NHS

Transparency in outcomes – a framework for the NHS

Government response to the consultation

DH Department of Health

DH INFORMATION READER BOX

Policy		Estates	
HR / Workforce		Commissioning	
Management		IM & T	
Planning /		Finance	
Clinical		Social Care / Partnership Working	

Document Purpose	For Information
Gateway Reference	15265
Title	Transparency in outcomes - a framework for the NHS. Government response to the consultation
Author	Department of Health
Publication Date	20 Dec 2010
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of Nursing, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Allied Health Professionals, GPs
Circulation List	Directors of PH, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads
Description	The formal Government response to the proposal and responses received as part of the consultation Transparency in outcomes - a framework for the NHS
Cross Ref	Liberating the NHS: legislative framework and next steps
Superseded Docs	NA
Action Required	NA
Timing	**NA**
Contact Details	Quality and Outcomes Policy Department of Health Skipton House 80 London Road London SE1 6LH
For Recipient's Use	

Contents

1. Introduction

1.1. This document provides the Government's formal response to the consultation *Transparency in Outcomes – a framework for the NHS*[1]. It explains the engagement process that took place during the 12 week consultation period and provides a summary of the consultation responses. This document should be read in parallel with the first NHS Outcomes Framework[2] which provides further context on the framework.

Why focus on outcomes?

1.2. *Equity and Excellence: Liberating the NHS*[3] set out a vision of an NHS that achieves amongst the best outcomes of any health service in the world. To achieve this, it outlined two major shifts:

- a move away from centrally-driven process targets which get in the way of patient care; and
- a relentless focus on outcomes and the quality standards that deliver them.

1.3. On 19 July 2010, the Government published proposals for developing an NHS Outcomes Framework in *Transparency in Outcomes – a framework for the NHS*. The framework's purpose is threefold:

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

1.4. The NHS Outcomes Framework sets out the outcomes that the new NHS Commissioning Board will be asked to achieve. It will then be for the NHS Commissioning Board to determine how best to deliver improvements against the selected outcomes by working with GP commissioning

[1] Available at www.dh.gov.uk/en/consultations/Closedconsultations/DH_11758
[2] *The NHS Outcomes Framework 2011/12*. Available at www.dh.gov.uk
[3] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

consortia, making use of the various tools and levers it will have at its disposal.

1.5. For example, the NHS Commissioning Board will commission the National Institute for Health and Clinical Excellence (NICE) to develop Quality Standards to define the quality of care which is needed to deliver the desired outcomes. Drawing on these Quality Standards, it will develop a Commissioning Outcomes Framework which it will use to hold GP commissioning consortia to account. Linked to this a quality premium will reward consortia for certain improved outcomes they achieve and for the effectiveness with which they manage their resources.

1.6. To support GP commissioning consortia in achieving improved outcomes, detailed commissioning guidance will be developed by the NHS Commissioning Board, alongside tools such as standard contracts and payment tariffs. These will support GP commissioning consortia to secure improved outcomes in the context of the needs of their local population.

1.7. The NHS Outcomes Framework seeks to capture all treatment activity for which the NHS is responsible. However, neither the Government nor the Department of Health will tell the NHS how the framework should be delivered - it is vital that the NHS locally has the flexibility to improve outcomes for its local population.

1.8. Consultations on outcomes frameworks for public health and adult social care have also been published. All three outcomes frameworks are designed to align where integration between the sectors is vital. For example, there are some outcomes that the NHS will not be able to deliver without working in partnership with Public Health England and adult social care services

1.9. To support integrated working, the *DH Business Plan 2011-2015: Consultation on the Transparency Framework*[4], published in November sets out the high-level impact indicators which describe the Department of Health's overarching goals for the NHS, Public Health England and adult social care services. These indicators focus on the issues that matter most to the health and well-being of the population or those using or affected by services. Integrated and/or aligned outcomes or goals across services will support the move towards a culture of working together to achieve what matters most to people.

[4] Available at www.dh.gov.uk/en/consultations/liveconsultations/dh_122220

Scope, principles and structure of the NHS Outcomes Framework

Principles

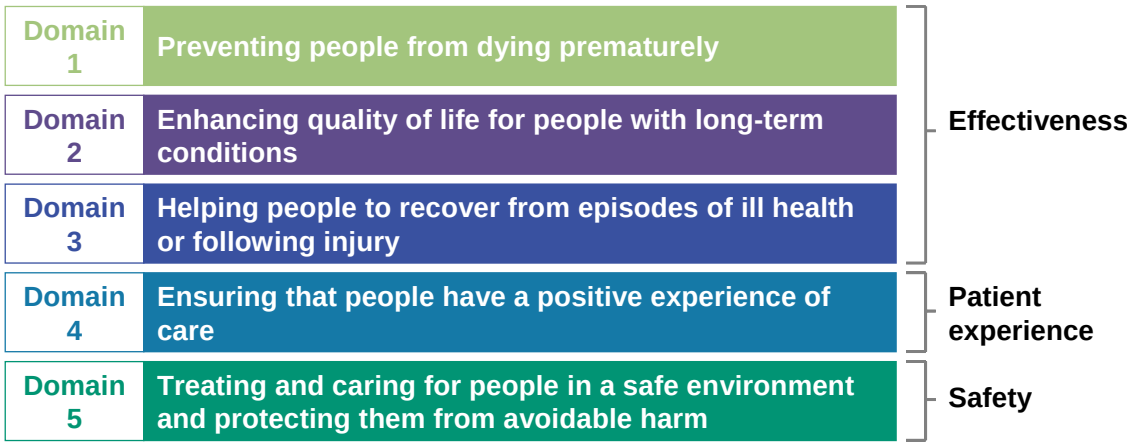
1.10. In order to guide the development of the NHS Outcomes Framework, the consultation proposed seven principles:

Figure 1 – Key principles

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

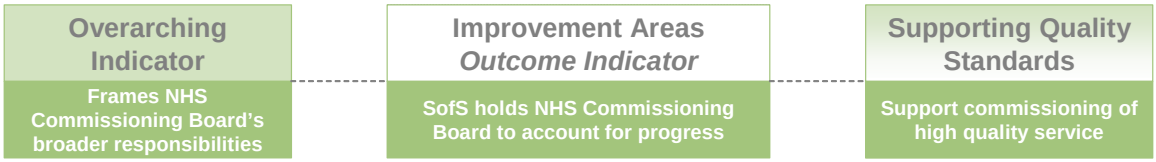
1.11. The consultation proposed that the framework should be structured around five high level outcome domains, spanning the definition of quality that has been embraced by the NHS: effectiveness, patient experience, and safety. See Figure 2 below:

Figure 2 – Five domains of the NHS Outcomes Framework



1.12. For each of the five domains, the consultation document proposed a similar structure, as set out in Figure 3:

Figure 3 – Structure of each domain in the NHS Outcomes Framework



- **overarching indicator**, allowing the Secretary of State to track the progress of the NHS as a whole in delivering outcomes in the domain;
- a small set of **improvement areas** identified where the NHS Commissioning Board will be tasked with delivering quality improvement and where it can be measured; and
- a supporting suite of **NICE Quality Standards** setting out what high quality care looks like for a particular pathway of care.

1.13. The scope, principles and structure proposed in the consultation were broadly supported by respondents, as Chapter 3 explains in detail. These have therefore been used as the basis of developing the first NHS Outcomes Framework for 2011/12.

2. Consultation process

2.1. The full public consultation on *Transparency in Outcomes – a framework for the NHS* ran for twelve weeks, between the 19 July and 11 October 2010.

2.2. The consultation document set out how an NHS Outcomes Framework might be developed, and sought the views of those working in the NHS, patients and members of the public about how this might be achieved. The consultation document asked 35 questions which spanned the following areas:

- the principles that would underpin the framework;
- the structure and approach that could be used to develop the framework;
- how the proposed framework could support equality across all groups and help reduce health inequalities;
- how the framework could support the necessary partnership working between public health and social care services needed to deliver the outcomes that matter most to patients and carers; and
- potential outcome indicators, including methods and rationales for selection.

2.3. The consultation document, and feedback form were available on the Department of Health's website and responses could be returned either by post or email.

2.4. An online discussion forum was created on the Department of Health's website to enable people to respond in a more informal environment. The forum received 58 comments on the consultation proposals.

2.5. All consultation responses received were logged and analysed by the Department of Health and were used to inform the development of the first NHS Outcomes Framework as this Government response explains.

Engagement events

2.6. As part of the consultation process, an extensive programme of engagement events took place designed to facilitate meaningful discussion and encourage patients, staff and other interested groups to put forward their views:

- events for NHS staff in every region of the country hosted by strategic health authorities; and
- events for patients and the voluntary sector in every region hosted by the Regional Voices network.

2.7. In addition to these events, a series of presentations, workshops and meetings took place between internal and external stakeholders, and Department of Health Ministers. Key events included:

- NHS Confederation White Paper Event – including representatives from across the full range of NHS organisations.
- National Stakeholder Forum White Paper Event - a group of senior leaders and experts from across all parts of the health and social care sectors.
- Social Partnership Forum - a partnership between the Department of Health, NHS Employers and NHS Trade Unions.
- Third Sector Sounding Board – a Department of Health network comprising representatives from voluntary and charitable bodies.

2.8. Full details of the range of engagement events are provided at Annex A

Details of consultation responses received

2.9. In total, 773 consultation responses were received from a wide range of stakeholders.

Organisation type	**Number of responses**	**% of overall response**
SHAs/PCTs	71	9.2
Professional Bodies	36	4.7
NHS	109	14.1
Local Authorities	27	3.5
Individuals/patients	52	6.7
Other*	478	61.8
Totals	**773**	**100**

* Includes: charities, patient groups, GP practices, pharmaceutical companies, Local Pharmaceutical Committees, Local Medical Committees, representative bodies, think tanks and unions.

2.10. The responses covered a broad spectrum of views, with some responses providing very detailed comments on specific outcome indicators, whilst others responded broadly to the overall themes of the consultation. Chapter 3 provides a summary of the key messages from the

consultation as a whole. Chapter 4 sets out the detail of the response to each question posed.

2.11. This document should be read in parallel with *The NHS Outcomes Framework 2011-12*, which sets out the indicators and shape of the framework, developed based on the responses received through the consultation process.

3. Key messages from consultation responses

3.1. The consultation responses showed there was overwhelming support for a focus on outcome measures rather than process targets. This support extended to the proposals for the scope, principles and structure of the NHS Outcomes Framework. Comments included:

"We think the DH's overall approach is highly innovative – we do not know of a sizable health system internationally with such a comprehensive framework for outcomes. In particular, we like the sharp focus on outcomes: the view that the outcomes framework is not primarily for performance management, but rather to drive continuous improvement; and the ambition to drive outcomes into every area of care"[5]*.*

"We welcome the proposal to shift the focus from process to outcomes and that the framework will include both clinical and patient reported outcome indicators. We agree that this shift will strengthen performance and quality and deliver real benefit to patients. We are also pleased that the quality definitions of effectiveness, safety and patient experience will remain central to the framework."[6]

"[We] strongly applaud the decision by Department of Health for England to move towards international benchmarking for outcomes. As the consultation document states, it is desirable to move away from process targets to outcomes measures.... The use of these indicators by the NHS as measures of performance is not only the right choice for England, it will also catalyze improvements in data quality."[7]

3.2. Whilst respondents recognised the opportunities that the framework presented for patients and healthcare professionals, there was also agreement about the challenges and difficulties in measuring outcomes. One recurrent theme was the need to ensure that outcomes that require partnership working between the NHS, adult social care and Public Health England are aligned and incentivise joint working. Comments included:

[5] University College London Partners
[6] NHS East Midlands
[7] OECD

"…The barriers to integration are well known, however, there is an opportunity for a new set of outcomes to breakdown the silo working that exists"[8]

"We believe the Government should develop overlapping outcomes frameworks for health, public health and social care against a coordinated timetable to ensure that the content is consistent and professionals from different sectors are working together to achieve shared outcomes."[9]

"The framework needs to measure integrated care: in addition to outcomes for health care, the NHS Commissioning Board needs to hold commissioners to account for the quality of integrated care, for example, through quality indicators focused on care transitions and care pathways, including social care. These need to be aligned with the roles of local authorities. The specific exclusion of outcomes relating to social care from this accountability framework potentially mitigates against promoting integration."[10]

3.3. Respondents were also highly supportive of the fact that the framework sought to measure patient reported outcomes and patient experience, as well as clinical outcomes.

"…we very much support the use of PROMs [patient reported outcome measures], and PROMS that capture the views of children, as well as their carers are best still. We also feel that clinicians have a valuable role to play in identifying service improvement area. We feel the best model to help service use and improve delivery based on outcomes, are models where the views of clinicians, children and carers are reviewed together - such models allow for 'triangulation' of outcomes (views of all three) - such triangulation allows a depth of understanding of outcomes that single view models alone cannot."[11]

"The inclusion of patient reported outcome measures (PROMs) and patient experience measures within the framework are thus very important in measuring that which would not be incorporated within clinical outcomes."[12]

3.4. In addition to the broader comments about the approach to the framework, we also received detailed comments on and suggestions of other outcome indicators, which have informed the selection of outcomes to be included in the first framework. This is explained in detail under each domain in Chapter 4. However, there were two recurring themes

[8] Turning Point
[9] NHS Confederation
[10] The King's Fund
[11] Specialist CAMHS Hertfordshire Partnership NHS FT
[12] National Rheumatoid Arthritis Society

coming out of these more detailed comments which it is worth mentioning as part of this summary:

- the importance of capturing quality of life from the patient's perspective as well as how effectively the NHS is treating conditions. We have taken this on board by seeking to capture patient reported, as well as clinically reported outcomes in the framework. In domain 2, we have decided to base the overarching indicator on a measure of health-related quality of life (EQ-5D[13]); carers' quality of life is measured on the same basis; and include indicators or functional ability (employment); and

- The importance of capturing outcomes for all age groups. Several domains were particularly at risk of excluding for example older people (domain 1) and children and young people (domain 3). To mitigate this risk, we have considered how the balance of indicators in each domain could disadvantage different age groups and so have included indicators relating to older people in domains 1 and 3, and on children in all domains (including a placeholder in domain 4).

3.5. Further detail on each of these indicators, and on how we have responded to concerns about the need to foster alignment between the NHS, Public Health England and adult social care, and how the framework will fit with the wider system are set out in the following chapter.

[13] EQ-5D™ is a trademark of the EuroQol Group. Further details can be found on their website: http://www.euroqol.org

4. Summary of responses and Government response

SCOPE, PRINCIPLES AND STRUCTURE OF THE NHS OUTCOMES FRAMEWORK

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?

4.1 **What we heard:** Respondents were broadly supportive of the seven key principles proposed in the consultation document.

4.2 The use of international comparisons generated significant debate. There were mixed views as to the benefit of using them. The King's Fund commented that *"there are many data, health system and other differences that make international comparisons problematic"* whilst also saying that *"international benchmarking is useful in examining variations in the quality of health care"*. The Organisation of Economic Cooperation and Development (OECD) said it *"strongly applauded the decision by the Department of Health to move towards international benchmarking for outcomes."*

4.3 Another recurrent theme was the need for explicit reference to value for money and cost-effectiveness. One respondent suggested including *"a separate economic value indicator, not just a quality focus with economics implied."*[14]

4.4 **Our response:** The Government is pleased that the principles of the NHS Outcomes Framework, which are set out in Figure 1 in Chapter 1, have been supported. We believe that these seven principles provide a sound and robust basis on which to develop the framework.

4.5 The Government agrees with the OECD's view of the use of international comparisons, and our vision is to deliver outcomes which are amongst the best in the world. We recognise the complexities in using international comparisons, but in order to measure our progress in

[14] EC Harris LLP

improving health outcomes, we need to be able to compare ourselves with other healthcare systems around the world. Whilst we have not chosen indicators on the basis of what can be compared internationally, we have sought to use indicators which are comparable where possible. Where international comparison is currently not possible, we will work with other countries, including through the OECD and EU, to encourage development of comparable datasets.

4.6 Although we have not explicitly set out the need for cost-effectiveness and value for money in the framework, we have been clear that levels of ambition against the indicators in the framework will need to be feasible and affordable within the spending settlement allocated to the NHS through the Spending Review. The first NHS Outcomes Framework does not have levels of ambition attached to it. When the NHS Commissioning Board is operational in shadow form, negotiations between the Secretary of State for Health and the NHS Commissioning Board will determine the levels of ambition within this spending envelope, ensuring that the impact of the NHS Outcomes Framework is financially viable and cost-effective.

Questions

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

4.7 **What we heard:** Respondents welcomed the inclusion of 'equality' as one of the seven principles and the intention to, as far as possible, disaggregate outcome indicators by equality characteristics and geographical area. However, it was recognised that the NHS Outcomes Framework alone would not lead to a narrowing of health inequalities and that to improve equality in health outcomes would *" require that the framework includes, or is otherwise attached to, a system of incentives/rewards/disincentives with sufficient 'teeth' to motivate health care commissioners and providers."* [15]

4.8 Respondents also recognised the difficulties and complexities of measuring outcomes and highlighted the limitations that current data sources have in disaggregating data by the protected equality characteristics and the risk of creating perverse incentives.

4.9 **Our response:** As set out in the consultation document, promoting equalities and reducing inequalities is one of the underlying principles of

[15] Picker Institute Europe

the framework. It is therefore encouraging that responses gave wide-ranging suggestions for how more equitable outcomes can be delivered. Furthermore, in selecting outcomes and determining how they should be measured, we have actively identified those groups who are at particular risk of exclusion.

4.10 The Government is aware that current data and data collections cannot adequately identify certain groups at present, such as people with a disability, and particularly those with learning disabilities. Indeed, the NHS Outcomes Framework makes it clear that people with learning disabilities are a particular group for whom we need to be able to better measure outcomes, and compare these with the rest of the population. As the framework evolves over time, outcome indicators will be refined with a view to being able to more fully measure and record health outcomes for all groups wherever it makes sense to do so.

4.11 Furthermore, the set of principles that the Secretary of State for Health and the NHS Commissioning Board will use when negotiating levels of ambition against the indicators in the NHS Outcomes Framework includes consideration of the variation and inequalities in health outcomes, taking into account equalities characteristics, disadvantage and where people live.

4.12 The Department of Health has also undertaken an Equality Impact Assessment, which has assessed the potential impact of the NHS Outcomes Framework against the protected equality characteristics. This is separately available on the Department of Health's website.[16]

Questions

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

4.13 **What we heard:** Many respondents identified potential difficulties in ensuring that outcomes are successfully integrated across the outcomes frameworks for the NHS, public health and adult social care. There was real concern that failure to do so would result in fragmented services and poor quality care for patients. Comments included: *"The proposal to create three outcomes frameworks for health, social care and public*

[16] http://www.dh.gov.uk/

health must ensure that we do not see different parts of the system being pulled in different directions."[17]

4.14 However, respondents also suggested practical and positive ways to encourage partnership working. For example, *"Joint outcome measures, joint care records and by ensuring the mechanics push towards common data sets, data sharing arrangements and processes that result in one information function. Joint commissioning is likely to support this as common measures can be monitored through contracts".*[18] Other suggestions for ensuring alignment across the three sectors focussed on how the new architecture would actually operate, including:

- commissioning across the whole pathway;
- pooled budgets and resources;
- removal of artificial barriers, both organisational and cultural;
- clear roles and responsibilities; and
- effective communication between organisations, particularly when a patient moves across organisational boundaries.

4.15 Responses to this question also commented on the difficulties in attributing the relative contribution of the NHS, public health and social care to improving certain outcomes. Comments included *"It can be a challenge to isolate the individual outcomes attributable to the contribution of specific healthcare professionals or providers in complex disease management pathways"*[19]*.* There was also debate as to whether having three separate frameworks would discourage integration of services, and whether it would be more appropriate *"to develop a single framework for all three."*[20]

4.16 **Our response:** The NHS Outcomes Framework will cover the treatment activity for which the NHS is responsible, and will be aligned with similar accountability mechanisms for adult social care and public health. The Government recognises that it is essential that indicators are aligned so that organisations are accountable for delivering integrated care. It is encouraging that some respondents did acknowledge the benefits of having individual frameworks for the NHS, public health and social care. Regional Voices observed that *"separating the 3 frameworks would help provide the evidence for relative investment in each area and could help*

[17] Association of Directors of Adult Social Services
[18] NHS Wakefield District
[19] Pharmaceutical Negotiating Services Committee
[20] Haringey Council

in decreasing health inequalities by helping to pinpoint where the inequalities lie."

4.17 A robust and effective accountability mechanism requires organisations to be held to account for that which they can deliver. The NHS, adult social care and public health sectors deliver services through their own delivery systems which, whilst they need to integrate, have their own structures and governance. Therefore, it is necessary to create accountability mechanisms at a national level which take account of the separate delivery systems. For the NHS, this will be the NHS Outcomes Framework; for adult social care, this will be through the Adult Social Care Outcomes Framework; and for Public Health England, this will be through the Public Health Outcomes Framework.

4.18 However, that is not to say that the three services, and indeed other public services such as children's services, housing or welfare services, do not need to join up and deliver integrated services to people. Indeed, some of the outcomes that matter most to people hinge on the effective integration across services. For example, for people with dementia, or who have suffered a stroke, the integration of care across the NHS and adult social care providers, is vital. Similarly, if mortality rates are truly to be tackled, public health interventions are essential to prevent people developing diseases such as heart disease, liver disease or cancer in the first place as often the NHS can only do so much to treat the condition once it has developed.

4.19 To support integration, the *DH Business Plan 2011-2015: Consultation on the Transparency Framework*[21] published on 8 November 2010 brings together outcomes that the health, public health and adult social care sectors are responsible for, demonstrating the importance of integration and collaboration, whilst recognising the unique contribution each service can make to improving health outcomes. These high level impact indicators are currently out for consultation.

Questions

5. Do you agree with the five outcome domains that are proposed in

[21] Available at www.dh.gov.uk/en/consultations/liveconsultations/dh_122220

Figure 2 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?[22]

4.20 **What we heard:** There was broad support for the five outcome goals or domains with many respondents also agreeing that these domains appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients. The BMA said that they *"believe that the five outcome [domains] cover the range of healthcare outcomes that the NHS is responsible for delivering to patients."* There were common suggestions for additional domains, on:

- prevention; and
- health inequalities.

4.21 In response to question 6, respondents often highlighted groups of service users who they felt were not adequately covered in the framework as it was proposed in the consultation document, including:

- those accessing end of life care;
- women using maternity services;
- children; and
- older people.

4.22 **Our response:** The Government maintains its view that the primary purpose of the NHS Outcomes Framework is to measure the treatment activity that the NHS is responsible for delivering. The development of a Public Health Outcomes Framework negates the need to create an additional domain on prevention. However, we do recognise the concerns respondents have regarding the alignment of outcomes across the three sectors.

4.23 The Government has designed sets of outcomes with a view to being able to hold sectors to account for providing joined up or integrated services where necessary. As previously mentioned, a separate Public Health Outcomes Framework is being published for consultation, and proposals for an Adult Social Care Outcomes Framework were published on 16 November.[23] In designing the first NHS Outcomes Framework, for

[23] *Transparency in outcomes – a framework for adult social care*, Department of Health, 16 November 2010. Available at http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_121509

the outcomes that depend on integration and alignment, indicators are replicated across the sectors or complementary indicators are included. All three frameworks are then brought together in the DH Public Sector Transparency Framework and contain the set of high level outcome indicators for the health, public health and social care sectors.

4.24 As explained, promoting equalities and reducing inequalities is one of the underlying principles of the framework. It also sets out ways in which the Government take this forward.

4.25 In response to comments about the representation of specific groups of service users in framework, the Government believes that the groups identified at paragraph 4.21 are all adequately covered in the framework:

- end of life care is now captured in Domain 4 (through proposals to develop an indicator based on the survey of bereaved carers);
- outcomes relating to maternity services are covered in Domains 1 (perinatal mortality including stillbirth), 4 (women's experience of maternity services) and 5 (admission of full-term babies to neonatal care); and
- children and older people are represented in each domain.

Question

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

4.26 **What we heard:** The majority of the respondents supported the proposed structure of the NHS Outcomes Framework. There was particular support for the use of NICE Quality Standards, and respondents welcomed the continuing emphasis on taking an evidence-based approach to developing the framework. One respondent said that *"The role of supporting Quality Standards will be vital in informing commissioners and providers of how to achieve the best possible outcomes for patients."*[24]

4.27 However, concerns were expressed about the number of NICE Quality Standards, and the timetable for delivering them. Several respondents observed that those clinical areas that do not have a NICE Quality Standard developed, may not be given as much attention by commissioners consideration as those that do. One comment suggested

[24] Lundbeck

that: *"there will be too many of them and that others of potential value will not be included and hence be neglected. There is a danger that a bureaucracy will build up around the structure."*[25]

4.28 **Our response:** The Government is pleased that there is broad consensus on the structure under each domain of the NHS Outcomes Framework. It is encouraging that respondents support the continued use of NICE Quality Standards. However, the Government notes the concerns that have been voiced regarding the timetable for developing the full suite of 150 Quality Standards. The Department of Health is working with NICE to accelerate its Quality Standard development process. It is important that this process builds on and integrates with the existing process for developing NICE clinical guidelines, as well as retaining the engagement of stakeholders. Indeed, we are announcing a further set of topics on which Quality Standards will be developed as part of the NHS Outcomes Framework.

4.29 NICE Quality Standards do not determine priorities for the NHS. They provided definitions of what high quality care looks like in particular pathways. The full suite of 150 will be designed to cover the majority of NHS treatment activity and all the outcomes in the NHS Outcomes Framework. They will be used by the NHS Commissioning Board to inform the development of the levers, incentives and support that it will provide for GP Commissioning Consortia as they seek to commission for improved outcomes.

[25] Royal College of Psychiatrists

DOMAIN 1: PREVENTING PEOPLE DYING PREMATURELY

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?

4.30 **What we heard:** The concept of including a focus on reducing avoidable deaths was broadly supported, but there were several issues raised in terms of what influences mortality, and alternatives to mortality measures:

- the domain should recognise that premature mortality is influenced by prevention and public health measures and by wider determinants of health, as well as NHS care;
- which conditions are considered 'amenable' to health care can vary according to different academics or experts;
- the effectiveness of care beyond just in-patient care, e.g. out of hours and care at home, should be captured as part of this domain;
- morbidity, particularly for children, and quality of life particularly for older people are as important as mortality when considering health outcomes; and
- 'independent survival' or survival for specific conditions, can be considered a more positive outcome measure than mortality.

4.31 **Our response:** The Government's view is that the primary purpose of the NHS Outcomes Framework is to measure the treatment activity that the NHS is responsible for delivering. The use of the overarching indicator 'Mortality from causes amenable to health care' is an attempt to reflect the contribution of NHS care, in all settings, on premature mortality. However, we recognise that this is not a precise science and not all premature deaths from the causes included will be avoidable through better health care, and some deaths not included as part of the indicator will be avoidable.

4.32 New measures need to be developed which allow the contributions of the NHS in treating people and of Public Health England in keeping people well to be measured. In the interim, a number of national outcomes relating to mortality will be shared between the NHS Commissioning Board and the Secretary of State for Health as head of Public Health England. How these national level outcomes might be pushed down to a

local level on the public health side is, however, subject to the separate consultation on the Public Health Outcomes Framework.

4.33 Reducing morbidity and improving quality of life are important outcomes for the NHS to deliver, and they will be reflected in the measures set out for *Domain 2: enhancing quality of life for people with long-term conditions* and *Domain 3: helping people to recover from episodes of ill-health or following injury.*

4.34 While measures of survival rather than mortality would allow a more accurate reflection of the NHS' contribution to helping people to recover from potentially fatal illness, it is difficult to measure survival without comprehensive registers of people diagnosed with the illness, which can be matched up with death registrations. The NHS Outcomes Framework includes cancer survival as the best measure of the NHS' contribution to preventing people from dying from cancer. This is possible because of the system of cancer registries throughout England. As part of future work to improve our ability to measure the NHS' contribution, the NHS Information Centre for Health and Social Care is exploring linkage of national audit data, Hospital Episode Statistics and the Office for National Statistics' (ONS) death certification data to create a possible composite indicator of 'survival following diagnosis'.

Question

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

4.35 There were several points of note in terms of the detail of how this domain would operate:

- an age-specific mortality approach might be more appropriate;
- improvement areas should be selected by breaking down amenable mortality into all its component causes or groups of causes;
- improvement areas should look at mortality from causes where there are interventions which are known to make a difference;
- questions were raised as to how this domain will address vulnerable and/or other demographic groups, for example, those with severe mental illness or learning disabilities;
- improvement areas should be selected according to where there are the biggest health inequalities; and

- it is risky to select improvement areas on the basis of how well England compares internationally on mortality from causes considered amenable to health care, or to use international comparisons alone to judge the success of the NHS in improving outcomes.

4.36 **Our response:** The Government accepts the suggestion that the NHS Commissioning Board should have to focus on component causes of mortality, rather than just the overall rate. The NHS Commissioning Board will be expected to focus on improving mortality across all of the components or conditions which constitute amenable mortality.

4.37 Work is currently being carried out by the ONS to update the definition of mortality from causes considered amenable to healthcare.

4.38 To ensure that the framework accounts for mortality in older people, an overarching indictor 'Life Expectancy at 75' has been included. On children, an improvement area focussing on 'Reducing deaths in young children' has been selected.

4.39 There is a strong inequalities gradient in amenable mortality (see evidence set out in the Equalities Impact Assessment) and the NHS Commissioning Board will consider inequalities in this and all the indicators in the NHS Outcomes Framework. Significant inequality across different population groups will also be considered as part of the setting levels of ambition. The NHS Outcomes Framework includes an indicator (in development) for this domain which directly addresses the high mortality rate in people with serious mental illness. While the data source and technology exist to enable deaths data to be linked with data for people with serious mental illness, this is not yet possible for people with learning disabilities.

4.40 International comparisons were just one of several criteria used to select improvement areas in this domain. International comparisons may be used by Secretary of State and the NHS Commissioning Board when negotiating levels of ambition for these indicators, and will take into account what is feasible and affordable in light of the spending envelope allocated to the NHS through the Spending Review.

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?

4.41 **What we heard:** The main points stemming from these questions were as follows:

- the proposed overarching indicator does not include the over 75s, as mortality amenable to healthcare is currently defined as deaths from amenable causes in the 0-74 age group. The rationale for this definition was felt by some respondents to be unclear;

- several indicators were suggested as suitable to address the issue of premature mortality in older people, including Healthy Life Expectancy , Disability Free Life Expectancy at 65, amenable mortality in older people, years of quality living, years of life lost, survival for older people, mortality for people with dementia.

4.42 **Our response:** The overarching indicator covers those aged 0-74 as there is consensus that it is in this age group that most premature deaths occur. However, to ensure that the NHS is held to account for doing all that it can to prevent avoidable deaths in older people, a second overarching indicator will be included in this domain of 'Life Expectancy at 75'. This indicator captures deaths in those aged 75 and over from all causes.

Question

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

4.43 **What we heard:** There were several suggestions for how the domain could better address mortality in children. Suggestions included:

- look at specific causes of death e.g. diabetes, epilepsy, respiratory disease, childhood cancers;
- include morbidity and well-being measures; address child mental health issues; include stillbirths in measures of perinatal mortality;
- recognise that infant mortality is influenced by public health measures; and
- include indicators on accidental injury and suicide.

4.44 **Our response:** The Government has included the following outcome indicators to account for mortality in children:

- infant mortality; and
- perinatal mortality

4.45 Deaths from avoidable childhood diseases such as measles are included in the current definition of ‘mortality amenable to healthcare’ and will be looked at separately, as part of the NHS Commissioning Board’s responsibility to improve mortality across all conditions included in the overarching indicator.

4.46 In recognising that ‘Infant Mortality’ is influenced by public health measures as well as NHS care, we have included it as a shared improvement area with the Public Health Outcomes Framework. Stillbirths will be included in the ‘Perinatal Mortality’ indicator to reflect NHS care in pre-pregnancy, pregnancy and childbirth.

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

Question

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

4.47 **What we heard:** There was mixed support for the use of patient reported outcome measures, some seeing it as a promising step, others recommending using clinically recorded indicators instead as they were felt to be less subjective. There was strong support for capturing quality of life for people with long-term conditions, and EQ-5D was recommended as a good way of capturing it. There were some comments that the proposed overarching indicators focussed on aspects of quality of life which, whilst important, were too narrow.

4.48 On this domain, there was support from those organisations without an interest in a particular disease or condition for the proposed generic approach, whilst predictably, those organisations representing a particular condition pushed explicit inclusion of an indicator on their condition, for example, urology, chronic obstructive pulmonary disease and asthma, and musculoskeletal conditions.

4.49 **Our response:** The Government has taken these comments on board and this is reflected in the development of an overarching indicator based on EQ-5D. This has the advantages of being a broad-based quality of life measure that is appropriate across the range of long-term conditions. This generic approach allows all long-term conditions to be equally considered and ensures that the increasing number of people with more than one long-term condition are also covered by the NHS Outcomes Framework. One of the proposed overarching indicators (feeling supported to manage their condition) has been included in the NHS Outcomes Framework as an improvement area.

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?

4.50 **What we heard:** There was concern that the domain's focus on using patient surveys may exclude those with poor (health) literacy and that the domain as proposed did not sufficiently cover children with long-term conditions. Concerns were also raised that the domain placed too much emphasis on physical health, not adequately covering mental health. Suggestions for future indicator development included ensuring that data for indicators was produced as part of routine care, and that carer and family perspectives were addressed.

4.51 **Our response:** The Government recognises the potential for data from surveys to be biased because of poor responses from those with poor (health) literacy. The NHS Outcomes Framework will include some indicators that are not based on survey data. Examples of these are the indicators that assess time spent in hospital by people with a long-term condition.

4.52 Children with long-term conditions are an important group for the NHS Outcomes Framework to cover; we have included an indicator of 'unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s'. We know that, for children with long-term conditions these three conditions make up 94% of emergency admissions. However, we realise that this does not cover all children with long-term conditions. In order to address this, we propose to develop the use of the EQ-5D-Y (a version specifically for children aged over 7) for inclusion in future frameworks. Children with mental illness are currently not well covered in the NHS Outcomes Framework. We are actively working to develop indicators where we have identified significant gaps in the framework and this is one of these.

4.53 Improvement areas in this domain have been selected to ensure that outcomes for adults with mental illness (enhancing quality of life for people with mental illness) and carers (enhancing the quality of life for carers) are covered by the NHS Outcomes Framework.

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?

4.54 **What we heard:** Several suggestions were put forward for cross-cutting topics on which NICE Quality Standards could be developed. (A full list of topics suggested by way of the consultation is available on request).

4.55 **Our response:** The long-term aim of the Department of Health is to develop a broad library of NICE Quality Standards covering the majority of NHS activity, helping the NHS to deliver the outcomes set out in the NHS Outcomes Framework. The National Quality Board (NQB) is overseeing the development of an evidence-based process for selecting topics for the rest of the library that will integrate and build on the process for selecting NICE clinical guidelines. Each of the cross-cutting topics suggested through the consultation will be considered as part of this selection process.

4.56 In advance of this process being finalised, a number of topics have already been referred to NICE for development. This list includes several topics related to long-term conditions as listed below. There are also a number of topics which will be referred to NICE in due course, once the scope of the topics have been determined. These include a topic on long-term conditions in general, referred to as 'long-term conditions / people with co-morbidities / complex needs'.

Quality Standards – initial topics of relevance to Domain 2	
• Alcohol Dependence • Asthma (including children and young people) • Bipolar disorder in adults • Bipolar disorder in children and adolescents • Chronic Heart Failure • Chronic Kidney Disease • COPD • Dementia • Depression • Diabetes (adults) • Diabetes (children) • Diagnosis and management of hepatitis B, all ages • Drug use disorders (over-16s)	• Epilepsy in adults • Epilepsy in children • Glaucoma • Long-term condition / people with co-morbidities / complex needs* • Management of ulcerative colitis • Osteoarthritis • Pain relief (to include young people)* • Pulmonary embolism • Reflux disease (gastro-oesophageal reflux disease) • Safe prescribing • Schizophrenia • Stroke treatment and rehabilitation • Urgent and emergency care*

**not yet referred – NQB identified them as priority areas for Quality Standard development as part of its most recent selection process, but additional work is required before they can be recommended for referral to NICE*

DOMAIN 3: HELPING PEOPLE TO RECOVER FROM EPISODES OF ILL-HEALTH OR FOLLOWING INJURY

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

4.57 **What we heard:** In this domain, there was recognition that it is difficult to capture all relevant activity and outcomes given the variety of conditions and health needs, but there was support for the ambition of trying to get as close as possible. Indeed, some felt that the focus on readmissions and bed days meant the domain was too reliant on activity or processes and so not sufficiently capturing outcomes from the patient's perspective. The risk of creating perverse incentives, specifically 'gaming' was felt to be particularly relevant in this domain.

4.58 The majority of respondents felt that the suggested indicators, while imperfect, were the best available options. Many highlighted the issues around interpretation of readmissions data. For example, readmission may not result from poor care, and may not even be linked to the previous episode. Many respondents also stressed the importance of choosing the right definition for conditions usually managed in primary care.

4.59 **Our response:** The Government has taken into account the concerns about the use of proxy measures as overarching indicators in this domain, and is mindful of the potential risks of perverse incentives. However, in line with many of the comments received, there is consensus that the proposed measures are the best currently available indicators for this purpose.

4.60 While both focus on hospital admissions, the indicator on 'emergency admissions for acute conditions that should not usually require hospital admission' is widely accepted as a proxy for the effectiveness of primary care, so this part of the system is captured.

4.61 In order to ensure that these indicators are applied in the best possible way, the Department of Health will be instigating some further work on both overarching indicators. On 'emergency readmissions within 28 days of discharge from hospital', work is required to investigate interpretation and to look into whether the indicator can be refined to look more specifically at readmissions that relate to poor recovery. On 'emergency

admissions for acute conditions that should not usually require hospital admission', the Department of Health will look at all the currently available definitions, and seek clinical input to assess whether one of these, or a new definition, is most appropriate.

Question

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

4.62 **What we heard:** A number of suggestions were received as to what indicators could be developed in the future. Many respondents proposed that functional outcomes, such as the patient's ability to work or carry out their normal activities, should be monitored following treatment. Others suggested other measures of recovery, such as the absence of pain, should be used, or that a generic patient reported outcome measure (PROM) could be developed that would apply to all patients.

4.63 A number of respondents suggested that indicators focused on the availability, take-up or effectiveness of services such as rehabilitation and home-based treatment.

4.64 **Our response:** Measuring functional ability following illness or injury, or developing a generic PROM, would directly measure the outcomes that are really important to patients, and so would fit well with the aims of the NHS Outcomes Framework. However, when these suggestions were investigated it became clear that no such data source exists across all conditions, and it would not be feasible to implement such a collection in the time available. These suggestions will be considered when developing future indicators.

4.65 The suggestions around the availability, take-up and effectiveness of services are valid indicators of the quality of care. However, this framework is designed to focus on outcomes, leaving the NHS free to decide which processes will best deliver these outcomes. As such, process measures such as these, while valid and important, are better suited for measurement elsewhere in the system and not in the NHS Outcomes Framework.

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?

4.66 **What we heard:** Many respondents felt that, while bed days are a valid way of identifying the major causes of illness and injury, such indicators lead to a focus on secondary care and miss conditions that do not usually lead to hospital admission. Splitting this domain by condition also has inherent problems: even the top causes of bed days for relevant conditions are a low proportion of total NHS bed days, so the coverage of the improvement areas will not be very broad.

4.67 Most respondents supported the use of PROMs for planned care, and suggested that PROMs should be developed for more conditions, or if possible a general PROM applicable to all patients. Some respondents suggested that a PROM for emergency care might be possible in the future.

4.68 A number of specific improvement areas and indicators were also suggested, including many valid outcome measures and proxies, as well as some process measures which are less relevant to this framework.

4.69 **Our response:** The limitations of using bed days to select improvement areas are recognised, but no viable alternative has been identified for the short-term. It may be possible to move to measuring functional and health status outcomes in this domain, rather than splitting it by condition.

4.70 PROMs will continue to expand to cover more procedures. The feedback from this consultation will be considered and the possibility of developing a generic PROM, or a PROM for emergency care, will be looked into. As more PROMs become available, it will be necessary to consider how they can be incorporated into the NHS Outcomes Framework.

4.71 The specific suggestions made by respondents have been considered when selecting improvement areas and indicators for this domain, and some have been included in the first NHS Outcomes Framework, such as whether older people are able to recover their independence following treatment, to be measured by ‘proportion of older people (65 and over) still at home 91 days after discharge from hospital into rehabilitation services’.

DOMAIN 4: ENSURING PEOPLE HAVE A POSITIVE EXPERIENCE OF CARE

Question
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?***

4.72 **What we heard:** Consultation responses were broadly supportive of the two-stage approach to this domain - covering a short term option based on available surveys, and a longer-term programme to develop future options that are better suited to the purpose of the framework.

4.73 Consultation responses also focussed on a wide range of additional issues for consideration, addressing both the short and longer-term development work. Responses covered the use of indicators, the underlying survey architecture, and future direction of travel for measuring patient experience in the NHS. For example:

- local measurement and ownership of experience measures as being key to achieving improvements in service quality;
- the need to ensure an appropriate overall balance is achieved across all tiers of the NHS. This means making sure that measures based on nationally co-ordinated collections complement and support locally bespoke systems and approaches for capturing feedback. This will enable progress to be tracked nationally, with comparisons being possible across local areas; but it will also ensure that the NHS has additional local insights to inform improvement activity;
- care is needed to avoid Domain 4 unintentionally establishing a ‘research’ and ‘tick-box’ industry that will constrain or divert the NHS from collecting feedback in order to improve the quality of local services, and to ensure they have a positive experience of care;
- there needs to be greater support for staff to assist them in their work to improve patient experience;
- the public, patients and wider stakeholders and other representative groups need to be fully involved in developing future options;
- it is important to recognise that patient experience measures have a very different focus and purpose to other more clinically-orientated indicators in the framework - success on one may not always mean success in the others;

- in some cases, there will be a need for a broader perspective on experience than is afforded by an exclusive focus on people who have recently used services; and
- special attention needs to be paid to ensuring that vulnerable patients and those who are excluded, hard to reach or seldom heard are fully included.

4.74 **Our response:** The Government notes the general support received for the proposals for a short-term approach to selecting overarching indicators for this domain. We also welcome the support received for our longer-term suggestion to develop a new indicator based on a limited set of core questions that can be included within all relevant surveys. This approach means that a wide range of care settings can be covered, and it will ensure a clear focus on the outcomes that matter most to patients. The Department of Health has started to work up options for consideration in future iterations of the NHS Outcomes Framework.

4.75 As this work is taken forward, we will also ensure that patients, service users, carers, NHS staff and wider stakeholders from across the NHS are all fully involved.

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

4.76 **What we heard:** On improvement areas for this first framework, respondents identified the need for measures covering services, care settings and different groups of patients and service users. As can be seen from some of the suggestions that are summarised below, proposals reflect a concern for robust indicators at an organisational level, but also relevant to particular groups of patients (including ones that have a specific focus on clinical conditions and care pathways) such as:

- children and young people;
- older people;
- carers;
- women and families using maternity services;
- people with learning disabilities, as well as others who are vulnerable, hard to reach or seldom heard;
- primary care, including out-of-hours services;
- urgent and emergency care;

- community care services;
- people with mental illness;
- those with long-term conditions;
- people with specific clinical conditions (including rare conditions) or who are following particular care pathways; and
- people receiving end of life care.

4.77 **Our response:** The Government has noted the strong support for the proposed improvement areas for 2011-12 proposed in the consultation document. These areas were selected based on criteria that include: data availability; whether the issue has been identified as a priority for patients; and where evidence suggests that the experience of particular groups is of paramount importance given their individual circumstances. The improvement areas and indicators have been drawn from a range of different surveys, and collectively they achieve a wide coverage of people's interactions with the NHS.

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?

4.78 **What we heard:** Responses were supportive of this suggestion, and for investigating whether dedicated patient experience standards are feasible. In developing standards in this area, responses advocated:

- working with patients to identify topics for NICE Quality Standards;
- extending NICE Quality Standards across age and demographic groups;
- looking at standards across different settings – e.g. acute, primary, community care, out-of-hours services, community pharmacy, and end of life care; and
- having a core set of standards that are universal for all client groups.

4.79 **Our response:** Taking all of this feedback into account and with immediate effect, NICE are developing a generic Quality Standard for patient experience, which will identify common themes and issues across most services. NICE is also developing a specific Quality Standard for adult mental health. As we develop future indicator options for this domain, it will be important for the Department of Health and NICE to consider which patient experience-specific Quality Standards, in addition to the two previously mentioned, should be developed.

4.80 All Quality Standards should have a patient experience dimension built into them, since patient experience is one of the three dimensions of quality. NICE will also be developing a series of standards which are particularly relevant to this domain, given the clear overlap with the improvement areas that have been selected. The table below sets out those that have already been or will be referred to NICE.

Quality Standards – initial topics of relevance to Domain 4	
• Patient Experience (generic) • Patient Experience in Adult Mental Health • Antenatal care • End of Life Care • Intrapartum care	• Nutrition in hospital, including young people • Postnatal care • Urgent and emergency care*

**not yet referred – NQB identified this as an important area for Quality Standard development as part of its most recent selection process, but additional work is required to determine the scope of the standard before they can be recommended for referral to NICE.*

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

4.81 **What we heard:** The consultation responses were positive about the overall approach to generating new indicators in the future. As with question 22, respondents proposed a wide variety of services, settings and different groups of patients and service users on which indicators should be developed.

4.82 **Our response:** The Government is committed to developing a better understanding of what matters most to patients, how patient feedback can best be captured, as well as measured and monitored on an ongoing basis. The Department of Health will be using the consultation feedback to initiate development of future indicator options for inclusion in future iterations of the framework. This is likely to require a range of new methodologies and approaches, and it will be key to develop them in ways that support and build on locally-led innovation and activity to improve patient experience at the front line.

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

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

4.83 **What we heard:** Whilst the majority of responses were supportive of the proposed five domains and many explicitly applauded the inclusion of a specific domain on patient safety, some respondents questioned the concept, and whether safety was in fact an outcome in itself. Several flagged that the domain focuses predominantly on acute care.

4.84 There were several concerns as to how such a domain would operate or the effect it would have on behaviour. Concerns included:

- the approach may lead to gaming and risk aversion, for example, organisations may report more trivial incidents, poorly record near misses and/or avoid tackling difficult cases;
- reporting in this domain could penalise higher performing organisations;
- it could be difficult to interpret the direction of travel through the overarching indicator, for example, whether an increase/decrease in reporting is good or bad; and
- there is a need to avoid duplicating CQC requirements.

4.85 **Our response:** The Government is aware of concerns relating to the three-part overarching indicator for patient safety, particularly the part on incident reporting. Despite the difficulties, many respondents still supported its inclusion, particularly as it would send a positive signal about its importance as part of an improved patient safety culture.

4.86 The Department of Health will continue to work with patient safety experts to ensure we properly understand how to interpret trends in safety incident reporting, and to understand the impact of including it in the NHS Outcomes Framework. The National Reporting and Learning Service is being updated, to facilitate better data collection – something respondents were keen to see, to ensure this indicator could be successfully used. Patient safety experts are also working on an appropriate definition for ‘similar incidents’, which forms the third part of the overarching indicator.

4.87 Respondents were concerned that this domain did not duplicate CQC requirements. Our intention has always been to focus on promoting excellence in safety, over and above the essential levels of quality and safety which are included in registration requirements. Therefore, we have decided not to include indicators relating to the essential levels of safety, such as Never Events in the framework, as these are already measured at trust level by CQC.

Question

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

4.88 **What we heard:** Several respondents raised issues around how safety issues would actually be measured and whether the National Patient Safety Agency's (NPSA) incident reporting system is sufficiently well structured or could support better incident reporting.

4.89 On the improvement areas, many respondents welcomed the inclusion of certain issues, with infection control, maternity and venous thromboembolism (VTE) receiving particular praise. Other respondents advocated for improvement areas on other issues such as:

- safety in mental health hospitals;
- safety pre-admission, in transition and on discharge;
- housekeeping/environment issues;
- measurement of self care and education to reduce risk; and
- safety for children and young people, including those with a mental illness.

4.90 **Our response:** Respondents made several suggestions for improvement areas in the patient safety domain. The Department of Health has therefore, had to make some difficult decisions to ensure we get the right balance across this domain, but equally across the whole NHS Outcomes Framework.

4.91 Overall, the proposed improvement areas are intended to reflect respondents' desire to address key sources of harm – such as VTE, pressure ulcers and hospital acquired infections – across specific patient groups including newborn and older children, pregnant women and older people.

4.92 The Government welcomes the broad support for improvement areas relating to infection control, maternity and VTE. In responding to

concerns about addressing child safety issues, we propose using an indicator on harm caused by 'failure to monitor' children in a clinical setting. This is a broad-based indicator capturing many activities that constitute safe care for children, and avoiding harm that can result from failing to provide appropriate care.

4.93 For other patient groups, a maternity indicator on avoiding admissions of newborn full-term babies to neonatal care has been selected. We propose including VTE and pressure ulcer indicators, issues particularly affecting older people, though also the wider population.

4.94 Respondents were keen on addressing mental health. Such issues are under consideration across the whole of the NHS Outcomes Framework, for example, in managing long-term conditions, and there are obvious links to public health, such as in preventing suicide. A possible acute care suicide-based indicator for the patient safety domain was considered and discounted on the grounds that it is closely linked to one of the national defined 'never events' and relates more to minimum safety standards rather than quality improvement.

4.95 Respondents felt we were overlooking housekeeping and care environment issues. While the Department of Health recognises that these are important issues, they are not outcomes in themselves, and the consequences of these issues are captured in, for example, the infection control indicator. Issues such as cleanliness are also captured by the CQC in their registration requirements.

GENERAL CONSULTATION QUESTIONS

Question
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?

4.96 **What we heard:** Of the responses received for question 27, one recurrent theme was the need to ensure that the views of vulnerable groups are sought and adequately reflected. There was a divergence of views about benefits and effects that national outcome indicators could have on outcomes for vulnerable groups and wider socio-economic inequalities. One set of respondents felt that by having outcome measures set at a national level it would have the necessary impact and political backing to reduce inequalities. In contrast, others felt that by having a national focus on inequalities would remove local flexibility to address the needs of their local populations. Overall, there was consensus that reducing health inequalities and promoting equality should be an underpinning factor across all outcomes in the framework, as proposed in the consultation document.

4.97 **Our response:** The responses confirm that our approach to promoting health equalities and reducing health inequalities is the right way forward. Subject to the will of Parliament, the NHS Commissioning Board will be required to consider inequalities in this and all the indicators in the NHS Outcomes Framework. It will also be subject to the provisions of the 2010 Equality Act. Requirements to consider significant inequality across different population groups may also be introduced as part of the setting of levels of ambition. The Department of Health will also tackle health inequalities more broadly through the Public Health Outcomes Framework and health premium. The healthcare of particularly vulnerable groups is being taken forward through the Health Inclusion Programme supported by Health Inclusion Board.

4.98 Over time, new outcome indicators will be developed with others being refined. This process should allow for indicators included in future iterations of the framework to be better broken down by equalities characteristics and local area. In developing the NHS Outcomes Framework, an Equalities Impact Assessment was undertaken, which

used an evidence-based approach to assess the potential impact of the framework. A copy of the EqIA is available on the DH Website[26].

Question

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

4.99 **What we heard:** The above question was included as part of a general section to capture broader aspects of the framework. Although, not explicitly set out in the consultation, sustainable development has a vital role in improving the efficiency and effectiveness of NHS resources, and any new developments should encourage this.

4.100 Respondents felt that as an organisation, the NHS needed to focus on sustainable development, and the inclusion of specific outcome indicators to encourage sustainability, such as 'the reduction of ecological impact' could be used as an incentive for NHS organisations to do this. It was widely commented that the benefits of sustainable development may not be realised for many years, and it is important that progress in this area continues during the transition period.

4.101 **Our response:** The Government believes that it is important that the NHS continues to make progress in improving sustainable development. The Department of Health considers it unlikely that the NHS Outcomes Framework will have a negative impact upon sustainability issues. A specific indicator has not been included in the NHS Outcomes Framework as its remit is confined to holding the NHS Commissioning Board to account for outcomes for patients and service users as a result of its treatment activity. How the NHS meets any sustainability objectives will be for the NHS Commissioning Board, commissioners and provider organisations to determine.

Question

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

[26] [Need link]

4.102 **What we heard:** Due to technical problems, the publication of the initial Impact Assessment (IA), was slightly delayed following the publication of the consultation document. This did cause some confusion for respondents, and is reflected in the responses. Some respondents were unclear as to the purpose of an IA. Of those respondents that did view the IA, some felt that it was an appropriate approach, whilst others considered it too 'traditional'.

4.103 **Our response:** The final IA for the first NHS Outcomes Framework presents the options associated with the costs of implementing the framework. It provides robust economic analysis to support each option, and any assumptions made. It is important to note that for 2011/12, levels of ambition will not be set, instead this period will be used to set baselines for the NHS.

4.104 This will help the NHS to begin to understand what an NHS focussed on outcomes will mean for individuals, organisations and health economies. The IA for the NHS Outcomes Framework reflects this, and sets out the options accordingly. A copy of the NHS Outcomes Framework Impact Assessment is available on the DH Website[27]. When the NHS Commissioning Board is in place in shadow form, negotiations between the Secretary of State and the NHS Commissioning Board will determine the levels of ambition. These will of course be feasible and affordable given the settlement to the NHS through the Spending Review.

Question

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

4.105 **What we heard:** In general, respondents thought improving health outcomes would result in the delivery of cost-effective services and value for money for the NHS budget. A number of suggestions and comments about how value for money might be achieved were received, such as improving clinical coding, and keeping data collections simple. Some respondents observed that high quality patient care and measuring outcomes may not always lead to value for money and trade offs would be necessary in a publicly-funded health service.

4.106 **Our response:** The Government believes that focussing on outcomes will provide a real opportunity for the NHS to deliver the best value for

[27] [Need link]

money. The removal of politically motivated process targets will free up clinicians to focus on delivering what matters to their patients. Moreover, when the first outcomes framework is operational in 2012/2013, the Secretary of State for Health and the NHS Commissioning Board will have negotiated the levels of ambition that will be attached to the framework. These levels of ambition will be ambitious but feasible and affordable within the limits of the Spending Review envelope.

Question

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

4.107 **What we heard:** A significant proportion of respondents felt that the role of NICE Quality Standards within the framework was positive. Respondents felt that more clarity was needed about the timescales for the development of the 150 NICE Quality Standards. Respondents also highlighted the importance of ensuring that Quality Standards foster integrated working across the NHS, public health and adult social care.

4.108 **Our response:** As explained in the response to question 7, the Department of Health is working with NICE to develop a process for accelerating its topic selection process. The full list of topics which have been referred to NICE is set out in Annex C in *The NHS Outcomes Framework 2011/12.*

POSSIBLE OUTCOME INDICATORS

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?

4.109 **What we heard:** The most common theme among respondents was the view that outcomes are the result of multiple factors, and therefore indicators are potentially difficult to interpret, though it was felt that broadly speaking, the right topics to measure had been suggested. Many respondents felt that it would be difficult and undesirable to estimate the relative contributions of the different parts of the health system to these outcome indicators. However, many felt that the solution was to measure across integrated care pathways and reflect partnership working across the NHS, public health and adult social care.

4.110 Respondents also emphasised the need to select outcomes that:

- could be measured robustly;
- were appropriately standardised; and
- could be used for comparative purposes

4.111 Some respondents felt that there was insufficient coverage of children and young people across the framework.

4.112 **Our response:** In proposing indicators for the NHS Outcomes Framework, the Department of Health has sought to identify indicators which represent the contribution of the NHS to improving health outcomes. Where this has not been possible, we have been clear that this is the case and have either included the best available indicators and/or committed to developing suitable measures.

4.113 Further work will look to improve existing indicators which are in varying degrees of readiness, and working with statistical and analytical experts to develop new robust, statistically sound indicators, underpinned by high quality data where there are gaps.

4.114 We are keen to ensure good coverage of all patient groups, including children and young people across the NHS Outcomes Framework, by disaggregating the indicators where we can, and by identifying outcomes that are relevant to particular groups in the most relevant parts of the framework.

4.115 We have examined international evidence on how to attribute the relative contributions of different parts of the health system to delivering on these outcomes. However, respondents have given us a clear message about ensuring partnership working across the different parts of the system and we will continue working with stakeholders to ensure this is built into the delivery of the proposed outcomes.

Questions

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

4.116 **What we heard:** The vast majority of respondents to this question were positive about the approach taken to selecting outcome indicators. There were some reminders of the need to work in partnership across the NHS, public health and adult social care.

4.117 **Our response:** The Government welcomes the support for the approach to selecting the outcome indicators, but is mindful of the need for these indicators to be robust. We will also continue to work with stakeholders across all parts of the health system to deliver improved health outcomes.

5. Next steps

5.1 The *NHS Outcomes Framework 2011/12* sets out next steps in developing and improving the framework, and indicators within it, over the coming years. It also explains how levels of ambition will be set through negotiations between the NHS Commissioning Board and Secretary of State for Health, and how in the longer- term the framework will be reviewed every 5 years to assess its effectiveness as an accountability mechanism and as a catalyst for improving quality and driving up health outcomes across the NHS.

Annex A

NHS Outcomes Framework – consultation and engagement events

Date	Event
21 July	Presentation at the Third Sector Sounding Board
26 July	Ministerial visit and engagement event -NHS East Midlands SHA
26 July	Ministerial visit and engagement event - NHS South Central SHA
26 July	Presentation at the National Stakeholder Forum
29 July	Presentation at the SHA Directors of Finance
03 August	Presentation at Transforming Community Service - Service User Adv Group
03 August	Presentation at Respiratory Disease Stakeholder Group
31 August	Amenable mortality workshop with analytical experts
01 September	Ministerial visit and engagement event - NHS London SHA
01 September	Ministerial visit and engagement event - NHS South East Coast
01 September	Physiological Measurement Stakeholder meeting
02 September	Ministerial visit and engagement event - NHS Yorkshire and Humber
02 September	SHA Medical Directors meeting
07 September	Regional Voices workshop - North West
07 September	Presentation at Foundation Trust Clinical leads
07 September	Presentation and workshop - Professional Bodies Quality meeting
08 September	Regional Voices workshop –South East
08 September	Workshop at NHS Confederation White Paper event
09 September	Ministerial visit and engagement event - NHS South West SHA
09 September	Regional Voices workshop - West Midlands
09 September	Diabetes Stakeholder meeting
10 September	Regional Voices workshop - London
13 September	Ministerial visit and engagement event - NHS East of England SHA
13 September	Ministerial visit and engagement event - NHS West Midlands SHA
14 September	Regional Voices workshop – South West
14 September	National Clinical Audit leads
15 September	Ministerial visit and engagement event - NHS North East
15 September	Healthcare Science Professional Bodies meeting
16 September	SHA Directors of performance
17 September	Ministerial visit and engagement event - North West
20 September	Regional Voices workshop- Yorkshire & Humber
22 September	Regional Voices workshop - North east
22 September	Neurological Stakeholders meeting
22 September	CNO Business meeting (London)
23 September	Regional Voices workshop - East Midlands
23 September	CNO Business meeting (Leeds)

23 September	DH Board meeting
24 September	Regional Voices workshop - South Central
28 September	SHA Quality Leads meeting
30 September	Respiratory Outcomes meeting
04 October	Vascular programme Voluntary Sector Stakeholders event
05 October	SHA Senior Lead Scientist event