NHS OUTCOMES FRAMEWORK 2012/13

EQUALITY ANALYSIS

Contents

1. Introduction

1.1 This equality analysis examines the potential impact that the NHS Outcomes Framework 2012/13[1] may have on the protected equalities characteristics. It will focus on the technical changes that have been to since the publication of the first NHS Outcomes Framework[2], in December 2010.

1.2 The White Paper, *Equity and Excellence*: *Liberating the NHS*[3] set out how the improvement of healthcare outcomes for all will be the primary purpose of the NHS. This means ensuring that the accountabilities running through the system are squarely focussed on the outcomes achieved for patients and not the processes by which they are achieved.

1.3 The NHS Outcomes Framework 2011/12, reflects the vision set out in the White Paper. Its purpose is threefold:

- to provide a national overview of how well the NHS is performing, wherever possible in an international context;
- to provide an accountability mechanism between the Secretary of State for Health and the proposed NHS Commissioning Board; and
- to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a stronger focus on tackling health inequalities.

1.4 The NHS Outcomes Framework is structured around five domains that the NHS should be aiming to improve. They focus on:

Domain 1:	Preventing people from dying prematurely;
Domain 2:	Enhancing quality of life for people with long-term conditions;
Domain 3:	Helping people to recover from episodes of ill-health or following injury;
Domain 4:	Ensuring that people have a positive experience of care; and
Domain 5:	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

[1] Available at: [dn: link to be confirmed]
[2] Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

[3] Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

1.5 The five domains were derived from the three part definition of quality first set out by Lord Darzi as part of the NHS Next Stage Review[4]. Domains one to three include outcomes that relate to the effectiveness of care, domain four includes outcomes that relate to the quality of patient experience and domain five includes outcomes that relate patient safety.

1.6 The Government has since built this definition of quality into the Health and Social Care Bill currently before Parliament and this frames the duties placed on the Secretary of State for Health, the NHS Commissioning Board and Clinical Commissioning Groups to continuously improve the quality of care provided to patients.

1.7 The outcomes and indicators in the framework were chosen with a view to capturing the majority of treatment activities that the NHS is responsible for delivering. The updated NHS Outcomes Framework sets out the progress that has been made in developing a more robust set of indicators.

Relevance to equality and diversity

1.8 In developing, the first NHS Outcomes Framework one of underpinning principles of the framework was to ensure that it encouraged the promotion of equality and reduce inequalities in outcomes from healthcare.

1.9 The framework will also help the NHS Commissioning Board to play its full part in promoting equality in line with the Equality Act 2010, and subject to the Parliamentary approval, to fulfil the health inequalities duties proposed in the Health and Social Care Bill for the Secretary of State for Health, NHS Commissioning Board and Clinical Commissioning Groups.

1.10 Annex A of the first NHS Outcomes Framework contained a breakdown of the indicators that could be disaggregated by the equality strands. It was acknowledged that data collections for some of the equality strands was more complete than for others. For example, there is better coverage for age and gender (questions are asked as standard and patients provide the information) than for religion or belief and sexual orientation.

1.11 It also outlined as set of principles that would guide the setting of levels of ambition for the outcomes included in the framework. One of these principles will take into account inequalities in health outcomes across a broad range of dimensions, including disadvantaged groups, area deprivation and equalities characteristics.

[4] Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101670

Progress made in promoting equality and addressing inequalities

1.12 Since the publication of the first NHS Outcomes Framework, the Department of Health has been taking forward strands of work to make sure that promoting equality and reducing health inequalities becomes an integral part of the framework.

1.13 This includes working with the NHS Information Centre to further explore the feasibility of disaggregating the indicators by the equality strands. This work is ongoing and it is intended that during 2012 sub-national data will be published. This will enable the Department to start to report on progress, as the data becomes available.

1.14 An updated assessment of the availability of disaggregated data is presented in chapter 2. As outlined above, we will be analysing this data as it becomes available, including evaluating whether the data, when broken down by different dimensions enables meaningful analysis to be carried out.

1.15 Options for assessing outcomes from the perspective of inequalities are being developed. A key part of this work, will be to select appropriate types of inequality measures for different indicators.

Engagement with stakeholders

1.16 Since the publication of NHS Outcomes Framework, the Department of Health has continued to work with interested parties and experts to improve the framework. Comments and questions about the NHS Outcomes Framework are welcomed and should be sent to nhsoutcomesframework@dh.gsi.gov.uk

Next steps

1.17 To ensure that tackling health inequalities and promoting equality becomes an integral part of the NHS Outcomes Framework, we will be undertaking the following actions:

- working with the NHS IC to establish the feasibility of disaggregating more of the indicators by the equality characteristics;
- analysing disaggregated data to see how trends for different groups might affect overall trends in the indicators; and
- carrying out a multi-dimensional analysis of disaggregated data – i.e. looking at equality dimensions simultaneously as well as looking at individual dimensions
- considering how the Mandate that is set for the NHS Commissioning Board might set specific objectives / levels of ambition against the framework which support the proposed health inequalities duties in the current Health and Social Care Bill. The process of developing the Mandate will involve a full public consultation.

2. Updated assessment of disaggregating the indicators

2.1 The information presented here is an update of the table published in the *NHS Outcomes Framework 2011/12* on the possible disaggregation of the indicators. We will keep this assessment under review as we work with the NHS Information Centre on developing some of the newer indicators.

2.2 Data collection remains more complete for some of the strands than others, for example there is better coverage (questions are asked as standard and patients provide the information) for age and gender than for religion and sexual orientation.

Key

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

Indicator details

		Sub-national breakdown			*Equality Strands (National Only)*						*Inequalities*	
	International comparisons	Regional	PCT/ LA	Provider	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Socio-economic group (NSSEC)	Deprivation (via postcode or area)
1. Preventing people from dying prematurely												
1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare	P	P*	P*	TBD	P	N	N	P	N	N	P*	P
1b Life expectancy at 75	N	P*	P*	TBD	N/A	N	N	Y	N	N	P*	P
1.1 Under 75 mortality rate from cardiovascular disease	Y	Y*	Y*	TBD	P	N	N	Y	N	N	P*	P
1.2 Under 75 mortality rate from respiratory disease	Y*	Y*	Y*	TBD	P	N	N	Y	N	N	P*	P
1.3 Under 75 mortality rate from liver disease	Y	Y*	Y*	TBD	P	N	N	Y	N	N	P*	P
1.4.i One-year survival for colorectal cancer	Y	P*	P*	TBD	Y	N	N	Y	N	N	TBD	P

	International comparisons	*Sub-national breakdown*			*Equality Strands (National Only)*						*Inequalities*	
		Regional	PCT/ LA	Provider	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Socio-economic group (NSSEC)	Deprivation (via postcode or area)
1.4.ii Five-year survival for colorectal cancer	Y	P*	P*	TBD	Y	N	N	Y	N	N	TBD	P
1.4.iii One-year survival for breast cancer	Y	P*	P*	TBD	Y	N	N	Y	N	N	TBD	P
1.4.iv Five-year survival for breast cancer	Y	P*	P*	TBD	Y	N	N	Y	N	N	TBD	P
1.4.v One-year survival for lung cancer	Y*	P*	P*	TBD	Y	N	N	Y	N	N	TBD	P
1.4.vi Five-year survival for lung cancer	Y*	P*	P*	TBD	Y	N	N	Y	N	N	TBD	P
1.4.vii Under 75 mortality rate from cancer	Y	Y*	Y*	TBD	P	N	N	Y	N	N	P*	P
1.5 Under 75 *mortality rate in people with serious mental illness (to be developed)*	Possible disaggregations to be assessed once the indicator is developed											
1.6.i Infant mortality	Y*	Y*	Y*	TBD	N/A	N	N	Y	N	N/A	Y	P
1.6.ii Perinatal mortality (including stillbirths)	N	Y*	Y*	TBD	N/A	N	N	Y	N	N/A	Y	P
1.7 *Reduced premature mortality in people with learning disabilities (to be developed)*	Possible disaggregations to be assessed once the indicator is developed											
2. Improving quality of life for people with long-term conditions												
2 Health related quality of life for people with long-term conditions	N	Y*	Y*	Y*	TBD	TBD	TBD	TBD	TBD	TBD	N	TBD
2.1 Proportion of people feeling supported to manage their condition	N	Y*	Y*	Y*	TBD	TBD	TBD	TBD	TBD	TBD	N	TBD
2.2 Employment of people with long-term conditions.	N	P*	P*	N	P	TBD	TBD	P	TBD	TBD	P	P
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive	TBD	Y*	Y*	Y*	Y	Y*	N	Y	TBD	N	TBD	Y
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	TBD	Y*	Y*	Y*	Y	Y*	N	Y	TBD	N	TBD	P
2.4 Health-related quality of life for carers	N	Y*	Y*	Y*	TBD	TBD	TBD	TBD	TBD	TBD	N	TBD
2.5 Employment of people with mental illness	N	P*	P*	N	P	TBD	TBD	P	TBD	TBD	P	P
2.6 *Improved quality of life for those with dementia – indicator to be developed*	Possible disaggregations to be assessed once the indicator is developed											
3. Helping people to recover from episodes of ill health or following injury												
3a Emergency admissions for acute conditions that should not usually require hospital admission	TBD	Y*	Y*	Y*	Y	Y*	N	Y	TBD	N	TBD	Y
3b Emergency readmissions within 28 days of discharge from hospital	N	Y*	Y*	Y*	Y	Y*	N	Y	TBD	N	TBD	Y
3.1 Patient reported outcome measures (PROMs) for elective procedures	N	Y*	Y*	Y*	Y	Y	N	Y	N	N	N	Y

	International comparisons	Sub-national breakdown			Equality Strands (National Only)						Inequalities	
		Regional	PCT/ LA	Provider	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Socio-economic group (NSSEC)	Deprivation (via postcode or area)
3.2 Emergency admissions for children with lower respiratory tract infections	TBD	Y*	Y*	Y*	Y	Y*	N	Y	TBD	N	TBD	Y
3.3 *An indicator on recovery from injuries and trauma (to be developed)*	Possible disaggregations to be assessed once the indicator is developed											
3.4 *Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months (to be developed)*	Possible disaggregations to be assessed once the indicator is developed											
3.5.i The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 days	N	Y*	Y*	Y*	Y	N	N	Y	N	N	N	Y
3.5.ii The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 120 days	N	Y*	Y*	Y*	Y	N	N	Y	N	N	N	Y
3.6 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services	N	Y*	Y*	N	N/A	Y	N	Y	Y	N	N	Y
4. Ensuring that people have a positive experience of care												
4a Patient experience of primary care i GP services ii Out of hours GP services iii NHS dental services	N	Y*	Y*	Y*	TBD	TBD	TBD	TBD	Y	TBD	N	TBD
4b Patient experience of hospital care	N	P*	P*	P*	Y	Y*	N	Y	N	N	N	P*
4.1 Patient experience of outpatient services	N	P*	P*	P*	Y	Y*	N	Y	N	N	N	P*
4.2 Responsiveness to in-patients' personal needs	N	P*	P*	P*	Y	Y*	N	Y	N	N	N	P*
4.3 Patient experience of A&E services	N	P*	P*	P*	Y	Y*	N	Y	N	N	N	P*
4.4i Access to GP Services	N	Y*	Y*	Y*	TBD	TBD	TBD	TBD	Y	TBD	N	TBD
4.4ii Access to dental services	N	Y*	Y*	Y*	TBD	TBD	TBD	TBD	Y	TBD	N	TBD
4.5 Women's experience of maternity services	N	P*	P*	P*	Y	Y*	N	Y	N	N	N	P*
4.6 Survey of bereaved carers	N	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
4.7 Patient experience of community mental health services	N	P	P	TBD	Y	Y*	N	Y	N	N	N	P*
4.8 *An indicator on children and young people's experience of healthcare (to be developed)*	Possible disaggregations to be assessed once the indicator is developed											

	International comparisons	Sub-national breakdown			Equality Strands (National Only)						Inequalities	
		Regional	PCT/ LA	Provider	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Socio-economic group (NSSEC)	Deprivation (via postcode or area)
5. Treating and caring for people in a safe environment and protecting them from avoidable harm												
5a Patient safety incident reporting	P	P	P	Y*	Y	N	N	P	N	N	N	N
5b Severity of harm	P	P	P	Y*	Y	N	N	P	N	N	N	N
5.1 Incidence of hospital-related venous thromboembolism (VTE)	TBD	Y	Y	Y	Y	Y*	N	Y	TBD	N	TBD	Y
5.2.i Incidence of healthcare associated MRSA infection	P	P	P	Y*	Y	P	N	Y	P	N	N	TBD
5.2.ii Incidence of healthcare associated *C. difficile* infection	P	P	P	Y*	Y	P	N	Y	P	N	N	TBD
5.3 Incidence of newly-acquired category 3 and 4 pressure ulcers	P	P	P	Y*	Y	P	N	Y	P	N	N	TBD
5.4 Incidence of medication errors causing serious harm	P	P	P	Y*	Y	N	N	P	N	N	N	TBD
5.5 Admission of full-term babies to neonatal care	N	Y	Y	Y	Y	Y*	N	Y	TBD	N/A	TBD	Y
5.6 Incidence of harm to children due to 'failure to monitor'	P	P	P	Y*	Y	N	N	P	N	N	N	TBD

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3. Evidence base

3.1 This chapter provides a summary of changes to the supporting evidence for the Equality Impact Assessment for The NHS Outcomes Framework 2011/12.

3.2 It should be read in parallel with the previous equality analysis and seen largely as supplemental to the arguments set out 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.

Domain 1 – Preventing people from dying prematurely

3.3 We are assessing the potential equality impacts of proposed changes to Domain 1 of the NHS Outcomes Framework. These changes are:

- Changing the overarching indicator on mortality from causes amenable to healthcare to reflect Potential Years of Life Lost (PYLL)
- Inclusion of all neonatal deaths rather than just early neonatal deaths.
- Proposed development of a new indicator relating to reducing excess premature mortality for people with learning disabilities

Age

3.4 For the PYLL indicator – for each ‘amenable’ disease, the intention would be to assess the number of years that would on average be foregone by a premature death.

3.5 The change in relation to neonatal deaths improves the coverage of the indicator.

Disability

3.6 The response to the consultation on the NHS Outcomes Framework highlighted improving outcomes for people with learning disabilities as an important issue for future iterations of the framework.

3.7 Following the *Innovation in Outcomes competition*[5] to identify new indicators for the framework, we are proposing to develop an indicator on reducing excess premature mortality for people with learning disabilities.

3.8 The purpose of committing to develop an indicator on this is in recognition of the fact that people with learning disabilities have a shorter life expectancy and risk of early death compared to the general population[6].

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

3.9 Dementia is a major cause of disability in later life, ahead of some cancers and cardiovascular disease and stroke[7].

3.10 The importance of improving dementia services was outlined in the National Dementia Strategy published in February 2009[8]. The government's response to the consultation on the NHS Outcomes Framework also highlighted dementia as important for future iterations of the framework.

3.11 Following the *Innovation in Outcomes competition* to identify new indicators for the framework, we are proposing to develop an indicator on improving the quality of life for people with dementia. The equality issues which affect people with dementia are summarised below[6]:

Ethnicity

3.12 Approximately 3% of the estimated overall number of people in England with dementia are from minority ethnic groups – representing about 15,000 people, and there may be a lower degree of knowledge of dementia amongst some ethnic groups.

3.13 Ethnicity was not raised as a significant factor in the consultation process on the National Dementia Strategy, but the Strategy nevertheless emphasises that services should take account of the fact that the needs

[5] NHS Outcomes Framework: Innovation in Outcomes competition

[6] Hollins S, Attard M, van Fraunhofer N, McGuigan SM, Sedgwick P. Mortality in people with learning disability: risks causes, and death certification findings in London. *Developmental Medicine and Child Neurology* 1998;40:50-56.
McGuigan SM, Hollins S, Attard M. Age specific standardised mortality rates in people with learning disability. *Journal of Intellectual Disability Research* 1995;39:527-31.

[7] Living Well with Dementia: A National Dementia Strategy – Equality Impact Assessment, Department of Health (2009) – available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_094054.pdf

[8] Living Well with Dementia: A National Dementia Strategy, Department of Health (2009) – available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058

of people from minority ethnic groups might be different from those of the majority population

Disability

3.14 As highlighted, dementia is one of the major causes of disability in the elderly. The needs of people with dementia who have learning disabilities may particularly require specifically-tailored approaches to care.

Gender

3.15 There are differences in age distribution of dementia incidence according to gender, with the proportion having dementia being higher at older ages for women than for men.

Age

3.16 Incidence of dementia increases with age. There are also a significant number of people, around 15,000, who develop dementia earlier in life.

Religion of belief

3.17 There is no obvious religious dimension to dementia

Sexual orientation

3.18 Robust information on this equality dimension does not exist.

<u>Domain 3 – Helping people to recover from episodes of ill-health or following injury</u>

3.19 Improving people's outcomes following stroke is a key part of the Stroke pathway, as reviewed by the Care Quality Commission in 2010.

3.20 The NHS Outcomes Framework 2011/12 included a placeholder indicator on improving stroke outcomes.

3.21 Following the *Innovation in Outcomes competition* to identify new indicators for the framework, we are proposing to develop an indicator based on recovery for stroke patients based on reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months.

3.22 The evidence relating to the outcome of stroke and experience of care suggests that there are inequalities by race/ethnicity, gender and age[9].

Race/ethnicity

3.23 There is some evidence of differences in stroke mortality outcomes for different ethnic groups. A 2005 British Medical Journal study reported that black patients in a south London population with first every stroke are more likely to survive than white patients[10].

3.24 However, Black and Minority Ethnic (BME) communities have lower uptake of Direct Payments, which can in some circumstances be an effective way of delivering support to stroke survivors.

Age and Gender

3.25 A study of 12,000 stroke survivors in England concluded that older patients were substantially less likely to receive lipid (cholesterol) lowering drugs, which is an effective treatment as part of secondary prevention of stroke.

3.26 Older people that have a stroke are also more likely to die from it than younger people, and although for over 75s, a higher proportion of men have had a stroke than women, the proportion dying is higher for women.

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

3.27 Improving children's services has long been recognised as an important issue[11] and the *NHS Outcomes Framework 2011/12* acknowledged the importance of understanding and improving children's experience of healthcare. A placeholder to develop an indicator for this area was therefore included in the framework.

3.28 Following the *Innovation in Outcomes competition* to identify new indicators for the framework, we are proposing to develop an indicator based on questions from the Children's Outpatient Experience Questionnaire.

[9] Equality Impact Assessment for Stroke Pathway Review, Care Quality Commission (2011) – available at http://www.cqc.org.uk/organisations-we-regulate/special-reviews-and-inspection-programmes/thematic-reviews/stroke-services

[10] Survival differences after stroke in a multiethnic population: follow-up study with the south London stroke register, BMJ 2005;331:431

[11] Getting the Right Start: National Service Framework for Children, Young People and Maternity Service: Standard for Hospital Services Department of Health (2003) – available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006182

Age

3.29 The purpose of committing to develop an indicator on this is in recognition of the fact that children and young people are a large part of the population, numbering around 12 million children, or just over a fifth of the population. Therefore, we must measure their experience of healthcare.

3.30 The inclusion of the indicator also recognises the needs of children in their own right, needing distinct and tailored services rather than receiving the same services as offered to adults.

Ethnicity

3.31 Children and young people from ethnic minority backgrounds make up about one fifth of the total population aged under 19 – a much higher proportion than for older people- and needs to be considered in the design and delivery of services that reflect this cultural diversity.

<u>Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm</u>

3.32 The main change to domain 5 of the NHS Outcomes Framework is the removal of the indicator on the number of ‘similar’ incidents.

3.33 The indicator on number of ‘similar’ incidents had not previously been defined and therefore no additional evidence relating to equalities is presented here.

3.34 However, the concept of learning from patient safety incidents will be picked up across several indicators currently in Domain 5. These cover safety incident reports and reducing the incidence of key harms such as healthcare associated infections, Venous Thromboembolism (VTE) and pressure ulcers. The overall assessment of equalities in relation to improving patient safety was set out in the Equalities Impact Assessment published alongside the *NHS Outcomes Framework 2011/12*.