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NHS Outcomes Framework

Indicators for health inequalities assessment

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Author:

NHS Group, Department of Health

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Contact details:

NHS Outcomes Framework, NHS Group, Department of Health

Room 234, Richmond House

79 Whitehall

London SW1A 2NS

nhsoutcomesframework@dh.gsi.gov.uk

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Introduction

1. The NHS Outcomes Framework, alongside the Adult Social Care and Public Health Outcomes Frameworks, sits at the heart of the health and care system. The NHS Outcomes Framework:

    - provides a national overview of how well the NHS is performing;
    - is the primary accountability mechanism, in conjunction with the mandate, between the Secretary of State for Health and NHS England; and
    - improves quality throughout the NHS by encouraging a change in culture and behaviour focused on health outcomes not process.

2. The NHS Outcomes Framework was developed in December 2010, following public consultation, and has been updated annually. Refreshing the NHS Outcomes Framework allows it to become a tool which reflects the current landscape of the health and care system, and to be better suited to approach the many challenges that the system faces.

3. This document is published as a supplement to the NHS Outcomes Framework 2015/16. The purpose of this document is to explain how the Department will use the NHS Outcomes Framework to assess how NHS England is meeting its mandate objective and legal duties to reduce health inequalities in a simple, transparent and meaningful way. Thus, this document will set out the initial list of NHS Outcomes Framework indicators for health inequalities assessment, to begin in 2015/16.

4. This document complements the ongoing work to make data available for NHS Outcomes Framework indicators which is disaggregated by equalities and inequalities characteristics.

Inequalities and the NHS Outcomes Framework

5. Health inequalities have been defined as: "Differences in health status or in the distribution of health determinants[1] between different population groups."[2] The World Health Organisation argues that:

> "avoidable health inequalities arise because of inequalities in society and in the conditions in which we are born, grow, live work and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social and economic forces."[3]

6. Some examples of inequalities dimensions are area deprivation, age, ethnicity, sex and socio-economic status.

7. The Health and Social Care Act 2012 amendments to the NHS Act 2006 introduced the first ever specific legal duties on health inequalities for the Secretary of State for Health, NHS England and Clinical Commissioning Groups (CCGs) to have regard to the need to reduce health inequalities. These include:

   - A duty on the Secretary of State to have regard to the need to reduce health inequalities between the people of England with respect to the benefits that may be obtained by them from the health service; and
   - Duties on NHS England and each CCG to have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved.

8. The Health and Social Care Act 2012 also requires the Secretary of State to make an assessment of and report on his own performance on the health inequalities duty, and to assess and report on how well NHS England have fulfilled theirs. NHS England is required to assess and report on how well each CCG has fulfilled its health inequalities duty. Indeed, reducing inequalities is one of the objectives within the mandate to NHS England, which states that success will be measured on inequalities as well as overall improvement against the

[1] Health determinants are the range of interacting factors that shape health and well-being. These include: material circumstances, the social environment, psycho-social factors, behaviour and biological factors. In turn, these are influenced by social position, itself shaped by factors such as education, occupation, income, gender, ethnicity and race (World Health Organisation, 2008)

[2] World Health Organisation, *Glossary,* 2008, http://www.who.int/hia/about/glos/en/index1.html

[3] World Health Organisation, *Closing the gap in a generation: Health equity through action on the social determinants of health*, 2008, http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf

NHS Outcomes Framework.

9. The Secretary of State has signalled that he intends to shift the assessment of both his and NHS England's inequalities duties onto a quantitative basis using the NHS Outcomes Framework and the Public Health Outcomes Framework. The approach will be developed over time, beginning in 2015/16.

10. In order that this commitment could be fulfilled in 2015/16, the Department consulted with stakeholders in the summer on an approach of selecting a number of indicators in the NHS Outcomes Framework for health inequalities assessment, based around a set list of criteria (see the paragraph below) and the health inequalities data available (see Annex A). It is the Department's long-term aim that all suitable NHS Outcomes Framework indicators are for health inequalities assessment. For the moment, this is impractical because of data constraints (see Annex A) and unresolved issues surrounding assurance effectiveness. Indeed, the Department is aware that reducing health inequalities is highly challenging, and that some are more amenable than others to NHS action. Therefore, the Department will steer a careful, yet progressive, course in order to tackle the issue of reducing health inequalities while retaining the effectiveness of NHS assurance.

11. Our criteria for selecting indicators for health inequalities assessment stipulated that indicators were to:

    - reflect the major areas of inequality of outcome;
    - reflect areas where the NHS could make a significant difference to the inequalities that people experience;
    - reflect areas of particular policy interest;
    - reflect the breadth of the NHS Outcomes Framework; and
    - cover as broad a range of inequalities dimensions (such as ethnicity, area deprivation, age, sex) as possible, where data allows.

12. Stakeholders were supportive of this plan. Thus, a commitment to undertaking this approach to health inequalities was set out in the NHS Outcomes Framework 2015/16, published in December 2014, and this document fulfils that commitment.

13. The Department has worked closely with both NHS England and stakeholders to produce a final selection of 11 indicators for health inequalities assessment from 2015/2016 that reflects the above criteria and data availability. The health inequalities data for these indicators will be published on the Health and Social

Care Information Centre's (HSCIC) indicator portal[4].

14. These indicators, and the specific health inequalities dimension(s) (such as area deprivation, ethnicity, age) for which they will be assessed, are set out in the table beginning on page 10. An explanation of why these particular indicators have been chosen, and by which health inequalities dimension(s) they will be assessed, is contained within the table. We have also updated our 'At a glance' NHS Outcomes Framework 2015/16 document to indicate which indicators are for health inequalities assessment. This is published on the NHS Outcomes Framework 2015/16 main page[5]. In Annex A of this document, we have set out tables which detail the availability of health inequalities data for all NHS Outcomes Framework indicators, not just the indicators for which we have selected for health inequalities assessment this year.

Overview of the indicators selected

15. An overarching indicator has been selected for each Domain, apart from Domain 5 (Treating and caring for people in a safe environment and protecting them from avoidable harm), for which there is no current health inequalities data. Not all overarching indicators have been selected – exclusion reflects either a small inequality or a lack of data.

16. There are more indicators proposed in Domain 1 (Preventing people from dying prematurely). This reflects a longer history of looking at inequalities concerning mortality, and therefore a greater understanding of the role of the NHS. Public Health also plays an important role in addressing these inequalities and many Domain 1 indicators included here are shared with the Public Health Outcomes Framework, which itself includes an overarching health inequalities indicator (0.2).

17. Overall, the health inequalities dimensions proposed for NHS Outcomes Framework indicators include area deprivation, age, ethnicity and sexual orientation.

18. A measure assessing differences in outcomes between the sexes has not been included. In many cases, differences in outcomes between the sexes will reflect differences in genetic predisposition to disease or demographic differences, rather than differences in NHS quality of care. However, the Department notes

[4] http://www.hscic.gov.uk/indicatorportal

[5] https://www.gov.uk/government/publications/nhs-outcomes-framework-2015-to-2016

that the HSCIC publishes data for males and females for most of the indicators in the list, and so differences in outcomes between males and females will continue to be monitored.

19. Data for the NHS Outcomes Framework indicators are less readily available for some established health inequalities dimensions (such as socio-economic status based on occupation or educational attainment). The availability of data on the existence, or extent, of health inequalities across the characteristics protected through the Equality Act is variable. A commitment has been made to disaggregate NHS Outcomes Framework indicators by these characteristics, where data allow, and this may highlight inequalities which could be used for health inequalities assessment as the set is developed.

20. The following indicators for health inequalities assessment in 2015/2016 include outcomes for children and young people:

    - 1b – Life expectancy at 75
    - 1.1 – Under 75 mortality rate from cardiovascular disease
    - 1.4 – Under 75 mortality rate from cancer
    - 2.3i – Unplanned hospitalisation for chronic ambulatory care sensitive conditions
    - 3a – Emergency admissions for acute conditions that should not usually require hospital admission

21. The following indicator for health inequalities assessment in 2015/2016 relates to inequalities in children's outcomes

    - 1.6i – Infant mortality

22. The following indicators for health inequalities assessment in 2015/2016 include outcomes for older people.

    - 1b – Life expectancy at 75
    - 2 – Health-related quality of life for people with long-term conditions
    - 2.3i – Unplanned hospitalisation for chronic ambulatory care sensitive conditions
    - 3a – Emergency admissions for acute conditions that should not usually require hospital admissions
    - 4ai – Patient experience of GP services

Future steps

23. The HSCIC is committed to making further data to monitor health inequalities available where feasible. The Department will look to expand the list of indicators for health inequalities assessment in due course, and is already in the process of considering additions to the current list for 2016/2017.

24. The Department will also consider whether some further inequalities dimensions could be included, such as outcomes for other groups with protected characteristics under the Equality Act, or vulnerable groups, including those who are homeless, sex workers, migrants or in the armed forces. Some of these may depend upon the availability of resources or new data sources.

25. This year the Department will also be seeking the views of the Outcomes Framework Technical Advisory Group (OFTAG) on the methodology for calculating age-related inequality for cancer survival. The Department expects that this work will be reflected in the list of indicators for health inequalities assessment in 2016/2017.

Table of NHS Outcomes Framework indicators for inequalities assessment

Key

Area Deprivation: the inequality gap is the difference between the top and bottom decile, divided by the median and converted to a percentage.

Ethnicity: the inequality gap is calculated by working out the difference between each ethnic group and white British, taking the largest difference and dividing by the average of all ethnicities and converting to a percentage.

Age: the inequality gap is the difference between the best outcome and worst outcome divided by the average of all age outcomes and converted to a percentage.

Sexual Orientation: the inequality gap is calculated by working out the difference between each sexual orientation and straight/heterosexual, taking the largest difference, dividing by the average and converting to a percentage.

The Slope Index of Inequality (SII): The Slope Index of Inequality (SII) is a measure of the social gradient in an indicator, i.e. how much the indicator varies with socio-economic status or deprivation. The SII summarises social inequalities across the whole population in a single number, which represents the range in the indicator between the most and least disadvantaged within the population, based on a statistical analysis of the relationship between the indicator and socio-economic status or deprivation across the whole population.

For example, the SII in life expectancy in England by area deprivation represents the range in life expectancy across England, from most to least deprived, based on a statistical analysis of the relationship between life expectancy and deprivation across the whole population. An SII of 10 years indicates that life expectancy for the most deprived is 10 years higher than for the least deprived in England. The higher the value of the SII, the greater the inequality.

Indicator	Health inequalities dimensions(s) for assessment	Time Period	Rationale for inclusion	Other HSCIC breakdowns
1a.i: Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare - Adults (ages 20+) [Overarching]	Area Deprivation (metric: Slope Index of Inequalities)	2003-2013	This is an overarching indicator which captures high level inequalities and ensures that inequalities in all amenable causes are monitored. There is a clear gradient in mortality amenable to healthcare by area deprivation. The gap from the top to bottom decile is 118%. This indicator also supports the achievement of the overarching Public Health Outcomes Framework indicator on inequalities in life expectancy, reflecting the component of inequalities in life expectancy that is amenable to healthcare.	Age Lower tier local authority Region Condition Gender
1b.i: Life expectancy at 75 - Males 1b.ii: Life expectancy at 75 - Females [Overarching]	Area Deprivation (metric: Slope Index of Inequalities)	1990-2013	This is an overarching indicator that captures mortality outcomes for over 75s. There is a clear gradient in life expectancy at 75 by area deprivation. The gap from top to bottom quintile is 17% for women and 22% for men. Previous analysis of inequalities in life expectancy for disadvantaged areas showed that the widening gap in life expectancy at birth has been driven by inequalities in life expectancy at 75, particularly for women. Including this indicator ensures that inequalities in mortality at older ages, including the impact of possible ageism in clinical practice on mortality, will be monitored.	Region Local authority Gender

1.1: Under 75 mortality rate from cardiovascular disease [Improvement]	Area Deprivation (metric: Slope Index of Inequalities)	2003-2013	Cardiovascular disease is the largest component of Potential Years of Life Lost and there is a clear gradient in cardiovascular mortality by area deprivation. The gap from the top to bottom decile is 142%. Some trends in inequalities in cardiovascular mortality have shown a narrowing gap, and the Secretary of State's letter to health system leaders setting out criteria for 2014/15 assessment against health inequalities legal duties indicated that previous progress on reducing absolute inequalities in cardiovascular mortality should be maintained.	Lower tier local authority Region Gender Age
1.4: Under 75 mortality rate from cancer [Improvement]	Area Deprivation (metric: Slope Index of Inequalities)	2003-2012	Cancer is the second biggest component of Potential Years of Life Lost and there is a clear gradient in cancer mortality by area deprivation. The gap from top to bottom decile is 73%. Some trends in inequalities in cancer mortality have shown a narrowing gap in the past, and the Secretary of State's letter to health system leaders setting out criteria for 2014/15 assessment against health inequalities legal duties indicated that previous progress on reducing absolute inequalities in cancer mortality should be maintained.	Lower tier local authority Region Gender Age
1.6.i: Infant mortality [Improvement]	Area Deprivation (metric: Slope Index of Inequalities or	1999-2012	This indicator captures an age group not covered by adult mortality. There is a clear gradient in infant mortality by area deprivation. The gap from the top to bottom quintile is 61%. The need to maintain progress on reducing inequalities in infant mortality	Lower tier local authority Region Gender

	Relative Index of Inequalities*)		was included in the Secretary of State's letter to health system leaders setting out criteria for 2014/15 assessment against the health inequalities legal duties. Previously, there has been focus on inequalities by social class, which provides an individual rather than area-based focus. The use of area deprivation is apt in this case because the Office for National Statistics have recently changed the methodology for assigning social class for infant mortality (it is now based on both parents' occupation rather than just father's occupation) and there is no historic time series on the new method. In addition, delivery is more readily focused on areas rather than social class/occupation. There are inequalities by age of mother and ethnicity. It is important to monitor these, but at national level area deprivation is the key focus.	Age
2: Health-related quality of life for people with long-term conditions [Overarching]	Area Deprivation (metric: Slope Index of Inequalities) Ethnicity**	2011/12 - 2013/14	This is an overarching indicator and so captures high-level inequality. Including ethnicity as well as deprivation broadens the inequality dimensions covered by the set as a whole, and highlights a larger inequality. The two dimensions complement each other, capturing issues for both diverse and non-diverse populations, but ensuring that issues for BME groups are given specific attention. There is a 22% gap in outcomes between ethnic groups with the highest and lowest health-related	Gender Age Sexual Orientation Religion Lower tier local authority Upper tier local authority

			quality of life (HRQOL). There is an inequality in HRQOL between groups for the entire population (not just those with a long-term condition) but the inequality is greater amongst those with a long-term condition, suggesting that there is something relating to the long-term condition that exacerbates the inequality.	Region Number of long-term conditions
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages) [Improvement]	Area Deprivation (metric: Slope Index of Inequalities or Relative Index of Inequalities*)	2003/4 - 2013/14	This indicator reflects the quality of management of long-term conditions in primary care, and there are clear inequalities by area deprivation. There is an area deprivation gap of 131% between the top and bottom decile.	Gender Age Lower tier local authority Upper tier local authority Region Condition
3a: Emergency admissions for acute conditions that should not usually require hospital admission (all ages) [Overarching]	Area Deprivation (metric: Slope Index of Inequalities or Relative Index of Inequalities*)	2003/4 – 2013/14	This is an overarching indicator in the Domain, complements indicator 2.3.i and reflects primary care quality. There are clear inequalities for area deprivation, with a gap of 80% between top and bottom decile.	Gender Age Lower tier local authority Upper tier local authority Region Condition
4a.i: Patient experience of primary care - GP	Area Deprivation	2011/12 -	This is an overarching indicator and reflects the quality of primary care. Access to healthcare	Gender

services [Overarching]	(metric: Slope Index of Inequalities or Relative Index of Inequalities*) Age Ethnicity** Sexual Orientation**	2013/14	services is an explicit aspect of health inequalities legal duties for NHS England and CCGs. Although we recognise that there may be differences in perceptions and expectations, experience broadly reflects area deprivation and probably reflects real differences in provision.	Religion Lower tier local authority Upper tier local authority Region
4.4.i Access to GP services [Improvement]	Area Deprivation (metric: Slope Index of Inequalities or Relative Index of Inequalities*) Age Ethnicity** Sexual	2011/12 - 2013/14	There have been longstanding inequalities in access to primary care (fewer GPs per head in deprived areas, taking account of need), and this has been a focus of action over several years. Access to healthcare services is an explicit aspect of the health inequalities legal duties for NHS England and CCGs.	Gender Religion Lower tier local authority Upper tier local authority Region

	Orientation**			

*The HSCIC's indicator assurance process will finalise the most appropriate metric of area deprivation for these indicators.
**The Department is currently developing the most appropriate metric for measuring ethnicity and sexual orientation, which will be finalised in the HSCIC's indicator assurance process.

The data for the above indicators (including the health inequalities data and other HSCIC breakdowns) are contained in the NHS Outcomes Framework section of the HSCIC indicator portal at: https://indicators.ic.nhs.uk/webview/

Full details on each indicator for health inequalities assessment – including how each inequalities dimension is calculated and the data sources used – are also available in the indicator specification documents on the HSCIC indicator portal. The links are below:

For the Domain 1 indicators: https://indicators.ic.nhs.uk/download/Outcomes%20Framework/Specification/NHSOF_Domain_1_S_V4.pdf

For the Domain 2 indicators: https://indicators.ic.nhs.uk/download/Outcomes%20Framework/Specification/NHSOF_Domain_2_S_V4.pdf

For the Domain 3 indicators: https://indicators.ic.nhs.uk/download/Outcomes%20Framework/Specification/NHSOF_Domain_3_S_V4.pdf

For the Domain 4 indicators: https://indicators.ic.nhs.uk/download/Outcomes%20Framework/Specification/NHSOF_Domain_4_S_V4.pdf

Annex A: Total available health inequalities data for each NHS Outcomes Framework indicator

Key

A – data available on HSCIC portal. Any values not attributed elsewhere are calculated using this data. In a few instances data should be available but is currently subject to revision so could not be presented.

D – data in development.

I – work is underway to determine the feasibility of making these data available

N – not available or not applicable. Either the data are not collected or are not robust enough to be published, for example, due to small numbers.

Figure in brackets is year of data presented

A * next to a letter means that there are problems with the data

Area Deprivation: the inequality gap is the difference between the top and bottom quintile, divided by the median and converted to a percentage.

Ethnicity: the inequality gap is calculated by working out the difference between each ethnic group and white British, taking the largest difference and dividing by the average of all ethnicities and converting to a percentage.

Age: the inequality gap is the difference between the best outcome and worst outcome divided by the average of all age outcomes and converted to a percentage.

Sexual Orientation: the inequality gap is calculated by working out the difference between each sexual orientation and straight/heterosexual, taking the largest difference, dividing by the average and converting to a percentage.

Sex: the inequality gap is the difference between male and female, divided by the average of the two and converted to a percentage.

Domain 1

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare **i. Adults**	A Gap between top and bottom quintile 46% of median (2011).	I ONS trend in all cause mortality shows decline in absolute socioeconomic inequality but a rise in relative inequality	A Gap 392% of crude average between 70-74 year olds and 90+ year olds (2012)	N	N	A M/F gap 21% of average (2012)	N	N	N	N	N	CCG OIS, Quality Premia, LOA
1a.ii Children and young people	I	I	I	N	N	A M/F gap 2.6% of average (2012). Considerable variation	N	N	N	N	N	

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
						over time in gap.						
1b Life expectancy at 75	A* Gap between top and bottom quintile 16% (F), 20% (M) of median (2008/10)	I	N	N	N	A M/F gap 14% of average (2012). Gap smaller than EU but women's LE lower	N	N	N	N	N	
1c Neonatal mortality and still births	A* Gap from top to bottom quintile of 51% of median (2012)	N	N	A* CQC 2009 highlighted a problem	N	A Gap 13% of average (2012)	N	N	N	N	N	
1.1 Under 75 mortality rate	A	I	A	N	N	A	N	N	N	N	N	PHOF 4.4

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
from cardiovascular disease	Gap from top to bottom quintile of 117% of median (2012)			CQC 2008 said deaths 50% higher in South Asian communities		M/F gap 75% of average						OIS
1.2 Under 75 mortality rate from respiratory disease	A Gap from top to bottom quintile of 175% of median (2012)	I	A	N	N	A Gap 35% of average (2012)	N	N	N	N	N	PHOF 4.7 OIS
1.3 Under 75 mortality rate from liver disease	A Gap from top to bottom quintile of 149% of median	I Alcohol related mortality for people in routine class 3.5	A Highest rate of alcohol related mortality in men and	N Irish, Scottish and Indian men have higher than	N	A Gap 21% of average (2012)	N	N	N	N	N	PHOF 4.6 OIS

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
	(2012)	(M) and 5.7 (F) times as high as managerial - HSQ 2011	women 55-64 – ONS 2013	average death rate from alcohol associated problems - JRF								
1.4 Under 75 mortality rate from cancer	A Gap from top to bottom quintile of 58% of median (2012)	I	A	N age-adjusted cancer mortality is generally lower among BME groups but can be high for some cancers, e.g. prostate cancer	N	A Gap 7% of average but gap closing – NCIN 2010	N	N	N	N	N	PHOF 4.5 OIS

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
				amongst BME men – Kings Fund								
i. One year survival from all cancers	I	I	A	I	N	D	N	N	N	N	N	
ii. Five year survival from all cancers	I	I	A	I	N	D	N	N	N	N	N	
iii. One year survival from breast, lung and colorectal cancer	I No relation between deprivation and survival for breast – NCIN 2010	I	A Reductions in mortality have been greater in younger than older people in the last decade – NCIN 2010	I Some indications that differences exist but data poor. Black women have lower survival than other groups -	N	D Little differences between M&F for cancers both suffer – NCIN 2010	N	N	N	N	N	OIS

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
				NCIN 2006								
iv. Five year survival from breast, lung and colorectal	I	I	A	I BME and Asian women have lower breast cancer survival – NCIN 2010	N	D	N	N	N	N	N	
1.4.v One-year survival from cancers diagnosed at stages 1 & 2	Possible breakdowns to be assessed once the indicator is developed											
1.4.vi Five-year survival from cancers diagnosed at stages 1 & 2	Possible breakdowns to be assessed once the indicator is developed											

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
1.5.i Excess under 75 mortality rate in adults with serious mental illness	D	I	A Gap 48% of crude average between 30-34 year olds and 70-74 year olds (2011/12)	N Higher rate of diagnosis for BME. Different pathways to care. POST 2007.	N	A Gap 4% of average (2011/12)	N	N	N	N	N	PHOF 4.9
1.5.ii Excess under 75 mortality rate in adults with common mental illness	Possible breakdowns to be assessed once the indicator is developed											
1.5.iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS	I	I	I	I	I	A	I	I	I	I	I	

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
services												
1.6.i Infant mortality	A* Gap between top and bottom quintile 61% of median (2012)	N	N Gap 51% of crude average between <20 year old mothers and 30-34 year old mothers	A* CQC 2009 highlighted a problem	N	A Gap 23% of average (2012)	N	N	N	N	N	PHOF 4.1
1.6.ii Five year survival from all cancers in children	I	I	A Gap 5.6% of crude average between under 4 year olds and 5-9 year olds	I	N	D	N	N	N	N	N	
1.7 Excess under 60 mortality rate	Possible breakdowns to be assessed once the indicator is developed											

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
in adults with a learning disability												

ONS Trend in All Cause Mortality 2001/3 – 2008/10 http://www.ons.gov.uk/ons/rel/health-ineq/health-inequalities/trends-in-all-cause-mortality-by-ns-sec-for-english-regions-and-wales--2001-03-to-2008-10/statistical-bulletin.html

Living Well for Longer, 2013 (using 2010 data, based on unpublished analysis underlying Figure 8 on p.10) , Department of Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181103/Living_well_for_longer.pdf

CQC 2008, Closing the Gap http://webarchive.nationalarchives.gov.uk/20100813162719/http://www.cqc.org.uk/_db/_documents/Closing_the_gap.pdf

HSQ 2011, Social inequalities in alcohol-related adult mortality by National Statistics Socio-economic Classification, England and Wales, 2001–03, Veronique Siegler, Alaa Al-Hamad, Brian Johnson, Claudia Wells Office for National Statistics and Nick Sheron Southampton University http://www.ons.gov.uk/ons/rel/hsq/health-statistics-quarterly/no--50--summer-2011/index.html

ONS 2013 http://www.ons.gov.uk/ons/rel/subnational-health4/alcohol-related-deaths-in-the-united-kingdom/2011/sty-alcohol-related-deaths.html

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NCIN 2006 Cancer incidence and survival by major ethnic group 2002-2006 http://publications.cancerresearchuk.org/downloads/Product/CS_REPORT_INCSURV_ETHNIC.pdf

POST 2007 Parliamentary office of Science and Technology, Ethnicity and Health http://www.parliament.uk/documents/post/postpn276.pdf

ONS 2014, Child Mortality Statistics http://www.ons.gov.uk/ons/rel/vsob1/child-mortality-statistics--childhood--infant-and-perinatal/2012/index.html

CQC 2009 Tackling the Challenge: Promoting race equality in the NHS in England http://webarchive.nationalarchives.gov.uk/20100813162719/http://www.cqc.org.uk/_db/_documents/Tackling_the_challenge_Promoting_race_equality_in_the_NHS_in_England.pdf

Domain 2

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
2 Health related quality of life for people with long term conditions	A Gap between top and bottom quintile 17% of median[6] (2012/13)	N	A Gap 33% of crude average between 18-24 year olds and 85+ year olds (2013/14)	A Gap of 22% between Chinese (high QoL) and Bangladeshi (low QoL) of crude average. (2012/13)[7]	A Gap of 17% between Jewish and Muslim of crude average (2012/13).	A Gap 2% of average (2012/13)	N	A Gap 12% between other and hetero-sexual of crude average (2012/13)	N	N	N	ASCOF 1A
2.1 Proportion of people feeling supported to	A Gap	N	A Gap 31%	A Gap 25%	A Gap of	A Gap 1% of	N	A Gap of	N	N	N	OIS

[6] For each category considered here, there is an inequality in health-related quality of life (HRQOL) between groups for the entire population (not just those with a long term condition) but the inequality is greater amongst those with a long term condition, suggesting that there is something relating to the long term condition that exacerbates the inequality. The exception to this is sexual orientation where the inequality in HRQOL for the entire population is exactly mirrored for those with long term conditions.

[7] Small groups removed

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
manage their condition	between top and bottom quintile 10% of crude average (2012/13)		of crude average between 65-74 year olds (more supported) and 24-25 year olds (less supported) (2012/13)	of crude average between British (more supported) and Chinese (less supported) (2012/13)	22% of crude average between Christian (most supported) and Muslim (least supported) (2012/13)	average (2012/13)		11% of crude average between Heterosexual (most supported) and "other" (least supported) (2012/13)				
2.2 Employment of people with long term conditions[8]	N	A Gap 9% between top and bottom quintiles of socioeconomic group	A Gap 6% between 40-44 year olds (experience biggest difference	A Gap 21% between Arab (biggest employment gap) and	A Gap 11% between Other religion (biggest employment gap)	A M/F gap is 1.8% (2013)	I	I	N	N	N	ASCOF 1E PHOF 1.8

[8] This indicator is expressed as the difference between the % employment of people with long term conditions (LTC) and the % employment of all people. A 5% gap in this table means that the group with a LTC with the smallest difference to the overall population of that group has a 5% smaller employment gap than the group with a LTC with the biggest difference to the overall population of that group.

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
		and 14% between top and bottom categories (2012)	to those without LTC) and 60-64 year olds (smallest difference) [9] (2012)	Chinese (smallest employment gap - Chinese report higher employment amongst those with a LTC) (2012)	and Jewish (smallest employment gap) (2012)							
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)	A	N	A Gap 155% of crude average between under 18 year olds and 75+ year olds	N	N	A M/F gap 0.3% of average (2012/13 q4)	N	N	N	N	N	OIS, Quality premia (as joint indicator)

[9] I have excluded the 16-19 category from this comparison. The data suggests that 16-19 year olds with a long term condition have very similar employment rates to those without but this figure is very variable, possibly as a result of government policy and the state of the economy influencing 16-19 year olds intentions to study.

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
			(2012/13)									
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	A	N	A Gap 149% of crude average between under 1 year olds and 3 year olds (2012/13)	N	N	A M/F gap 24% of average (2012/13)	N	N	N	N	N	OIS, Quality premia (as joint indicator)
2.4 Health related quality of life for carers	A Gap between top and bottom quintile 10% of crude average	N	A Gap 26% of crude average between 18-24 year olds and 85+ year olds	A Gap 11% between Pakistani (lowest QOL) and Chinese (highest QOL) of	A Gap 10% of crude average between Jewish (highest QoL) and Other	A M/F gap 0.5% of average (2012/13)	N	A Gap 11% of crude average between heterosexual (highest QoL) and Other	N	N	N	ASCOF 1D

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
	(2012/13)		(2013/14)	crude average[10]	(Lowest QOL)			(lowest QoL)				
2.5.i Employment of people with a mental illness	N	A Gap 17% between top and bottom quintiles and 50% between top and bottom categories (2012)	A No consistency over which age group has the biggest and smallest employment gap	A Gap 10% Arab (biggest employment gap) and Asian British (smallest employment gap) Some groups missing.	A Gap 22% between Jewish (biggest employment gap) and Buddhist (smallest employment gap)	A M/F gap 13%	I	I	N	N	N	ASCOF 1F PHOF 1.8
2.5.ii Health-related quality of life for people with mental illness	Possible breakdowns to be assessed once the indicator is developed											

[10] Data for a number of ethnic groups and religions unavailable due to small numbers

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
2.6.i Estimated diagnosis rate for people with dementia	N	N	N	N	N	N	N	N	N	N	N	PHOF 4.16
2.6.ii A measure of the effectiveness of post-diagnostic care in sustaining independence and improving quality of life	Possible breakdowns to be assessed once the indicator is developed											
2.7 Health-related quality of life for people with three or more long term conditions	Possible breakdowns to be assessed once the indicator is developed											

Domain 3

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
3a Emergency admissions for acute conditions that should not usually require hospital admission	A	N	A Gap 94% of crude average between under 18 year olds (less admissions) and 75+ year olds (more admissions) (2012/13)	N	N	A M/F gap 9% of average (2011/12 q4)	N	N	N	N	N	OIS, Quality premia (as joint indicator)
3b Emergency readmission within	A Gap	N	D	D	N	A M/F gap	N	N	N	N	N	PHOF 4.1 OIS,

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
30 days of discharge	between top and bottom quintile 21% of median (2010/11).					0.7% (2010/11)						Quality premia (as joint indicator)
3.1.i Total health gain as assessed by patients for elective procedures: physical health related procedures[11]	Possible breakdowns to be assessed once the indicator is developed											
3.1.ii Total health gain as assessed by patients for elective procedures: psychological therapies	Possible breakdowns to be assessed once the indicator is developed											
3.1.iii Recovery in quality of life for	Possible breakdowns to be assessed once the indicator is developed											

[11] Self reported measure. Need to check evidence of bias in self reporting between groups under consideration.

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
patients with mental illness												
3.2 Emergency admissions for children with LRTI	A	N	A	N	N	A M/F gap 30% of average but further investigation required to show whether incidence of LRTI also differs. (2012/13)	N	N	N	N	N	OIS
3.3 Survival from major trauma	Possible breakdowns to be assessed once the indicator is developed											
3.4 Proportion of stroke patients reporting an improvement in	Possible breakdowns to be assessed once the indicator is developed											

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
activity/lifestyle on the Modified Rankin Scale at 6 months												
3.5.i Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at 30 days	A	N	A Gap 34% of average between 65-69 and 85-89 year olds (2012)	N	N	A M/F gap 17% of (2012)	N	N	N	N	N	OIS
3.5.ii Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at 120 days	A	N	A Gap 66% between 60 to 64 and 90+ year olds (2012)	N	N	A M/F gap 4% of average (2012)	N	N	N	N	N	OIS
3.6.i Proportion of older people who were still at home 91 days after discharge	N	N	A Gap 7% of average	N	N	A M/F gap 6% of average	N	N	N	N	N	ASCOF 2B

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
from hospital into reablement/rehabilitation service			between 65 to 74 and 85+ year olds (2013/14)			(2013/14)						
3.6.ii Proportion of older people who were offered rehabilitation following discharge from acute or community hospital	N	N	A Gap 164% of average between 65 to 74 and 85+ year olds (2013/14)	N	N	A M/F gap 48% of average (2013/14)	N	N	N	N	N	
3.7i Decaying teeth	Possible breakdowns to be assessed once the indicator is developed											
3.7ii Tooth extractions in secondary care for children under 10	Possible breakdowns to be assessed once the indicator is developed											

Domain 4

	Deprivation	Socio-economic	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil	Gender reassignme	Pregnancy and	Use in other
4a.i Patient experience of GP services[12]	A Gap 4.7% of median (2012/13)	N	A Gap 15% of average between older people (best experience) and adults (worse experience) (2012/13)	A* Gap 13% of average between white British (best experience) to Asian/Asian British (worst experience)[13] (2012/13)	A Gap 15% of average between Christian (best experience) to Sikh (worst experience) based on wave 1 13/14 GPPS	A* Gap 1.2% of average (2012/13)	N	A Gap 6% of average between heterosexual (best experience) to bisexual (worst experience) based on wave 1 12/13 GPPS	N	N	N	
4a.ii Patient experience of GP	A Gap 3% of	N	A Gap 15%	A* Gap 66% of	A Gap 17% of	A* M/F Gap	N	A Gap 15% of	N	N	N	OIS

[12] Care will need to be taken in the interpretation of survey breakdowns as groups may have systematically different expectations against which they are rating a service as “good” or “fairly good”. Research is underway to give us a greater understanding of these biases.

[13] Not all groups included

	Deprivation	Socio-economic	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil	Gender reassignme	Pregnancy and	Use in other
Out of Hours services	median (2013/14)		of average between 85+ year olds (best experience) and 55-64 year olds (worst experience) (2013/14)	average between Black or Black British (best experience) to white British (worst experience) (2013/14)	average between Christian (best experience) and Buddhist (worst experience) wave 1 13/14 GPPS	7% of average (2013/14)		average between heterosexual (best experience) and gay/lesbian (worst experience) (2013/14)				
4a.iii Patient experience of NHS Dental Services	A Gap 4% of median (2013/14)	N	A Gap 12% of average between 75 to 84 year olds (best experience) and 25 to 34 year olds (worst experience) (2013/14)	A* Gap 160% of average between Asian or Asian British (best experience) to white British (worst experience) (2013/14)	D*	A* M/F Gap 2% of average (2013/14)	N	D*	N	N	N	

	Deprivation	Socio-economic	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil	Gender reassignme	Pregnancy and	Use in other
4b Patient experience of hospital care	N	N	I	A Gap 11% of average between White Irish (most positive) and Chinese (least positive)[14]	I	I	I	I	N	N	N	
4c Friends and family test	Possible breakdowns to be assessed once the indicator is developed											
4d.i Patient experience categorised as poor or worse: primary care	Possible breakdowns to be assessed once the indicator is developed											
4d.ii Patient experience categorised as	Possible breakdowns to be assessed once the indicator is developed											

[14] Not all groups included

	Deprivation	Socio-economic	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil	Gender reassignme	Pregnancy and	Use in other
poor or worse: hospital care												
4.1 Patient experience of outpatient services	N	N	I	I	N	I	I	N	N	N	N	
4.2 Responsiveness to in-patients' personal needs	N	N	I	I	I	I	I	I	N	N	N	
4.3 Patient experience of A&E services	N	N	I	I	I	I	I	I	N	N	N	
4.4.i Access to GP services	A Gap 5% of median	N	A Gap 27% of average between 85+ (best experience) and 18-21 year olds	A Gap 22% of average between best experience (British) and worst experience	A Gap 22% of average between best experience (Christian) and worst	A M/F gap 0.3% of average	N	A Gap 7% of average between best experience (heterosexual) and worst (lesbian/gay)	N	N	N	

	Deprivation	Socio-economic	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil	Gender reassignme	Pregnancy and	Use in other
			(worst experience)	(Pakistani) of booking a GP appointment – wave 1 13/14 GPPS	experience (Sikh) of booking a GP appointment – wave 1 13/14 GPPS			of booking a GP appointment – wave 1 13/14 GPPS				
4.4.ii Access to NHS dental services	A Gap 3% of median	N	A Gap 4% of average between 75 -84 year olds (best experience) and 25-34 (worst experience)	A	D*	A M/F gap 1.3% of average	N	D*	N	N	N	
4.5 Women's experience of maternity services	N	N	I	I	N	N	I	N	N	N	N	
4.6 Bereaved	I	N	D	I	I	D	N	N	N	N	N	OIS

	Deprivation	Socio-economic	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil	Gender reassignme	Pregnancy and	Use in other
carers' views on the quality of care in the last 3 months of care												
4.7 Patient experience of community mental health services	Possible breakdowns to be assessed once the indicator is developed											
4.8 Children and young people's experience of healthcare	Possible breakdowns to be assessed once the indicator is developed											
4.9 People's experience of integrated care	Possible breakdowns to be assessed once the indicator is developed											

NHS England 2013 - Statistical bulletin: Overall patient experience scores: 2013 community mental health survey update
http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/09/stats-1-bull1.pdf

Domain 5

	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Sex	Disability	Sexual orientation	Marriage and civil partnership	Gender reassignment	Pregnancy and maternity	Use in other frameworks
5a Deaths attributable to problems in care	Possible breakdowns to be assessed once the indicator is developed											
5b Severe harm attributable to problems in care	Possible breakdowns to be assessed once the indicator is developed											
5.1 Incidence of hospital related VTE	I	I	I	I	I	I	I	I	I	I	I	
5.2.i Incidence of healthcare associated MRSA infection	I	N	I	N	N	I	N	N	N	N	N	OIS, Quality premia (as joint indicator)
5.2.ii Incidence of healthcare associated C Difficile infection	I	N	I	N	N	I	N	N	N	N	N	OIS, Quality premia (as joint indicator)

5.3 Proportion of patients with category 2, 3 and 4 pressure ulcers	Possible breakdowns to be assessed once the indicator is developed											
5.4 Hip fractures from falls during hospital care	Possible breakdowns to be assessed once the indicator is developed											
5.5 Admission of full-term babies to neonatal care	I	I	I	I	N	I	I	N	N	N	N	
5.6 Patient safety incidents reported	N	N	I	I	N	I	I	N	N	N	N	

Notes on the table

Whilst attempts have been made to give a degree of comparability between the breakdowns and indicators, it is not safe to compare the % difference in outcomes by sex with the % difference in outcomes by ethnicity and conclude, for example, that the sex inequality is greater than the ethnicity inequality. One reason for that is that there are more ethnic groups than gender groups so we would expect a greater range in results.

The gap as percentage of the average has been calculated crudely. The difference was found between the group with the best outcomes and the category with the worst outcomes. This was then divided by the unweighted average of the outcomes for each group to give a sense of scale of the difference. An unweighted average was used so that the outcomes of each group had equal weight. For area deprivation quintiles, the difference was divided by the median – the value of the indicator for the third quintile.

For outcomes indicators 2.2 and 2.5 which are already expressed as a percentage difference in employment between people with a long term condition/learning disability and the general population, the Department has used the difference between the group with the smallest employment difference and the group with the biggest employment difference – these have not been scaled by the average employment difference as these are already percentages.

Breakdowns for which there are some extremely small groups, such as ethnicity and religion, have been removed because their results are too variable over time for conclusions to be drawn. Care needs to be taken in considering the extent of inequality for these indicators.

The difference in outcomes has not been calculated where there are concerns with the data (marked as A*) as such data would be misleading.

For socio-economic status there are a vast number of groups. The Department has, therefore, grouped these into quintiles based on their health outcomes and looked at the difference in the (weighted) mean outcome for the quintile. This gives a measure of the extent of inequalities by socio-economic group, but the socio-economic status groups that are included in each quintile may not relate closely to each other. This also averages out some potentially large inequalities within the calculated quintiles.

Some of the information, particularly from reports, is quite dated. It is not clear how rapidly the inequalities situation might have changed.