Consultation response

Response from The King's Fund to the consultation *Transparency in outcomes: a framework for the NHS*

11 October 2010

Introduction

The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

We welcome the opportunity to comment on *Transparency in Outcomes: a Framework for the NHS*. This is one of a series of responses by The King's Fund to the government's proposed reforms covering commissioning, regulation and local democratic legitimacy, all of which are available from our website. For an overview of our response to the government's proposals, please see *http://www.*kingsfund.org.uk/nhswhitepaper.

Main points and recommendations

The outcomes framework will be a central component of the mandate through which the Secretary of State will hold the NHS Commissioning Board to account. It is crucially important that the assessment framework for the NHS Commissioning Board drives improvements in health and health care outcomes and patient experience, reduces inequalities, and does not create unintended consequences or distort clinical priorities. Our principal recommendations about the proposed framework are outlined below.

- **The outcomes framework should be broad and high level:** We recommend that a framework for assessing the performance of the NHS Commissioning Board should be broad and high level. The inclusion of a large number of highly specific indicators could distort priorities, create perverse incentives and constrain local determination of need and ways of delivering improvement in health care. Such a high-level framework can be supported by a limited set of measures, leaving flexibility – within the overall framework – for local commissioners and services to set areas for improvement.

- **The relationship between the outcomes framework and the commissioning framework needs careful consideration:** Para 1.15 says that the framework will not be used to manage performance in the NHS. Yet experience shows that measures designed as national goals often get translated into local targets and are used for assessment and management of performance. There is a particular risk of this occurring with the highly specific and narrowly defined indicators. Although it is not yet clear how the outcomes framework and the NHS commissioning framework will relate to each other, it is important that the former is sufficiently high level (see above) and that the latter includes a comprehensive set of measures in order to avoid a short-sighted focus on performance against particular measures included in the outcomes framework to the exclusion of others. It is also important that the commissioning framework for assessing the performance of GP consortia goes beyond the outcomes framework to include the commissioning skills and performance of GP consortia.

- **International comparability is best served by using an internationally recognised framework:** A considerable amount of work has been done in the United Kingdom and internationally on developing conceptual frameworks for assessing the performance of health care systems – eg, by the Organisation for Economic Co-operation and Development (OECD) (Arah *et al* 2006). They have been developed on the basis of evidence and consensus about the elements of performance that should be measured. We strongly recommend using one of these well-recognised models rather than creating a new framework, especially given the conceptual and practical challenges in trying to summarise measures of health system performance. It may prove less challenging in terms of developing supporting measures, be less open to controversy, and would support the principle of international comparison as part of the framework. The OECD framework, for example, has parallels with the proposed outcomes framework, with some differences: it includes health improvement and risk factors, and has the three themes of effectiveness, safety and patient experience cross-cutting the salient dimensions of health status, with equity as an overarching dimension (Kelley and Hurst 2006).

- **Public health, health improvement and health inequalities should be included:** The framework focuses on outcomes that the NHS can influence, working in partnership with other public services where required. We understand that public health and prevention will be covered in the forthcoming public health White Paper. Public health, health improvement and reducing health inequalities are essential and integral functions of the NHS, with the potential for general practice to play a key role via both its commissioning and provider roles. These roles must be incorporated into any framework for assessing the performance of the NHS Commissioning Board and also reflected in the framework against which GP consortia will be held to account by the Board. The exclusion of public health and health improvement from a framework relating to NHS commissioning (p 48) risks diluting the roles of the NHS and general practice in these key areas of health care delivery and may give GP consortia little motivation to engage in public health.

- **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 (p 48) potentially mitigates against promoting integration.

- **It is important to identify what improvements are expected over what time period, given the level of investment in the NHS:** The consultation does not set out how improvement will be assessed – ie, what will constitute acceptable/unacceptable performance in relation to the measures listed in the framework, performance on which is likely to be variable (in terms of both rates and direction of change) and may or may not be related to the quality of care. It is critically important that there are clear criteria for determining whether or not the NHS is delivering health improvement and timely, high-quality, patient-centred and integrated care that is commensurate with the levels of investment and demonstrates value for money.

- **The framework should provide some guidance on what the balance is between improving outcomes and the costs of doing so:** At a time of fiscal austerity, improving outcomes irrespective of cost is not a viable option. The Board and commissioners will need broad principles and criteria to inform their decision-making and guidance on how issues of cost-effectiveness should be addressed in the drive to improve outcomes.

- **Process measures are also important:** Implicit in the outcomes framework is an assumption that the best way to account for and improve health outcomes is to emphasise the measurement of outcomes. Although the framework acknowledges that process measures will be needed locally to drive increased performance, we think it is important that the outcomes framework includes relevant process measures. Further information about the pros and cons of process and outcome measures is included in our answer to question 31 of the consultation.

We are not commenting on the specific indicators included in Annex A because we think the first step is to get the right overarching framework.

Further responses to individual questions

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

Principles

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

Partly, but we think some additional issues need consideration:

Balanced: While the overall aim of balance is laudable, translating this into measures is more challenging. Many of the proposed measures cover selected aspects of care. The framework for the National Commissioning Board needs to be high level. The large set of very specific indicators included currently may lead to short-sightedness and fragmentation.

Focused on what matters to patients and health care professionals: While there is evidence of an association between staff experience and patient experience (Raleigh *et al* 2009), the framework assumes that patients and professionals value the same things; this is not always the case. It is important that the drive to attain outcomes must not be at the expense of taking patients' preferences into account.

Promoting excellence and equality: Excellence and equality are two separate principles. Excellence could perhaps be better described as quality improvement in health care. While we think it is important for any national indicators to be measurable by dimensions of inequality, disaggregation to local areas mitigates against this being used as a national framework only and risks it being used for performance managing the NHS (contrary to para 1.15). Some of the proposed indicators will also raise problems of measurement – eg, small numbers at disaggregated level etc.

Focussed on outcomes that the NHS can influence, working in partnership with other public services: It is often not possible to disentangle the impact of NHS care on health outcomes from the impact of wider determinants (the domains of patient experience and safety are probably the two exceptions to this). Furthermore, the NHS and general practice have a significant role to play in public health, improving population health, and tackling health inequalities – as part of both their commissioner and provider roles (Marmot 2010, National Audit Office 2010, Boyce *et al* 2010, Hutt and Gilmour 2010, Ali *et al* 2008). The delineation between roles/budgets for GP consortia (NHS commissioning) and local authorities (public health, inequalities, social care) could lead to a divide between 'treatment' and 'prevention' services, which this assessment framework could exacerbate. It is therefore important that any framework for assessing the performance of the NHS and general practice covers all the functions regarded as their core business and that it is aligned with the roles of local authorities.

Internationally comparable: We agree that international benchmarking is useful in examining variations in the quality of health care. However, as the document recognises, there are many data, health system and other differences that make international comparisons problematic. For this reason, we do not think that international comparability should be a basis for making unequivocal judgements about the NHS's relative performance. Indeed the OECD Health Care Quality Indicator project qualifies its international comparisons work accordingly. Furthermore, if international comparability is to be a principle underpinning the outcomes framework, then the domains of the framework should be equivalent to those used in other international health system comparisons.

We agree that intra-UK comparisons are most likely to be useful and would support the development of this.

Evolving over time: We recommend that there is a clear process for the periodic revision of the outcomes framework and clarity about who has responsibility for this.

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

Some additionally important principles are outlined below.

- **Ensuring comprehensive coverage of the population:** The indicators need to avoid a focus on secondary care and ensure that all population groups and areas of care are covered, such as children with complex needs; people with mental health problems, dual diagnosis or disability; end-of -ife care.

- **Supporting integrated care** (eg, across health care providers, and across health and social care).

- **Cost-effectiveness**: The framework is presumably not justifying any improvement in outcome/longevity irrespective of cost, so clarity is needed about the underlying principles for balancing gains in outcome against cost. The impact assessment suggests that there will be other forms of accountability for the Board but these are not set out nor is the way that these will interact with the accountability for outcomes. These relationships need to be clearer as they could lead to dissenting views between the Commissioning Board and the Secretary of State/HM Treasury about whether outcomes have been affected by the financial allocation.

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

The outcomes framework needs to have an explicit focus on inequalities and to define what would constitute acceptable and unacceptable reductions in inequitable outcomes and health inequalities. Experience from the four UK countries shows that a successful health inequalities strategy needs to be underpinned by clarity over the main determinants and dimensions of health inequality that are to be reduced and the indicators used to measure progress (Marmot 2010).

To reduce inequalities and measure impact it is necessary to influence and measure the intermediate determinants of unequal outcomes (National Audt Office 2010, Marmot 2010). Using outcomes alone (as with the life expectancy and infant mortality targets of the previous government) as a basis for assessing performance has been shown to be an unsatisfactory basis for driving accountability and tackling inequalities.

Although public health and prevention will be addressed in a separate consultation, tackling inequity and reducing health inequalities should be core business for the NHS and general practice as both providers and commissioners. Annex 2 of the Marmot Review provides an indicator framework for inequalities (Marmot 2010).

Process measures are important as they measure interventions designed to improve intermediate and longer-term outcomes of care, many of which are key drivers of health inequalities – eg, tackling risk factors for poor health such as smoking, obesity, etc. Process measures are therefore critical for reducing inequity in access and quality of care and for reducing health inequalities. There is also a need to have measures of equitable and timely access to health care and to ensure compliance with equality legislation.

It is important to ensure that data flows can support disaggregation by the dimensions of inequality. While many datasets include age and sex, the recording of ethnicity in particular needs to be extended and improved. The Information Strategy due out for consultation later this year should address these important issues.

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

By definition indicators are specific to topics. This potentially jeopardises the principle of integration because it could reinforce an organisational perspective. To mitigate against this, we suggest:

- using indicators along whole care pathways– eg, stroke – as per standards set by the National Institute for Health and Clinical Excellence (NICE) and mentioned at para 3.16
- including measures of the quality of integrated, co-ordinated care, which can impact on quality of life and patients' experience of services but may not translate directly into hard outcomes
- making local organisations accountable for the same, system-level measures to foster co-operation. This means aligning the framework to the roles of local authorities to incentivise close working between GP consortia and local authorities in delivering integrated care across patient pathways, and health and social care. The specific exclusion of outcomes relating to social care (p 48) mitigates against this.

Five domains

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

Our overarching comments on the proposed domains are as follows.

- We strongly recommend using a well-recognised international model rather than creating a new framework, especially given the conceptual and practical challenges in trying to summarise measures of health system performance.
- Domain 1 is focused on mortality. The NHS and general practice have a key role to play in helping people to lead healthy, disability-free and independent lives, not just longer lives – ie, in both 'adding years to life and life to years' (Marmot 2010). Mortality is an especially poor indicator for infants and children because very few die.
- Access and waiting are critical elements of NHS performance and we recommend they are included in the framework as a generic dimension. Timely access to care is important to patients and can impact significantly on physical and mental well-being. Economic pressures on the NHS could result in longer waits for treatment, and there is substantial evidence of variable and inequitable access to therapeutic interventions.
- There are some services and groups that do not readily fit into this framework or under any domain – for example, maternity, end-of-life care and palliative care services, and people with disabilities. How the performance of these services will be accounted for therefore needs further thought.
- End-of-life care could be an additional domain here rather than only as part of the patient experience domain (the amount of money spent on health care in the last six months of life is very significant in terms of lifetime health care spend, and cost effectiveness of this is a huge issue that is not just about patient expereince).

6. Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients? (Public health and prevention will be covered in a separate consultation linking to this framework as appropriate)

Please refer to our introductory comments and our reponses to Q1-Q5 about comprehensiveness of the framework.

Structure

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

While the proposed structure works conceptually, there could be practical problems.

The structure (Figure 2 on page 15) assumes a causal link between its three elements (the overarching indicator, the improvement areas, and the supporting NICE quality standards). However, NICE quality standards may not cover the full range of services reflected in the overarching indicator. NICE quality standards (as with stroke, venous thromboembolism (VTE), dementia) are in the main process measures, and while these are expected to deliver better care, compliance with the selected NICE standards may not translate into improvement in the indicators in the selected improvement areas and in turn into improved hard outcomes such as reduced mortality and hospital admissions. The consultation document also says that only some topics will be selceted for quality standards, so coverage of the NICE standards in the framework will in any case be partial (and risk distorting clinical priorities).

It is therefore unlikely that there will be a clear relationship (or possibly even any relationship) between the three component elements of the structure. This could make interpretation of performance difficult, especially as performance is likely to be variable across the various indicators in each tier of the structure. This raises concerns about how the framework will operate in practice.

It is also unlikely in our view that the majority of NHS services will have a quality standard. There will be 150 quality standards and yet there are more than 350 care pathways in Map of Medicine (which in itself is far from comprehensive in some specialties).

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

Domain 1 - Preventing people from dying prematurely

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

Mortality amenable to health care is an appropriate overarching indicator.

We note Annex A includes all-age all-cause mortality. We suggest also including healthy life expectancy.

If the definition of this domain can be extended beyond mortality, we suggest including a measure of physical and mental well-being.

There needs to be some consideration of costs in relation to improving outcomes and the principles of choosing domains, in particular, the assertion that 'people should not die early where medical intervention could make a difference'. The role of NICE and the relative and absolute cost-effectiveness of treatments are important considerations, as presumably the framework is not proposing improving outcomes irrespective of cost.

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

Given the focus on mortality, the choice of the major killers is not unexpected. However:

- circulatory disease and cancer jointly account for about two-thirds of all deaths, so there is a need to consider other causes of mortality
- cancer survival has long lead-lag times and is useful for monitoring and driving change, but it is less suitable as a measure of contemporaneous performance - process measures

are more useful for this; although lead-lag effects are less marked for mortality from the other causes listed, again supplementary process measures could provide a better marker of contemporary NHS performance
- for cancer, it is important to also monitor incidence, which, for some cancers, is linked to primary prevention measures, screening and early diagnosis, all of which are central to good-quality health care.

The use of mortality as an outcome ignores the significant morbidity associated with, for example, respiratory disease, mental illness and multiple chronic conditions.

As discussed above, intra-UK comparisons to identify improvement areas might be more fruitful than international comparisons, as we know that the measures are more directly comparable and that there are significant differences in outcomes in different areas of the country.

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

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

An indicator on excess deaths of older people in summer could also be included.

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

Infant mortality is an inadequate indicator because of the low number of infant deaths (about 3000 annually). Likewise, deaths from respiratory disease in children aged 0–14 will be low. And both these indicators are very limited measures of child health. Lifelong health is largely determined in infancy and childhood, and this illustrates again the problem with using mortality as an outcome measure. Further, use of infant mortality as an overarching indicator could result in short-term drivers of mortality being prioritised over those that drive child health more generally (and therefore longer-term outcomes).

Intermediate outcomes might be more significant in children in predicting early mortality (which might be much more significant in terms of years of life lost than those who actually die in childhood). We recommend that an indicator framework such as in the Marmot Review informs development of priorities in this section (Marmot 2010).

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

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

Given the challenges of trying to summarise this large and complex dimension of health care into one or two overarching indicators, and the limited data sources that can reflect it adequately, we think the proposals are adequate. However, they are too generic to be discerning about performance or to give pointers to areas for improvement, and they could be influenced by factors unrelated to the quality of care such as the growing prevalence and complexity of long-term conditions and/or disabilities, respondent expectations changing over time, etc. We also note that the proposed overarching indicators only relate to adults.

In our response to Q5, we have recommended that timely access to services is included in the framework as a generic dimension. For example, there is substantial evidence that access to therapeutic interventions such as coronary artery bypass surgery, percutaneous coronary intervention, and joint replacements is variable geographically and inequitable for some socio-demographic groups. This could impact on mortality but is also critically important for functional ability and quality of life, especially for those with long-term conditions, and may not be captured by high-level national surveys such as those described in the overarching indicators for this domain.

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

Yes, but such indicators would be subject to the same caveats as stated for Q13.

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?

As stated in our main recommendations above and for Q4, in addition to outcomes for health care, the NHS Commissioning Board needs to hold commissioners to account for outcomes associated with integrated care, including between health and social care. This is increasingly important given the growing prevalence of long-term conditions and co-morbidities.

It is important to ensure that the range of population groups and conditions are adequately covered – eg, the mental health indicators in Annex A focus only on serious mental illness, and there is relatively little coverage of children in this section. Pathways and integrated care indicators are important here.

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

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

Emergency hospital admissions/bed days and re-admissions may reflect quality of primary, secondary and tertiary prevention, but they could also be influenced by confounding factors such as increasing prevalence of long-term conditions and co-morbidities, reconfiguration of services, hospital admission policies, etc. Interpretation could be problematic, and increasing rates may not necessarily indicate deteriorating quality of care.

Recovery from injury is not reflected in the overarching measures, nor is injury among children and adults in Annex A.

Overall, this domain is very focused on acute care. There is also a need to consider dimensions of recovery that may not entail admission to hospital. We recommend including some indicators relating to primary care– for example, the management of depression and mental illness, and access to psychological therapies.

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

A measure of occupational function similar to that suggested for long-term conditions might be able to highlight recovery from ill health.

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

We agree that patient-reported outcome measures (PROMs) for specific surgical procedures (hip and knee replacements, hernia, varicose veins) are very useful markers of health status following elective surgery, but they do not show whether or not the rates for these procedures (ie, access) are commensurate with need locally and in demographic and socio-economic population sub-groups. There is, for instance, strong evidence of inequity in access to joint replacements (Judge *et al* 2010, Raleigh *et al* 2010). Access to therapeutic interventions such as cataracts, joint replacements, heart surgery can impact significantly on recovery and quality of life and should be monitored to ensure appropriate and equitable access to services, improving functional status, and prudent use of resources.

We agree that indicators for the most frequent causes of unplanned admission among different age groups could be a useful approach to measuring potentially preventable admissions. But there is an issue of how to achieve balance without an extensive list of indicators. The list at Annex A is a mix of admission and re-admission rates, includes very few indicators for children (and none on injury in children), and includes an indicator on re-admissions following hysterectomy but no indicators, for example, for mental health.

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

Domain 4 - Ensuring people have a positive experience of care

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

We agree that patient experience should have equal status alongside other elements of the framework and should be constructed in broadly the same way. The existing arrangements are not ideal and need further development.

In the short term, we agree it will be helpful to track performance on a standard subset of survey questions. However, we do not agree that the same subset of questions should be used across all surveys. It is possible that in different parts of the health system, the key issues for patients may not be the same. Future iterations of the framework should be informed by research on what matters to patients with different clinical problems and in different parts of the system. We also think it is important for local organisations to capture patient experience for individual specialities and clinical areas/services but this should not be incorporated into an overall national framework.

We recommend that the themes selected for the overarching indicator correspond with those in established, evidence-based frameworks for patients' experience. We recommend the Institute of Medicine's internationally recognised and research-based definition of patient-centred care, which has six dimensions:

- empathy and responsiveness to preferences
- co-ordination and integration
- information, communication and education
- physical comfort
- emotional support, relieving fear and anxiety
- involvement of family and friends.

NHS patient experience surveys to date show that, for example, the composite domain scores show little year-on-year change, so they may not be a sensitive enough measure for holding the NHS Commissioning Board to account. Further, summary composite measures of patient experience (for example, the measure used in CQUIN) can pose problems of interpretation and are useful for improvement locally only if it is clear what weights are attached to the different indicators in the composite and how they score. So the use of composites should not dilute the importance of ensuring that providers focus on responses to individual survey questions.

Decisions about patient surveys should be made in the context of all new data collections required by the framework (see our response to question 31).

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

Yes, in broad terms, but it is critical to make sure that the core questions contributing to the overarching indicators matter to patients and are genuinely patient-centred. So, for example, questions about access and waiting times should measure patients' satisfaction with or their perceptions of the wait, as well as how long they actually waited.

England has one of the largest survey programmes of patient experience internationally, and some of these surveys have been adapted for use in other countries such as the Netherlands and Canada. Considerable work over many years, including with different groups of patients to establish what is important to them, was invested in the development of these surveys. For cost-effectiveness reasons, this work and the experience gained from it needs to be built on rather than starting again from scratch.

As the results of the different surveys to date show little year-on-year change, the frequency of undertaking surveys should also be a consideration on cost grounds.

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

Measures of patient experience need to be developed for these service areas. We welcome the inclusion of end-of-life care; however, we think the views of patients themselves, as well as of those closest to them, should be recorded.

For reasons of cost-effectiveness, we reiterate the need to build on the experience of the existing survey programme. For example, the maternity survey underwent extensive development work, including with the National Perinatal Epidemiology Unit. And the survey of inpatients in mental health services demonstrated the challenges of surveying this group of patients and associated problems of low response rates, etc.

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?

Yes, we think that the development of measures for clinical services and clinical groups should be progressed and that measures should not be dependent on the timetable for developing quality standards for patient experience.

In order for measures to be useful in quality improvement they must be meaningful to clinicians. This requires attention to be paid to how patient populations are segmented. Clinicians, individually and in multi-professional teams, should relate to the data and the measures as coming from 'my/our patients'.

The King's Fund Point of Care team is currently working on a project with King's College London National Nursing Research Unit for the Department of Health and the NHS Institute for Innovation and Improvement looking at determining what matters most to patients along five specific pathways: elective hip replacement; depression; chronic obstructive pulmonary disease; diabetes; stroke.

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

Yes, but see also our response to Q21. We agree that it is right also to involve relatives and carers in the development of measures and to see them as an important source of feedback. Developing meaningful measures for frail and older people with complex co-morbidities will be challenging but is especially important.

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

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

We agree that indicators relating to safety pose a number of problems, especially when used as measures of performance. Interpretation is beset with problems of under-reporting and reporting cultures whereby higher reported rates may indicate a more safety-aware organisation. The evidence shows that safety events are both under- and variably reported, so we agree with the principle that the number of reported events should be rising.

However, it does not follow that the severity of reported events or the frequency of repeat events should be decreasing – this assumes that all events of a given severity or type are already being reported, which is unlikely to be the case, especially as reporting levels differ significantly across sectors, being higher for acute services, lower for mental health services and negligible for primary care.

The use of safety indicators in the context of performance accountability carries a significant risk of unintended consequences. While it is important for the framework to encompass safety, its use in this context should be to promote safety awareness, an open learning culture and improved recording. Many of the indicators listed for this domain are based on events that are under-recorded. Although the framework does not clarify how the indicators will be used to judge performance, it must avoid the risk of negative consequences such as exacerbating the under reporting and recording of adverse events and near-misses.

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

Yes, but it is limited largely to acute services. The measurement of safety in mental health services and primary care services, for example, also needs to be driven up as a lever for quality improvement.

The Agency for Healthcare Research and Quality (AHRQ) safety indicators also provide useful options for inclusion (Raleigh *et al* 2008) although, like many of the proposed indicators for this domain, they are subject to under-reporting.

The NHS patient and staff surveys include questions pertaining to safety that can usefully be included. Staff perspectives are especially pertinent in terms of feedback on the quality and safety of their working environment.

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?

By selecting some very specific indicators in each of the domains, there is a risk of disadvantaging those population groups/patients not covered by the indicators.

With the focus on outcomes and omission of, for example, access and waiting times, there is a real risk that inequities may not be addressed and could even worsen.

Promoting equality depends critically on (a) monitoring variations for different population sub-groups and areas, (b) having clear goals for what improvement looks like, and (c) having clarity about what interventions and performance management processes will drive equality. These issues are inadequately addressed in the framework currently.

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

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

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

See our main recommendations above.

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

- As discussed in our main recommendations, implicit in the outcomes framework is an assumption that the best way to account for and improve health outcomes is to emphasise the measurement of outcomes. Although the framework acknowledges that process measures will be needed locally to drive increased performance, we think the outcomes framework needs to include relevant process measures. For example, the NICE quality standards for stroke, VTE and dementia include many quality measures related to processes of care.

  Both outcome and process measures have advantages and disadvantages (Smith *et al* 2009, Davies 2005, Rubin *et a*l 2001, Mant 2001, Institute of Medicine 2006, Raleigh and Foot 2010), and a mix of both is recommended (Donabedian 1966). Many health outcome measures (other than perhaps measures of safety and patient experience) reflect the impact of health care and also wider determinants. Clinical outcome measures also reflect the impact of many factors in addition to the quality of health care, so appropriate risk adjustment is imperative for comparing outcomes meaningfully. The relationship between health care quality and health outcomes is not always direct, thus good health care processes (eg, in palliative care or care for people with disabilities) may not necessarily translate into improved outcomes, and vice versa, improving outcomes (eg, life expectancy) can conceal poor-quality care. Outcome measures are also subject to problems of lead-lag time effects– eg, current outcomes may reflect the prevalence of risk factors (eg, coronary heart disease mortality) or quality of care in the past (eg, cancer survival), and they exclude measurement of current interventions that could impact on future outcomes – eg, smoking cessation. Clinical outcomes are most appropriate for specialist secondary care services (eg, cardiac surgery mortality), where the association between intervention and outcome is more direct (Lester and Roland in Smith *et al* 2009).

  We also think it is unlikely that there will be statistically meaningful changes in many of the outcome measures to enable them to be used for the purposes of accountability. This is because outcomes are often low-probability events making change difficult to measure reliably, adding to problems of interpretation and attribution.

  A combination of process and outcome measures, as recommended by international experts (Smith *et al* 2009, Donabedian 1966, Arah 2006, Westert *et al* 2008, Leatherman and Sutherland 2008, Institute of Medicine 2001) would offer significant advantages, including stronger links to the evidence base for treating a condition, improved attribution of change in care quality to NHS care, a reduction in the requirements for (potentially complex) risk adjustment, and more statistically robust measures of improvement. Process measures also capture aspects of care that are valued by patients and may not be reflected in outcomes. Process measures also have the significant advantages that they measure contemporaneous performance and more directly reflect the quality of care.

  On this basis we would recommend strengthening the position of process measures to improve the NHS Commissioning board's accountability via the assessment framework and to reduce the risk of biases in measurement and implementation of the very kind that the framework expressly seeks to avoid.

- It will be important to ascertain which measures may be subject to external influences unrelated to the performance of commissioners or the quality of NHS care. For example, emergency bed days, admission and re-admission rates could reflect changing patterns of disease prevalence, configuration of services, changes in admission policies, etc.

- Both the relative costs of (including costs of development, implementation and collection) and the potential for improvement offered by any new data collections required by the framework (including patient surveys) should be reviewed in the round to inform decisions about new data collections. Such an assessment should form part of the forthcoming Information Strategy. There are many demands for new information (such as patient surveys), and for strengthening areas in which information is weak (such as general practice, community care). It is important that priorities are determined on the basis of a rigorous cost-benefit analysis.

- It is unclear what the unit of measurement is –ie, which/how many indicators are population based and which are, for example, for trusts or other providers? This is an important consideration for several reasons: it is relevant if the indicators are to be disaggregated, and it is important for clarity about how they will be applied through the system to the NHS commissioning framework and beyond.

ANNEX A: Identifying Potential Outcome Indicators

Potential indicators

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

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

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

Principles for selecting indicators

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

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