TRANSPARENCY IN OUTCOMES: A FRAMEWORK FOR THE NHS (ENGLAND) BMA SUMMARY

Background

On 12 July 2010 the Secretary of State for Health, Andrew Lansley, released a White Paper on health reform entitled Equity and Excellence: Liberating the NHS setting out an ambitious agenda for the NHS for the next five years.

As part of the White Paper consultative process Transparency in Outcomes: a framework for the NHS was released on 19 July 2010. This consultation document provides greater detail on proposals for the development of a new NHS Outcomes Framework which the Government hopes will improve the quality of healthcare by focusing on outcomes, and provide for clear accountability through the NHS for those outcomes. Responses to the consultation document are due by **11 October 2010.**

This work is to link to the Coalition Government's broader cross-government approach to performance in public services which is to be published alongside the Comprehensive Spending Review later in 2010.

CHAPTER 1 – The purpose of this consultation

The White Paper is clear that in the improvement of healthcare outcomes should be the primary purpose of the NHS.

The consultation document proposes the development of a new NHS Outcomes Framework which will:

- **Improve the quality of healthcare and accountability** within the NHS by focusing on the outcomes achieved for patients rather than the process by which they are reached;
- Drive the NHS towards achieving excellence rather than minimum standards;
- **Provide an indication of the overall performance of the system in an international context**;
- Consist of a **focused set of national outcome goals** that will provide an indication of the NHS's overall performance;
- **Provide a means by which patients, carers, the public and Parliament can hold the Secretary of State for Health to account** for the NHS;
- **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;
- **Bring 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; and
- **Not be used as a tool to performance manage providers of NHS care**.

Once in place 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 the best use of the various tools and levers it will have at its disposal.

Transparency in Outcomes: a framework for the NHS is asking for views on a number of topics:

- The principles that should underpin the new NHS Outcomes Framework;
- A proposed structure and approach that could be used to develop the framework;
- How the proposed framework can support equality across all groups and can help reduce health inequalities;

- 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 for patients and carers; and
- Potential outcome indicators, including methods for selection that could be presented in this framework.

The definition of quality, established by Lord Darzi in the 2008 Next Stage Review, will continue to be used and built upon. The three components of this quality definition are:

- The **effectiveness** of treatment provided to patients;
- 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.

In terms of measuring these three areas it is proposed that the following should be considered:

- **The structure 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 process 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?
- **The outcome of care** – what actually happens to the health of the patient (the outcome) as a result of the treatment and care they receive?

The NHS Commissioning 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;
- Will draw on NICE Quality Standards to support it in designing payment mechanisms and incentive payments such as the Commissioning for Quality and Innovation Payment Framework (CQUIN);
- **Will work with clinicians, patients and the public to develop the set of indicators it will use to operationalise the national outcome goals** set by the Secretary of State. These might draw upon existing measures such as the Vital Signs Indicators where they are clinically relevant or reflect other improvements, as well as those indicators included on the menu of Indicators for Quality Improvement;
- **Will be responsible for the design and development of a commissioning framework for GP consortia.** This framework will flow from and support the delivery of the national outcome goals set by the Secretary of State; and
- **Will be in existence in its shadow form from 1 April 2011.**

CHAPTER 2 – Scope, principles and structure of an NHS Outcomes Framework

The scope

- The **current performance framework regime will be replaced with separate frameworks for outcomes** that set the direction for the NHS, public health and social care.
- These frameworks are to provide for clear and unambiguous accountability and enable better joint working.
- The primary purpose of the NHS Outcomes Framework will be to focus on the outcomes that the NHS can deliver through the provision of treatment and healthcare.
- **There are some outcomes that the NHS cannot achieve on its own; these will necessitate partnerships with public health and prevention services, adult social care services, children's services and other local services.**
- **A crucial part of developing the NHS Outcomes Framework will be considering how it will incentivise more integrated care.**

- 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 their healthcare choices.

A number of key principles are proposed to underpin the development of the NHS Outcomes Framework. These are:

Accountability and transparency

- The NHS Outcomes Framework is to sharpen the accountabilities in the system for delivering better and more equitable outcomes.
- **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 progress for themselves.**
- More detail on the information to be publicly available will be set out in the DH's information strategy to be launched in autumn 2010.

Balanced

- A balanced set of outcomes will be chosen that span Lord Darzi's three dimensional definition of quality as previously mentioned.

Focused on what matters to patients and healthcare professionals

- Indicators are to record the effectiveness of treatment from both the clinical and patient perspective and **include clinical outcome measures and patient reported outcome measures (PROMs).**
- Professionals are to recognise the clinically relevant indicators as both relevant and as accurately tracking the delivery of improved quality and outcomes for patients.
- **Staff engagement and partnership working** will be a key part of developing the proposals.

Promoting excellence and equality

- **Ensuring that providers of NHS care meet minimum standards or the essential levels of quality and safety is the responsibility of the Care Quality Commission (CQC).**
- **The NHS Outcomes Framework should recognise the importance of reducing inequalities and promoting equality.** Given the social gradient in most health outcomes, the most potential health gain will often be available from lower parts of the gradient, from disadvantaged groups and areas.
- As far as possible outcomes will 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 geographical area and 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

- As far as possible **the NHS will be held to account for outcomes that it alone can influence.**
- For all outcome indicators **where relevant the 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.**

- **The DH will consult on frameworks for public health and social care in the coming months as part of an integrated cross service approach** in the Spending Review.

Internationally comparable

- Outcomes will not be selected solely in areas where the NHS is performing less well than other international healthcare systems.
- **International comparisons can only be based on what comparable data is available and may not always reflect the most important quality improvement challenges facing the NHS.**
- **Wherever possible and appropriate the framework will include outcome indicators which are internationally comparable, for instance amongst OECD nations, or groups such as the European Union (EU) 15[1] or EU-27[2]**
- 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.
- **The DH as a first step will support the development of metrics that allow intra-UK comparisons to be made.**

Evolving over time

- The first NHS Outcomes Framework **will use existing outcome indicators for which data can and is being collected.**
- Thus the Outcomes Framework for 2011/12 may not necessarily meet all of the principles set out in this paper.
- **The Outcomes Framework will evolve and be reviewed annually** to ensure that it focuses on the most important issues and accommodates new and better outcome indicators as they become available.

Structure of the NHS Outcomes Framework
It is proposed that the framework is developed around a set of **five outcomes domains** that attempt to capture what the NHS should be delivering for patients. These are:
1. Preventing people from dying prematurely (effectiveness element of quality)
2. Enhancing quality of life for people with long-term conditions (effectiveness element of quality)
3. Helping people to recover from episodes of ill health or following injury (effectiveness element of quality)
4. Ensuring people have a positive experience of care (patient experience element of quality)
5. Treating and caring for people in a safe environment and protecting them from avoidable harm (safety element of quality)

Structure of each domain
Each of the five domains will have:

- **An overarching outcomes 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 include a mechanism for ensuring that the NHS Commissioning Board maintains its focus on overseeing the commissioning of a comprehensive healthcare service;
- **A small set of approximately five or more specific improvement areas with corresponding indicators** - the NHS Commissioning Board will be tasked with securing improved outcomes through its role in overseeing the GP commissioning consortia. As far as possible these improvement areas will be chosen by an evidence based approach;
- **A corresponding outcome indicator for each of the specific improvement areas;** and

[1] For a list of the EU-15 see http://www.eea.europa.eu/help/eea-help-centre/faqs/what-is-the-eu-15
[2] For a list of the EU-27 see http://www.eea.europa.eu/help/eea-help-centre/faqs/what-is-the-eu-27

- **Supporting NICE Quality Standards** – these will provide an authoritative definition of what high quality care looks like for a particular care pathway or service. **GP consortia will refer to them when commissioning locally.** The DH currently commissions NICE to produce these Quality Standards but this responsibility will shift to the NHS Commissioning Board once it is established.

Over the next five years NICE will produce a library of approximately 150 Quality Standards covering the majority of NHS activity. Given that these standards are likely to focus on a pathway of care, any one is likely to span two or more domains of the NHS Outcomes Framework.

Risks and limitations

- There is a risk that outcome indicators will distort behaviour and disadvantage patients. It is possible that focusing on delivering an outcome in one area will involve neglecting others.
- In an attempt to avoid this, the framework will need to be as comprehensive as possible.
- Carefully chosen proxy measures may be used in the short-term as comprehensive outcome indicators are not always possible or feasible.
- Each of the domains face different challenges in respect of available indicators and developing appropriate, accurate and representative indicators is complex and labour intensive.
- Over time new indicators will become available which should improve the framework.

CHATPER 3 – What would an NHS Outcomes Framework look like?

This chapter puts forward proposals for what the overarching outcome indicators for each of the five domains 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. **There will almost certainly be debate as to which category certain conditions fall into.**

Domain 1: Preventing people from dying prematurely

Two underlying principles have been used for this domain:

- **People should not die early where medical intervention could make a difference.** 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; and
- **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.

Overarching indicator

- Following the above principles, the overarching indicator for this domain should show 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.
- A suite of Quality Standards will support the delivery of improved outcomes in this domain.

Improvement areas

- Internationally comparable mortality statistics can be used to identify component conditions of mortality amendable to healthcare on which England performs worse than comparable countries.

- It is proposed that **these causes should be considered as possible improvement areas in this domain.**
- **Following this logic the two causes with the most scope for improvement are heart disease and stroke.**
- **There are a number of cancers on which the UK performs at or worse than the level of comparable countries** so, if included, a broader outcome on cancer mortality would cover a number of relevant areas.
- **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 was selected then survival measures may be more appropriate outcome indicators.

Other considerations

Older people

- **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, are applicable to all age groups.**

Children

- As mortality amendable to healthcare is dominated by deaths in older adults **there is a risk that children will be neglected when selecting improvement areas.**
- There is therefore an argument to **include an outcome specifically relating to children.**
- **The UK appears to perform badly on perinatal deaths** (although this may be the result of a coding issue) **for which an appropriate indicator would be infant mortality; and respiratory diseases in children aged 0-14.**

Inequalities

- Some patient groups such as those with serious mental illness have significantly worse mortality outcomes that 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 where there are significant inequalities in outcomes.**

Cost effectiveness

- **It is 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 specifically addressed in the Impact Assessment that will accompany the NHS Outcomes Framework for 2011/12.**

<u>Domain 2: Enhancing quality of life for people with long-term conditions</u>

Three underlying principles have been used for this domain:

- **Treating the individual. Patients do not see themselves as a condition. 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 outcomes that are important to those living with long-term conditions such as living or working independently.** The importance of acute episodes that can develop into long-term

conditions is also recognised and that good management can reduce their frequency and severity; and

- **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 they want to achieve. It is proposed to separately identify appropriate functional outcomes for children, adults and older people** (e.g. a functional outcome for children could include their ability to attend school).

Overarching indicator

- **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** e.g. the Labour Force Survey 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.'**
- **More detailed information on quality of life for those with long-term conditions could be obtained through a PROM or similar.**
- There are standard questionnaire-based tools for measuring quality of life such as EQ-5D which is currently included in the Health Survey for England and could potentially be included in other national surveys.
- A suite of Quality Standards will support the delivery of improved outcomes in this domain.

Improvement areas

- **International comparisons are not available for some of the outcomes important to people with long-term conditions.**
- It is not possible to select areas based on improvement potential.
- **It is proposed to select a set of outcomes that address the things that are most important to patients** following the principles previously outlined.
- **The interaction between healthcare and other services will be particularly important in this domain e.g. between health and social care.**

<u>Domain 3: Helping people to recover from episodes of illness or following injury</u>

Meeting the needs of all age groups has been taken as a guiding principle for this domain. The aims of this domain can be expressed as two broad outcomes:

- **Preventing conditions from becoming more serious.** For these conditions the NHS should aim to minimise the impact on people's lives; and
- **Helping people recover from serious illness or injury.** The NHS should aim to ensure that those who suffer from serious illness or other debilitating event recover quickly to their original health status or close to it.

Overarching indicator

- It has not been possible to identify a single indicator that covers this domain in its entirety.
- In the future it may be possible to develop indicators that focus more explicitly on outcomes and reduce the risk of perverse incentives.
- A suite of Quality Standards will support the delivery of improved outcomes in this domain.
- The indicators set out below are an attempt to cover the two outcomes outlined above. They are proxies for outcomes:
    - **Emergency hospital admission for acute conditions usually managed in primary care -** this shows how well the NHS is doing at preventing curable conditions from becoming more serious and largely reflects outcomes achieved in primary care; and

- **Emergency bed days associated with repeat acute admissions -** 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.

Improvement areas

- **PROMs are a powerful way of measuring health outcomes as perceived by patients and are applicable to this domain.**
- **PROMs are currently collected for some specific elected procedures and could be applied to a broader array of procedures or more generally in the future.**
- **For unplanned care** (such as fractures and strokes) it is proposed to look at the causes that are the most important for each age group and to select outcome indicators to cover these areas e.g. consider causes leading to most emergency bed days and the proportion of all emergency bed days attributable to each.

Domain 4: Ensuring people have a positive experience of care

There are four underlying assumptions for this domain:

- **Patient experience must be a vital element of the NHS Outcomes Framework;**
- **The existing arrangements for collecting patient experience information do not lend themselves well to the NHS Outcomes Framework requirements.** There are challenges in developing at a national and local level appropriate patient feedback systems to assist the NHS to understand and improve the patient experience;
- **It is necessary to measure patient experience now,** to drive a step change in improvement – new and improved patient feedback mechanisms will inform future iterations of the framework; and
- **Ensuring that a balanced approach is achieved so that this work supports and complements locally led innovation and focused improvement activity.**

Overarching outcome indicator

- Current available options are constrained by the existing national survey arrangements and the limited ability of standardised national data. Most centrally coordinated surveys are conducted at organisational level and focus on different NHS services and settings.
- **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 recently by the independent healthcare regulator and the DH; and
  - Categorising the chosen questions under five separate patient experience themes, which can be aggregated to form an overall score. The five themes are: access and waiting; safe, high quality coordinated care; better information, more choice; building closer relationships; and a clean, friendly comfortable place to be.
- **The long-term approach is:**
  - To develop an overarching outcome indicator that is based on a limited set of core questions that can be included within all surveys;
  - For patient experience to be as robust and comprehensive as that for clinical effectiveness and patient safety;
  - To 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; and
  - To involve standardisation to provide quality assurance, value for money and comparative benchmarking.

Improvement areas

- The following improvement areas are to be included in the framework:
  - **Primary and community services;**
  - **Acute care;**

- **Mental health services;**
- **Children and young people;**
- **Maternity services; and**
- **End of life care.**

In the short-term, outcome indicators will be identified for these areas on what is currently available.

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

- NICE Quality Standards will be developed to support improved outcomes in this domain.
- Three underlying principles are proposed:
  - **Protecting people from further harm –** the NHS should provide care 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 within a culture that promotes reporting safety incidents and
  - **Learning from mistakes –** organisations must learn from incident reports and make tangible changes.

Overarching indicator

- **The overarching outcome indicator is to include three measures:**
  - **The number of incidents reported** (recognising that an effective patient safety culture is one where incidents are reported, this should be rising in the short-term and comparable with other services in the long-term);
  - **The severity of the harm** (this should be decreasing, demonstrating a good patient safety learning culture); and
  - **The number of similar incidents** (this should be decreasing, demonstrating that guidance, best practice and safety alerts are being complied with).

Improvement areas

- Patient safety affects all aspects of healthcare including the actual treatment provided, the system in which that treatment is provided and the physical building and surrounding in which the treatment is provided and the systems of care operate.
- There are also certain patient groups who require a particular safety focus e.g. children.
- Five proposed improvement areas are:
  - Safe treatment e.g. never-events, medication errors;
  - Safe discharge/transition e.g. emergency re-admissions;
  - Patient environment e.g. cleanliness and minimising avoidable infections;
  - Safety culture e.g. openness about mistakes and reporting; and
  - Vulnerable groups e.g. maternity, older people.

ANNEX A – Possible outcome indicators

To start the selection process for outcome indicators this annex contains an initial list of potentially relevant outcome indicators.

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
1 April 2011 – NHS Commissioning Board established in shadow form
Autumn 2011 – NHS Outcomes Framework reviewed and re-issued
1 April 2012 – NHS Commissioning Board formally established

Consultation questions

Principles

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?
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 outcome domains that are proposed as making up the NHS Outcomes Framework?
6. Do they (the five outcome frameworks) appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?

Structure

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

Domain 1 – Preventing people from dying prematurely

8. Is 'mortality amendable 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 is an appropriate way to select improvement areas in this domain?
10. Does the proposed NHS Outcomes Framework take sufficient account of avoidable mortality in older people?
11. If not, what would be a suitable outcome indicator to address this issue?
12. Are either of the suggestions 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 appropriate for overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?
14. Would indicators such as those suggested 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 appropriate for 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 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?

Domain 4 – Ensuring people have a positive experience of care

20. Do you agree with the proposed interim option for an overarching outcome indicator?
21. Do you agree with the proposed long-term approach for the development of an overarching outcome indicator?
22. Do you agree with the proposed improvement areas and the reasons for choosing those areas?

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

25. Do you agree with the proposed overarching outcome indicator?
26. Do you agree with the proposed improvement areas 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 better 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

32. What are the strengths and weaknesses of any of the potential outcome indicators 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 these appropriate principles on which to select outcome indicators? Should any other principles be considered?