Liberating the NHS:

Transparency in outcomes – a framework for the NHS

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Foreword

There can be no doubt that over the last decade the hard work and dedication of staff working throughout the NHS has brought about major improvements in outcomes for patients. However, progress has not been universal and even where improvement has been achieved it has not always been as fast or as deep as it could have been.

All too often, the NHS has been hamstrung by a focus on nationally determined process targets which have had a distorting effect on clinical priorities, disempowered healthcare professionals and stifled innovation. We therefore need to recalibrate the whole of the NHS system so it focuses on what really matters to patients and carers and what we know motivates healthcare professionals - the delivery of better health outcomes.

We should be ambitious in our aspirations. We should aim for the NHS to deliver amongst the best outcomes for patients in the world - not just in a few services but in all service areas.

The Coalition Government's White Paper, "*Equity and Excellence: Liberating the NHS"*, set out how the improvement of healthcare outcomes for all will be the primary purpose of the NHS. This means ensuring that the accountabilities running throughout the system are squarely focussed on the outcomes achieved for patients- not the processes by which they are achieved.

This accountability starts with the Secretary of State and the Government. Liberating the NHS from central control and political interference does not mean abdicating responsibility for whether the NHS succeeds or fails. I, and all future Secretaries of State should be judged on our success in creating a continuously improving NHS as measured by the outcomes that it is achieving for patients.

This consultation document is about establishing that accountability at a national level in an open and transparent way. It is about determining how the success of the NHS should be judged and, therefore, the success of the Government in delivering our vision for healthcare.

But, with the NHS delivering over 1400 hospital-based procedures and interventions for 7 million elective admissions a year, around the same number of non-elective admissions and approximately 300 million general practice consultations a year, this is no easy task. It will take a significant change in the culture and focus of the NHS, driven by staff who are empowered, engaged and well supported to provide better patient care.

We are therefore looking for your help in constructing an NHS Outcomes Framework. A framework that will act as a catalyst for driving up quality and promoting equity and excellence across all services and that will provide an indication of the overall performance of the system in an international context. A transparent framework that will be used to hold the new NHS Commissioning Board to account for progress but equally one that patients, carers and the public can use to hold the Government to account.

The Rt Hon Andrew Lansley CBE MP
Secretary of State for Health

1. The purpose of this consultation

Introduction

1.1. The White Paper *Equity and Excellence: Liberating the NHS* set out the Government's strategy for the NHS[1]. The intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

1.2. *Liberating the NHS* makes clear the Government's policy intentions, and provides a coherent framework. Further work lies ahead to develop and implement detailed proposals. In progressing this work, the Department will be engaging with external organisations, seeking their help and wishing to benefit from their expertise.

1.3. This document, *Transparency in outcomes: a framework for the NHS,* provides further information on proposals for developing an NHS Outcomes Framework. It seeks views on a number of specific consultation questions.

1.4. This is part of a public consultation on specific aspects of the White Paper. The initial suite of supporting papers also includes:

- *Commissioning for patients*
- *Regulating healthcare providers*
- *Local democratic legitimacy in health*
- *The review of arm's-length bodies*

1.5. The Government will publish a response prior to the introduction of a Health Bill later this year.

1.6. Chapter 3 of the White Paper explained how, in future, the Secretary of State would hold the NHS to account for improving healthcare outcomes through a new NHS Outcomes Framework. A framework that would be made up of a focused set of national outcomes set by the Secretary of State and against which a new NHS Commissioning Board would be held to account. There was also a clear commitment to working with clinicians, patients, carers and representative groups to create this framework and identify outcome indicators that are based on the best available evidence.

[1] Available at: http://www.dh.gov.uk/LiberatingtheNHS

What are we consulting on?

1.7. The purpose of this consultation is to seek the help of those working in the NHS and the patients, carers and public it is there to serve in developing the first NHS Outcomes Framework. This consultation asks for views on:

- the principles that should underpin the framework (Chapter 2);
- a proposed structure and approach that could be used to develop the framework (Chapter 2);
- how the proposed framework can support equality across all groups and can help reduce health inequalities (Chapter 2);
- how the proposed framework can support the necessary partnership working between public health and social care services needed to deliver the outcomes that matter most to patients and carers (Chapter 2); and
- potential outcome indicators, including methods for selection, that could be presented in the framework (Chapter 3 and Annex A).

1.8. This consultation therefore forms part of the overall public consultation on the White Paper and its constituent parts, on which the Department is currently actively seeking views. The Coalition Government is taking forward this work in partnership with external organisations, seeking their help and expertise in developing proposals that work in practice. This work will link to the broader cross-government approach to performance, which will be published alongside the Spending Review later this year.

Why focus on outcomes? A question of accountability

1.9. In a system as vast and diverse as the NHS, responsible for spending some £80bn of taxpayers' money, and delivering critical services to so many, it is essential to get the accountabilities right at every level of the system. These accountabilities must be focussed on delivering high quality outcomes for patients.

1.10. However, unless we are clear about what we mean by quality and are able to measure it, there can be no meaningful accountability. The NHS Next Stage Review[2] led by Lord Darzi helped the NHS define quality as:

- the **effectiveness** of the treatment and care provided to patients;

[2] *High Quality Care for All: NHS Next Stage Review Final Report*, Department of Health, 30 June 2008

- the **safety** of the treatment and care provided to patients; and
- the broader **experience** patients and their carers have of the treatment and care they receive.

1.11. In terms of measuring these three areas, it is legitimate to look at:

- **the structures of care** – based on robust evidence, how should treatment and care be structured in order to maximise the chance of a good outcome for the patient?
- **the processes of care** – based on robust evidence, what are the things that should be done to maximise the chance of a good outcome for the patient? and
- **the outcomes of care** – what actually happens to the health of the patient - the outcome - as a result of the treatment and care they receive?[3]

1.12. However, at a national level the focus and accountability should, as far as possible, be centred around the outcomes of care. Locally, the structures and processes of care will need to be monitored but focusing on these too heavily at a national level can lead to a distortion of clinical priorities and risks creating a whole system of accountability that it is more concerned with the means than the result - an accountability system that has lost sight of the purpose of the NHS.

What do we mean by an "NHS Outcomes Framework"?

1.13. The NHS Outcomes Framework will be made up of a focussed set of national outcome goals that will provide an indication of the overall performance of the NHS.

1.14. These outcome goals will provide a means by which patients, the public and Parliament can hold the Secretary of State for Health to account for the overall performance of the NHS. They will also provide a mechanism by which the Secretary of State can hold the new NHS Commissioning Board to account for securing improved health outcomes for patients through the commissioning process.

1.15. Beyond accountability, it is intended that the NHS Outcomes Framework will act as a catalyst for driving up quality across all NHS services. It will not,

[3] The structure-process-outcome formulation was included in *Evaluating the Quality of Medical Care,* Donabedian, A; Milbank Memorial Fund Quarterly: Health and Society 44 (3; pt. 2):166–203; 1966.

however, be used as a tool to performance manage providers of NHS care. The framework and the national outcome indicators it will include will also bring about greater transparency about the quality of healthcare services by guiding the publication of broader and more locally relevant information for use by patients, their carers and the public.

1.16. Once set, it will be for the NHS Commissioning Board to determine how best to deliver improvements against the selected outcomes by working with GP consortia and making use of the various tools and levers it will have at its disposal. For example, the Board will be able to commission Quality Standards from NICE, which it will then use to provide more detailed commissioning guidance on how best to meet the national outcome goals included in the framework. The Board will also be able to draw on these Quality Standards to support it in designing payment mechanisms and incentive schemes such as the Commissioning for Quality and Innovation (CQUIN) Payment Framework.

1.17. In addition, the NHS Commissioning Board will work with clinicians, patients and the public to develop the set of indicators it will use to operationalise the national outcome goals sets by the Secretary of State. For example, this might draw upon existing measures such as the Vital Signs indicators[4] where they are clinically relevant or reflect other improvements that are important to patients, as well as those indicators included on the menu of *Indicators for Quality Improvement*[5].

1.18. The design and development of a commissioning framework for GP consortia, as discussed in detail in an accompanying consultation document, *Liberating the NHS: commissioning for patients*,[6] will also be the responsibility of the NHS Commissioning Board. This commissioning framework will need to flow from and support the delivery of the national outcome goals set by the Secretary of State in the NHS Outcomes Framework.

1.19. This consultation document begins to describe what the NHS Outcomes Framework will look like. Taking into account your responses and the business plan the Department of Health will agree as part of the Spending Review, the first NHS Outcomes Framework 2011/12 will be developed. This will set out what the Secretary of State will expect of the NHS Commissioning Board (which will be in existence in its shadow form from 1 April 2011).

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[4] Vital Signs and Existing Commitments can be found in the NHS Operating Framework for 2010/11 at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

[5] The menu of Indicators for Quality Improvement is available at http://www.ic.nhs.uk/services/measuring-for-quality-improvement

[6] Available at: http://dh.gov.uk/liberatingtheNHS

2. Scope, principles and structure of an NHS Outcomes Framework

2.1. The previous chapter set out the Government's vision for improvement in quality and healthcare outcomes as being the primary purpose of all NHS funded-care, what is meant by an outcome and the purpose of an NHS Outcomes Framework. This chapter provides more detail on the scope of the framework and proposes a set of principles which the Government will use to develop the NHS Outcomes Frameworks as it evolves over the coming years. It also puts forward a structure for the framework and seeks views on this.

Scope

2.2. The White Paper set out how the current performance regime will be replaced with separate frameworks for outcomes that set direction for the NHS, public health and social care, which provide for clear and unambiguous accountability, and enable better joint working. The primary purpose of the NHS Outcomes Framework will, therefore, be to focus on the outcomes that the NHS can deliver through the provision of treatment and healthcare.

2.3. However, there will of course be some outcomes which the NHS cannot deliver alone, but where it will need to work in partnership with public health and prevention services. Similarly, if we are to really focus on what matters most to patients, many of the outcomes that are likely to feature in the final NHS Outcomes Framework will require the NHS to work with adult social care services, children's services and other local services. The approach to outcomes in adult social care will be developed using the same principles and designed to align outcomes across the NHS and its local partners as far as possible.

2.4. Local authorities will promote integration and partnership working between the NHS, adult social care, public health and other local services. They will bring together partners to agree local priorities for the benefit of patients and taxpayers, informed by community and neighbourhood needs. A crucial element in designing the NHS Outcomes Framework will be considering how it will incentivise more integrated care.

2.5. The NHS Outcomes Framework will include the national outcomes goals which will be used by the Secretary of State to monitor the progress of the NHS Commissioning Board. The NHS Commissioning Board will be free to determine how these outcomes will be translated into a broader framework

covering all NHS funded care which it will use to hold GP consortia to account and which will provide the public with meaningful information on which to base choices about their healthcare.

Principles

2.6. The proposed principles that will guide the development of the NHS Outcomes Framework are set out below.

Key principles
• Accountability and transparency • Balanced • Focused on what matters to patients and healthcare professionals • Promoting excellence and equality • Focused on outcomes that the NHS can influence but working in partnership with other public services where required • Internationally comparable • Evolving over time

Accountability and transparency

2.7. The NHS Outcomes Framework is intended to sharpen the accountabilities in the system for delivering better and more equitable outcomes – it is not about setting priorities for the service. The Secretary of State for Health will use the NHS Outcomes Framework as a balanced scorecard or dashboard to monitor the progress of the NHS in delivering care to patients.

2.8. Accountability can only be effective if it is matched by transparency. The data against each of the outcomes that are presented in the NHS Outcomes Framework will be made publicly available, so that the NHS and public can see the progress of the NHS for themselves. More detail on this will be set out in the Department of Health's information strategy in the autumn.

Balanced

2.9. To make sure that the NHS Outcomes Framework provides an accurate reflection of the overall progress of the NHS, a balanced set of outcomes will be chosen. They will be used to hold the NHS Commissioning Board to account for overseeing the commissioning of a comprehensive healthcare service.

2.10. This will span the definition of quality which Lord Darzi set out in 2008[7] and which the NHS has embraced:

- Effectiveness
- Patient experience
- Safety

2.11. The following chapter describes proposals for developing the NHS Outcomes Framework, ordered around these aspects of quality.

Focused on what matters to patients and healthcare professionals

2.12. The White Paper articulated a vision that would make the NHS more accountable to patients and that would free staff from excessive bureaucracy and top-down control.

2.13. This means including indicators that record the effectiveness of treatment from the clinical perspective but also from the perspective of patients. The indicators included in the framework therefore need to cover both clinical outcome measures as well as patient reported outcome measures (PROMs). It also means recognising the importance of measuring the experience of patients when judging the progress of the NHS and the safety of care that is being delivered.

2.14. Freeing professionals from excessive bureaucracy means measuring the progress of the NHS against outcomes that are clinically relevant and that professionals themselves recognise as accurately tracking the delivery of improved quality and outcomes for patients.

2.15. As set out in *Equity and Excellence: Liberating the NHS*, staff who are empowered, engaged and well supported provide better patient care. The White Paper committed the Government to promote staff engagement and partnership working. This will be a key part of the development of the aims of the White Paper and the proposals set out in this document, and why the Government is publishing this full and open consultation document, and seeking your views.

Promoting excellence and equality

2.16. The purpose of the NHS Outcomes Framework will be to drive the NHS towards achieving excellence rather than minimum standards. Ensuring that

[7] *High Quality Care for All: NHS Next Stage Review Final Report*, Department of Health, 30 June 2008

providers of NHS care meet minimum standards or the essential levels of quality and safety is the responsibility of the Care Quality Commission.[8]

2.17. The NHS Outcomes Framework should recognise the importance of reducing inequalities and promoting equality. For example, because of the social gradient in most health outcomes, the most potential health gain will often be available from the lower reaches of the gradient, from disadvantaged groups and areas.

2.18. Therefore, as far as possible, outcomes will also be chosen so that they can be measured by different equalities characteristics and by local area. The delivery of outcomes is likely to vary according to geographic area and across different population groups. By collecting data that makes the outcomes understandable according to equalities characteristics and by area the Government and NHS Commissioning Board will be in a position to promote equality and tackle inequalities in outcomes.

Focused on outcomes that the NHS can influence but working in partnership with other public services where required

2.19. As far as possible, the NHS (and its constituent parts) will be held to account for outcomes that it alone can influence. For all outcome indicators, where relevant, the NHS Outcomes Framework should identify the extent to which the NHS will be held accountable, as distinct from the contribution of public health interventions and social care services.

2.20. There will, of course, be outcomes that can only be delivered for patients and carers if the NHS works in partnership with the new public health service that will be created and with social care services. The Department of Health will be constructing and consulting on outcomes frameworks for these sectors in coming months as part of an integrated cross-service approach in the Spending Review. These will be developed so that strategies can be developed to ensure that organisations provide complementary and integrated services.

Internationally comparable

2.21. The Government's vision for the NHS is for it to be a world leader in healthcare provision. At its best, the NHS is world class. But, the NHS today still achieves relatively poor outcomes in some major areas when compared to its peer countries.

2.22. However, outcomes included in the framework should not be selected solely in areas where the NHS is performing less well than other international

[8] Details on registration can be found on the CQC's website at http://www.cqc.org.uk/

healthcare systems, as this perspective may not identify what matters most to patients. International comparisons can only be based on what comparable data is available and this may not always reflect the most important quality improvement challenges facing individual healthcare systems. Nevertheless, wherever possible and appropriate, the NHS Outcomes Framework will include outcome indicators which are internationally comparable, for example amongst OECD nations[9], or the EU 15, or 27[10].

2.23. Interpreting international comparisons is complex and making comparisons for new indicators is costly and takes time. So, the importance of making intra-UK comparisons should not be underestimated and can be a relatively simpler approach. This has been used by organisations such as the Nuffield Trust[11] and The Health Foundation[12]and as a first step, the Department of Health will support the development of metrics that allow intra-UK comparisons to be made.

Evolving over time

2.24. The first publication of the NHS Outcomes Framework will, as a starting point, use existing outcome indicators for which data can be collected. This will mean that the NHS Outcomes Framework for 2011/12 may not necessarily meet all of the principles set out in this chapter. However, the nature of the changes to the NHS landscape that were announced in the White Paper and the time lag to develop new indicators means that the NHS Outcomes Framework will evolve over time. It will be reviewed annually to ensure that it focuses on the most important issues and so that it can accommodate new and better outcome indicators as they become available.

Questions

1. ***Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework?***

2. ***Are there any other principles which should be considered?***

3. ***How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?***

[9] Organisation for Economic Co-operation and Development. Details of member countries are available at http://www.oecd.org/document/58/0,3343,en_2649_201185_1889402_1_1_1_1,00.html

[10] As defined in the *Glossary of Statistical Terms*, OECD, available at http://stats.oecd.org/glossary/

[11] Most recently in Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution, *Nuffield Trust, January 2010*

[12] See Quality in Healthcare in England, Wales, Scotland, Northern Ireland: an intra-UK chartbook at http://www.health.org.uk/document.rm?id=1022

4. ***How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?***

Structure of the NHS Outcomes Framework

2.25. The NHS Outcomes Framework will include a balanced set of outcome goals spanning effectiveness, patient experience, and safety. To achieve this, it is proposed that the NHS Outcomes Framework should be developed around a set of five outcome domains that attempt to capture what the NHS should be delivering for patients. The five domains are set out in Figure 1 below.

Figure 1 – Five domains of the NHS Outcomes Framework

Questions

5. ***Do you agree with the five outcome domains that are proposed in Figure 1 as making up the NHS Outcomes Framework?***

6. ***Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?***[13]

Structure of each domain

2.26. Figure 2 explains how the framework will be structured for each of the five outcome domains.

[13] **Please note** that public health and prevention will be covered in a separate consultation, linking to this framework where appropriate

Figure 2 – Structure of each domain in the NHS Outcomes Framework

Overarching outcomes indicator

2.1 For each domain, the NHS Outcomes Framework will identify an **overarching outcome indicator or set of indicators**, allowing progress of the NHS to be tracked across the breadth of NHS activity covered by the domain. It will provide a mechanism for ensuring that the NHS Commissioning Board does not lose sight of its role in overseeing the commissioning of a comprehensive healthcare service.

Improvement Areas

2.27. For each domain there will then be a small set of specific areas identified in which the NHS Commissioning Board will be tasked with securing improved outcomes through its role in overseeing the commissioning process to be led by GP consortia. These **improvement areas** will be chosen, as far as possible, according to an evidence-based method or approach.

2.28. For each of the specific improvement areas, a corresponding **outcome indicator** will be identified in order to hold the NHS Commissioning Board to account for the progress being made. As already explained, the new system of accountability that the NHS Outcomes Framework will introduce will evolve over time. The first NHS Outcomes Framework will be populated in the short term by outcome indicators that are already available for measurement.

NICE Quality Standards

2.29. Finally, the delivery of the outcomes in the NHS Outcomes Framework will be supported by a suite of **NICE Quality Standards**[14]**.** The White Paper set out the crucial role NICE Quality Standards will play in supporting the delivering of improved outcomes by informing the commissioning process. The Department of Health currently commissions NICE to produce these standards but this function will transfer to the NHS Commissioning Board once it is established and GP consortia will refer to them when commissioning services locally.

[14] More information on NICE Quality Standards is available on the NICE website at: http://www.nice.org.uk/aboutnice/qualitystandards

2.30. Quality Standards provide an authoritative definition of what high quality care looks like for a particular care pathway or service. They are developed by NICE, working in partnership with clinicians, leading experts and healthcare specialists in that particular field, drawing on available evidence of best practice.

2.31. Over the next 5 years, NICE will produce a library of approximately 150 Quality Standards covering the majority of NHS activity to support the NHS in delivering the outcomes in the NHS Outcomes Framework. Given that these standards will tend to focus on a pathway of care, any one Quality Standard is likely to span two or more domains of the NHS Outcomes Framework The first three Quality Standards were published on 30 June, on stroke treatment and rehabilitation, dementia care, and the prevention of venous thromboembolism.[15]

Question

7. Does the proposed structure of the NHS Outcomes Framework under each domain seem sensible?

Risks and Limitations

2.32. Even with indicators which focus on outcomes, there is still a risk of distorting behaviour in a way that is not best for patients. It is possible that, in order to deliver an outcome in one area, local NHS organisations will end up neglecting other areas. To avoid this, it is important that the NHS Outcomes Framework strives to be as comprehensive as possible, covering most of what the NHS should be delivering for all patients.

2.33. In practice, comprehensive outcome indicators are not always available or feasible, and it may even be necessary, at least in the short term, to use some carefully chosen proxy outcome measures. It will therefore be important to take a view of the NHS Outcomes Framework as a whole, including the links between the various indicators, and to design it to avoid undesirable distortions of behaviour.

2.34. Developing indicators which measure outcomes accurately, representatively and in a timely fashion is complicated and takes time. Over time new indicators will become available which will improve the NHS Outcomes Framework's ability to accurately judge the outcomes being delivered for

[15] The first three Quality Standards can be downloaded at: http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp

patients. Each of the domains face different challenges in respect of the indicators available, which are explained later in this document.

2.35. The following chapter takes you through how the NHS Outcomes Framework might be constructed. Annex A sets out example outcome indicators. These may not be the best or the most suitable indicators, so your views on these are very welcome as part of this consultation.

3. What would an NHS Outcomes Framework look like?

Annex A provides additional information about the indicators referred to in this chapter, as well as possible alternative indicators and other relevant technical points. Interested readers should refer to Annex A at the points indicated in this chapter.

3.1. The previous chapter proposed a structure for the NHS Outcomes Framework based around five outcome domains:

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

3.2. Each of the above domains would then be covered by:

- **An overarching outcome indicator** or indicators to measure progress across the breadth of NHS activity covered by the domain
- Approximately **five, more specific, improvement areas** with supporting outcome indicators to measure progress of the NHS against each improvement area
- **A suite of supporting Quality Standards** developed by NICE setting out the structures and processes of care that the evidence suggests would be most likely to deliver improved outcomes for the overall domain as well as the specific improvement areas within the domain

3.3. Taking this structure as a starting point for consultation, the rest of this chapter puts forward proposals for what the overarching outcome indicators for each domain could be; a method for selecting the specific improvement areas within each domain; and, based on that method, what some of the potential improvement areas and their supporting outcome indicators might be.

Annex A 1
Design principles for outcome indicators

3.4. Developing a framework like this will never be straightforward or neat. The categorisation of the outcomes proposed may not be perfect, and there will almost certainly be debate as to which category certain conditions fall into.

DOMAIN 1: PREVENTING PEOPLE FROM DYING PREMATURELY

3.5. In thinking through what outcome indicators might be presented in this domain, two underlying principles have been used.

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

Overarching Indicator

3.6. Following the principles set out above, the overarching indicator for this domain should tell us whether the NHS is reducing mortality in areas where it can make a difference. **Mortality amenable to healthcare** measures the number of deaths that occur from a pre-defined set of conditions that have been judged to be amenable to healthcare interventions, and so should not lead to deaths at specified ages. More detail on this outcome indicator can be found in Annex A.

Annex A 2
Technical details of indicators

Question

8. Is 'mortality amenable to healthcare' an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?

Improvement Areas

Annex A 3

Selecting improvement areas based on mortality data

3.7. It is reasonable to assume that lower mortality rates from a particular condition in other countries indicate that mortality rates here could be improved, although different recording and coding practices can skew these comparisons. Internationally comparable mortality statistics, such as those collated by the World Health Organisation[16], can therefore be used to identify the component conditions of mortality amenable to healthcare on which England performs worse than comparable countries (see Annex A for UK comparisons)[17]. The proposal is that these causes should be considered as possible improvement areas in this domain, and following this logic the two causes with the most scope for improvement (excluding those with known coding issues) are **heart disease** and **stroke**.

3.8. Some of the causes set out in the table in Annex A can logically be grouped into broader topic areas. For example, while breast cancer is one of the areas on which the UK appears to perform worst, there are a number of other cancers on which the UK also performs at or worse than the level of comparable countries, so a broader outcome on **cancer** mortality would cover a number of relevant areas.

Annex A 4

Technical details of indicators

3.9. However, international comparisons on cancer more commonly use survival rates than mortality (because mortality is affected by incidence as well as survival once diagnosed), so if cancer is selected as an improvement area then survival measures may be more appropriate outcome indicators. International comparisons on cancer survival show that England performs worse than comparable countries. Poorer survival rates as well as mortality rates add weight to the argument for cancer's inclusion. See Annex A for more details on survival and other specific indicators.

Question

9. Do you think this is an appropriate way to select improvement areas in this domain?

[16] http://www.euro.who.int/en/what-we-do/data-and-evidence/databases

[17] UK data is more readily available and is a reasonable approximation for England, which makes up 84% of the UK's population. It will be possible to make the same comparisons for England in the future.

Other Considerations

Older people

3.10. This domain necessarily looks at premature deaths (rather than all deaths), as healthcare cannot hope to keep people alive indefinitely. The definition of mortality amenable to healthcare used here defines 'premature' as under the age of 75. This is a widely used definition, but whether a death at any age is premature depends on the specific circumstances. Considering all deaths above a particular age as 'not premature' discriminates against older people who still lead healthy and fulfilling lives.

3.11. The proposed NHS Outcomes Framework currently accounts for mortality in older people in two ways:

- many avoidable deaths for older people occur in hospital and are covered by the fifth domain, *treating and caring for people in a safe environment and protecting them from avoidable harm*; and
- some outcome indicators relating to the specific improvement areas that could be used in this domain, such as one-year and five-year cancer survival or healthy life expectancy at 65 (see Annex A), are applicable to all age groups.

Annex A 5
Technical details of indicators

3.12. However, it may still be necessary to consider including an outcomes indicator that specifically addresses mortality in older people, such as healthy life expectancy at 65 (see Annex A).

Questions

10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed?

11. If not, what would be a suitable outcome indicator to address this issue?

Children

3.13. Sheer weight of numbers means that mortality amenable to healthcare is dominated by deaths in older adults, and there is a risk that children will be neglected when selecting improvement areas. There is therefore an argument for including an outcome specifically relating to children. There are two items in the table in Annex A (section 5) that relate specifically to children and that the UK appears to perform badly on: perinatal deaths (although this may be

Annex A 5
Technical details of indicators

the result of a coding issue) – for which an appropriate indicator would be **infant mortality**; and **respiratory diseases** in children aged 0-14.

Question
12. Are either of these appropriate areas of focus for mortality in children? Should anything else be considered?

Inequalities

3.14. Some groups of people, for example those with serious mental illnesses, have significantly worse mortality outcomes than the population as a whole. While the NHS will aim to narrow inequalities in all the outcome indicators in this framework, it may be desirable to select some improvement areas in where there are significant inequalities in outcomes.

Cost effectiveness

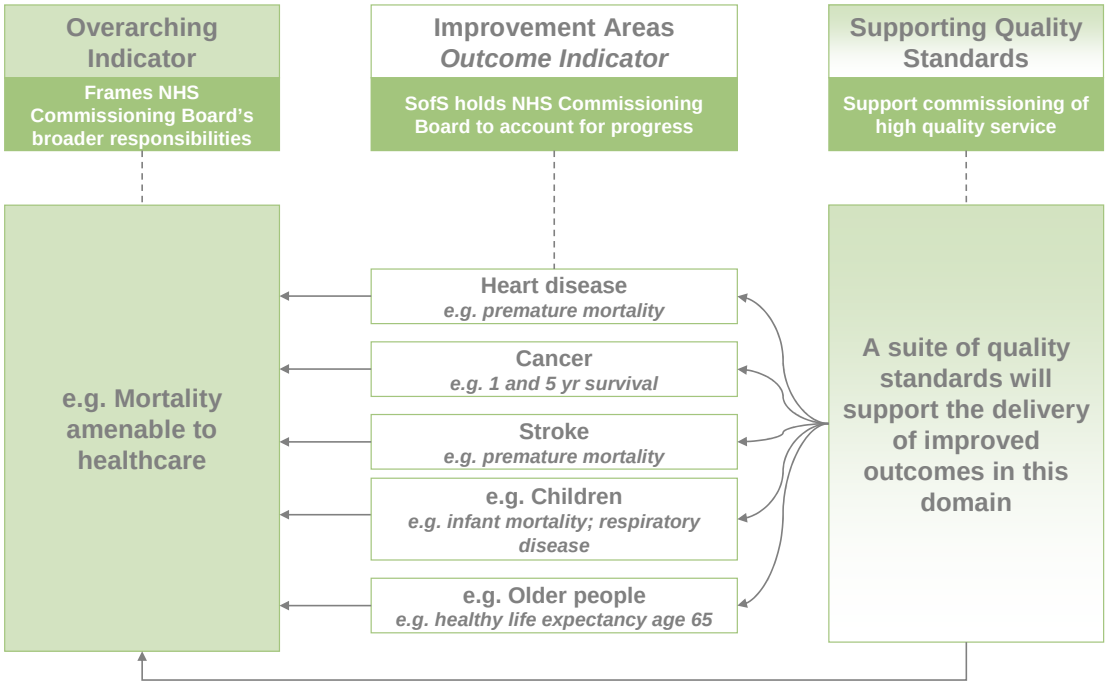
3.15. It will be essential to ensure that improvements in mortality amenable to healthcare represent a cost-effective use of resources and do not inadvertently divert resources from areas where a greater scope for improved health gain may exist. This will be assessed explicitly in the Impact Assessment that will accompany the final NHS Outcomes Framework for 2011/12.

Quality Standards

3.16. To support commissioning for excellent outcomes in all domains of this framework, there will be a suite of quality standards setting out what high quality care looks like across all major pathways of care. Some topics for Quality Standard development will be selected to reflect areas that are most important to improving outcomes in this domain.

3.17. Based on the above method and analysis, Figure 3 illustrates what this domain might look like.

Figure 3 - Preventing people from dying prematurely



DOMAIN 2: ENHANCING QUALITY OF LIFE FOR PEOPLE WITH LONG-TERM CONDITIONS

3.18. This domain is concerned with the treatment and care the NHS provides to people living with long-term conditions, including those with mental health related long-term conditions. In thinking through what outcome indicators might be presented in this domain, three underlying principles have been used.

- **Treating the individual.** Patients do not see themselves as a condition; they see themselves as people who have one or more long-term conditions. 29% of people with long-term conditions now live with more than one condition,[18] and it is expected that in the future this proportion will rise further. Looking at conditions individually risks ignoring the needs of this increasingly significant group, so it is proposed to take a general view of the needs of and desired outcomes for those with long-term conditions, both mental and physical.
- **Functional and episodic outcomes.** The framework should focus on the outcomes that are important to those living with long-term conditions. These relate to the debilitating effect that the conditions can have on their lives, such as preventing them from being physically active, working or living independently. The importance of acute episodes that can develop into long-term conditions is also

[18] General Lifestyle Survey 2008-09

recognised, and that good management of the condition can reduce their frequency and severity.

- **Meeting the needs of all age groups.** People with long-term conditions of different ages have different needs, particularly in relation to the functional outcomes that they want to achieve. As such it is proposed to separately identify appropriate functional outcomes for children, adults, and older people.

Overarching Indicator

Overarching indicators currently available

Annex A 6
Technical details of indicators

3.19. While an overarching measure of quality of life for those with long-term conditions is not currently available, there are existing surveys that collect information that is relevant to this domain: the Labour Force Survey[19] measures the "percentage of people with long-term conditions where day to day activity is affected"; and the GP patient survey currently measures the "percentage of people feeling supported to manage their condition".

Question

13. Are either of these appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?

Overarching indicators that could be developed

Annex A 6
Technical details of indicators

3.20. More detailed information on quality of life for those with long-term conditions could be obtained through a Patient Reported Outcome Measure (PROM), or similar, for long-term conditions in general. There are standard questionnaire-based tools for measuring quality of life, such as EQ-5D[20], which is currently included in the Health Survey for England and could potentially be included in other national surveys.

Question

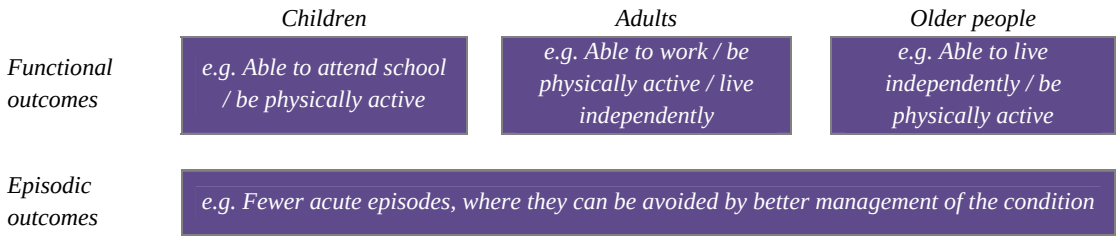
14. Would indicators such as these be good measures of NHS progress in this domain? Is it feasible to develop and implement them? Are there any other indicators that should be considered for the future?

[19] http://www.statistics.gov.uk/CCI/SearchRes.asp?term=labour+force+survey&x=31&y=12
[20] http://www.euroqol.org/

Improvement Areas

3.21. International comparisons are not available for some of the outcomes that are important for people with long-term conditions, so it is not possible to infer a level of performance that the NHS should be able to achieve. As such, it is not possible to select areas based on improvement potential, so it is proposed to select a set of outcomes that address the things that are most important to those with long-term conditions. Following the logic, set out above, of identifying functional and episodic outcomes for different age groups, figure 4 shows how the improvement areas might look.

Figure 4 – functional and episodic outcomes that are important to different age groups



3.22. The interaction between healthcare and other services will be particularly important in this domain. Many of the outcomes set out in figure 4, such as whether older people are able to live independently, can only be achieved through effective partnership working between the health and social care systems.

3.23. Data on some of the outcomes set out in figure 4 are not routinely collected, so relevant outcome indicators may not currently exist in all cases. Annex A contains a list of the relevant outcome indicators that do currently exist, as well as others that could be developed.

Annex A 7
Technical details of indicators

Quality Standards

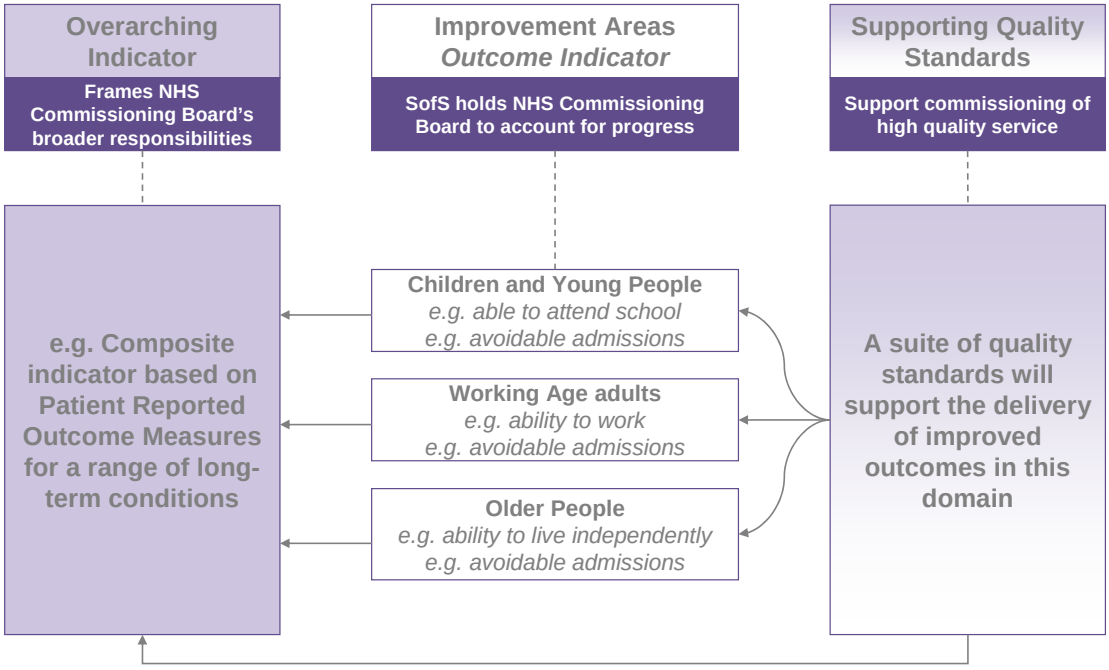
3.24. To support commissioning of excellent outcomes in all domains of this framework, there will be a suite of quality standards setting out what high quality care looks like across all major pathways of care. Some topics for Quality Standards will be selected to reflect areas that are most important to improving outcomes in this domain.

Question

15. As well as developing Quality Standards for specific long-term conditions, are there any cross-cutting topics relevant to long-term conditions that should be considered?

3.25. Based on the above method and analysis, Figure 5 below illustrates what this domain might look like.

Figure 5: enhancing quality of life for people with long-term conditions



DOMAIN 3: HELPING PEOPLE TO RECOVER FROM EPISODES OF ILLNESS OR FOLLOWING INJURY

3.26. This domain is about achieving the best possible outcomes for people who develop treatable conditions or who suffer injuries. The aims of this domain can be expressed as two broad outcomes.

- **Preventing conditions from becoming more serious**. Some conditions should not, in the presence of timely and effective healthcare, become serious. For these conditions, the NHS should aim to minimise the impact on people's lives.
- **Helping people recover from serious illness or injury**. As well as preventing deaths, the NHS should aim to ensure that, as far as possible, those who suffer a serious illness or other debilitating event

recover quickly and painlessly to their original health status, or close to it.

3.27. In thinking through what outcome indicators might populate this domain, **meeting the needs of all age groups** has again been taken as a guiding principle. Although older people are the biggest users of NHS services, it is important that the needs of other age groups are not ignored. People of different ages have different healthcare needs and this is reflected in the approach to this domain.

Overarching Indicator

Overarching indicators currently available

3.28. Due to the diversity of this domain, it has not been possible to identify a single indicator that covers its entirety. Instead, it is more easily dealt with as the two related outcomes set out above: preventing conditions from becoming more serious; and, helping people to recover from serious illness or injury. The indicators set out below are an attempt to cover these two aspects using what is currently available. These indicators are not pure outcomes but proxies for outcomes:

Annex A 8
Technical details of indicators

- **Emergency hospital admissions for acute conditions usually managed in primary care**
  This indicator shows how well the NHS is doing at preventing curable conditions from becoming more serious, and largely reflects the outcomes achieved in primary care.
- **Emergency bed days associated with repeat acute admissions**
  Most conditions, if treated effectively, should not require repeat admissions to hospital. Where patients are readmitted for emergency care, it is an indication that the outcome of their original treatment was not as good as it should have been.[21]

Question

16. Are these appropriate overarching outcome indicators for this domain? Are there any other indicators that should be considered?

[21] Two definitions of each of these indicators are set out in Annex A, section 8

Overarching indicators that could be developed

3.29. In the future it may be possible to develop indicators for this domain that focus more explicitly on outcomes and so reduce the risk of perverse incentives. These may be based on patient reported measures, although current methodologies are not general enough to cover the whole domain.

Annex A 8
Technical details of indicators

Question

17. What overarching outcome indicators could be developed for this domain in the longer term?

Improvement Areas

3.30. Patient Reported Outcome Measures (PROMs) are a powerful way of measuring health outcomes as perceived by patients, and are applicable to this domain. However, current methodologies for acute care require questions to be asked of the patient before and after treatment, and so can only be applied routinely to planned episodes of care. While in future it may be possible to develop similar measures for unplanned care, this is not a realistic proposition in the short term.

3.31. It is therefore proposed that PROMs be used in this domain to monitor outcomes in planned care. PROMs are currently collected for some specific elective procedures, and could be applied to a broader array of other procedures, or more generally, in the future.

3.32. For unplanned care the proposal is to look at which causes are the most important for each age group, and to select outcome indicators to cover these areas. One way of identifying suitable areas of focus is to look at emergency bed days, which is a measure of the likelihood of someone needing emergency care for a given cause, and how long they are likely to be in hospital. Figure 6 shows the causes that lead to the most emergency bed days for children, adults and older people.

Annex A 9
Methodology for identifying common causes of emergency care

Figure 6 – causes leading to most emergency bed days and the proportion of all emergency bed days attributable to each (excluding long-term conditions)

Children	
Fractures (excluding head injuries)	6%
Bronchiolitis	6%
Upper respiratory tract infection	5%
Pneumonia*	3%
Head injury	2%

Adults	
Fractures (excluding head injuries)	4%
Stroke	3%
Pneumonia*	3%
Depression	2%
Heart attack	1%

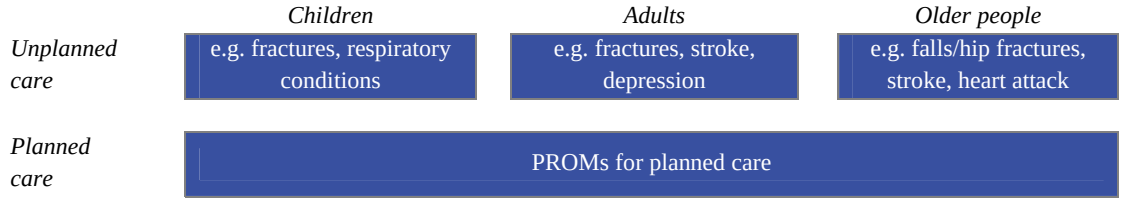
Older people	
Fractures (excluding head injuries)	11%
of which hip fractures	*8%*
Stroke	7%
Pneumonia*	7%
Heart attack	2%
Head injury	1%

* there are known coding issues with pneumonia, so it may be over-represented here

3.33. Figure 7 gives an overview of the improvement areas for this domain, following the logic set out in the previous paragraphs. Annex A contains a list of outcome indicators that are relevant to this domain, some of which might be suitable for inclusion in the framework.

Annex A 10
Technical details of indicators

Figure 7 – improvement areas for planned and unplanned care



Questions

18. Is this a suitable approach for selecting some improvement areas for this domain? Would another method be more appropriate?

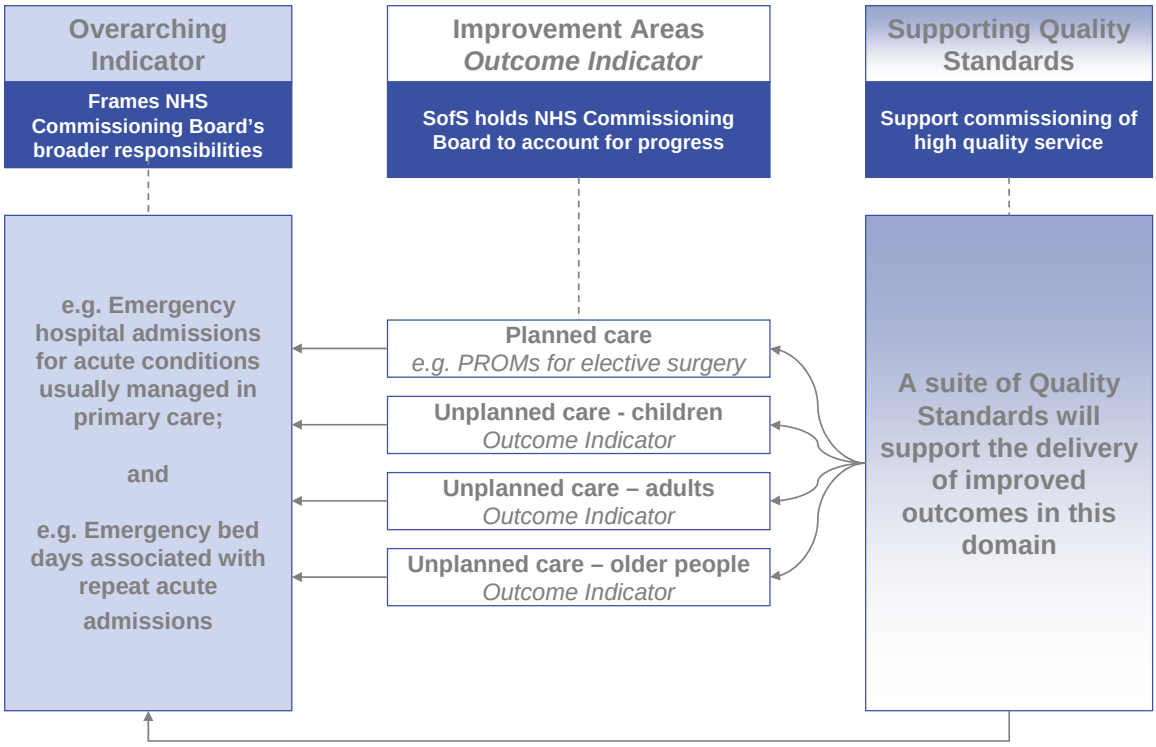
19. What might suitable outcome indicators be in these areas?

Quality Standards

3.34. To support commissioning for excellent outcomes in all domains of this framework, there will be a suite of quality standards setting out what high quality care looks like across all major pathways of care. Some topics for Quality Standards will be selected to reflect areas that are most important to improving outcomes in this domain.

3.35. Based on the above method and analysis, Figure 8 illustrates what this domain might look like

Figure 8: helping people to recover from episodes of illness or following injury



DOMAIN 4: ENSURING PEOPLE HAVE A POSITIVE EXPERIENCE OF CARE

3.36. Quality of care includes the quality of caring. This means how personal care is - the compassion, dignity and respect with which patients are treated, and the extent to which they are given the level of comfort, information and support they require.

3.37. The principle of asking patients and carers to provide direct feedback on the quality of their experience, treatment and care is now standard among health care systems worldwide, and a number of initiatives are in place which seek to make international comparisons.

3.38. This domain has been developed on the basis of four underlying principles or assumptions:

- **Patient experience must be a vital element of the NHS Outcomes Framework** - a health service that delivers the outcomes that matter most cannot only look at how well it is treating people in clinical or medical terms;
- **The existing arrangements for collecting patient experience information do not lend themselves well to the requirements of the NHS Outcomes Framework.** This is a relatively new area of

focus for the NHS and the national and local infrastructure for measuring and monitoring quality *from the patients' point of view* is at a relatively early stage of development There is a degree of challenge and development required nationally and locally over the coming years to create appropriate patient feedback systems to assist the NHS to understand and improve the experience of patients. This consultation seeks your views on proposals for developing a new generation of outcome indicators for patient experience; and

- **It is necessary to measure patient experience now, to drive a step change in improvement** – the evolutionary approach to developing the NHS Outcomes Framework will ensure that new and improved patient feedback mechanisms will be able to inform future iterations of the framework. This consultation sets out some interim options based on what is possible now within the existing national survey infrastructure; and
- **Ensuring that a balanced approach is achieved - so that this work fully supports and complements locally-led innovation and focused improvement activity.** These proposals are based on the key principle that the real benefits of looking at patient experience lie in local clinical teams developing a culture and process for routinely asking their own patients and service users for structured feedback and then acting on what this feedback is telling them about the services they provide.

3.39. With this in mind, this domain of the NHS Outcomes Framework will be constructed in broadly the same way as for the effectiveness elements of the framework.

Overarching Outcome Indicator

3.40. A **short term interim approach** for immediate use as an overarching indicator, **and a longer term approach** for future development is proposed.

3.41. The reason for this two stage approach is that the initial options available for developing an overarching indicator are currently constrained by the existing national survey arrangements, and the limited availability of standardised national data. Most centrally coordinated surveys are conducted at organisation-level, and focus on different NHS services and settings[22] – such

Annex A 11
An overview of patient experience indicators

[22] This includes the GP Patient Survey, the NHS National Patient Survey Programme, and the National Cancer Survey. Further information on each respectively are available via the following web links:

- http://www.gp-patient.co.uk/

as GP practices, inpatients, outpatients, A&E, mental health services, maternity and cancer services. The frequency with which these surveys are conducted varies, so not all take place on an annual basis. The relatively small sample size of most surveys also means that results cannot be reliably analysed below the overall organisation level. More information on the current survey infrastructure is included in Annex A.

3.42. Whilst the interim option is not considered ideal, it is widely recognised by the NHS and so will provide short-term continuity while future indicators (and related survey options) are being developed.

3.43. The short term approach involves:

- tracking performance on a predefined subset of survey questions across available and relevant surveys. This is in line with the approach used in recent years by the independent healthcare regulator and the Department of Health to monitor performance in reported patient experience.[23,24] The chosen questions are categorised under five separate patient experience themes, which can be aggregated to form an overall score for each separate survey that is conducted in any one year.
- The five themes are: access and waiting; safe, high quality coordinated care; better information, more choice; building closer relationships; and clean, friendly comfortable place to be.
- This approach can be applied to surveys that are due to be conducted and published in the next year or so, potentially covering primary care, adult in-patients, maternity services, and community mental health services.

Question

20. Do you agree with the proposed interim option for an overarching outcome indicator?

3.44. The proposed **long-term approach** is to develop an overarching outcome indicator that is based on a limited set of core questions that can be included

- http://www.cqc.org.uk/usingcareservices/healthcare/patientsurveys.cfm
- http://www.quality-health.co.uk/2010cancersurvey.html

[23] Further information is available on the CQC and DH websites: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098525

[24] Further information on the results to date are available on the DH website: http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_087516

within all surveys, so covering all relevant care settings and focusing directly on the outcomes that matter most to patients. These questions would ask patients whether they received the care and services they need, and its overall quality (for example, whether it met their requirements, enabled them to maintain their health, or enhanced their quality of life). Appropriate questions are not included within the existing survey programmes, so development work on the precise indicator is required.

Question
21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator?

Improvement Areas

3.45. The available evidence base for identifying robust **improvement areas** is extremely limited - especially in terms of the coverage of current surveys across different conditions, pathways and services. On this basis, it is not possible to set out precise patient experience indicators at this stage – although we can identify broad areas where more focused work is required. It is therefore proposed that the following improvement areas be included in the NHS Outcomes Framework:

- **Primary and community services** – people rely on primary care services for their day-to-day health and well-being, and to access hospital care. During the course of their lives, most people will also come into contact with NHS community services, which provide essential advice, care and support. Both are important areas that warrant closer monitoring of the experience of patients and service users;
- **Acute care –** recent high profile failures in NHS hospitals, such as Mid Staffordshire NHS Foundation Trust, reinforce the importance of continuing to measure the experience of patients in acute care settings (such as accident and emergency, in-patient and out-patient services);
- **Mental health services** – patients with mental health conditions are among the more vulnerable groups receiving NHS care and so specific emphasis should be placed on measuring their experiences. This improvement area could look at the different settings in which care is provided, for example, community mental health services and in-patient mental health services;

- **Children and young people** – children account for up to 40% of GP visits and are frequent users of A&E. However, the NHS has found it more difficult to collect and understand the experience of children and their parents or carers than that of adult patients. There are particular issues and difficulties, both practical and ethical, about surveying children, but these are not insurmountable. Work will be carried out to investigate the possibilities for measuring children's (and their parents' or carers') experiences of their care in a sensitive and appropriate way;
- **Maternity services** – maternity services provide the first significant personal experience of healthcare and for many people, is considered the 'touchstone' of an organisation's quality of care. Adverse events in maternity services make sensational news whereas excellent care is rarely acknowledged or publicly praised. While reducing perinatal mortality is an outcome that needs to be achieved, it does not reflect the circumstances of the overwhelming majority of parents. Positive outcomes need to be measured not only in terms of a healthy baby, but in ways that take into account the new family's experience of using maternity and newborn services;
- **End of life care** – approximately 500,000 people die each year, yet it is very difficult to assess the quality of the care that they receive at the end of life, as the only outcome is death. Society places a very high value on making sure that people have the best possible experience of care at the end of life, and so it is important to assess this experience. This will be measured by recording the views of those closest to the bereaved.

Question

22. Do you agree with the proposed improvement areas and the reasons for choosing those areas?

3.46. For each of these areas, outcome indicators will be identified based on what is available in the **short term**. For in-patient services, the measure developed as a national goal for inclusion within the Commissioning for Quality and Innovation (CQUIN) payment framework for acute care services[25] could be

[25] Further information is available from the DH and NHS Institute for Innovation and Improvement websites:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443
http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

used. This is based on producing an overall composite measure score for "responsiveness to the personal needs of patients"[26].

3.47. This composite approach provides a picture of performance for each separate survey, but also over time – with national results being disaggregated down to a local and organisation level. This enables a comparative and time series view of performance on patient experience to be constructed across each of the pre-defined set of questions. The information collected and resulting insight would not only measure progress but also identify where improvements could be made.

3.48. Over **the medium to long term**, new outcomes indicators for improvement areas should be based on the same principles as the national CQUIN goal for acute services (set out above). We envisage these indicators extending across the full range of services and settings covered by national surveys. The initial focus will be on surveys that have already been developed (such as community mental health, maternity, A&E and outpatients services), and extending to other newly developed surveys once they are available.

Quality Standards

3.49. To support commissioning excellent outcomes in all domains of this framework, there will be a suite of Quality Standards setting out what high quality care looks like across all major pathways of care. Some topics for Quality Standards will be selected to reflect areas that are most important to improving outcomes in this area.

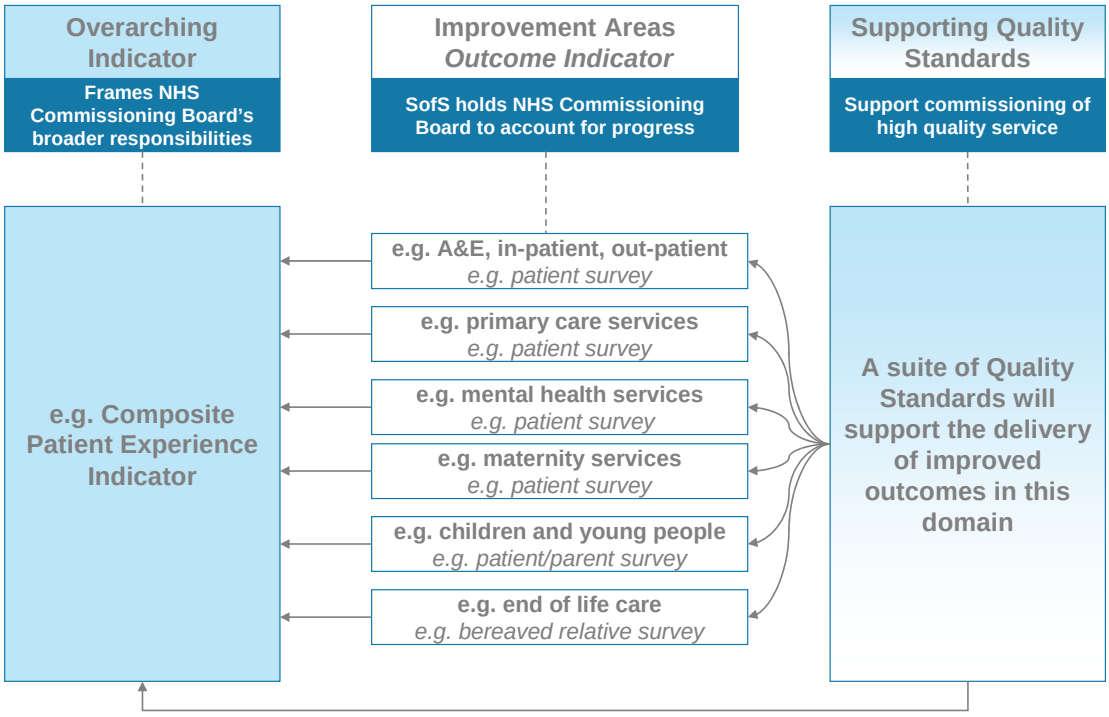
3.50. Although Quality Standards will generally encompass all three domains of quality - effectiveness, patient experience and safety – your views are welcomed on whether the development of dedicated patient experience Quality Standards should be considered for certain services or client groups.

Question
23. Would there be benefit in developing dedicated patient experience Quality Standards for certain services or client groups? If yes, which areas should be considered?

[26] This composite measure is based on five survey questions, covering a range of issues – such as patients being involved in decisions about their care, being able to talk to hospital staff about their worries and fears, having enough privacy, being given information about medication side effects, and being informed who to contact if worried about after leaving hospital. This survey is scheduled to be conducted annually, so providing a regular measure of patient experience.

3.51. Based on the above method and analysis, Figure 9 below illustrates what this domain might look like.

Figure 9: ensuring people have a positive experience of care



Future development of this domain

3.52. Over time, the ambition is for the approach to patient experience to be as robust and comprehensive as that for clinical effectiveness and patient safety. This will involve assessing how best to extend and improve national survey arrangements, with the aim of putting in place a more balanced set of surveys covering a range of settings, services, pathways and patient groups.

3.53. A standardised approach to this work will provide quality assurance and value for money, and it will also facilitate comparisons and benchmarking. A balanced approach to the frequency of national surveys will also be required, which supports and complements locally-led innovation and focused improvement activity.

3.54. To achieve this ambition, it is proposed that this work should involve:

- developing a better understanding of patient experience along specific service lines – for example, within acute care settings (for example, covering inpatient, outpatient and A&E services);

- expanding this focus to take better account of other areas of service provision – such as those covering primary and community care services, maternity services, end of life care, and cancer services;
- identifying services or areas where little work has been conducted to date, but which will provide an insight into how best to approach the work more generically. For example:
    - long term conditions which cut across conventional organisational boundaries (for example chronic obstructive pulmonary disease, diabetes, community rehabilitation services);
    - specific medical procedures or treatments, perhaps allied to available Patient Reported Outcome Measures (PROMS) (see Domain 2 for further details);
    - complex and multiple service use (for example, mental health, frail and older people with complex co-morbidities); or
    - the experiences of particular groups of people who may not have been fully incorporated within the range of surveys conducted to date (such as such as children, young people, and carers).

Question
24. Do you agree with the proposed future approach for this domain?

DOMAIN 5: TREATING AND CARING FOR PEOPLE IN A SAFE ENVIRONMENT AND PROTECTING THEM FROM AVOIDABLE HARM

3.55. As far back as 1863, Florence Nightingale said that *" the very first requirement in a hospital [is] that it should do the sick no harm"*[27]. Keeping patients safe means ensuring that the care environment is safe and clean, reducing avoidable harm such as medication errors and reducing rates of healthcare associated infection.

3.56. In developing this domain of the NHS Outcomes Framework, three underlying principles have been used:

[27] *Notes on Hospitals*, Florence Nightingale, 1863

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

Overarching Indicator

3.57. Patient safety is a challenging area in which to identify and deliver good outcomes, as the desired outcome is often the absence rather than presence of an event – i.e. preventing a harmful incident. Therefore, as well as reducing harmful incidents it is vital that the NHS is effective at recognising and reporting safety issues to foster greater understanding of how to deliver safe care.

3.58. For patient safety, an **overarching outcome indicator** should ensure that the NHS has an active patient safety culture, in which organisations are keeping individual patients safe. The proposal is to construct an overarching outcome **indicator**, including three measures:

Annex A 12
Technical details of indicators

i. the number of incidents reported (this should be rising in the short term and comparable with other services in the long term);
ii. the severity of harm (this should be decreasing); and
iii. the number of similar incidents (this should be decreasing).

3.59. An effective patient safety culture is one where an organisation is reporting incidents on an **increasing** basis in the short term and on a comparable basis with other high performing services in the longer term, demonstrating a good reporting culture (i). But this has to be balanced by a **decrease** in the levels of severity, particularly incidents resulting in severe harm and death, demonstrating a good learning culture (ii). There should also be a **reduction**

in the number of the same types of event as this is a good indication that the organisation is implementing and complying with guidance, best practice, and with safety alerts (iii).

3.60. This indicator would provide an indication of whether a just and open safety culture is developing in an organisation, as well as indicating whether more or fewer patients are experiencing unacceptable harm. It would also indicate how well an organisation is learning.

Question
25. Do you agree with the proposed overarching outcome indicator?

Improvement Areas

3.61. Safer care not only leads to a better life for patients and their families – safer care is generally less expensive. Patient safety affects all aspects of health care activity, including:

- the actual treatment provided to people;
- the system in which that care and treatment is provided; and
- the physical building and surroundings in which the treatment is provided and the systems of care operate (patient environment).

3.62. There are also certain vulnerable groups who require a particular focus when it comes to safety: those about to give birth, children, older people, people requiring mental health services and people with learning disabilities. The principles underpinning the proposed overarching outcome indicator – reducing harm and learning from mistakes – can be applied to these groups as well as safe care generally, using the same data source. In addition to this, consideration will be given to whether additional safety outcome measures in these areas could be developed.

3.63. Therefore, the proposed improvement areas have been defined so that they are relevant across the whole of health care. Five specific areas for improvement have been identified, and relevant indicators are included in Annex A. These areas are:

Annex A 13
Technical details of indicators

- **Safe treatment** – e.g. Never Events, reduced venous thromboembolism (VTE), Falls, Medication Errors
- **Safe discharge/transition** – e.g. Emergency re-admissions

- **Patient Environment** – e.g. minimising avoidable infections, cleanliness
- **Safety culture** – e.g. openness about mistakes (reporting)
- **Vulnerable groups** – e.g. maternity, older people

Question
26. Do you agree with the proposed improvement areas and the reasons for choosing those areas?

3.64. The identified improvement areas are provisional. The evidence and methods for choosing certain indicators will be refined in advance of finalising the NHS Outcomes Framework, informed by responses to this consultation.

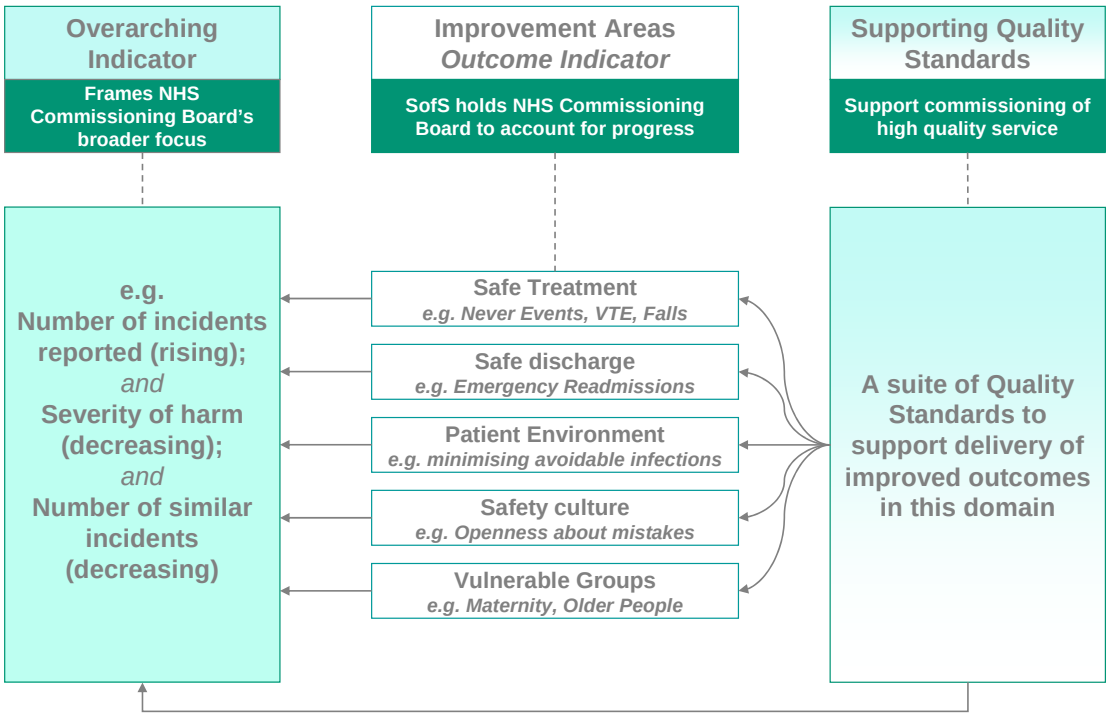
Quality Standards

3.65. To support commissioning excellent outcomes in all domains of this framework, there will be a suite of Quality Standards setting out what high quality care looks like across all major pathways of care. Some topics for Quality Standards will be selected to reflect areas that are most important to improving outcomes in this area. For example, one of the first three quality standards published by NICE was on the prevention of venous thromboembolism[28].

3.66. Based on the above method and analysis, Figure 10 sets out what this domain might look like.

[28] The VTE prevention NICE quality standard was published on 30 June 2010 and is available at http://www.nice.org.uk/aboutnice/qualitystandards/vteprevention/VTEqualitystandard.jsp

Figure 10 - Treating and caring for people in a safe environment and protecting them from avoidable harm



4. Next steps: How can you be involved?

Consultation Questions

4.1. Throughout this document, you are asked questions on the proposals for developing the NHS Outcomes Framework. Your views by way of responses to this consultation are essential to constructing an NHS Outcomes Framework that reflects what matters most to patients, and that is clinically relevant.

4.2. If your views do not fit under any of the specific questions included in Chapters 2 and 3, the following questions are more general, asking you about the proposals for the NHS Outcomes Framework overall, and the Impact Assessment which has been published alongside this consultation document.

Questions

27. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcomes for all patients and, where appropriate, NHS staff?

28. Is there any way in which the proposed approach to the NHS Outcomes Framework might impact upon sustainable development?

29. Is the approach to assessing and analysing the likely impacts of potential outcomes and indicators set out in the Impact Assessment appropriate?

30. How can the NHS Outcomes Framework best support the NHS to deliver best value for money?

31. Is there any other issues you feel have been missed on which you would like to express a view?

4.3. These questions, and all the specific questions from Chapters 2 and 3 are set out in **Annex B**.

Next Steps

4.4. This consultation document is the first step in getting active involvement from those who work in the NHS, those who use its services and those who are

clinical and healthcare experts. A full engagement process will be running over a 12 week period from publication of this document.

Timeline to the NHS Outcomes Framework

- **19 July 2010** – publication of consultation document and consultation opens
- **July – October 2010** – engagement process as part of full public consultation
- **11 October 2010** – consultation closes
- **End October / early November 2010** – Government response to the consultation
- **End 2010 / early 2011** - publication of the first NHS Outcomes Framework alongside the NHS Operating Framework for 2011/12

Engagement Process – how to get involved

4.5. This consultation is a formal public consultation in line with the Government Code of Practice on consultations. It will run for the full 12 week period. More details on what a formal consultation means is set out at **Annex C**, along with contact details for comments on the consultation process itself.

4.6. There are a number of questions in this document, both on specific areas of the NHS Outcomes Framework and more generally on which your views are being sought. You can respond to this consultation by:

- coming along to one of our regional events for NHS staff and patients which will be held across the country, details of which will be posted on the DH website shortly; or
- responding to the questions in this document by completing a template which can be downloaded from our website at www.dh.gov.uk/liberatingtheNHS and returning it to us by 11 October 2010 via
  - *email:* nhswhitepaper@dh.gsi.gov.uk
  - *post:* Consultation Responses
    Quality and Outcomes Policy Team
    Room 602A, Skipton House
    80 London Road
    London
    SE1 6LH

Beyond the Engagement Process

4.7. On 1 April 2011, the NHS Commissioning Board will be established in shadow form. It will be held to account by the Secretary of State through the new NHS Outcomes Framework 2011/12.

4.8. The NHS Outcomes Framework will be reviewed and re-issued in Autumn 2011, ahead of the NHS Commissioning Board being formally established (subject to parliamentary approval) on 1 April 2012.

ANNEX A – Possible outcome indicators

Introduction

Selecting outcome indicators to populate the framework

The structure of the Outcomes Framework proposed in Chapter 3 will require the selection of two levels of outcome measure:

- an overarching indicator(s) for each of the five domains; and
- outcome indicators to measure progress in each of the improvement areas in all five domains.

The eventual set of outcome indicators to underpin the NHS Outcomes Framework will be arrived at by a careful process of analysis of the relevance of indicators to the proposed improvement areas; their technical validity; their practical feasibility; and the potential costs and benefits flowing from their use in the NHS Outcomes Framework.

The purpose of this annex – a starting point

To start this selection process, an initial list of potentially relevant outcome indicators has been assembled in this annex. The list includes both indicators that currently exist and those that have been proposed for development. Indicators have been selected for initial consideration on the basis of two essential criteria:

- they are, at least in part, a health outcome measure; and
- they are, at least in part, directly influenced by healthcare actions.

Clearly, many other legitimate measures of quality of care are available. The focus here, however, has been to identify – as far as possible – *outcome* measures, as opposed to indicators of the quality of clinical processes.

An assessment has also been made for each indicator against three other desirable criteria:

- whether it can be disaggregated to sub-national geographical areas and/or equalities dimensions[29];

[29] The six key equality dimensions of race, disability, gender, age, sexual orientation and religion or belief

- whether international comparative data are currently available; and
- whether it is currently collected.

How to respond to this annex

This initial list will undergo more detailed assessment and analysis while this consultation is running. Suggestions for other, more relevant outcome indicators will be very welcome, and will be put through the same assessment and analysis process. Specific feedback on the strengths and weaknesses of any of the potential indicators set out in this annex would also be very helpful.

It is recognised that many of the outcome indicators proposed below may be impacted upon not only by NHS healthcare actions, but also by public health and / or social care interventions. Suggestions are welcomed on how shared responsibility for such outcomes indicators might be attributed to the NHS, public health or social care, and how their relative contributions might be estimated.

Questions

32. What are the strengths and weaknesses of any of the potential outcome indicators listed below with which you are familiar?

33. Are other practical and valid outcome indicators available which would better support the five domains?

34. How might we estimate and attribute the relative contributions of the NHS, public health and social care to these potential outcome indicators?

Using this annex

The structure of this annex

This annex follows the structure of chapter 3 of the main consultation document, taking each of the five proposed domains in turn and listing relevant outcome indicators for each, as well as covering any other technical issues. It should be read alongside chapter 3, which highlights the points at which interested readers should refer to the annex.

Key to indicator information

This annex rates the outcome indicators identified on five criteria that will be considerations when deciding whether the indicators are appropriate for use in the outcomes framework. Each indicator is scored on the following scale:

Y Criteria fully or largely met

P Criteria partly met

N Criteria not met

? Information not available

Links to further information

The websites listed below are rich sources of currently available indicators, and information about those indicators. Most include many process as well as outcomes measures.

- The Information Centre for Health and Social Care (IC)
  http://www.ic.nhs.uk/
- Office of National Statistics (ONS)
  http://www.statistics.gov.uk
- Patient Reported Outcomes Measures (PROMS)
  http://www.ic.nhs.uk/services/patient-reported-outcomes-measures-proms
- Hospital Episodes Statistics (HES)
  http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937
- Quality and Outcomes Framework (QOF)
  http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework
- Commissioning for Quality and Innovation (CQUIN) payment framework
  http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html
- Labour Force Survey
  http://www.statistics.gov.uk/CCI/SearchRes.asp?term=labour+force+survey&x=31&y=12
- National Hip Fracture Database (NHFD)
  http://www.nhfd.co.uk/
- NHS Comparators
  https://www.nhscomparators.nhs.uk/NHSComparators/Login.aspx
- Clinical and Health Outcomes Knowledge Base (NCHOD)
  http://www.nchod.nhs.uk/
- Indicators for Quality Improvement (IQI)
  http://www.ic.nhs.uk/services/measuring-for-quality-improvement
- National Indicator Set:
  http://www.communities.gov.uk/publications/localgovernment/updatednidefinitions

- OECD Health Data
  http://www.ecosante.org/index2.php?base=OCDE&langs=ENG&langh=ENG&ref=YES&sessionid=0b674c314b12274cceca8210648564df
- WHO
  http://www.euro.who.int/en/what-we-do/data-and-evidence/databases
- EUROCARE
  http://www.eurocare.it/
- Amenable Mortality: discussion of technical issues (2004)
  http://www.nuffieldtrust.org.uk/ecomm/files/21404avoidablemortality2.pdf
- Amenable Mortality: International Comparisons (Nolte & McKee 2003 paper)
  http://www.bmj.com/cgi/content/full/327/7424/1129?ijkey=c9397b45fe1c75f152868f2fd1417b8de6a19851
- Amenable Mortality: International Comparisons (Nolte & McKee 2008 paper)
  http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2008/Jan/Measuring-the-Health-of-Nations--Updating-an-Earlier-Analysis.aspx
- Amenable Mortality: NCHOD definition
  http://www.nchod.nhs.uk/NCHOD/compendium.nsf/361d5bea85d84b7c802573a30020fcd5/0369316d2ebea946652570d1001cb76c!OpenDocument

Specific outcome indicators and technical issues

The main body of the annex follows.

GENERAL ISSUES

1. Design principles for outcome indicators (paragraph 3.3)

This consultation has focused on indicators that:

- measure health outcomes rather than NHS processes;
- are broad indicators - capturing as much NHS business and as many patients and conditions as possible ;
- can be significantly influenced by healthcare (where possible any public health and social care contribution is excluded from the indicators);
- focus on areas where there is evidence that performance can be improved;
- can be disaggregated by age, sex, geography, other equalities strands and other variables such as condition ;
- are meaningful to the public;

- are statistically sound; and
- can be measured from April 2011 (for the initial set).

Questions

35. Are these appropriate principles on which to select outcome indicators? Should any other principles be considered?

DOMAIN 1: PREVENTING PEOPLE FROM DYING PREMATURELY

2. Overarching indicators (paragraph 3.6)

	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Mortality amenable to healthcare	Y	Y	P	P	Y
All age all cause mortality	Y	P	Y	Y	Y

Technical considerations around amenable mortality

- There is no one agreed definition of amenable mortality; we have used the Nolte & McKee 2008[30] definition for the illustration in Figure 2.
- The indicator is not regularly calculated for international comparison, but can be calculated using existing international comparative data, subject to agreeing a definition.
- Most definitions of amenable mortality only include deaths under 75. Some causes are only considered amenable in younger age groups, e.g. diabetes under 50.
- In practice, some of the mortality included may not be amenable to healthcare, and some will be preventable by public health measures and the wider environment.
- There will be a time-lag in measurement of the indicator – the latest internationally comparative data is at least two years old.

[30] E. Nolte and C. M. McKee (2008). Measuring The Health Of Nations: Updating An Earlier Analysis. *Health Affairs*

- There can be a significant time lag between diagnosis and outcomes – outcomes seen may be a result of interventions several years previously, especially with cancer.
- The National Centre for Health Outcomes Development (NCHOD) currently collects this indicator nationally, but uses a slightly different definition.

3. Selecting improvement areas based on mortality data (paragraphs 3.7 and 3.8)

The table below presents age-standardised death rates per 100,000 from causes amenable to healthcare (ages 0-74; definition from Nolte & McKee 2008; data from World Health Organisation online mortality database). UK[31] rates are compared with the median rate of a comparable set of European countries (the EU-15; Greece is excluded as it does not submit data). All international comparisons should be interpreted with caution, due to differences in registration systems and coding conventions.

Cause	*UK*	*EU-15 median*	*Difference*
Ischaemic heart disease: 50% of deaths	22.26	16.31	+5.95
Pneumonia[32]	6.56	3.44	+3.12
Perinatal deaths, all causes (excl. stillbirths)[33]	4.42	3.35	+1.07
Stroke	14.40	13.64	+0.76
Peptic ulcer	1.47	0.79	+0.68
Breast cancer	10.70	10.20	+0.50
Epilepsy	1.50	1.07	+0.42
Congenital cardiovascular anomalies	1.32	1.05	+0.28
All respiratory diseases ages 0-14 (excl. pneumonia, influenza)	0.28	0.10	+0.18
Abdominal hernia	0.35	0.17	+0.17
Chronic rheumatic heart disease	0.62	0.45	+0.16
Cholelithiasis and cholecystitis (gallstones)	0.35	0.25	+0.10
Tuberculosis	0.28	0.22	+0.06
Appendicitis	0.11	0.05	+0.05
Maternal death	0.12	0.07	+0.05
Hodgkin's disease	0.35	0.30	+0.04
Skin cancer	0.26	0.22	+0.04
Cervical cancer	1.08	1.05	+0.03

[31] UK data is more readily available and is a reasonable approximation for England, which makes up 84% of the UK's population. It is possible to make the same comparisons for England in the future.
[32] There are known coding issues here; deaths assigned to pneumonia may have a different underlying cause
[33] There are differences in the way in which countries record neonatal deaths, so rates may not be comparable

Cause	*UK*	*EU-15 median*	*Difference*
Misadventures to patients during surgical and medical care	0.29	0.27	+0.02
Diabetes	0.52	0.50	+0.02
Whooping cough	0.01	0.00	+0.01
Benign prostatic hyperplasia	0.02	0.02	+0.00
Measles	0.00	0.00	+0.00
Diseases of the thyroid	0.07	0.08	-0.00
Leukaemia	0.60	0.61	-0.00
Cancer of the uterus	0.03	0.04	-0.01
Testicular cancer	0.09	0.11	-0.01
Intestinal infections	0.01	0.02	-0.02
Influenza	0.03	0.05	-0.02
Hypertensive disease	1.89	1.92	-0.03
Colorectal cancer	10.92	11.08	-0.16
Other infections (diphtheria, tetanus, septicaemia, poliomyelitis)	1.43	1.90	-0.47
Nephritis and nephrosis	1.09	1.65	-0.56

4. Improvement areas (paragraph 3.9)

Mortality itself is measurable and internationally comparable, and so is an appropriate outcome indicator to use for many of these improvement areas. There are some exceptions where there are known issues, for example differences in coding and recording practices both between and within countries (e.g. pneumonia). There are also other ways of addressing this issue, such as using survival rather than mortality data. Some specific indicators are set out below.

	Essential		*Desirable*		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Premature mortality from ischaemic heart disease, 0-74 years (ONS)	Y	P	P	Y	Y
Premature mortality from all cardiovascular disease, 0-74 years (ONS)	Y	P	P	Y	Y
30-day mortality after first time Coronary Artery Bypass Graft (incomplete national coverage) (CCAD)	Y	P	P	N	Y
30-day mortality after first time aortic valve replacement (incomplete national coverage) (CCAD)	Y	P	P	N	Y
30 day mortality following congenital heart disease surgery (national coverage incomplete for age 16+) (CCAD)	Y	P	P	N	Y
Premature mortality from stroke, 0-74 years (ONS)	Y	Y	P	Y	Y
Premature mortality from cancer, 0-74 (ONS)	Y	P	P	Y	Y
One- and five-year cancer survival (ONS, EUROCARE, OECD; note time lag)	P	Y	P	Y	Y

5. Other considerations (paragraphs 3.11 and 3.13)

The following indicators could potentially be used to take account of mortality in children and older people.

	Essential		*Desirable*		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Healthy life expectancy at age 65 (ONS)	Y	P	P	Y	Y
Excess winter deaths (ONS)	Y	P	P	N	Y
Infant mortality (ONS)	Y	Y	Y	Y	Y
Premature mortality from respiratory disease, 0-14 (ONS)	Y	P	P	Y	Y
Amenable mortality for people with serious mental illness (ONS / MHMDS, Information Centre)	Y	Y	Y	N	N

DOMAIN 2: ENHANCING QUALITY OF LIFE FOR PEOPLE WITH LONG-TERM CONDITIONS

6. Overarching indicators (paragraphs 3.19 and 3.20)

	Essential		*Desirable*		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Percentage of people with long-term conditions where day to day activity affected (Labour Force Survey)	Y	P	Y	N	Y
Percentage of people with long-term conditions feeling supported to manage condition (currently in the GP Patient Survey)	Y	Y	Y	N	Y
Percentage of people with a long-term condition who say they are confident are that they can manage their own health	Y	Y	N	N	P
Generic PROM for all patients with long-term conditions	Y	Y	P	N	N

7. Improvement areas (paragraph 3.23)

The indicators set out in the table below resulted from an initial review of outcome indicators in this area. In the main body of this document the preferred option of using functional and episodic outcomes that apply to all conditions has been set out, but the list below also includes condition-specific outcome indicators that currently exist.

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
PROMs for specific long-term conditions	Y	Y	P	N	P
Percentage of people with long-term conditions who report that their health affects the amount or type of work they can undertake (Labour Force Survey)	Y	P	Y	N	Y
Emergency hospital admissions for ambulatory care sensitive conditions – chronic (NHS Comparators)	P	Y	P	P	Y
Emergency hospital admissions for specific chronic conditions usually managed in primary care (NCHOD)	P	Y	P	P	Y
Emergency hospital admissions: for children with asthma (NCHOD)	P	Y	P	N	Y
Emergency hospital admissions: for fractured proximal femur (NCHOD)	P	P	P	N	Y
Emergency hospital admissions: for diabetic ketoacedosis and coma (NCHOD)	P	Y	P	N	Y
Emergency hospital admissions: for schizophrenia (NCHOD)	P	P	P	N	Y
Emergency admissions related to: alcohol dependence; drug dependence (HES)	P	P	Y	N	P
Proportion of adults with learning disabilities in employment (Information Centre)	P	P	P	N	Y
Unplanned hospital re-admissions for schizophrenia and bipolar disorder (OECD Health at a Glance)	P	Y	P	Y	Y
Proportion of adults in contact with secondary mental health services in employment (Information Centre)	P	P	P	N	Y
Percentage of patients aged 18 years and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the previous 15 months (Information Centre: QOF)	Y	Y	P	N	Y
Range of outcome measures for Coronary Heart Disease (cholesterol, blood pressure) (Information Centre: QOF)	Y	Y	P	N	Y
Range of outcome measures for Stroke (cholesterol, blood pressure) (Information Centre: QOF)	Y	Y	P	N	Y
Percentage of patients with hypertension in whom the last blood pressure is 150/90 or less (Information Centre: QOF)	Y	Y	P	N	Y
Range of outcome measures for diabetes, 17 years and over (cholesterol, blood pressure, HbA1c) (Information Centre: QOF)	Y	Y	P	N	Y
Range of outcome measures for diabetes in children (cholesterol, blood pressure, HbA1c) (Information Centre: QOF)	Y	Y	?	N	N
The percentage of patients on the chronic kidney disease register in whom the last blood pressure reading is 140/85 or less, 18 years and over (Information Centre: QOF)	Y	Y	P	N	Y
Diabetes acute complication rate (OECD Health at a Glance)	Y	Y	Y	Y	Y
Health of the Nation Outcome Scale (HoNOS), for people with mental illness (MHMDS, Information Centre)	Y	P	P	P	P
Proportion of people with dementia who do not stay in hospital longer than people without dementia do for similar conditions (HES)	P	Y	Y	N	P

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Mortality from suicide and injury of undetermined intent	Y	P	Y	Y	Y
Indicators for sickle cell in children: pain management; or avoidance of serious complications such as stroke	Y	Y	?	N	N

It may also be possible to develop other outcome indicators in the future.

- Specific questions relating to the functional outcomes that are relevant for each age group could be included in national surveys.
- It may be possible to use data collected by other Government departments, such as workforce data from DWP, to infer functional outcomes. Work would be needed to ensure that any such inferences are valid.

DOMAIN 3: HELPING PEOPLE TO RECOVER FROM EPISODES OF ILLNESS OR FOLLOWING INJURY

8. Overarching indicators (paragraphs 3.28 and 3.29)

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Emergency hospital admissions for acute conditions usually managed in primary care (NCHOD)	P	Y	P	P	Y
Emergency hospital admissions for Ambulatory Care Sensitive Conditions – acute (NHS Comparators)	P	Y	P	P	Y
Emergency bed days associated with repeat acute admissions (2+ pa) (HES)	P	Y	Y	N	P
Percentage of emergency admissions to any hospital in England occurring within 28 days of the last, previous discharge from hospital after admission (NCHOD)	P	Y	P	N	Y

9. Methodology for selecting the most common causes of emergency care (paragraph 3.32)

Hospital Episode Statistics (HES) provide information about the number of bed days that result from emergency admissions. These bed days can be linked to the primary diagnosis of the patient, indicated by an ICD-10 code, and so it is possible to estimate

the number of bed days that relate to a given cause, as long as the ICD-10 codes for that cause are known. For the purpose of this consultation, a list of causes and corresponding ICD-10 codes was taken from work previously carried out by the National Quality Board (NQB) to identify areas that should be prioritised for quality improvement activities.

10. Improvement areas (paragraph 3.33)

	Essential		*Desirable*		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
PROMS for specific surgical procedures (hip replacement, knee replacement, hernia, varicose veins)	Y	Y	Y	P	Y
Emergency hospital admissions for children with gastroenteritis (NCHOD)	P	P	P	N	Y
Emergency hospital admissions for children with lower respiratory tract infections (NCHOD)	P	P	P	N	Y
Fragility fractures: The proportion of patients recovering to their previous levels of mobility - walking ability at 30 and 120 days (National Hip Fracture Database)	Y	Y	P	N	P
Health status 6 months after stroke	Y	P	?	N	N
Identification and successful treatment of HepC patients	Y	P	?	N	N
Emergency re-admissions to hospital within 28 days of discharge: for fractured proximal femur (NCHOD)	P	Y	P	N	Y
Emergency re-admissions to hospital within 28 days of discharge: for stroke (NCHOD)	P	Y	P	N	Y
Emergency re-admissions to hospital within 28 days of discharge: for hysterectomy (NCHOD)	P	Y	P	N	Y
Emergency re-admissions to hospital within 28 days of discharge: for primary hip replacement surgery (NCHOD)	P	Y	P	N	Y
Proportion of patients of all ages (or over 75) discharged back to usual place of residence within 28 days of emergency admission with various conditions (HES/NCHOD)	P	P	P	N	P
Proportion of Older People (65 and over) who were still at home after 91 days following discharge from hospital into rehabilitation services (Information Centre)	P	P	P	N	Y
Acute admissions as a result of falls or falls injuries for over 75s (HES)	P	P	Y	N	Y
The proportion of all falls and hip fractures which are repeat incidents (National Hip Fracture Database)	P	P	P	N	Y

DOMAIN 4: ENSURING PEOPLE HAVE A POSITIVE EXPERIENCE OF CARE

There are currently very few outcome indicators collected nationally in relation to this domain, so rather than providing a list of indicators, this section of the annex gives an overview of the current state of play and direction of travel with respect to measuring patient experience.

11. An overview of patient experience indicators (paragraph 3.41)

The self-reported experience of patients and service users is an important indicator of the quality of service delivery, and it can turn the spotlight on the issues which patients themselves identify as in need of improvement – many of which would otherwise go unmonitored and unmeasured. The use of nationally coordinated surveys is a cost effective way to collect structured and standardised patient feedback, and it is a relatively new development within the NHS. By asking patients questions about specific aspects of their recent treatment and care episode, the overall aim is to produce directly actionable and benchmarkable data[34].

A number of national-level patient experience surveys have been conducted[35], but the focus in recent years has been on developing a range of organisation-level surveys across a broad range of services and settings. Each survey typically covers a wide range of topics covering all phases of the treatment/care episode – including, for example, access and waiting, admission and discharge arrangements, clinician communications, information provision, and facilities and the wider physical environment.

The table below sets out the main organisation-level nationally coordinated patient surveys that have been conducted over the last ten years. These are mainly derived from the **NHS National Patient Survey Programme**[36, 37] and the **GP Patient**

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[34] This focus on direct experience makes this a different approach to that used in many other surveys that are conducted among the general public, and/or ask them to rate or evaluate services overall (such as is the case with the British Social Attitudes Survey – see link below):
http://www.natcen.ac.uk/study/british-social-attitudes-25th-report/findings

[35] For example, covering General Practice (1998, 2002), and patients who have experienced a stroke (2005, 2006), coronary heart disease (1999, 2004), and cancer (2000, 2004). Building on these national-level surveys, the Department has also recently established the National Cancer Patient Experience Survey. This is now underway, and it covers all NHS adult acute trusts in England who provide cancer care, so providing a national and organisation level measure of patient experience. (Further information is available via the following weblink).
http://www.quality-health.co.uk/2010cancersurvey.html

[36] Further information, including results from all surveys, are available on the website of the Care Quality Commission:
http://www.cqc.org.uk/usingcareservices/healthcare/patientsurveys.cfm

[37] In recent years, the Department of Health has also established a survey covering NHS patients who are have been treated by an Independent Sector Treatment Centre (ISTC). This is modelled on the adult

Survey[38]**,** which are thought to be among the most comprehensive and largest survey programmes in existence.

The existing arrangements for collecting patient experience information do not currently fit with the requirements of the NHS Outcomes Framework. Our aim is for patient experience to be as robust and comprehensive as that for clinical effectiveness and patient safety. On this basis, we have set out a series of proposals for developing and extending the infrastructure for measuring and monitoring quality *from the patients' point of view*. Given the purpose of the Outcome Framework, the focus in here is on developing a series of survey options and arrangements that produce robust national outcome goals, but which will also crucially meet local information requirements and assist local benchmark comparisons. A key consideration in taking these proposals is to ensure a balanced approach is achieved, so that this work fully supports and complements locally-led innovation and focused improvement activity.

Year	Survey
2001/02	Adult inpatients*
2002/03	Outpatient services*
	A&E/Emergency services*
	PCT residents registered with a GP*
2003/04	Adult inpatients*
	PCT residents registered with a GP*
	Young patients (day case and inpatient) *
	Users of community mental health services (CPA) *
	Users of ambulance (urgent/emergency – Category a & b) services*
2004/05	Outpatient services*
	A&E/Emergency services*
	PCT residents registered with a GP*
	Users of community mental health services (CPA) *
2005/06	Adult inpatients*
	Users of community mental health services (CPA) *

inpatient survey programme which forms part of the NHS national patient survey programme, and further details are available from the Department of Health website http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_083011

[38] Further information is available via the following weblink: http://www.gp-patient.co.uk/

Year	Survey
	PCT residents registered with a GP*
2006/07	Adult inpatients*
	Users of community mental health services (CPA) *
2007/08	GP Patient Survey
	Users of maternity services*
	Adult inpatients*
	PCT residents registered with a GP*
	Users of community mental health services (CPA) *
	A&E/Emergency services*
2008/09	GP Patient Survey
	ISTC survey
	Adult inpatients*
	Ambulance (category C) *
	Mental health inpatients*
2009/10	GP Patient Survey
	ISTC survey
	Outpatient services*
	Adult inpatients*
	Users of community mental health services (CPA) *
2010/11	ISTC survey
	Adult inpatients*
	Users of maternity services*
	Users of community mental health services (CPA) *

* This survey forms part of the NHS National Patient Survey programme

DOMAIN 5: TREATING AND CARING FOR PEOPLE IN A SAFE ENVIRONMENT AND PROTECTING THEM FROM AVOIDABLE HARM

12. Overarching indicators (paragraph 3.58)

	Essential		*Desirable*		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Number of incidents reported (NPSA)	P	Y	Y	Y	Y
Severity of harm of incidents reported (NPSA)	Y	Y	P	P	Y
Number of similar incidents (NPSA)	P	Y	P	P	Y

13. Improvement areas (paragraph 3.63)

Safe treatment

	Essential		*Desirable*		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Number of never events reported in period (NPSA)	P	Y	P	P	Y
Number of other critical adverse events reported in period (NPSA)	P	Y	P	P	Y
Incidence of pressure ulcers (HES/NPSA)	Y	Y	Y	P	Y
Incidence of VTE (HES)	Y	Y	Y	P	Y
Incidence of in-patient falls (NPSA)	P	Y	Y	P	Y
Incidence of medication errors (NPSA)	P	Y	P	P	Y
Number of readmission episodes due to safety/error (HES)	P	Y	Y	?	Y
Number of controlled drugs incidents (NPSA/CQC)	P	Y	P	P	Y

Safe discharge/transition

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Number of emergency readmissions (HES)	P	P	Y	Y	Y
Medicines reconciliation compliance (NPSA)	P	Y	P	?	Y
Patient reported experience of medicines management (CQC patient survey)	Y	Y	P	N	Y

Patient environment

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Patient survey reported cleanliness (CQC patient survey)	P	Y	P	?	Y
MRSA incidence (HPA)	Y	Y	Y	Y	Y
C.Diff incidence (HPA)	Y	Y	Y	Y	Y
Incidence of surgical site infections (orthopaedics) (HPA)	Y	Y	P	P	Y
Number of central line infections in Intensive Care Units (HPA and NPSA via Matching Michigan)	Y	Y	P	Y	Y
Incidence of ventilator associated pneumonia (HES)	Y	Y	P	P	Y
Incidence of urinary catheter related infections (HES)	Y	Y	P	P	Y

Safety culture

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Errors reported as discussed with patients/relatives/carers	P	Y	N	?	N
Number of safety-related complaints from patients in period	P	Y	N	?	N

Vulnerable groups

	Essential		Desirable		
	Measure of Health Outcome	*Significantly influenced by healthcare*	*Disaggregation by Equalities & Geography*	*International comparisons available*	*Currently collected*
Children - medication errors due to weight calculation errors (NPSA)	Y	Y	P	?	Y
Children - preventable deterioration (NPSA)	Y	Y	P	?	Y
Older people - pressure ulcers (NPSA/HES)	Y	Y	P	P	Y
Older people - medication errors (NPSA)	P	Y	P	P	Y
Older people - preventable delirium	Y	Y	?	?	?
Learning disabilities - medication errors (communication and comprehension) (NPSA)	Y	Y	P	?	Y
Learning disabilities - preventable deterioration (NPSA)	Y	Y	P	?	Y
Learning disabilties - misdiagnosis (communication and comprehension) (NPSA/HES)	P	Y	P	?	Y
Mental Health – inpatient suicides (NPSA/NCEPOD)	Y	Y	Y	N	Y
Maternity – haemorrhage (NPSA)	Y	Y	P	P	Y
Maternity - unexpected or unplanned admission of term baby (>37 weeks) to neonatal care (NNAP database)	P	P	Y	P	Y
Maternity - medication errors (epidural) (NPSA)	P	Y	P	P	Y

ANNEX B – Consultation questions

CHAPTER 2: Scope, purpose and principles of an NHS Outcomes Framework

Principles

1. Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework (page 10)?

2. Are there any other principles which should be considered?

3. How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?

4. How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?

Five domains

5. Do you agree with the five domains that are proposed in Figure 1 (page 14) as making up the NHS Outcomes Framework?

6. Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?[39]

Structure

7. Does the proposed structure of the NHS Outcomes Framework under each domain seem sensible?

[39] **Please note** that public health and prevention will be covered in a separate consultation, linking to this framework where appropriate

CHAPTER 3: What would an NHS Outcomes Framework look like?

Domain 1 - Preventing people from dying prematurely

8. Is 'mortality amenable to healthcare' an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?

9. Do you think the method proposed at paras 3.7-3.9 (page 20) is an appropriate way to select improvement areas in this domain?

10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed in para 3.11 (page 21)?

11. If not, what would be a suitable outcome indicator to address this issue?

12. Are either of the suggestions at para 3.13 (pages 21) appropriate areas of focus for mortality in children? Should anything else be considered?

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

13. Are either of the suggestions at para 3.19 (page 24) appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?

14. Would indicators such as those suggested at para 3.20 (page 24) be good measures of NHS progress in this domain? Is it feasible to develop and implement them? Are there any other indicators that should be considered for the future?

15. As well as developing Quality Standards for specific long-term conditions, are there any cross-cutting topics relevant to long-term conditions that should be considered?

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

16. Are the suggestions at para 3.28 (page 27) appropriate overarching outcome indicators for this domain? Are there any other indicators that should be considered?

17. What overarching outcome indicators could be developed for this domain in the longer term?

18. Is the proposal at paras 3.30-3.33 (page 28-29) a suitable approach for selecting some improvement areas for this domain? Would another method be appropriate?

19. What might suitable outcome indicators be in these areas?

Domain 4 - Ensuring people have a positive experience of care

20. Do you agree with the proposed interim option for an overarching outcome indicator set out at para 3.43 (page 32)?

21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator set out at para 3.44 (page 32-33)?

22. Do you agree with the proposed improvement areas and the reasons for choosing those areas set out at para 3.45 (pages 33-34)?

23. Would there be benefit in developing dedicated patient experience Quality Standards for certain services or client groups? If yes, which areas should be considered?

24. Do you agree with the proposed future approach for this domain, set out at paras 3.52-3.54 (pages 36-37)?

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

25. Do you agree with the proposed overarching outcome indicator set out at para 3.58 (page 38)?

26. Do you agree with the proposed improvement areas proposed at para 3.63 (page 39-40) and the reasons for choosing those areas?

General Consultation Questions

27. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcomes for all patients and, where appropriate, NHS staff?

28. Is there any way in which the proposed approach to the NHS Outcomes Framework might impact upon sustainable development?

29. Is the approach to assessing and analysing the likely impacts of potential outcomes and indicators set out in the Impact Assessment appropriate?

30. How can the NHS Outcomes Framework best support the NHS to deliver best value for money?

31. Is there any other issue you feel has been missed on which you would like to express a view?

ANNEX A: Identifying Potential Outcome Indicators

Potential indicators

32. What are the strengths and weaknesses of any of the potential outcome indicators listed in Annex A with which you are familiar?

33. Are other practical and valid outcome indicators available which would better support the five domains?

34. How might we estimate and attribute the relative contributions of the NHS, Public Health and Social Care to these potential outcome indicators?

Principles for selecting indicators

35. Are the principles set out on pages 48 and 49 on which to select outcome indicators appropriate? Should any other principles be considered?

ANNEX C – The Consultation Process

Criteria for consultation

This consultation follows the 'Government Code of Practice'. In particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks - the policies in this document were included in the NHS White Paper, *Liberating the NHS*, which was launched on 12 July for a 12 week consultation period closing on 11 October;
- be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the Code of Practice and related guidance is on the Better Regulation website at: www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE
e-mail: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter (available at www.dh.gov.uk).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A response to this consultation will be made available at www.dh.gsi.gov by the end of this year.

Transparency in outcomes – a framework for the NHS
Department of Health

July 2010