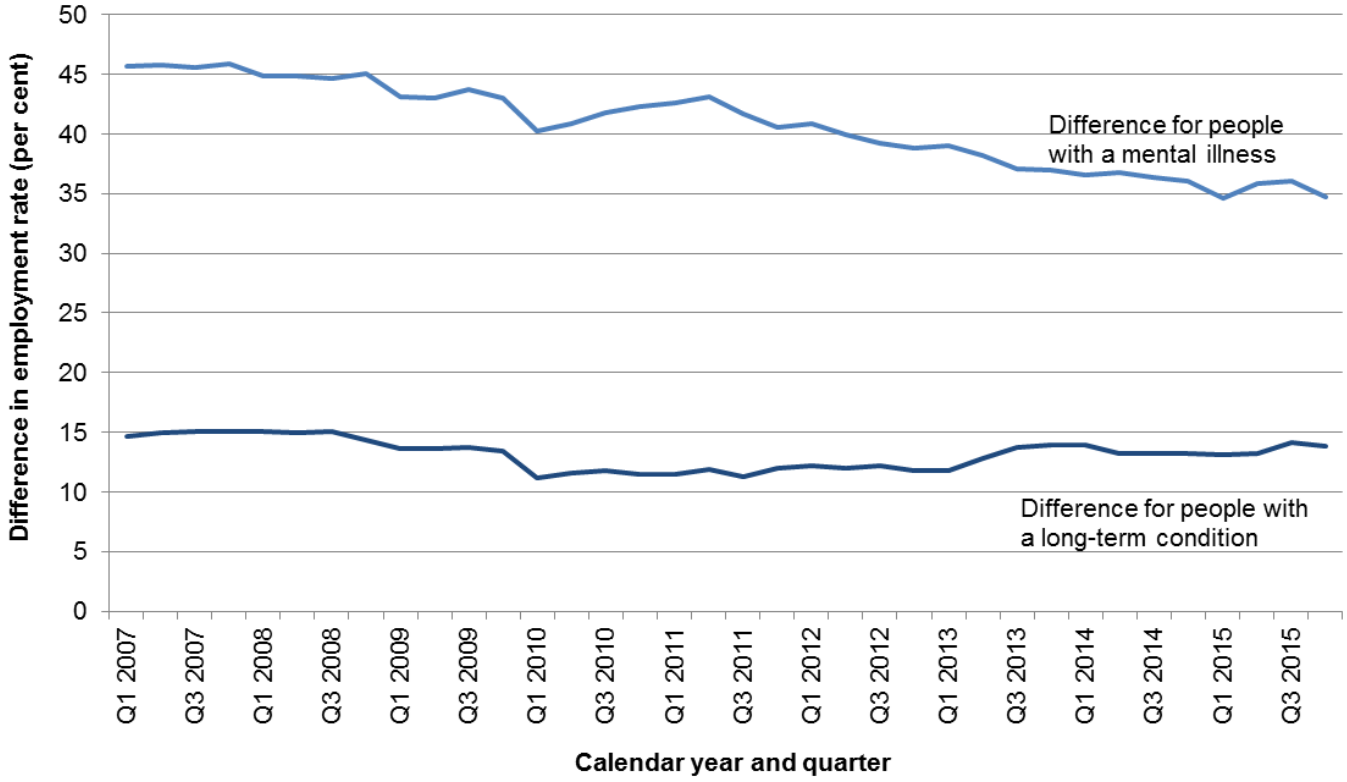
The Q4 2015 data estimate that for every 100 people in the general population, 74.6 were in employment giving an employment rate of 74.6 per cent. The general population employment rates are used in the indicator calculation in order to reduce the effect that issues with the wider economy could have on the employment rates of different groups.

In the same quarter, the employment rate for people with a long-term condition was 60.9 per cent. Calculating the difference between the LTC employment rate and the general population employment rate gives a 13.8 percentage point gap which is the latest indicator value for indicator 2.2.

The employment gap is wider for individuals suffering from a mental illness. The employment rate for this group was 39.9 per cent in the latest quarter and the latest indicator value for indicator 2.5.i shows there is a 34.7 percentage point gap when compared to the general population.

A large percentage gap shows that there is inequality between people with an LTC or mental illness, and the general population. It is unlikely that this inequality could be completely removed but it is acknowledged that the NHS can make a difference. These indicators show improvement when the values are decreasing and therefore when inequality is decreasing. The following chart shows the national indicator values for each of these indicators.

Figure 12: Employment of people with long-term conditions and with mental illness (NHS Outcomes Framework indicators 2.2 and 2.5.i)
Percentage difference in employment rates between the general population and people with long-term conditions or mental illness, 2007 to 2015



Source: ONS Labour Force Survey

For individuals with a long-term condition (indicator 2.2), the latest data point (Q4 2015) shows some improvement on last quarter. The gap decreased from 14.1 to 13.8 percentage points, although confidence intervals aren't currently available to test for statistical significance. The trends for this indicator have changed over time; the gap decreased between 2007 and 2010, but has increased gradually since then which suggests an increasing level of inequality for people with long-term conditions compared to the general population. The indicator was at its lowest level in Q1 2010 when the difference was 11.2 percentage points.

Progress in the overarching indicator for domain two is also challenging. Indicator 2 measures the health-related quality of life for people with long-term conditions. The quality of life scores for this indicator have remained similar over the four-year time series suggesting that on average, people with long-term conditions have not felt any change in their quality of life over this period.

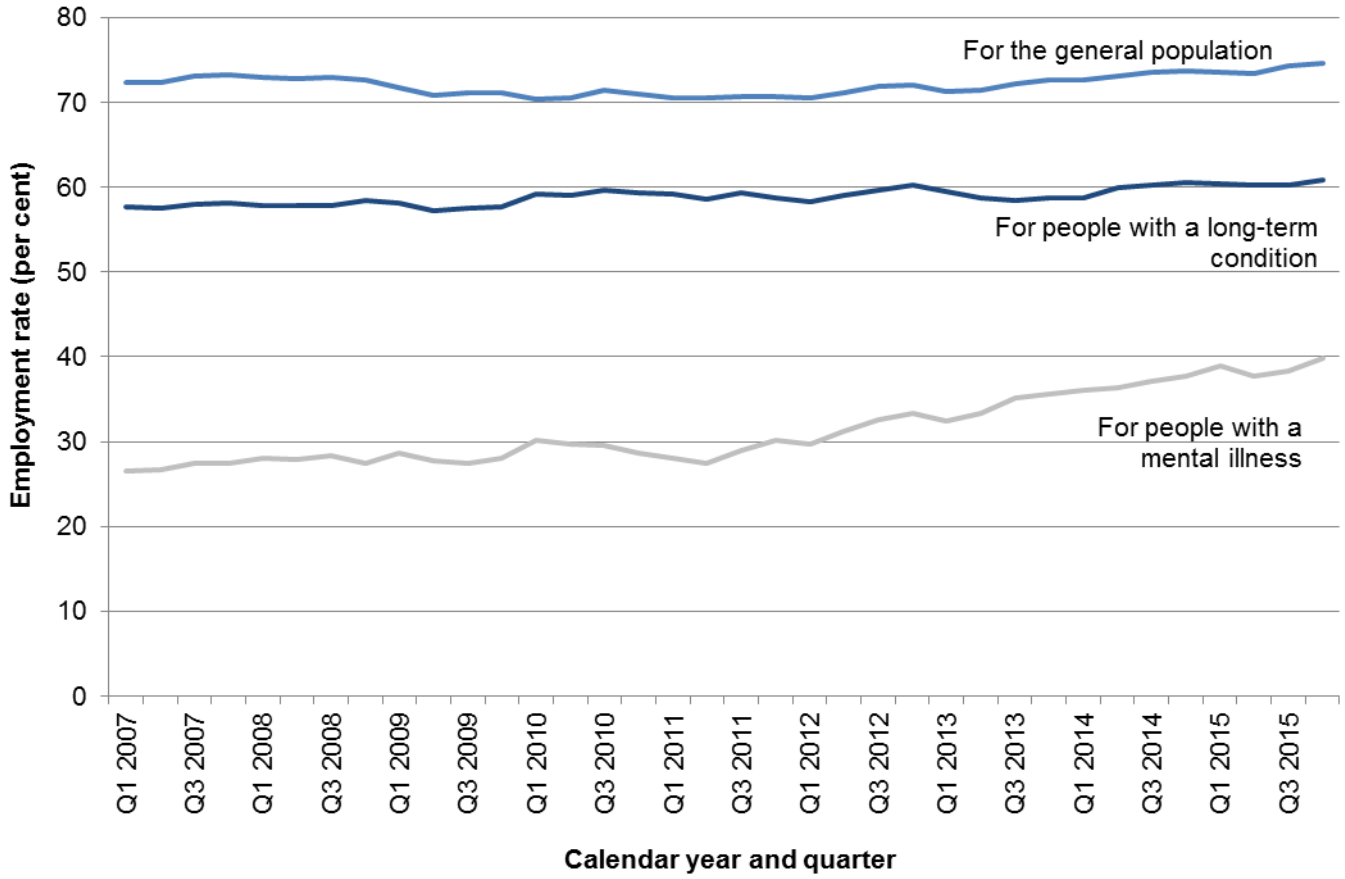
The latest data for people with a mental illness (indicator 2.5.i) shows the employment gap was 34.7 percentage points in Q4 2015. This is an improvement on last quarter and continues the long-term trend of improvement. The gap has been generally decreasing since Q2 2011 when the indicator value was 43.1 percentage points. Similar to indicator 2.2, there was a change in the trend during 2010 when there were some increases in the indicator value.

There could be several factors affecting these changes in 2010. The UK economy had just come out of recession at that time, having been in recession between Q2 2008 and Q2 2009. There were also political changes in 2010 following the general election of that year. Changing priorities and spending patterns may also have contributed to changes in the indicator values.

Employment rates

The following chart looks at the separate employment rates to understand more about what was happening to the underlying figures used to calculate the indicator values.

Figure 13: Employment of people with long-term conditions and with mental illness (NHS Outcomes Framework indicators 2.2 and 2.5.i)
Employment rates for the general population and people with long-term conditions or mental illness, 2007 to 2015



Source: ONS Labour Force Survey

The chart shows that people from the mental illness group are much less likely to be in work than a person from the overarching long-term condition group and that all of the employment rates have been growing in recent years to some extent.

The employment rate of people with a mental illness has grown strongly over the time series. In Q1 2007, it was estimated that only 26.6 per cent of this group were in work. In Q4 2015, estimates suggest that 39.9 per cent of this group are in work, an improvement of 50.0 per cent over the period.

The growth of the employment rate of people with a mental illness could be a result of many factors. It is important to note that the increase in the estimated rate of mental illness within the working age population could in itself have an impact on the employment rate. The employment rate increase could be a result of changes over time in the underlying characteristics of the individuals surveyed. This could be affected by more people feeling able to talk about their mental illness, for example.

The government and the NHS have increased their focus on mental health in recent years. The government published *No health without mental health*[16] in 2011, which details a strategy for improving mental health outcomes. This is the first public health strategy to give equal weight to both mental and physical health. The NHS have implemented the *Improving Access to Psychological Therapies*[17] programme which helps people with anxiety or depression to access talking therapies and could potentially reduce the duration and severity of these illnesses.

There have been a number of charities campaigning in recent years to improve conditions for people with mental illnesses. The *Time to Change* campaign[18] is run by the charities Mind and Rethink Mental Illness. The campaign runs a wide range of projects which aim to reduce stigmatisation and discrimination of people with mental illnesses. The *City Mental Health Alliance*[19] was founded by businesses in London in order to create a culture of good mental health for City workers, share best practice and increase mental health understanding.

Figure 13 also shows that the employment rate of people with an LTC has grown over time but at a much slower rate than for people with a mental illness. The LTC employment rate has improved by 5.5 per cent over the time series from 57.7 per cent in Q1 2007.

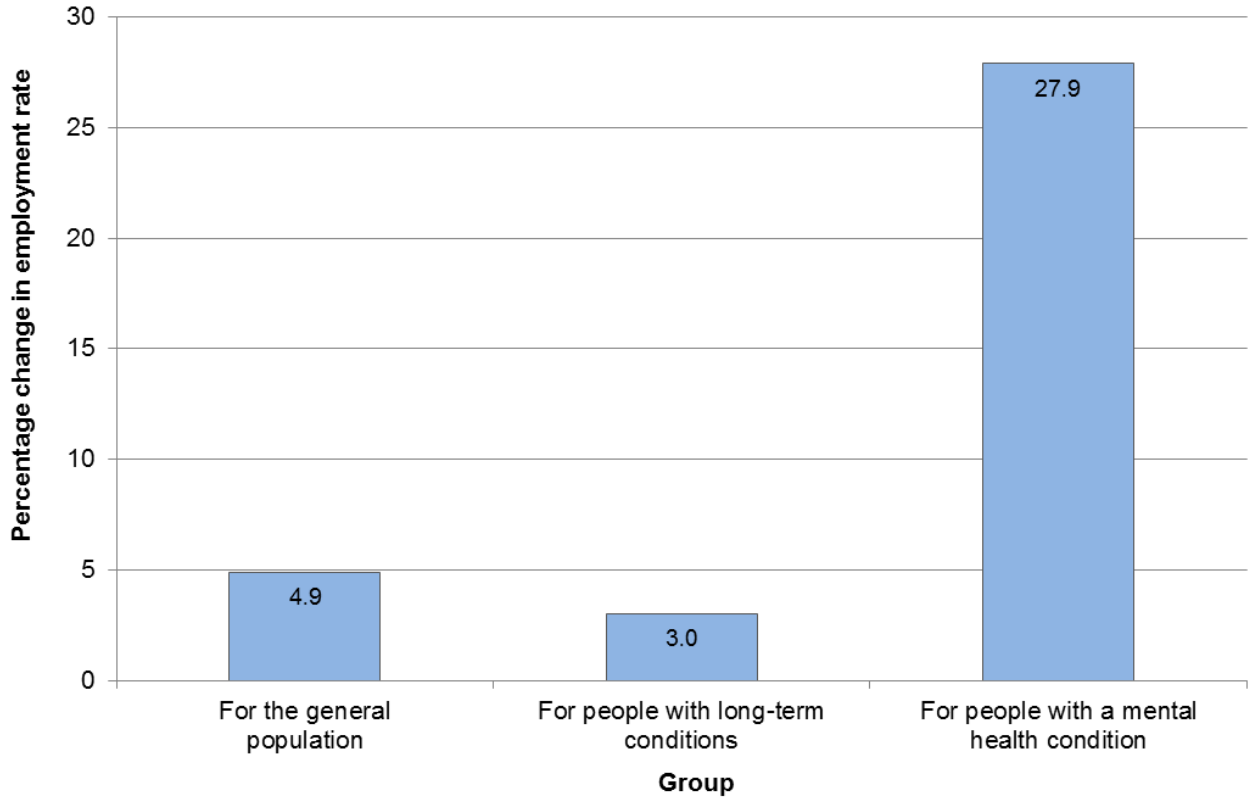
The general population employment rate was falling at the start of the time series in figure 13, and this roughly corresponds with the timing of the recession. The rate remained fairly static in the years following the recession but has been generally increasing from around Q2 2012.

[16] http://www.iapt.nhs.uk/silo/files/no-health-without-mental-health.pdf
[17] http://www.iapt.nhs.uk/about-iapt/
[18] http://www.time-to-change.org.uk/about-us/what-is-time-to-change
[19] http://citymha.org.uk/

Effect of employment rate changes

It is important to note that indicators 2.2 and 2.5.i are related to the general population employment rate, but can improve or deteriorate at the same time as employment rates are rising. This happens when the rate of growth for general population employment is faster than that of the indicator groups. The following chart looks at this in more detail. The chart shows the percentage change in the employment rates for each of the groups from Q2 2012, when the general population employment rate began to increase.

Figure 14: Employment of people with long-term conditions and with mental illness (NHS Outcomes Framework indicators 2.2 and 2.5.i)
Percentage change in employment rates for the general population, people with long-term conditions and people with a mental illness, between Q2 2012 and Q4 2015



Source: ONS Labour Force Survey

The chart shows that the pace of growth between Q2 2012 and Q4 2015 has been different for each of the groups. The employment rate for people with long-term conditions grew at a slower rate (3.0 per cent) than the general population employment rate (4.9 per cent) and this is the reason for the deterioration in the indicator value over this time period.

The mental health employment rate has grown by 27.9 per cent over the same period and this is much higher than the 4.9 per cent growth of the general population rate. This is the reason for the continued improvement of indicator 2.5.i.

The employment rate change for people with a mental illness is strikingly higher than the long-term condition group of which they form a part. This is due to the substantial growth of the mental illness group as a proportion of the LTC group, which has increased from 21.0 to 28.6 per cent over the period. People with a mental illness are less likely to be in work and therefore increasing their proportion of the group reduces the rate of growth for the overall LTC group.

Indicator 2.7 - Health-related quality of life for people with three or more long-term conditions

Indicator 2.7 is a new indicator, published for the first time in this release, which measures the health-related quality of life for the growing group of people who identify themselves as having three or more long-term conditions. The individuals included in this indicator are a subset of the individuals included in indicator 2, health-related quality of life for people who identify themselves as having a long-term condition. The purpose of these indicators is to allow the Secretary of State for Health to monitor whether health-related quality of life is improving over time for these groups of people.
Indicator 2.7 was developed because it is recognised that people need to be treated as a whole person and that those with multiple conditions are likely to have more complex needs.

The data for these indicators are derived from the GP Patient Survey (GPPS)[20] which asks a range of questions about patients' experiences of NHS care and in particular primary care. The GPPS publication is an official statistic. Patients are eligible for the survey if they have a valid NHS number, have been registered with a GP in England for at least six months and are at least 18 years old.

Health-related quality of life refers to an individual's perception of their day-to-day well-being in relation to five key areas:

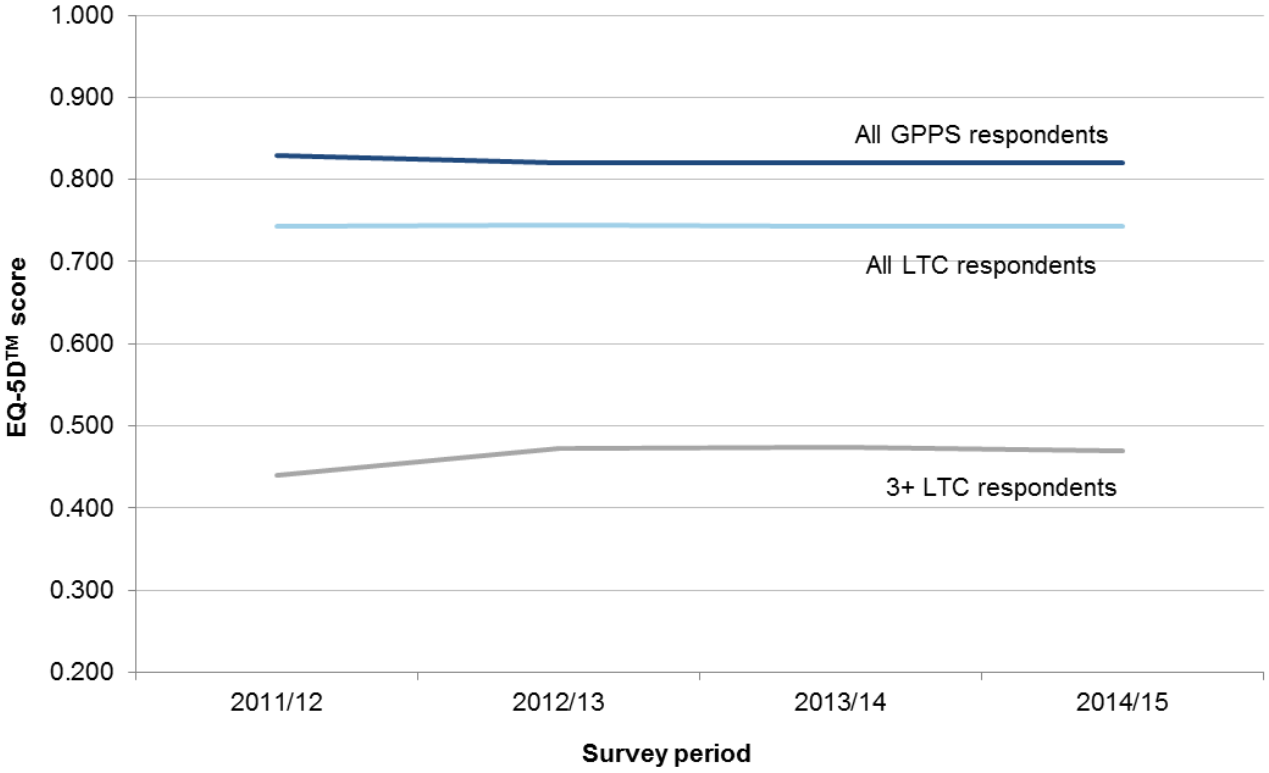
- Ability to walk around
- Ability to perform self-care activities (washing or dressing themselves)
- Ability to perform their usual activities (work, study etc.)
- Levels of pain or discomfort
- Levels of anxiety or depression

Individuals provide information about their well-being in relation to these areas through the GPPS and this is used to calculate an EQ-5D™ index score, a validated measure of health status which is used world-wide. Index scores range from -0.594 and 1.000, with 1.000 being allocated to patients who report the best possible health state for each area.

The following chart shows the EQ-5D™ scores for different groups of people over the last four years.

[20] https://gp-patient.co.uk/

Figure 15: Health-related quality of life for all people with long-term conditions and people with three or more long-term conditions (NHS Outcomes Framework indicators 2 and 2.7)
Health-related quality of life (EQ-5D™) scores, 2011/12 to 2014/15



Source: GP Patient Survey

For all individuals who responded to the 2014/15 GP Patient Survey, the average EQ-5D™ score was 0.821. The chart shows that this figure has remained at a similar level over the time series.

The average EQ-5D™ scores for people with long-term conditions are generally lower than the England average. In 2014/15, the average score for people with any long-term condition (indicator 2) was 0.743 and this has also remained at a similar level over the time series. This suggests that people with an LTC have not generally changed their perceptions of their quality of life.

The chart shows that for people with three or more long-term conditions, the EQ-5D™ scores are substantially lower; the average score for this group of individuals was 0.470 in 2014/15. There was some improvement between 2011/12 and 2012/13 when the average score increased from 0.440 to 0.473 but there has been very little change since then.

Domain 4 - Overview

Domain 4 is concerned with ensuring people have a positive experience of care. The indicators in domain 4 provide a picture of changes in patients' experience of NHS care, including access to care. They are based on information obtained directly from patients or their carers using patient surveys.

Knowledge of patient experience can highlight poor care and lead to service improvement (NHS Confederation, 2010)[21]. The Mid-Staffordshire NHS Foundation Trust Public Inquiry[22] highlights that the quality of patient experience is an important indicator of the underlying performance of a service provider.

Personal experience and the experience of friends and family have been identified as important considerations when patients have a choice over service providers. As such, information about other patients' experience increases transparency, and can help to support and increase patient choice and control.

Use of nationally coordinated surveys facilitates benchmarking over time and across the country where sample sizes allow. With this information, local clinicians and managers can understand the experience of local patients, and can assess where improvements could be made.

Indicator 4.6 - Bereaved carers' views on the quality of care in the last three months of life

Indicator 4.6 focusses on the experience of care at the end of life. This indicator is based on responses to the National Survey of Bereaved People[23] (VOICES) which is an official statistics publication, managed by the Office for National Statistics (ONS).

The survey asks carers or relatives of deceased adults about the quality of care provided for the deceased in the last three months of their life. The use of bereaved relatives as a proxy for the views of people approaching the end of life has been extensively tested in research settings. The validity of this approach has been well established especially for questions on service provision and use, and on evaluation of care.

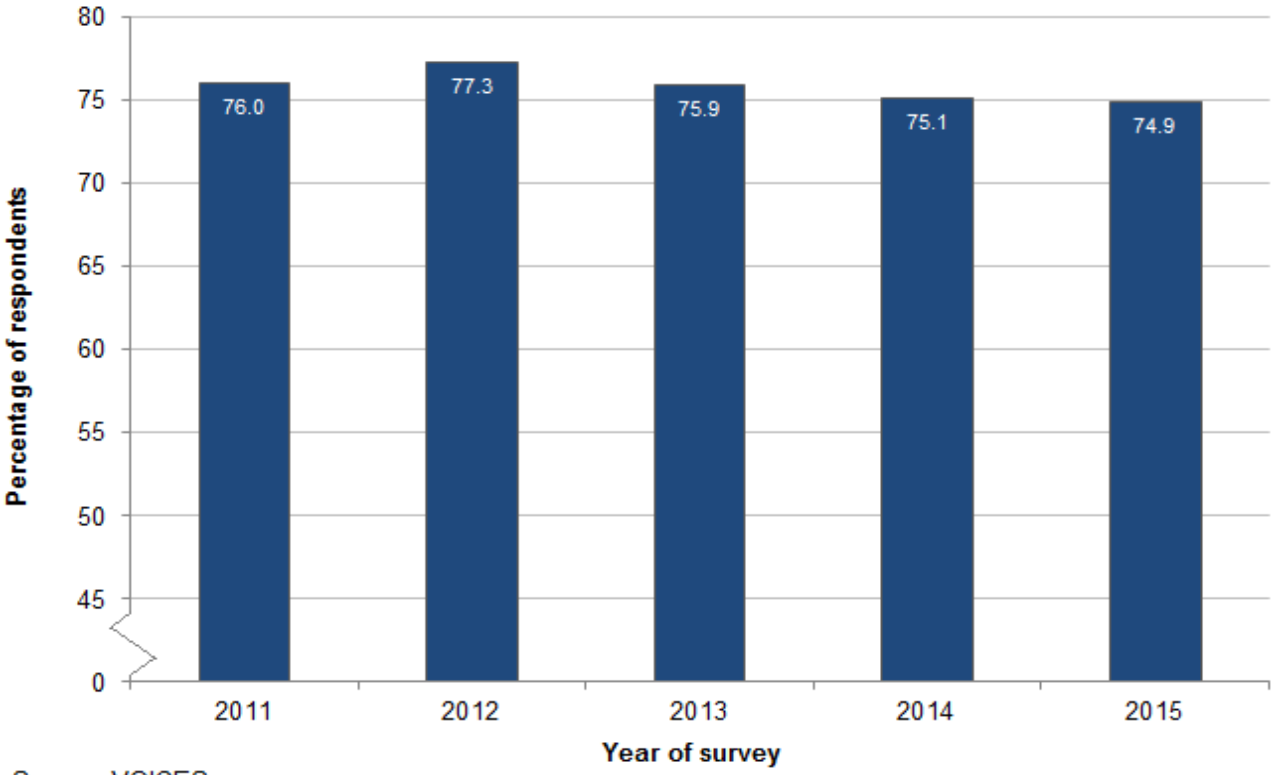
The indicator values are calculated by adding together the percentages of respondents who gave ratings of outstanding, excellent or good to the following question from the survey:

Overall, and taking all services into account, how would you rate his/her care in the last three months of life?

Figure 16 shows all of the indicator values in the time series.

[21] NHS Confederation report - click here
[22] http://www.midstaffspublicinquiry.com/report
[23] http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem

Figure 16: Bereaved carers' views on the quality of care in the last three months of life (NHS Outcomes Framework Indicator 4.6)
Percentage of respondents giving an overall rating of care as either outstanding, excellent or good, 2011 to 2015

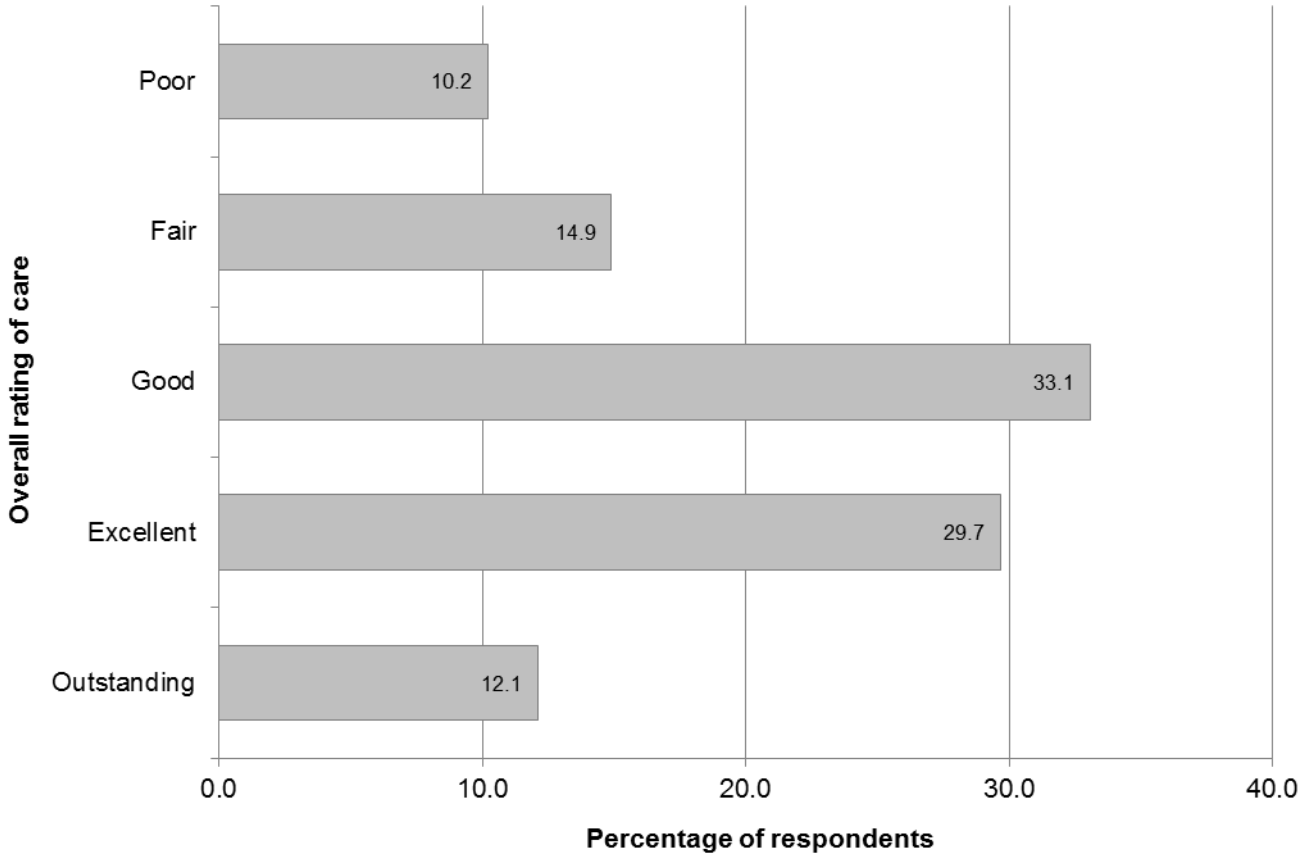


Source: VOICES survey

The chart suggests there has been little change over the five-year time series from 76.0 in 2011. Positive opinions of end of life care may have decreased very slightly over the last three years, however, confidence intervals are not currently presented in the indicator data files and therefore it is not currently possible to say whether this is due to a true change or random variation in the data.

The following chart breaks down the responses to the overall rating of care question.

Figure 17: Bereaved carers' views on the quality of care in the last three months of life (NHS Outcomes Framework Indicator 4.6)
Responses and percentage of responses to the overall rating of care question, 2015

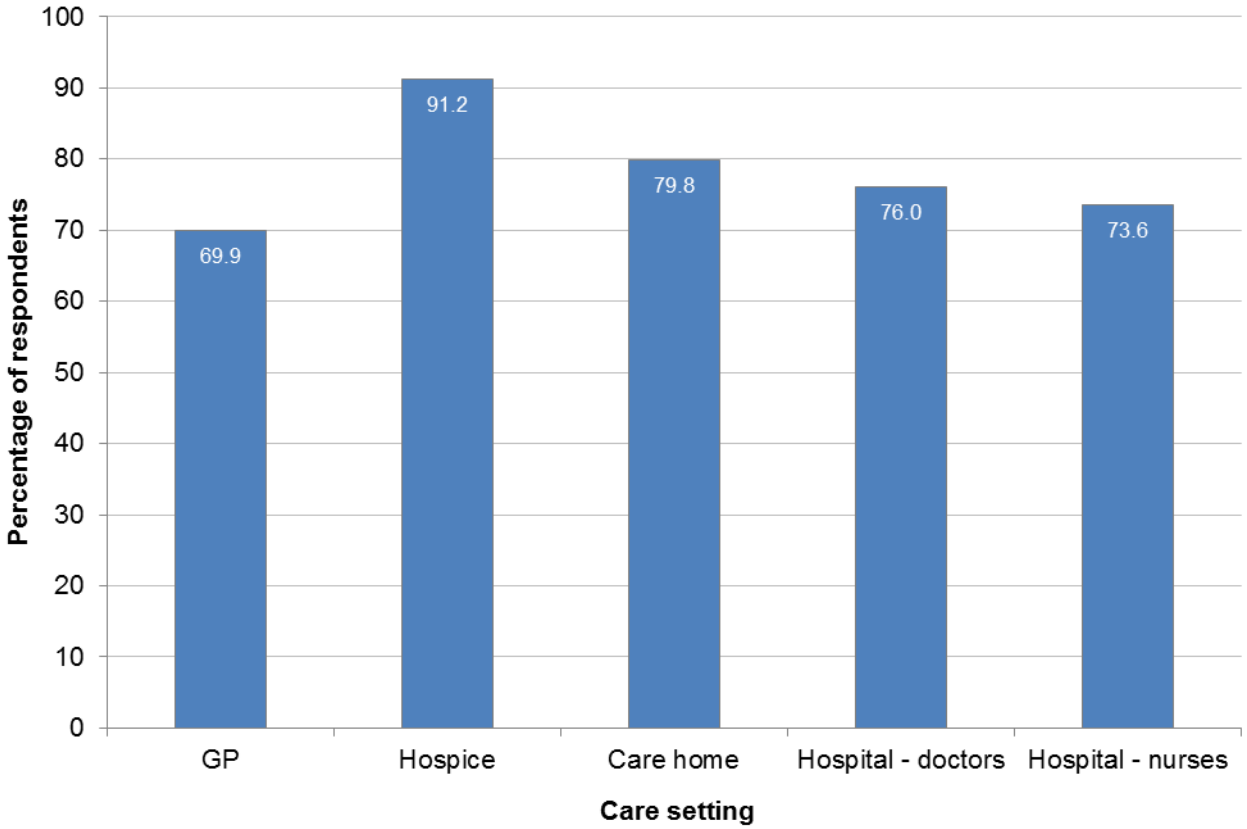


Source: VOICES survey
Figures may not add up to 100 per cent due to rounding

The indicator values are constructed by adding together the percentage of respondents who said care was outstanding, excellent or good. The chart shows that in 2015, a large proportion of the indicator value was generated by people giving the highest ratings of care. 29.7 per cent of respondents said the care was excellent and 12.1 per cent said the care was outstanding, and this is a similar pattern to previous years. One in ten people (10.2 per cent) had a poor experience of end of life care and gave the lowest rating.

The VOICES survey also asks questions about the quality of care in specific care settings. The following chart looks at the percentage of responses that were good or excellent for each of the settings covered in the indicator data files. There is no outstanding response category for these questions.

Figure 18: Bereaved carers' views on the quality of care in the last three months of life (NHS Outcomes Framework Indicator 4.6)
Percentage of respondents giving a rating of excellent or good for each care setting, 2015



Source: VOICES survey

The setting most frequently given good or excellent ratings for end of life care in the 2015 survey was hospices, with 91.2 per cent of respondents giving this answer. This is much higher than for other care settings. GPs received the lowest proportion of good and excellent ratings at 69.9 per cent.

There has been very little change in these figures over the five-year time series. Comparing 2011 data to 2015 data, only the hospital setting has seen changes of greater than two percentage points. The percentage of respondents saying hospital care from doctors was good or excellent has grown by 2.3 percentage points between these data points and the equivalent figure for hospital nurses shows a 5.7 percentage point increase.

Appendix – Release details

The below table shows the time periods and disaggregations which have been added or updated in the indicator data files for this release. Data files for all indicators can be found on our indicator portal at the following address: https://indicators.hscic.gov.uk

Title	Updates
1c Neonatal mortality and stillbirths	New data for 2014: England Gender Age of mother Lower tier local authority Region Deprivation quintile (using IMD 2015) Revised deprivation data 1999 to 2013 (using IMD 2015)
1.4.i One-year survival from all cancers	New data for 2014 follow-ups: England Age group
1.4.ii Five-year survival from all cancers	New data for 2014 follow-ups: England Age group
1.6.i Infant mortality	New data for 2014: England Gender Age of mother Lower tier local authority Region Deprivation quintile (using IMD 2015) Revised deprivation data 1999 to 2013 (using IMD 2015)
2.2 Employment of people with long-term conditions	New data for Q4 2015 (October to December): England Gender Age group Ethnicity Region Unitary authority/local area NS-SEC category Religion
2.5.i Employment of people with mental illness	New data for Q4 2015 (October to December): England Gender Age group Ethnicity

	Region Unitary authority/local area NS-SEC category Religion Condition
2.7 Health-related quality of life for people with three or more long-term conditions	*New indicator* Four years new data from 2011/12 to 2014/15: England Gender Age Ethnicity Sexual orientation Religion Deprivation decile Lower tier local authority Upper tier local authority Region
3.5.i Hip fracture: Proportion of patients recovering to their previous levels of mobility / walking ability at 30 days	No new data, presentational change only: Deprivation quintile labels have been re-ordered to align them with rest of framework. Quintile 1 is now the most deprived rather than the least deprived.
3.5.ii Hip fracture: Proportion of patients recovering to their previous levels of mobility / walking ability at 120 days	No new data, presentational change only: Deprivation quintile labels re-ordered to align with rest of framework. Quintile 1 is now most deprived rather than least deprived.
4.1 Patient experience of outpatient services	No new data, presentational change only: Trust name column added to data file.
4.6 Bereaved carers' views on the quality of care in the last 3 months of life	New data for 2015: England level only
5.6 Patient safety incidents reported	New data for Apr - Jun 2015 and Jul - Sep 2015: Severe harm and death figures for England New data for Jul - Sep 2015 and Oct - Dec 2015: All incident figures for England New data for Oct 2014 - Sep 2015: Medication error figures for England New data for Apr - Sep 2015: Severe harm and death figures for providers New data for Apr - Sep 2015: All incident figures for providers

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