



Department
of Health

Refreshing the NHS Outcomes Framework: 2015- 2016

Technical Appendix

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Refreshing the NHS Outcomes Framework 2015-2016: Technical Appendix

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Introduction

Indicators in the NHS Outcomes Framework

Since 2010 the Department of Health has been improving the NHS Outcomes Framework by refining existing measurement indicators and developing new indicators. This technical annex contains the full list of proposed amendments to indicators for inclusion in the 2015/2016 NHS Outcomes Framework.

Indicators in the NHS Outcomes Framework are grouped around five domains. In each Domain, indicators are categorised as follows:

- *Overarching indicators* – Indicators of outcomes across the breadth of activity covered by each domain;
- *Improvement areas* – There are two types of improvement area indicator:
 - *Sub-indicators* – Indicators which are, at least partially, a sub-set of the overarching indicators but which merit independent emphasis;
 - *Complementary indicators* – Indicators which complement the overarching indicators and extend the coverage of the domain.

Together, the overarching indicators and the improvement areas provide a measurement framework to enable assessment of the NHS's contribution to outcomes in each Domain, often jointly with public health and social care services, in the context of an understanding of external drivers of outcome.

The status of each indicator is shown by the following classification:

- *Live* – Indicator development is complete. Where available, the data for live indicators are published on the Health and Social Care Information Centre (HSCIC) Indicator Portal (<http://www.hscic.gov.uk/indicatorportal>);
- *In development* – Some elements of the indicator definition require further development;
- *Placeholder* – A need to measure this outcome has been identified, and one or more potential sources have been identified, but an indicator is yet to be developed, and publication on the HSCIC Indicator Portal is not imminent.

This technical appendix contains details of proposed amendments to indicators following the review on the NHS Outcomes Framework for 2015/16. The incorporation of these proposals into the 2015/16 refresh of the NHS Outcomes Framework is contingent upon feedback received by stakeholders as part of this review.

Technical details for all current indicators can be found in the Technical Appendix for the 2014/15 NHS Outcomes Framework¹ (for 'placeholder' and 'in development

¹https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257032/nhs_of_technical_append.pdf

indicators) and on the Health and Social Care Information Centre (HSCIC) Indicator Portal² (for 'live' indicators), which is updated quarterly. The HSCIC Indicator Portal also provides historical time series and disaggregations. As new placeholder / in development indicators go live, these will also be added to the site.

Timely reporting of data

Before NHS Outcomes Framework data can be published on the HSCIC Indicator Portal, there is a lengthy collection, processing and publication process – typical of very large data-sets.

Work is underway to improve the timeliness of NHS Outcomes Framework data publication, without compromising the robustness of data on the HSCIC Indicator Portal.

Assessing progress against the NHS Outcomes Framework

The NHS Outcomes Framework forms an essential part of the way in which the Secretary of State for Health holds NHS England to account. The Mandate to NHS England³ sets an objective to demonstrate progress against all the five domains and all the outcome indicators in the NHS Outcomes Framework.

The Department of Health will hold NHS England to account and is continually reviewing progress made against the Mandate objectives. To support openness and transparency the intention is to publish progress reports measuring NHS England's progress, including against the indicators in the NHS Outcomes Framework.

Any assessment of progress against the NHS Outcomes Framework should be made in the context of analysis of external drivers and their expected impact on outcomes.

International comparisons

The Mandate to NHS England includes an objective to demonstrate progress “where possible, by comparing our services and outcomes with the best in the world”. The domain sections of the 2014/15 Technical Appendix⁴ provide details on what internationally comparable data is currently available. The Department of Health and NHS England are also working actively with the Organisation for Economic Co-operation and Development (OECD) to understand the differences between

² <http://www.hscic.gov.uk/indicatorportal>

³ See paragraph 11 on page 6 of the NHS Mandate for 2014-15:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256406/Mandate_14_15.pdf

⁴

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257032/nhs_of_technical_append.pdf

countries' data systems and to improve comparability of the OECD's Health Care Quality Indicators.

Alignment with the Public Health Outcomes Framework (PHOF) and Adult Social Care Outcomes Framework (ASCOF)

This Technical Appendix also sets out where proposed indicators are to be shared or complementary with the Public Health or Adult Social Care Outcomes Frameworks:

- *Shared indicators* – those where there is a shared responsibility between the named services and the indicator is identical in each framework;
- *Complementary indicators* – those where there are different indicators in the frameworks that measure the same issue from complementary perspectives.

In both cases, joint contributions will be required to deliver improved outcomes.

Criteria for inclusion of new indicators in the 2015/16 NHS Outcomes Framework refresh

Essential criteria

In order to be included as a new overarching or improvement area indicator in the NHS Outcomes Framework (no matter what's its classification), the criteria outlined below must be met.

I - Outcomes-focus

The indicator must be a measure of health outcome⁵ to be included in the NHS Outcomes Framework.

II - Parsimony

The addition of new indicators must maintain the parsimony of the NHS Outcomes Framework, i.e. minimising the number of indicators in order not to undermine the rationale for the framework as a whole as a focus for accountability and improvement.

Methods to maintain the parsimony of the NHS Outcomes Framework include the publication of supplementary information and/or indicators and disaggregations as contextual information to complement NHS Outcomes Framework indicators themselves.

III - Clarity of Purpose

There must be clarity with regards what the indicator will measure and why. The following are required in order to meet this criterion:

- A unique name for the indicator which differentiates it from, or specifically associates it with, other indicators and which is sufficiently descriptive to convey meaning when referred or quoted without supporting meta-data;
- A clear statement about the purpose of the indicator, including the sought direction of change. The rationale must be clearly set out, be plausible, and capable of being understood by a diverse audience.

⁵ Or interim outcome as a suitable proxy e.g. avoiding emergency readmissions as an interim outcome of a full recovery following a hospital procedure.

IV - Interpretable and actionable

Providers and/or commissioners should in principle be able to take action to improve a bad position suggested by an adverse indication i.e. the indicator is amenable to health and care intervention.

The presentation of the indicator should therefore be suitable such that potential users are able to interpret its values.

The indicator should therefore be capable of detecting variability that is important enough to warrant further investigation, and there should be evidence that suggests there are cost effective interventions that would have a positive impact on the outcome measured.

V - Affordable and Value for Money

Indicator construction and data collection must be affordable. In addition, indicator construction must not incur disproportionate costs (to the benefits from its inclusion in the NHS Outcomes Framework).

VI - Additionality

How this criterion is met depends upon whether an indicator is proposed as an overarching indicator or as an improvement area indicator.

A new overarching indicator should fill a significant gap in the NHS Outcomes Framework, an outcome that is important for patients and amenable to improvement by the NHS but for which significant change would not be registered by an existing NHS Outcomes Framework indicator.

An improvement area indicator should either complement the overarching indicator or call attention to an area of outcome that merits particular attention:

- An indicator may complement overarching indicators where it covers an important *aspect* of outcome that is not covered by the Overarching indicator⁶;
- Where a proposed new improvement area indicator is already captured by an Overarching indicator in full, a clear evidence base is required as to why the outcome in question warrants enhanced attention via inclusion in the NHS Outcomes Framework improvement areas. This might be because there is particular scope for improvement in that area, or because a particular group has particularly poor outcomes.

⁶ For example, in Domain 3 the existing overarching indicators measure only the absence of adverse outcomes; the complementary improvement indicators capture also the extent of recovery.

VII - Feasibility

In order to be included as a placeholder indicator, confidence is required that an indicator can be developed that will meet the 'in development' criteria (set out below).

In order to be included as an 'in development' indicator, the feasibility criteria set out below must be met. In order to progress from 'in development' to 'live' an indicator must also receive formal assessment by the Health and Social Care Information Centre (HSCIC) Methodology Review Group (MRG).

VII.a Definition

A clear and unambiguous description of the indicator and its measurement units is required– this should include all major inclusions and exclusions.

VII.b Methodological and technical soundness

The methods used support the stated purpose. The following are required in order to meet this criterion:

- The data used are reliable enough to support the indicator and its derivations. The quality of the data is above the threshold of acceptability, and this threshold is explicitly defined in the methodology, and accepted by experts. The effect of data quality issues upon the indicator are known;
- The indicator construction, and/or relevant derivations from it are explicitly defined and justified, to the extent that it is possible to reconstruct the indicator and/or derivations using the base data;
- The indicator will not generate any perverse incentives or risk 'gaming'⁷;
- The indicator is sensitive to true events, not significantly distorted by biases;
- Alternative data sources have been considered;
- Data are available with sufficient frequency and timeliness to enable desired improvement actions to be visible;
- Data are expected to be available in the long-term.

⁷ The indicator is not capable of being manipulated in some way to influence the measured outcome without the intended improvement actions taking place.

Desirable Criteria

As discussed above, there are several desirable characteristics which although not essential for inclusion, make an indicator's case for inclusion in the NHS Outcomes Framework more compelling. These are outlined below:

Clear timetable for delivery

Having a clear timetable for delivery increases confidence that an indicator can be fully developed to the required standard for inclusion in the NHS Outcomes Framework.

Aligned with the Mandate and known ministerial priorities

Where there are gaps in the NHS Outcomes Framework or known improvement areas, the case for an indicator's inclusion is strengthened if aligned with the Mandate and/or known ministerial priorities.

Supports alignment of the outcomes frameworks

It is desirable that indicators in the NHS Outcomes Framework support alignment with both the Public Health Outcomes Framework (PHOF) and Adult Social Care Outcomes Framework (ASCOF).

Potential to disaggregate by equalities / inequalities characteristics

It is desirable that disaggregations to sub-national level (e.g. region / CCG and/or by equalities/inequalities characteristics) are possible. Disaggregations by equalities/inequalities characteristics make it possible to assess progress against these as well as average outturn, aiding NHS England in its required legal duties.

The technical robustness criteria (discussed above) also apply to such disaggregations.

Supports robust international comparisons

It is desirable that indicators in the NHS Outcomes Framework support robust international comparisons of health outcomes.

The Indicator selection process

Policy teams within NHS England and DH

NHS England and the Department of Health officials have clinical, technical and policy expertise and responsibility for each domain area, as well as for specific areas such as cancer, stroke, emergency admissions, children and young people, and mental health. Proposals are formulated for indicators based on perceived gaps in the framework, or specific requests from the technical groups (see below). All indicators proposed for inclusion into the NHSOF must satisfy the indicator selection criteria, as set out above.

Outcomes Framework Technical Advisory Group

The Outcomes Framework Technical Advisory Group (OFTAG) provides external technical advice to Ministers regarding NHS Outcomes Framework development. OFTAG's members are independent academic and clinical experts.

Coverage and Refinement sub-Group (CRG)

The Coverage and Refinement sub-Group is a subsidiary external advisory group to OFTAG. CRG provides advice to OFTAG by: considering coverage of the NHS Outcomes Framework and seeking to resolve gaps; seeking to maximise use of existing datasets in the NHS Outcomes Framework; and promoting alignment of the NHS Outcomes Framework with the Public Health Outcomes Framework and Adult Social Care Outcomes Framework.

Refreshing the NHS Outcomes Framework 2015/16

Domain 1: Preventing people from dying prematurely

Domain 1	
Number	Description
1.c	Reclassify Indicator 1.6.ii as an overarching indicator (1c)
1.4.iii, iv	Add new placeholders for one- and five-year cancer survival in stage 1 & 2
1.5.ii	Introduce a placeholder indicator for 'Excess <75 mortality rate in adults with common mental health problems'

1.4. v, vi Cancer survival with early stage diagnosis

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 1: Preventing people from dying prematurely
Outcome sought	Capture improvement in cancer survival amongst cancers that are diagnosed early.
Status	Placeholder
Rationale for inclusion	There is both lead time and length bias in the current cancer survival indicators. These new indicators will allow a more robust interpretation of cancer survival outcomes.
Detailed descriptor	<p>Plain English description: A measure of survival at one and five years following early diagnosis of cancer.</p> <p>Technical description: A measure of the proportion of people still alive after i) one and ii) five years following a diagnosis of cancer at stage 1 or stage 2.</p>
DATA SOURCES	
Data sources	National cancer registry.
Reporting frequency	To be determined

Publication timing		
ICD-10 codes	ICD-10 codes	Condition
		To be determined. Likely to be invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin.
CONSTRUCTION		
Proposed calculation methodology	To be determined. Will link to PHOF indicator 2.19 – Cancer diagnosed at early stage.	
Changes since previous publication		
Technical issues remaining to be resolved		

1.5.ii Excess <75 mortality rate in adults with common mental health problems

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 1: Preventing people from dying prematurely
Outcome sought	Reduce premature mortality in adults with common mental health problems
Status	Placeholder
Rationale for Inclusion	<p>Until now, the only mental health indicator in Domain 1 of the NHS Outcomes Framework was excess mortality for people with serious mental illness (defined as in contact with secondary mental health services)</p> <p>However, we did not have any indicator for people with common mental health problems. These people would never be in touch with secondary mental health services and only receive support from primary care services.</p>

Detailed descriptor	<p>Plain English description:</p> <p>A measure of the extent to which adults with a GP-diagnosed common mental health problems (such as depression and anxiety)⁸ die younger than adults in the general population</p> <p>Technical description:</p> <p>The ratio of the directly age-standardised mortality rate for people aged 18 to 74 with a GP-diagnosed common mental health problem (such as depression and anxiety) to the directly age-standardised mortality rate for the general population of the same age, expressed as a percentage.</p>		
DATA SOURCES			
Data sources	<p>GP Extraction Service (GPES)</p> <p>ONS: mortality data</p> <p>ONS: mid-year population estimates (to standardise the measure)</p>		
Reporting frequency	Annual		
Publication timing			
ICD-10 codes	ICD-10 codes	Condition	
	F32,F33,F41,F42,F43.1,	Depression, generalised anxiety disorder, mixed anxiety and depressive disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, or social anxiety disorder (NICE definition of common mental health problems)	
CONSTRUCTION			
Proposed calculation methodology	<p>Those people aged 18-74, whose GP Patient Record notes one of the following conditions: depression, generalised anxiety disorder, mixed anxiety and depressive disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and social anxiety disorder over a period of time (i.e. a year) are identified and matched by their NHS number to ONS mortality statistics covering the same period. The mortality rate in the population with common mental health problems is directly standardised to the national population. This is then compared to the national rate using a standardised mortality ratio.</p>		

⁸ Only deaths occurring a minimum of one year after diagnosis are counted to exclude cases where the diagnosis of a terminal physical condition (leading to the person's death) has given rise to the mental health problem.

Changes since previous publication	N/A
Technical issues remaining to be resolved	The number of years needed to have a sufficient sample size needs to be discussed with colleagues in the Information Centre.

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

Domain 2	
Number	Description
2.3.ii	Introduce a placeholder indicator for 'Alcohol related hospital admissions'.
2.5.ii	Introduce a placeholder for 'Health-related quality of life for people with mental health problems'
2.7	Introduce an in development indicator for 'Health related quality of life for people with multiple long term conditions'
2.8.i	Introduce a placeholder for 'Decaying, Missing and Filled (DMF) teeth'.
2.8.ii	Introduce a placeholder for 'Inpatient tooth extractions (<10s)'

2.5.ii Health-related quality of life for people with mental health problems

OVERVIEW

Indicator Family Name	NHS Outcomes Framework – Domain 2: Enhancing quality of life for people with long-term conditions
Outcome sought	Better (health-related) quality of life for people with mental health problems
Status	Placeholder
Rationale for inclusion	The only existing indicator of quality of life for people with mental health conditions is employment of people with mental health problems. This is quite a limited proxy for quality of life for people with mental health problems.
Detailed descriptor	<p>Plain English description:</p> <p>The methodology is being developed. It is expected that the indicator will be based on a summary of patients' rating on those dimensions of quality of life which are likely to be affected by mental health conditions. The details of this indicator will be confirmed after John Brazier publishes his research on the development of a generic patient reported outcome measure, the questionnaire for which is expected to be published in April 2015.</p> <p>Technical description:</p> <p>The methodology is being developed. It is expected that the indicator</p>

	will be based on an average score on the <i>Recovery Quality of Life</i> (ReQoL) questionnaire.
DATA SOURCES	
Data sources	Yet to be accommodated.
Reporting frequency	
Publication timing	
CONSTRUCTION	
Proposed calculation methodology	Each answer-option for each question in the ReQoL will be assigned a value (allowing different weightings). These values will be summed and the average will be taken.
Changes since previous publication	
Technical issues remaining to be resolved	The tool that would be used to collect this information is still in development. Therefore there are a range of technical issues still to be considered including identifying how this information will be collected on a routine basis.

2.8.i Average level of tooth decay in NHS patients

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 2: Enhancing Quality of Life for people with long term conditions
Outcome sought	Improved oral health as measured by reduced decay of teeth
Status	Placeholder in 14/15; in development, from March 2015; and to go live from March 2016
Rationale for inclusion	Fills a significant gap in coverage of the NHSOF - 29.8 million unique visits to NHS commissioned dentistry services last year.
Detailed descriptor	<p>Plain English description:</p> <p>A measure of the average number of decayed teeth for those people who regularly visit an NHS dentist</p> <p>Technical description:</p> <p>Average number of decayed teeth for patient who have attended a NHS dentist two or more times; as measured by their most recent course of treatment that took place during the reporting period and</p>

	where the previous attendance was no more than two years before the most recent, excluding urgent treatment, free treatment, referrals and edentate patients
DATA SOURCES	
Data sources	NHS BSA: FP 17 form
Reporting frequency	Quarterly (financial year)
Publication timing	Autumn/winter after the end of the follow-up year
CONSTRUCTION	
Proposed calculation methodology	Arithmetic mean of recorded level of decay for patient who have attended a NHS dentist two or more times; as measured by their most recent course of treatment that took place during the reporting period and where the previous attendance was no more than two years before the most recent, excluding urgent treatment, free treatment, referrals and edentate patients
Changes since previous publication	N/A – this is a new indicator
Technical issues remaining to be resolved	The FP17 form needs to be adapted to collect the appropriate data items. NHS BSA have been contacted by NHS England to discuss feasibility

2.8.ii Secondary care tooth extraction for people aged 10 years and younger

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 2: Enhancing Quality of Life for people with Long Term Conditions
Outcome sought	Reduced levels of people aged 10 years and younger who are referred to secondary care for tooth extractions
Status	Placeholder in 14/15; in development from March 2015; to go live from March 2016
Rationale for	Fills a gap in the NHS Outcomes Framework for outcomes not

inclusion	covered by the above oral health indicator – the preventative and access aspects of NHS commissioned dentistry services.
Detailed descriptor	<p>Plain English description: A measure of the level of tooth extractions for people aged 10 years and under in secondary care</p> <p>Technical description: A count of Finished Consultant Episodes (FCEs) for extraction of one or more decayed primary or permanent teeth having a main procedure (OPCS4) code of F09 – surgical removal of tooth or F10 – simple extraction of tooth (derived from OPER_1D3), for 0 to 10 year olds (derived from START_AGE), in an identified financial year (derived from EPIEND)</p>
DATA SOURCES	
Data sources	HSCIC: HES dataset
Reporting frequency	Annually (calendar year)
Publication timing	Autumn/winter after the end of the follow-up year
CONSTRUCTION	
Proposed calculation methodology	A count of Finished Consultant Episodes (FCEs) for extraction of one or more decayed primary or permanent teeth having a main procedure (OPCS4) code of F09 – surgical removal of tooth or F10 – simple extraction of tooth (derived from OPER_1D3), for 0 to 10 year olds (derived from START_AGE), in an identified financial year (derived from EPIEND)
Changes since previous publication	New indicator
Technical issues remaining to be resolved	Some extraction activity takes place in community settings. Work is ongoing to make sure it is captured by HES

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

Domain 3		
Number	Description	Paper Reference
3.1	Refinement of the existing PROMs indicators: from 5 to 2 - one for physical conditions and one for mental health conditions	OFTAG (14)(01)(02)
3.1.iii	Introduce a placeholder indicator for “Recovery in Quality of life measured after mental health procedures”.	OFTAG CR (7)(2)

3.1 Total health gain as assessed by patients for elective procedures

- i. *Physical health related procedures*
- ii. *Mental health related procedures*

OVERVIEW

Indicator Family Name	NHS Outcomes Framework – Domain 3: <i>Helping people to recover from ill-health or following injury</i>
Outcome sought	Increased health gain from planned physical health related procedures and planned mental health related procedures
Status	In development – expected to go live in 2015. The physical health component is currently reported separately for each procedure. The mental health component is now in development expected to go live in 2014/15.
Rationale for inclusion	Rationalising these PROMS indicators support the commitment to parity of esteem, and provide an incentive to expand PROMS to other procedures.
Detailed descriptor	Plain English description: This indicator measures improvements in health as both a result of planned physical health related procedures – such as medical procedures for groin hernia, hip replacement, knee replacement and varicose veins – and planned mental health related procedures – such as NHS psychological therapies for people with depression and anxiety disorders. Technical description: Total health gain from patients who report an improvement in health status following either elective physical health related procedures or

	<p>mental health related procedures.</p> <p>Physical health related procedures currently cover groin hernia, hip replacement, knee replacement and varicose veins. Mental health related procedures will cover psychological therapies provided under the Improving Access to Psychological Therapies (IAPT) programme in England. Initially, these procedures will focus on people with depression and anxiety disorders.</p>
DATA SOURCES	
Data sources	<p>For physical health related procedures:</p> <p>PROMs dataset, published by the Health and Social Care Information centre (HSCIC) (available at: http://www.hscic.gov.uk/proms)</p> <p>For mental health related procedures:</p> <p>Improving Access to Psychological Therapies (IAPT) dataset, published by the Health and Social Care Information centre (HSCIC) (available at: http://www.hscic.gov.uk/article/2021/Website-Search?q=routine+iapt+monthly+data+quality&area=both)</p>
Reporting frequency	<p>For physical health related procedures:</p> <p>Annually</p> <p>For mental health related procedures:</p> <p>Publication planned quarterly and annually.</p>
Publication Timing	<p>For physical health related procedures:</p> <p>Final annual confirmed PROMS data are released approximately 18 months after the end of the reporting year. Data for 2011/12 were released in October 2013.</p> <p>For mental health related procedures:</p> <p>Final 2012/13 data, the first year in the data collection, were published on January 2014.</p>
CONSTRUCTION	
Proposed calculation methodology	<p>For physical health related procedures:</p> <p>The EQ-5D index case-mix adjusted average health gain is reported separately for groin hernia, hip replacement, knee replacement and varicose veins. Additionally the number of eligible episodes is provided for each of the four procedures at England and Provider level. This information is used to calculate the total health gain, which is published at national level only.</p> <p>Then, the total health for these procedures will be added up to produce the total health gain following physical procedures.</p> <p>For mental health related procedures:</p> <p>This measure is now in development.</p>

	<p>The indicator will be based on client-reported outcomes collected during Improving Access to Psychological Therapies (IAPT) sessions using Patient-Reported Outcome Measures (PROMs) such as the Patient Health Questionnaire (PHQ-9), the Generalised Anxiety Disorder 7 (GAD-7) and Anxiety Disorder Specific Measures (ADSM).</p> <p>Higher scores in these scales suggest increased severity of the mental health condition. Each of these outcome scales has a threshold above which the client is deemed to have a clinical diagnosis of a common mental disorder and each of these scales also includes a measurement error.</p> <p>Using these scales the indicator will measure health gain for each IAPT client in terms of the severity of their condition before and after treatment. Outcomes for all clients who have a clinical diagnosis of a common mental disorder prior to treatment and who have reported PROMs in two or more IAPT sessions will be aggregated in the indicator.</p>
Changes since previous publication	<p>Aggregating total health gain separately for physical related planned procedures and mental health planned procedures allows the indicator to expand by including new PROMs measures when available without the need to create a new sub-indicator for each new measure. A procedure breakdown will be published thereby informing on health gain for each procedure separately.</p> <p>The Department is working closely with HSCIC and NHS England to finalise the definition of the indicator 3.1ii. It is expected that this definition will be confirmed during the 2014/15 financial year.</p>
Technical issues remaining to be resolved	<p>These proposed changes will be submitted to the Health and Social Care Information Centre's Indicator Assurance Service, the publisher of the NHS Outcomes Framework indicators' data.</p>

3.1.iii Recovery in Quality of Life for patients with mental health problems

OVERVIEW

Indicator Family Name	NHS Outcomes Framework – Domain 3: Helping people to recover from episodes of ill health or following injury
Outcome sought	More increased recovery of people with mental health problems to recover
Status	In development
Rationale for inclusion	The current indicator 3.1 relates to IAPT services, a primary care intervention. This new proposed indicator will measure recovery for people receiving secondary mental health services.

<p>Detailed descriptor</p>	<p>Plain English description:</p> <p>The methodology is being developed. It is expected that the indicator will be either the average change or (if feasible) the proportion of people who received treatments for mental health problems whose improvement in their quality of life indicator over the treatment has been greater than a clinically important minimum change.</p> <p>Technical description:</p> <p>The methodology is being developed. It is expected that the indicator will be <u>either</u> the average change in the (sum of) ratings to items 9, 10, 11 and 12 of the Health of the Nation Outcomes Scale (HoNOS) between each patient's initial assessment / first treatment and his/her last assessment / treatment appointment <u>or</u> (if feasible) the proportion of people whose change in the (sum of) ratings to items 9, 10, 11 and 12 of the Health of the Nation Outcomes Scale (HoNOS) between initial assessment / first treatment and last assessment / treatment appointment has been greater than a clinically important minimum change.</p>
<p>DATA SOURCES</p>	
<p>Data sources</p>	<p>Mental Health Minimum Dataset</p>
<p>Reporting frequency</p>	<p>Annual (financial year)</p>
<p>Publication timing</p>	
<p>CONSTRUCTION</p>	
<p>Proposed calculation methodology</p>	<p>The sum of the assigned values for each answer-option (0 – No problem, 1 – Minor problem requiring no action, 2 – Mild problem but definitely present, 3 – Moderately severe problem, 4 – Severe to very severe problem) for each of questions 9, 10, 11 and 12 of the HoNOS questionnaire is calculated for each patient's first and last appointment. The indicator will be either the average change in these scores or the proportion of patients whose improvement has been greater than a clinically important minimum value.</p>
<p>Changes since previous publication</p>	
<p>Technical issues remaining to be resolved</p>	<p>HoNOS measures quality of life for patients based on clinicians' reports and only covers secondary care. Ideally, this indicator would measure quality of life as reported by patients and will cover patients in different settings. The Department is aware that research on these issues is underway and will consider improving this indicator in light of available evidence.</p>

Domain 4: Ensuring people have a positive experience of care

Domain 4	
Number	Description
4d.i/ii	Introducing a new composite indicator of 'Patient experience of care that is characterised as being poor or worse'

4d.i Patient experience of primary medical care that is characterised as being poor or worse

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 4: Ensuring that people have a positive experience of care
Outcome sought	Improved patients' experience of primary medical care
Status	In development – expected to be live in April 2015.
Rationale for inclusion	It is problematic for anybody to have a poor or worse experience of care and as such it is an important outcome to be measured. The indicator will complement the existing indicators 4ai and 4aii so that NHS England is held to account for improving patient experience on average as well as for those in receipt of poor or worse experience of care.
Detailed descriptor	Across two questions from the GP Patient Survey, the average number of responses that characterise patient experience of care as being poor or worse per 100 patients.
DATA SOURCES	
Data sources	GP Patient Survey
Reporting frequency	Annual (financial)
Publication timing	Three to four months after the end of the financial year
CONSTRUCTION	
Proposed calculation methodology	<p>Numerator</p> <p>The total weighted number of responses of 'fairly poor' or 'very poor' across the two questions in the survey.</p> <p>The two questions from the GP Patient Survey are:</p>

	<p>Q28: Overall, how would you describe your experience of your GP Surgery?</p> <p>Q45: Overall, how would you describe your experience of Out of Hours GP services?</p> <p>Denominator</p> <p>The total weighted number of respondents to at least one of the two questions.</p> <p>Calculation</p>
Changes since previous publication	N/A
Technical issues remaining to be resolved	To subject the methodology to the HSCIC Indicator Assurance Service.

4d.ii Patient experience of hospital care that is characterised as being poor or worse

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 4: Ensuring that people have a positive experience of care
Outcome sought	Improved patients' experience of hospital care
Status	In development – expected to be live in April 2015.
Rationale for inclusion	As for 4d.i
Detailed descriptor	Across 13 questions from the NHS Adult Inpatient survey, the average number of responses that characterise patient experience of care as being poor or worse per 100 patients.
DATA SOURCES	
Data sources	NHS Adult Inpatient Survey
Reporting frequency	Annual (financial)

Publication Timing	Two months after the end of the financial year												
CONSTRUCTION													
Proposed calculation methodology	<p>The measure is proposed to be constructed from 13 questions selected from those that form the existing over-arching indicator 4b – Patient experience of hospital care. The questions and the responses that characterise patient experience as being poor or worse were selected by a group of patient experience policy experts. Starting with the full list of questions the experts filtered out those questions where either the question or the associated responses were judged to be too subjective or ambiguous for characterising patient experience as poor or worse or where the questions were not relevant for the majority of patients. With the 13 selected questions, the experts then judged in a consistent way which of the response options available for each question best characterised patient experience as being poor or worse.</p> <p>Numerator</p> <p>The total weighted number of responses that characterise experience of care as being poor or worse across the selected 13 questions from the existing over-arching indicator 4b – Patient experience of hospital care.</p> <p>Denominator</p> <p>The total number of respondents to at least one of the 13 questions.</p> <p>The table below lists the questions on which the indicator is based. The right hand column lists the associated responses that have been selected as characterising ‘poor’ experience of care.</p> <table border="1" data-bbox="432 1391 1350 2018"> <thead> <tr> <th data-bbox="432 1391 778 1503">Question</th> <th data-bbox="778 1391 1043 1503">Response options</th> <th data-bbox="1043 1391 1350 1503">Selected responses to characterise poor experience of care</th> </tr> </thead> <tbody> <tr> <td data-bbox="432 1503 778 1615">Q16. “Were you ever bothered by noise at night from hospital staff?”</td> <td data-bbox="778 1503 1043 1615">“No”; “Yes”</td> <td data-bbox="1043 1503 1350 1615">Yes</td> </tr> <tr> <td data-bbox="432 1615 778 1816">Q17. In your opinion, how clean was the hospital room or ward that you were in?</td> <td data-bbox="778 1615 1043 1816">“Very clean”; “Fairly clean”; “Not very clean”; “Not at all clean”</td> <td data-bbox="1043 1615 1350 1816">"Not very clean" OR "Not at all clean"</td> </tr> <tr> <td data-bbox="432 1816 778 2018">Q21. How would you rate the hospital food?</td> <td data-bbox="778 1816 1043 2018">“Very good”; “Good”; “Fair”; “Poor”</td> <td data-bbox="1043 1816 1350 2018">Poor</td> </tr> </tbody> </table>	Question	Response options	Selected responses to characterise poor experience of care	Q16. “Were you ever bothered by noise at night from hospital staff?”	“No”; “Yes”	Yes	Q17. In your opinion, how clean was the hospital room or ward that you were in?	“Very clean”; “Fairly clean”; “Not very clean”; “Not at all clean”	"Not very clean" OR "Not at all clean"	Q21. How would you rate the hospital food?	“Very good”; “Good”; “Fair”; “Poor”	Poor
Question	Response options	Selected responses to characterise poor experience of care											
Q16. “Were you ever bothered by noise at night from hospital staff?”	“No”; “Yes”	Yes											
Q17. In your opinion, how clean was the hospital room or ward that you were in?	“Very clean”; “Fairly clean”; “Not very clean”; “Not at all clean”	"Not very clean" OR "Not at all clean"											
Q21. How would you rate the hospital food?	“Very good”; “Good”; “Fair”; “Poor”	Poor											

	Q24. When you had important questions to ask a doctor, did you get answers that you could understand?	“Yes, always”; “Yes, sometimes”; “No”; “I had no need to ask”	"No"
	Q26. Did doctors talk in front of you as if you weren't there?	“No”; “Yes, sometimes”; “Yes, often”	"Yes, often"
	Q27. When you had important questions to ask a nurse, did you get answers that you could understand?	“Yes, always”; “Yes, sometimes”; “No”; “I had no need to ask”	"No"
	Q29. Did nurses talk in front of you as if you weren't there?	“No”; “Yes, sometimes”; “Yes, often”	"Yes, often"
	Q31. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	“No”; “Yes, sometimes”; “Yes, often”	Yes, often
	Q32. Were you involved as much as you wanted to be in decisions about your care and treatment?	“Yes, definitely”; “Yes, to some extent”; “No”	"No"
	Q37. Were you given enough privacy when being examined or treated?	“Yes, always”; “Yes, sometimes”; “No”	Yes, sometimes OR No
	Q39. Do you think the hospital staff did everything they could to help control your pain?	“Yes, definitely”; “Yes, to some extent”; “No”	No
	Question	Response options	Selected responses to characterise poor experience of care
	Q51. On the day you left hospital, was your discharge delayed for any reason?	“No”; “Yes”. Exception: Records excluded	"Yes" (not including exceptions)

		<p>where:</p> <p>i) the answer to "What was the main reason for the delay?" is "Something else" AND</p> <p>ii) the answer to Q61, "How long was the delay?" is NOT "longer than 4 hours"</p>	
	<p>Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?</p>	<p>"Yes, always"; "Yes, sometimes"; "No"</p>	<p>Yes, sometimes OR No</p>
<p>Calculation</p>			
<p>Changes since previous publication</p>	<p>N/A</p>		
<p>Technical issues remaining to be resolved</p>	<p>To subject the methodology to the HSCIC Indicator Assurance Service</p>		

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

Domain 5	
Number	Description
5.6	REMOVE existing Indicator 5.6 – Incidence of harm to children due to ‘failure to monitor’
5a, 5b	5a Deaths- and 5b Severe harm- attributable to problems in healthcare
5.4	Hip fractures from falls during hospital care
5.6	Patient safety incidents reported

REMOVAL OF INDICATOR	
5.6 – Incidence of harm to children due to ‘failure to monitor’	
OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm
Outcome sought	Reduced incidence of harm to children due to ‘failure to monitor’
Status	Live – to be removed from the NHS Outcomes Framework in 2015-16
Rationale for <u>exclusion</u> from the framework	The proposal to remove the indicator is because of the unsuitable data source and that there are no alternative data sources available on which the indicator could be based. There are also some technical issues with the calculation methodology. See ‘Technical Issues’ section below.
Detailed descriptor	The total number of patient safety incidents, causing harm to children (<18 years old) due to failure to monitor, reported to the National Reporting and Learning Service (NRLS) by provider organisations
DATA SOURCES	
Data sources	National Reporting and Learning System (NRLS), Quarterly Data Summary.
Reporting frequency	NRLS data Annual (calendar year)
Publication timing	NRLS - six months after the end of the reporting period

CONSTRUCTION	
Calculation methodology	<p>Data Filter and Calculation</p> <p>The indicator is the number of events that meets all of the criteria defined below.</p> <ol style="list-style-type: none"> 1. Condition Age at incident <18 Rationale Indicator definition of children. 2. Condition Country = England Rationale This indicator is to measure activity in England. 3. Condition Degree of harm excludes the category “No Harm” Rationale This indicator is to measure reported incidents where harm occurred. 4. Condition Care setting = acute and location level 1 = acute/general hospital Rationale This indicator looks at acute hospitals. 5. Condition One of the following is true: <ol style="list-style-type: none"> i. (Incident type lvl1 = implementation of care and Incident type lvl2 = delay or failure to monitor) or ii. (Incident type lvl1 = treatment procedure and Incident type lvl2 = (treatment procedure – delay or failure or treatment procedure - inappropriate or wrong)) or iii. (Incident type lvl1 = clinical assessment <p>This specifies the indicator definition for incidents due to failure to monitor.</p>
Changes since previous publication	<p>It is proposed that this live indicator is removed from the framework as it is not fit-for-purpose. Replacement of this indicator is planned in the longer term by development of the overarching indicators to include children.</p>
Technical issues remaining to be resolved	<p>The proposal to remove the indicator is because of the unsuitable data source and that there are no alternative data sources available on which the indicator could be based. There are also some technical issues with the calculation methodology.</p>

	<p>The data source from which it is derived – the National Reporting and Learning System (NRLS) – is no longer viewed as an appropriate source for measuring the incidence of harm as incident reporting is not an accurate or reliable indicator of actual safety⁹ or outcomes. The purpose of the National Reporting and Learning System is to provide opportunities to learn from reported incidents and trends in reporting levels can be used as an indicator or reporting culture.</p> <p>The algorithm used to identify the intended type of incidents is capturing too broad a set of incidents. A recent internal review of a random sample of 50 out of 306 cases from one quarter of data found that only between 3% and 15% of the data represents the intended type of incidents. The breakdown of the 50 cases is below:</p> <ul style="list-style-type: none"> • 3 refer to failure to monitor in the sense intended by this indicator (physiological signs and symptoms of deteriorating condition not taken or not recognised or not acted on); • 11 could possibly be counted as failure to monitor if the definition was stretched as far as possible (some sense of some aspect of their condition not being recognised promptly e.g. a pregnant 16 year old who may have been in early labour but did not get appropriate vaginal examination) • 35 have nothing to do with child deterioration (most often refer to pressure injuries from devices or IVs displaced, but there are a miscellaneous collection of items here); • 1 is clearly not a child though their age is recorded as 0.25 years. <p>An appropriate denominator needs to be identified as the indicator is currently calculated as a raw count.</p>
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5.4 Hip fractures from falls during hospital care

OVERVIEW

Indicator Family Name	NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm
Outcome sought	Reduced incidence of hip fractures from falls during hospital care
Status	In development
Rationale for inclusion	This is one of the major sources of patient safety harms, with approximately 2,500 cases a year. Patients who are already ill have very poor outcomes and greatly extended lengths of stay.

⁹ <http://www.jphres.org/index.php/jphres/article/view/jphr.2013.e27>

Detailed descriptor	<p>Plain English description</p> <p>The number of hip fractures from falls during hospital care as a proportion of all hospital admissions.</p> <p>Technical description</p> <p>Incidence of hip fractures from falls during hospital care</p>
DATA SOURCES	
Data sources	<p>National Hip Fracture Database (NHFD)</p> <p>Hospital Episode Statistics (HES)</p>
Reporting frequency	<p>To be determined</p>
Publication timing	<p>To be determined</p>
CONSTRUCTION	
Proposed calculation methodology	<p>Numerator</p> <p>The numerator will be sourced from the National Hip Fracture Database (NHFD), with a filter applied to the [admitted from] field that records where the hip fracture occurred: The [admitted from] field currently has the following options:</p> <ul style="list-style-type: none"> • Own home/sheltered housing • Residential care • Nursing care • This hospital site • Other hospital site of this trust • Other hospital trust <p>Denominator</p> <p>The denominator will be the total number of hospital admissions recorded in Hospital Episode Statistics (HES).</p>
Changes since previous publication	<p>N/A</p>
Technical issues remaining to be resolved	<ul style="list-style-type: none"> • Formal approval to use NHFD for this purpose. • Amendment to the existing field, [admitted from], in the NHFD that records where the patient was admitted from, so that it more clearly states that it is about where the hip fracture occurred. • Calculation methodology, including any standardisation • In time we hope to expand the indicator to cover hip fractures from falls in all healthcare settings. We will need to work with the NHFD to amend the options of the [admitted from] field so that patients in NHS-funded settings outside of hospital can be identified.

5.6 Patient safety incidents reported	
OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm
Outcome sought	Improved readiness of the NHS to report harm and to learn from it
Status	In development – expected to be live by 2015-16
Rationale for inclusion	Not applicable as indicator already exists – see box on ‘Changes since previous publication.’
Detailed descriptor	<p>Plain English description</p> <p>The number of patient safety incidents reported to the National Reporting and Learning Service (NRLS) by provider organisations, per 100,000 population.</p> <p>A patient safety incident (PSI) is defined as ‘any unintended or unexpected incident(s) that could have, or did, lead to harm for one or more person(s) receiving NHS funded healthcare’.</p> <p>Technical description</p> <p>The number of patient safety incidents reported to the National Reporting and Learning Service (NRLS) by provider organisations, per 100,000 population</p>
DATA SOURCES	
Data sources	<p>National Patient Safety Agency, (Source Provider: National Reporting and Learning System (NRLS), Quarterly Data Summary).</p> <p>National Patient Safety Agency, (Source Provider: National Reporting and Learning System (NRLS), Organisation Patient Safety Incident Reports.</p> <p>ONS Mid-Year Population Estimates</p>
Reporting frequency	<p>National Level – quarterly (calendar year)</p> <p>Trust Level – bi-annually (calendar year)</p>
Publication timing	Six months after the end of the reporting period
CONSTRUCTION	
Proposed calculation methodology	<p>Numerator</p> <p>The numerator is the number of patient safety incidents, as submitted to the National Reporting and Learning System by an organisation based in England. Some organisations, such as community</p>

	<p>pharmacy which submit for England and Wales, and those submitted via eForms who choose not to disclose the organisation where the incident occurred, are excluded.</p> <p>Denominator</p> <p>For national level figures, the rate is per hundred thousand population as per the ONS Mid-year population estimates.</p> <p>Disaggregated data are calculated by type of trust. The choice of denominator and rate is dependent of the type of organisation, as detailed in the following table.</p> <table border="1" data-bbox="416 591 1431 1088"> <thead> <tr> <th>Type of Trust</th> <th>Denominator</th> <th>Rate</th> </tr> </thead> <tbody> <tr> <td>Acute</td> <td>Admissions</td> <td>100*(total incidents/admissions)</td> </tr> <tr> <td>Mental health</td> <td>Bed days</td> <td>1000*(total incidents/bed days)</td> </tr> <tr> <td>PCO Inpatient provision</td> <td>Bed days</td> <td>1000*(total incidents/bed days)</td> </tr> <tr> <td>PCO No Inpatient provision</td> <td>Count of incidents only</td> <td>-</td> </tr> <tr> <td>Ambulance</td> <td>Count of incidents only</td> <td>-</td> </tr> </tbody> </table> <p>Disaggregations</p> <p>The indicator will be reported by the following disaggregations, each of which will be available with a further split by adult and child age groups:</p> <ul style="list-style-type: none"> • Severe harm or death • No harm • Incidents of type medication error <p>The degree of harm for a patient safety incident is defined in the NRLS as follows:</p> <ul style="list-style-type: none"> • ‘severe’ – the patient has been permanently harmed as a result of the PSI where ‘permanent harm’ is defined as permanent lessening of bodily functions; including: sensory, motor, physiological or intellectual; and • ‘death’ – the PSI has resulted in the death of the patient 	Type of Trust	Denominator	Rate	Acute	Admissions	100*(total incidents/admissions)	Mental health	Bed days	1000*(total incidents/bed days)	PCO Inpatient provision	Bed days	1000*(total incidents/bed days)	PCO No Inpatient provision	Count of incidents only	-	Ambulance	Count of incidents only	-
Type of Trust	Denominator	Rate																	
Acute	Admissions	100*(total incidents/admissions)																	
Mental health	Bed days	1000*(total incidents/bed days)																	
PCO Inpatient provision	Bed days	1000*(total incidents/bed days)																	
PCO No Inpatient provision	Count of incidents only	-																	
Ambulance	Count of incidents only	-																	
<p>Changes since previous publication</p>	<p>There are several changes to this indicator that was previously 5a: <i>Patient safety incidents reported</i>. These changes are:</p> <ul style="list-style-type: none"> • A move from an over-arching to an improvement area indicator to better reflect the nature of the outcome. Improved readiness of the NHS to report and learn from harm is an important but 																		

	<p>intermediate outcome of safe care.</p> <ul style="list-style-type: none"> • Disaggregation of patient safety incidents into types, levels and by patient age groups
Technical issues remaining to be resolved	None

Gaps in Inequalities Outcome Data

Identifying where there may be significant inequalities in outcome

The following table is a first attempt to apply the first selection criterion as detailed in the *Equalities and marginalised groups* chapter in the stakeholder engagement document – reflect major areas of inequality – to the outcomes framework indicators.

The information presented is from breakdowns of the outcomes framework indicators, available via the Health and Social care Information Centre portal, and existing research into specific issues. *This table is still in development and we welcome information from stakeholders, both from comprehensive research and softer information from engagement that would help create a more complete picture.*

We recognise that it will not be feasible to obtain a full set of inequalities information in a reasonable time frame (and some information may always be difficult to obtain). We will therefore apply the criteria to the best information available, following consultation, to determine the set of inequalities indicators for the outcomes framework. As further information becomes available, or as the inequalities landscape changes, we can revisit this set of indicators.

We have examined outcomes by age only for indicators 2.1, 2.2 and 2.5 for which outcomes for a particular group are compared with outcomes for the population as a whole. We are seeking advice from stakeholders about how to interpret different outcomes for people of different age for other indicators. We are considering a range of approaches, including adjusting outcomes by fragility and comparing outcomes of different age groups between regions (controlling for deprivation).

By focussing on protected characteristics and deprivation we capture a wide range of possible dimensions of inequality. However, we recognise that there may be other dimensions that are amenable to healthcare that are not captured here. *We welcome views from stakeholders about other aspects of inequality that ought to be considered in the outcomes framework.*

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. Expected in 2014/15

I – feasibility of breakdown under investigation

N – breakdown not feasible

Figure in brackets is year of data presented

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

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	Gap between top and bottom quintile 46% of median (2011).	ONS trend in all cause mortality shows decline in absolute socioeconomic inequality but a rise in relative inequality	A	N	N	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	M/F gap 2.6% of average (2012). Considerable variation over time in gap.	N	N	N	N	N	
1b Life expectancy at 75	Gap between top and bottom quintile 16% (F), 20% (M) of median (2008/10)	I	N	N	N	M/F gap 15% of average (2012). Gap smaller than EU but women's LE lower	N	N	N	N	N	

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
1.1 Under 75 mortality rate from cardiovascular disease	D Living well for longer finds gap from top to bottom quintile of 121% of median for males and 135% of median for females. CQC 2008 said major contributor to inequality	I	A	N CQC 2008 said deaths 50% higher in South Asian communities	N	M/F gap 75% of average	N	N	N	N	N	PHOF 4.4 OIS
1.2 Under 75 mortality rate from respiratory disease	D Living well for longer finds gap of 179% (M) and 182% (F) of median. Gap constant or increased recently.	I	A	N	N	Gap 35% of average (2012)	N	N	N	N	N	PHOF 4.7 OIS

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
1.3 Under 75 mortality rate from liver disease	D Living well for longer finds gap of 185% (M) and 141% (F). Gap constant or increasing.	I Alcohol related mortality for people in routine class 3.5 (M) and 5.7 (F) times as high as managerial - HSQ 2011	D Highest rate of alcohol related mortality in men and women 55-64 – ONS 2013	I Irish, Scottish and Indian men have higher than average death rate from alcohol associated problems - JRF	N	D Gap 21% of average (2012)	N	N	N	N	N	PHOF 4.6 OIS
1.4 Under 75 mortality rate from cancer i. One year survival from all cancers	I Significant gap largely due to poor survival of lung cancer which has higher prevalence in deprived areas – NCIN 2010	I	D	I age-adjusted cancer mortality is generally lower among BME groups but can be high for some cancers, e.g. prostate cancer amongst BME men – Kings Fund	N	D N - Gap 7% of average but gap closing – NCIN 2010	N	N	N	N	N	PHOF 4.5 OIS
ii. Five year survival from all cancers	I	I	D	I	N	D	N	N	N	N	N	

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
iii. One year survival from breast, lung and colorectal cancer	I No relation between deprivation and survival for breast – NCIN 2010	I	D Reductions in mortality have been greater in younger than older people in the last decade – NCIN 2010	Some indications that differences exist but data poor. Black women have lower survival than other groups - NCIN 2006	N	N Little differences between M&F for cancers both suffer – NCIN 2010	N	N	N	N	N	OIS
iv. Five year survival from breast, lung and colorectal	I	I	D	I BME and Asian women have lower breast cancer survival – NCIN 2010	N	D	N	N	N	N	N	
1.5 Excess under 75 mortality rate in adults with serious mental illness	D	I	A	Higher rate of diagnosis for BME. Different pathways to care. POST 2007.	N	Gap 3% of average (2011/12)	N	N	N	N	N	PHOF 4.9

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
1.6 i. Infant mortality	Gap between top and bottom quintile 74% of median (2010)	A*	Difference in mortality rate between mothers <20 yrs and 30-34 years is 55% of mean rate – ONS 2014	A* CQC 2009 highlighted a problem	N	Gap 26% of average (2011)	N	N	N	N	N	PHOF 4.1
1.6 ii. Neonatal mortality and still birth	A*	A*	Difference in still birth rate between mothers <20 and 30-34 yrs is 45% of mean rate. Neonatal gap is 58% - ONS 2014	A* CQC 2009 highlighted a problem	N	A	N	N	N	N	N	
1.6 iii. Five year survival from all cancers in children	I	I	I	I	N	D	N	N	N	N	N	
1.7 Excess under 60 mortality rate in adults with a learning disability	Being developed											

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/hsg/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>

JRF, Joseph Rowntree Foundation, Ethnicity and Alcohol, A review of the literature, 2010 <http://www.jrf.org.uk/publications/ethnicity-alcohol-review>

NCIN 2010 Evidence to March 2010 on cancer inequalities in England http://www.ncin.org.uk/cancer_type_and_topic_specific_work/topic_specific_work/equality

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	Gap between top and bottom quintile 17% of median ¹⁰ (2012/13)	N	A	Gap of 22% between Chinese (high QoL) and Bangladeshi (low QoL) of crude average. (2012/13) ¹¹	Gap of 17% between Jewish and Muslim of crude average (2012/13).	Gap 2% of average (2012/13)	N	Gap 12% between other and heterosexual of crude average (2012/13)	N	N	N	ASCOF 1A
2.1 Proportion of people feeling supported to manage their condition	Gap between top and bottom quintile 10% of crude average (2012/13)	N	Gap 31% of crude average between 65-74 year olds (more supported) and 24-25 year olds (less supported) (2012/13)	Gap 25% of crude average between British (more supported) and Chinese (less supported) (2012/13)	Gap of 22% of crude average between Christian (most supported) and Muslim (least supported) (2012/13)	Gap 1% of average (2012/13)	N	Gap of 11% of crude average between Hetrosexual (most supported) and "other" (least supported) (2012/13)	N	N	N	OIS

¹⁰ For each category considered here, 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. 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.

¹¹ Small groups removed

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
2.2 Employment of people with long term conditions ¹²	N	Gap 9% between top and bottom quintiles of socioeconomic group and 14% between top and bottom categories (2012)	Gap 6% between 40-44 year olds (experience biggest difference to those without LTC) and 60-64 year olds (smallest difference) ¹³ (2012)	Gap 21% between Arab (biggest emp gap) and Chinese (smallest emp gap - Chinese report higher employment amongst those with a LTC) (2012)	Gap 11% between Other religion (biggest emp gap) and Jewish (smallest emp gap) (2012)	M/F gap is 1.4% (2012)	I	I	N	N	N	ASCOF 1E PHOF 1.8

¹² 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.

¹³ 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.

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
2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	Gap between top and bottom quintile 98% of median (2011/12 q4)	N	A	B/W gap 68% of mean ¹⁴ (2010/11 q4, subset of groups used)	N	M/F gap 0.3% of average (2012/13 q4)	N	N	N	N	N	OIS, Quality premia (as joint indicator)
2.3 ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	A (No info on portal currently)	N	A	A*	N	A	N	N	N	N	N	OIS, Quality premia (as joint indicator)
2.4 Health related quality of life for carers	Gap between top and bottom quintile 10% of crude average (2012/13)	N	A	Gap 11% between Pakistani (lowest QOL) and Chinese (highest QOL) of crude average ¹⁵	Gap 10% of crude average between Jewish (highest QoL) and Other (Lowest QOL)	M/F gap 0.5% of average (2012/13)	N	Gap 11% of crude average between heterosexual (highest QoL) and Other (lowest QoL)	N	N	N	ASCOF 1D

¹⁴ It is understood that the coding of ethnicity in the Hospital Episode Statistics (HES) is imperfect. Ethnicity measures for 2.3i, 2.3ii, 3a, 3b and 3.2 therefore need to be treated with caution.

¹⁵ Data for a number of ethnic groups and religions unavailable due to small numbers

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
2.5 Employment of people with a mental illness	N	Gap 17% between top and bottom quintiles and 50% between top and bottom categories (2012)	No consistency over which age group has the biggest and smallest employment gap	Gap 10% arab (biggest emp gap) and Asian british (smallest emp gap) Some groups missing.	Gap 22% between Jewish (biggest emp gap) and Buddhist (smallest emp gap)	M/F gap 13%	I	I	N	N	N	ASCOF 1F PHOF 1.8
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 Indicator tbc												ASCOF 2F

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	Gap between top and bottom quintile 73% of median (2010/11 q4)	N	A	Gap other ethnic group 102% higher admissions than mixed group. (2010/11 q4) (some groups missing)	N	M/F gap 9% of average (2011/12 q4)	N	N	N	N	N	OIS, Quality premia (as joint indicator)
3b Emergency readmission within 30 days of discharge	Gap between top and bottom quintile 21% of median (2010/11).	D	D	D	N	M/F gap 0.7% (2010/11)	N	N	N	N	N	PHOF 4.1 OIS, Quality premia (as joint indicator)
3.1 Total health gain as assessed by patients for elective procedures: i Hip replacement, ii Knee replacement, iii Groin hernia, iv Varicose veins, v Psychological therapies¹⁶	A No clear social gradient (2011/12)	N	A	A*	N	Groin 27% Hip 9% Knee 14% Varicose 10% of average (2011/12)	A	N	N	N	N	OIS
3.2 Emergency admissions for	A (but not updated)	N	A	A*	N	M/F gap 30% of average	N	N	N	N	N	OIS

¹⁶ Self reported measure. Need to check evidence of bias in self reporting between groups under consideration.

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
children with LRTI						but further investigation required to show whether incidence of LRTI also differs. (2012/13)						
3.3 Proportion of people who recover from major trauma	Being developed											
3.4 Proportion of patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months	Being developed											
3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days	I	N	A	N	N	M/F gap 17% of average at 30 days and 4% at 120 days (2012)	N	N	N	N	N	OIS
3.6 i Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation service	N	N	A	N	N	M/F gap 4% of average (2012)	N	N	N	N	N	ASCOF 2B

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
3.6 ii Proportion offered rehabilitation following discharge from acute or community hospital	N	N	A	N	N	M/F gap 50% of average (2012/13)	N	N	N	N	N	

Domain 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
4a i Patient experience of GP services ¹⁷	Gap 4.7% of median (2012/13)	N	D*	Gap 13% of average between white British (best experience) to Asian/Asian British (worst experience) ¹⁸ (2012/13)	D*Gap 15% of average between Christian (best experience) to Sikh (worst experience) based on wave 1 13/14 GPPS	Gap 1.2% of average (2012/13)	N	D* Gap 6% of average between heterosexual (best experience) to bisexual (worst experience) based on wave 1 13/14 GPPS	N	N	N	
4a ii Patient experience of GP Out of Hours services ⁸	D*	N	D*	D* Gap 15% of average between Irish (best experience) and Indian (worst experience) – wave 1 13/14 GPPS ¹⁹	D*Gap 17% of average between Christian (best experience) and Buddhist (worst experience) wave 1 13/14 GPPS	D* Gap 5% of average based on wave 1 13/14 GPPS	N	D*Gap 15% of average between heterosexual (best experience) and gay/lesbian (worst experience) – wave 1 13/14 GPPS	N	N	N	OIS
4a iii Patient experience of NHS Dental Services	D*	N	D*	D*	D*	D*	N	D*	N	N	N	
4b Patient	N	N	I	Gap 11% of	I	I	Will be	I	N	N	N	

¹⁷ 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.

¹⁸ Not all groups included

¹⁹ Not all groups included

Domain 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
experience of hospital care ⁸				average between White Irish (most positive) and Chinese (least positive) ²⁰			available in NHS England August bulletin					
4c Friends and family test	Being developed											
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	

²⁰ Not all groups included

Domain 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
4.4 Access to i GP services ⁸ and ii NHS dental services	D*	N	D*	D* gap 22% of average between best experience (British) and worst experience (Pakistani) of booking a GP appointment – wave 1 13/14 GPPS	D* gap 22% of average between best experience (Christian) and worst experience (Sikh) of booking a GP appointment – wave 1 13/14 GPPS	D* No significant difference – wave 1 13/14 GPPS	N	D* gap 7% of average between best experience (heterosexual) and worst experience (lesbian/gay) of booking a GP appointment – wave 1 13/14 GPPS	N	N	N	
4.5 Women's experience of maternity services	N	N	I	I	N	N	I	N	N	N	N/a	
4.6 Bereaved carers' views on the quality of care in the last 3 months of care	I	N	D	I	I	D	N	N	N	N	N	OIS

Domain 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
4.7 Patient experience of community mental health services	N	N	I	A wider set of survey questions indicates a 17% gap between highest (African) and lowest (Bangladeshi) of average. NHS England 2013 ²¹	I	I	N	I	N	N	N	
4.8 Children and young people's experience of healthcare	Being developed											
4.9 People's experience of integrated care	Being developed											ASCOF 3E

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>

²¹ Based on groups with more than 100 responses. Several ethnic groups had very low response rates

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 Patient safety incidents reported	N	N	I	I	N	I	I	N	N	N	N	
5b Safety incidents involving severe harm or death	N	N	I	I	N	I	I	N	N	N	N	
5c Hospital deaths attributable to problems in care	Being developed											
5.1 Incidence of hospital related VTE	Being developed											
5.2 Incidence of healthcare associated infection i MRSA and ii C. Difficile	I	N	I	N	N	I	N	N	N	N	N	OIS, Quality premia (as joint indicator)
5.3 Incidence of newly acquired category 2.3 and 4 pressure ulcers	Being developed											
5.4 Incidence of medication errors causing serious harm	I	N	I	I	N	I	I	N	N	N	N	
5.5 Admission of full-term babies to neonatal care	I	I	I	I	N	I	I	N	N	N	N	

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
5.6 Incidence of harm to children due to failure to monitor	I	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. (There are pros and cons of this but it was done for speed and simplicity.) For 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, we have just used the difference between the group with the smallest employment difference and the group with the biggest employment difference – we haven't scaled by the average employment difference as these are already percentages.

For breakdowns (ethnicity, religion) where there are some extremely small groups we have had to remove these 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. We therefore grouped these into quintiles based on their health outcomes and looked at the difference in (weighted) mean outcome for the quintile. This gives a measure of the extent of inequalities by socioeconomic 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.

Glossary

A&E department – Type 1

A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

A&E department – Type 2

A consultant led single specialty accident and emergency service (e.g. Ophthalmology, Dental) with designated accommodation for the reception of patients.

A&E Survey

The A&E survey is coordinated nationally by the Care Quality Commission (CQC) as part of the NHS patient survey programme. It asks about the experiences of people who have visited an emergency department. The A&E survey was conducted in 2003, 2004 and 2008. Almost 50,000 people aged 16 and over who had attended emergency departments in January, February or March 2008 responded to the 2008 survey, a response rate of 40%.

www.nhssurveys.org/results

Adult Social Care Combined Activity Return (ASC-CAR)

The Adult Social Care Combined Activity Return is a social care return managed by the Health and Social Care Information Centre (HSCIC). It provides information to support national indicators and data on the number of adults in residential and nursing placements funded by councils with adult social services responsibilities.

<http://www.hscic.gov.uk/socialcarecollections2013>

Adult Social Care Outcomes Framework (ASCOF)

The Adult Social Care Outcomes Framework sets out the desired outcomes for adult social care and how these will be measured. The framework is a set of outcome measures, which have been agreed to be of value both nationally and locally for demonstrating the achievements of adult social care.

<https://www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014>

Ambulatory Care Sensitive (ACS) conditions

Ambulatory care sensitive (ACS) conditions are chronic conditions that can respond to care in an ambulatory care setting (e.g. at home or in the community rather than in an acute hospital). Actively managing patients with ACS conditions – through vaccination, better self-management, disease-management or case-management, or lifestyle interventions – prevents acute exacerbations and reduces the need for emergency hospital admission.

CCG

Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. They replace Primary Care Trusts (PCTs).

Cohort

A cohort is a group of individuals who share a common characteristic or experience during a particular time-period. In the context of the NHS Outcomes Framework, a cohort is a group of individuals who were born in the same time period. A cohort effect in the, context of the NHS Outcomes Framework, is variations over time between individuals who are born in different time periods, all other things being equal.

Community Mental Health Services Survey

The Community Mental Health Services Survey is coordinated nationally by the Care Quality Commission (CQC) as part of the NHS patient survey programme. This survey has been run annually since 2003/04 and assesses the care experience of patients receiving community mental health services. The 2012 survey took the views of more than 15,000 people who received care or treatment for a mental health condition, including those who received care co-ordinated under the Care Programme Approach (CPA), but excluding patients under the age of 18, between July and September 2011, achieving a response rate of 32%.

<http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/community-mental-health-survey-2012>

Deprivation

Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. Deprivation is one of the 'Inequality and Equality strands' (see separate Glossary entry), and for the purpose of the NHS OF is measured by the Index of Multiple Deprivation (IMD) (see separate Glossary entry).

Emergency admission

When admission is unpredictable and at short notice because of clinical need.

http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp

Episode

The Healthcare Commission defines an episode as a single period of hospital care under one consultant, e.g. treatment of Patient A in hospital by Consultant A for a broken leg (see further example under Glossary entry 'Spell').

Equality Analysis

One of the underpinning principles of the NHS Outcomes Framework is to encourage the promotion of equality and reduce inequalities in outcomes from healthcare. The framework helps NHS England to play its full part in promoting equality in line with the Equality Act 2010, and to fulfil the health inequalities duties in the Health and Social Care Act (2012).

GP Patient Survey (GPPS)

The GPPS is run by Ipsos MORI. It assesses patients' experiences of the access and quality of care they receive from their local GPs, dentists and out-of-hours doctor services. Every 6 months, around 1.36 million questionnaires are sent out to adult patients, randomly selected from all patients registered with a GP in England. This means that each year around 2.7 million different patients in England are sent the questionnaire, and the overall response rate in 2012/2013 was 35%.

www.gp-patient.co.uk

Gratitude Bias in Patient Experience Surveys

Gratitude bias may occur when feelings of gratitude for the treatment received by the patient cause them to be less critical of the healthcare professionals who cared for them and of the

quality of care received. The feelings of gratitude may inhibit negative evaluations and promote positive evaluations.

Healthcare Associated Infections (HCAI)

HCAI are infections resulting from medical care or treatment in hospital, nursing homes or the patient's own home.

www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HCAI

Health Outcome

A health outcome is a change in the health status of an individual, group or population, which is attributable to an intervention or series of interventions.

Hospital Episodes Statistics (HES)

HES is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.

<http://www.hscic.gov.uk/hes>

ICD-10 codes

See Glossary entry for 'International Classification of Diseases'.

Index of Multiple Deprivation

The English Indices of Multiple Deprivation identify the most deprived areas across the country. They combine a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. The Indices are used widely to analyse patterns of deprivation, identify areas that would benefit from specific initiatives or programmes and as a tool to determine eligibility for specific funding streams.

<https://www.gov.uk/government/collections/english-indices-of-deprivation>

Inequality and Equality strands

In the Equalities breakdown table, in both the NHS Outcomes Framework Equality Analysis and this Technical Appendix, Inequality and Equality strands refer to the Equalities Protected characteristics (Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation), as defined in the Health and Social Care Act 2012, plus 'Deprivation' and 'Socio-economic status' (see separate Glossary entries for definitions).

Indicator Assurance Pipeline Process (IAPP)

The IAPP was developed by the Health & Social Care Information Centre on behalf of the National Quality Board (NQB). Its purpose is to ensure that outcome indicators used nationally are quality-assured and have open and transparent methodologies for all to access and use as they require.

<http://www.isb.nhs.uk/library/standard/239>

Infant Mortality

Infant mortality refers to deaths within the first year following live birth, usually expressed as a rate per 1,000 live births. Also see Glossary entries for 'Live Birth', 'Neonatal Mortality' and 'Stillbirth'.

Inpatient survey

The Inpatient Survey is coordinated nationally by the Care Quality Commission (CQC) as part of the NHS patient survey programme. Patients who were admitted to hospital with at least one overnight stay, excluding those who were treated for maternity or psychiatric reasons, are eligible to complete the survey. The last inpatient services survey was conducted between September 2012 and January 2013. Over 64,000 inpatients aged 16 and over responded to the survey, a response rate of 51%.

<http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/inpatient-survey-2012>

International Classification of Diseases (ICD)

The ICD is published by the World Health Organization (WHO). It is the international standard diagnostic classification for all general epidemiological and many health management purposes and clinical use. It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States. The illnesses, diseases and injuries suffered by hospital patients are currently recorded using the International Classification of Diseases, Tenth Revision (ICD-10), published by the World Health Organization (WHO). ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as from 1994. The classification is the latest in a series which has its origins in the 1850s. Typically, information about a patient's diagnosis is recorded in their notes by the clinician treating them and then translated into ICD-10 codes by a clinical coder.

www.who.int/classifications/icd/en

Labour Force Survey (LFS)

The LFS, which began in 1973 as an annual survey, is a unique source of articulated information using international definitions of employment and unemployment and economic inactivity, together with a wide range of related topics such as occupation, training, hours of work and personal characteristics of household members aged 16 years and over. From March 1992, quarterly data were made available and the survey became known as the Quarterly Labour Force Survey (QLFS).

<http://discover.ukdataservice.ac.uk/series/?sn=2000026>

Live Birth

A baby showing signs of life at birth after becoming completely expelled from its mother. Also see Glossary entries for 'Infant Mortality', 'Neonatal Mortality', and 'Stillbirth'.

Lower Respiratory Tract Infection (LRTI)

Lower respiratory tract infection, while often used as a synonym for pneumonia, can also be applied to other types of infection including lung abscess and acute bronchitis. Symptoms include shortness of breath, weakness, high fever, coughing and fatigue.

Maternity Services Survey

The Maternity Services Survey is co-ordinated nationally by the Care Quality Commission (CQC) as part of the NHS patient survey programme. The maternity survey was conducted in 2007 and 2010. Over 25,000 women who had given birth in January or February 2010 responded to the 2010 survey between April and August 2010, a response rate of 52%. All women aged 16 and over who received care from any of the 144 NHS Trusts in England and who had either given birth in a hospital, birth centre, maternity unit or at home were eligible to take part.

www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/maternity-services-survey-2010

Mental Health Minimum Dataset (MHMDS)

The Mental Health Minimum Data Set (MHMDS) contains record-level data about the care of adults and older people using secondary mental health services. The MHMDS covers not only services provided in hospitals, but also in outpatient clinics and in the community, where the majority of people in contact with these services are treated. It brings together key information from the mental health care pathway that has been captured on clinical systems as part of patient care. During processing, this information is compiled into a single patient record.

<http://www.hscic.gov.uk/mhmds>

Modified Rankin Scale (mRS)

The mRS measures the overall independence of stroke patients in daily life and, in this modified version, accommodates language disorders and cognitive defects. It also refers to previous activities, which could be important because patients may be independent but experience restrictions in comparison to their former lifestyle and feel dissatisfied with this.

From: van Swieten J, Koudstaal P, Visser M, Schouten H, et al. (1988). Inter-observer agreement for the assessment of handicap in stroke patients. *Stroke* 19 (5): 604–607.

<http://stroke.ahajournals.org/content/19/5/604.full.pdf>

National Bereavement Survey (Views of Informal Carers – Evaluation of services (VOICES))

VOICES is a questionnaire on the experiences of care provided at the end of life developed by a research team based in the University of Southampton. There are several versions of VOICES including a version designed specifically for hospice and specialist palliative care services, developed in conjunction with St Christopher's Hospice (VOICES-SCH), a stroke version, a heart disease version and a VOICES short-form.

www.southampton.ac.uk/voices

National Hip Fracture Database (NHFD)

The NHFD is a joint venture of the British Geriatrics Society and the British Orthopaedic Association, and is designed to facilitate improvements in the quality and cost effectiveness of hip fracture care. As a national audit project, the NHFD is supported by NHSIC's National Clinical Audit Support Programme (NCASP). The NHFD is intended to focus attention on hip fracture both locally and nationally, benchmark its care across the country, and use continuous comparative data to create a drive for sustained improvements in clinical standards and cost effectiveness.

www.nhfd.co.uk

Neonatal Mortality

Neonatal mortality refers to deaths within the first 28 days following live birth, usually expressed as a rate per 1,000 live births. Also see Glossary entries for 'Infant Mortality', 'Live Birth', and 'Stillbirth'.

NHS Safety Thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring, and analysing patient harms, and 'harm free' care. Safety Thermometer data is collected by teams across the health economy on a monthly or quarterly basis.

<http://www.hscic.gov.uk/thermometer>

Outpatient Survey

The Outpatient Survey is coordinated nationally by the Care Quality Commission (CQC) as part of the NHS patient survey programme. It assesses patients' experiences of their most recent visit to an outpatient department. The last Outpatient Survey was conducted between June and

October 2011. Over 72,000 outpatients aged 16 and over responded to the survey, a response rate of 53%.

<http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/outpatient-survey-2011>

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures (hip replacement; knee replacement; groin hernia; varicose veins), PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys. PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires before and after a procedure. Headline participation rate for the coverage period of April 2103 was 70.2%.

<http://www.hscic.gov.uk/proms>

Period Life Expectancy

Period life expectancy at a given age for an area is the average number of years a person would live if he or she experienced the particular area's age-specific mortality rates for that time period throughout his or her life. It makes no allowance for any later actual or projected changes in mortality. In practice, death rates of the area are likely to change in the future so period life expectancy does not therefore give the number of years someone could actually expect to live. In addition, people may live in other areas for at least some part of their lives.

www.gad.gov.uk/Demography%20Data/Life%20Tables/Period_and_cohort_eol.html

Primary Care

Primary care captures community based health services that are usually the first, and often the only, point of contact that patients have with the health service. It covers services provided by family doctors (GPs), community and practice nurses, community therapists (such as physiotherapists and occupational therapists), community pharmacists, optometrists, dentists and midwives.

Public Health Outcomes Framework (PHOF)

The Public Health Outcomes Framework sets out the desired outcomes for public health and how these will be measured. The framework concentrates on two high-level outcomes to be achieved across the public health system. These are: increased healthy life expectancy, and reduced differences in life expectancy and healthy life expectancy between communities.

<http://www.dh.gov.uk/health/2012/01/public-health-outcomes/>

Reablement / Rehabilitation

Reablement/rehabilitation services are focused on improving people's health, well-being, confidence and independence after an acute episode of ill health, injury or a gradual decline in functioning in the community. They include all episodes of support provided that are intended to be time limited and aim at maximising the independence of the individual and reducing/eliminating their need for on-going support.

Region

In England, the region is the highest tier of sub-national division used by central government. The classification previously called 'Government Offices for the Regions' is used to maintain a regional level geography for statistical purposes. The regions are: North East; North West; Yorkshire and Humber; East Midlands; West Midlands; East of England; London; South East; South West.

<http://www.ons.gov.uk/ons/guide-method/geography/beginner-s-guide/administrative/england/government-office-regions/index.html>

Resident Population

The estimated resident population of an area includes all people who usually live there, whatever their nationality. Members of UK and non-UK armed forces stationed in the UK are included and UK forces stationed outside the UK are excluded. Students are taken to be resident at their term time address.

www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/2009/index.html

Sentinel Stroke National Audit Programme (SSNAP)

The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by auditing stroke services against evidence based standards. SSNAP will build on the work of the National Sentinel Stroke Audit (NSSA) and the Stroke Improvement National Audit Programme (SINAP).

<http://www.rcplondon.ac.uk/projects/sentinel-stroke-national-audit-programme>

Socio-economic status

Socio-economic status is an economic and sociological combined measure of a person's economic and social position in relation to others. Socio-economic status is one of the 'Inequality and Equality strands' (see separate Glossary entry), and is measured by the ONS's National Statistics Socio-economic Classification (NS-SEC).

<http://www.ons.gov.uk/ons/guide-method/classifications/current-standard-classifications/soc2010/soc2010-volume-3-ns-sec--rebased-on-soc2010--user-manual/index.html>

Stillbirth

A child born after 24 or more weeks completed gestation which did not, at any time after becoming completely expelled from its mother, breathe or show signs of life. Also see Glossary entries for 'Infant Mortality', 'Live Birth', and 'Neonatal Mortality'.

Trauma Audit & Research Network (TARN)

TARN's aim is to collect clinical and epidemiological data in order to provide a statistical base to support clinical audit, aid the development of trauma services and inform the research agenda.

www.tarn.ac.uk

Annex A

1 Preventing people from dying prematurely

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
 i Adults ii Children and young people
 1b Life expectancy at 75
 i Males ii Females
 1c Neonatal mortality and stillbirths

Improvement areas

Reducing premature mortality from the major causes of death
 1.1 Under 75 mortality rate from cardiovascular disease (PHOF 4.4*)
 1.2 Under 75 mortality rate from respiratory disease (PHOF 4.7*)
 1.3 Under 75 mortality rate from liver disease (PHOF 4.6*)
 1.4 **Cancer outcomes**
 i One- and ii Five-year survival from all cancers
 iii One- and iv Five-year survival from breast, lung and colorectal cancer
 v One- and vi Five-year survival at stage 1&2
 vii Under 75 mortality rate from cancer (PHOF 4.5*)

Reducing premature death in people with mental illness
 1.5 i Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9*)
 ii Excess under 75 mortality rate in adults with common mental health problems
 iii Mortality from suicide and injury of undetermined intent (PHOF indicator 4.10**)

Reducing deaths in babies and young children
 1.6 i Infant mortality (PHOF 4.1*)
 ii (previously 1.6.iii) Five year survival from all cancers in children

Reducing premature death in people with a learning disability
 1.7 Excess under 60 mortality rate in adults with a learning disability

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

Overarching indicators

2 Health-related quality of life for people with long-term conditions (ASCOF 1A**)

Improvement areas

Ensuring people feel supported to manage their condition
 2.1 Proportion of people feeling supported to manage their condition

Improving functional ability in people with long-term conditions
 2.2 Employment of people with long-term conditions (ASCOF 1E** , PHOF 1.8*)

Reducing time spent in hospital by people with long-term conditions
 2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions
 ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
 iii Alcohol-related hospital admissions (PHOF 2.18*)

Enhancing quality of life for carers
 2.4 Health-related quality of life for carers (ASCOF 1D**)

Enhancing quality of life for people with mental illness
 2.5 i Employment of people with mental illness (ASCOF 1F** & PHOF 1.8**) *ii Health related quality of life for people with mental health problems*

Enhancing quality of life for people with dementia
 2.6 i Estimated diagnosis rate for people with dementia (PHOF 4.16*)
 ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life (ASCOF 2F**)

Dental Health
 2.8 i Decaying teeth
 ii Under 10 tooth extractions in secondary care

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
 3b i Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11*)

Improvement Areas

Improving outcomes from planned treatments
 3.1 Total health gain as assessed by patients for elective procedures
 i Physical Health-related procedures
 ii Mental Health-related procedures
 iii Recovery in Quality of life for patients with mental health problems

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
 3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
 3.3 Survival from major trauma

Improving recovery from stroke
 3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

Improving recovery from fragility fractures
 3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service (ASCOF 2B[1]*)
 ii Proportion offered rehabilitation following discharge from acute or community hospital (ASCOF 2B[2]*)

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
 i GP services
 ii GP Out-of-hours services
 iii NHS dental services
 4b Patient experience of hospital care
 4c Friends and family test
 4d Poor patient experience

Improvement areas

Improving people's experience of outpatient care
 4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
 4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
 4.3 Patient experience of A&E services

Improving access to primary care services
 4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
 4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
 4.6 Bereaved carers' views on the quality of care in the last 3 months of life

Improving experience of healthcare for people with mental illness
 4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
 4.8 Children and young people's experience of outpatient services

Improving people's experience of integrated care
 4.9 People's experience of integrated care (ASCOF 3E**)

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

Overarching indicators

5a (previously 5c) Deaths attributable to problems in healthcare
 5b Severe harm attributable to problems in healthcare

Improvement areas

Reducing the incidence of avoidable harm
 5.1 Deaths from venous thromboembolism (VTE) related events
 5.2 Incidence of healthcare associated infection (HCAI)
 i MRSA
 ii C. difficile
 5.3 Proportion of patients with category 2, 3 and 4 pressure ulcers
 5.4 Incidence of medication errors causing serious harm
 5.5 Hip fractures from falls during hospital care

Establishing a culture of safety
 5.6 Patient safety reporting

Improving the safety of maternity services
 5.7 (previously 5.5) Admission of full-term babies to neonatal care

NHS Outcomes Framework 2015/16 at a glance – DRAFT

Alignment with Adult Social Care Outcomes Framework (ASCOF) and/or Public Health Outcomes Framework (PHOF)

* Indicator is shared
 ** Indicator is complementary

Indicators in italics are placeholders, pending development or identification