

## **White Paper "Equity and Excellence - Liberating the NHS" Scope, purpose and principles of an NHS Outcomes Framework**

### ***Response from Academy of Medical Royal Colleges***

#### ***Principles***

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

Yes - As noted below, it is strongly recommended that a principle of ensuring patient safety be added. In terms of the implementation of the framework, a question arises surrounding how this implementation will be carried through at a local level.

It is important to be alert to the dangers of unintended consequences. Whilst the Government has been clear that items included in the framework are not the only issues of importance, the NHS may have a tendency to behave as if the indicators explicitly set out nationally in the outcomes framework are the new targets to be followed at the expense of other areas. Avoiding this requires a cultural and psychological change beyond a simple statement of intent.

It is important that the framework is recognised as evolving and changing rather than providing all the answers at this time. Whilst the measures in the framework must be robust, it is important make a start with the framework rather than waiting for perfection.

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

As stated, it is strongly recommended that patient safety be included in the principles, if not a principle in its own right. It is important to reiterate that there will be issues, outside of the framework, that will need to be addressed.

Another area to be considered is efficiency/value for money. Little benefit at the cost of a great deal of clinical input is poor quality, inefficient care.

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

Without knowing exactly how the strategy will look, it is difficult to comment on the potential effectiveness of the NHS Outcomes Framework. However, there remains a need to focus on various public health items within the framework to support equitable outcomes and reduce health inequalities recognizing that public health outcomes make take longer to come to fruition and be difficult to measure. Outcomes focused on upstream prevention targeted at those in greatest need will be a great help in reducing inequalities. Also, thought is needed surrounding how this will be presented at a local level in determining changes to clinical processes.

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

Where services are silo'ed and an integrated approach is lacking, it is necessary to look at the work that has been done on clinical pathways involving quality indicators working across sectors (example - NICE and child health in Scotland, GIRFEC). It is also important to define those organisations/persons accountable and those responsible for

the delivery of process.

### ***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?**

Yes

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

While the topic of recovery from ill health is focused on, the addition of a sixth domain on the prevention of ill health or a clearer integration into the existing domains is needed.

Certain conditions span the breadth of these domains. If only one is used to accurately measure the outcome of said condition, it will not appropriately cover the pathway of care. As stated previously, the population issues of equity and efficiency are left unaddressed.

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

Caution must be taken to acknowledge areas of care that are difficult to measure and that often, in some areas (e.g. diagnostics), outcome measures are not possible at all. Also, transparency is necessary in outlining the methodology behind the quality standards. A danger exists in focusing on the more prevalent and costly conditions in lieu of holistic care management.

## **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?**

In a broad sense, the information that results from comparing large groups of population might be useful, however for individual hospitals the natural variability of chance plays a bigger role and will no doubt skew any meaningful measure of mortality at this level. The definition of amenable to healthcare needs to be clarified, as currently every clinical intervention could be justified, even when the chances of meaningful survival are low.

**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?**

Yes, however a comprehensive look needs to be taken at all conditions equally.

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

No, premature death in this case is related to those under 75, which is inaccurate. Up-to-date, gendered life expectancy data should be used as the marker. Also, an adjustment is need for years of life lost in childhood mortality.

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

Life expectancy may be a better indicator as looking only at under 75 does not accurately reflect current life expectancy predictions. Additionally, extending life often leads to further years of ill-health and disability. The focus should be kept on adding years of quality living.

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

Individual Colleges and Faculties may comment on specific outcome indicators as they see fit.

***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?**

Potentially including the provision of respite care and the ability to manage events or complications at home or in the community could be considered.

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

Individual Colleges and Faculties may wish to comment on specific outcome indicators as they see fit.

**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?**

Suggestions have included, child protection, length of stay and patient transfer, mental and social needs of patients, end of life care, patient and health worker communication, and vocational outcomes (missed work days, etc.).

***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?**

Individual Colleges and Faculties may comment on specific outcome indicators as they see fit.

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

It may be that recovery from ill health specialty specific measures may be more valuable than overarching composite outcome indicators in this case.

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

This does not seem to be a comprehensive methodology of collecting outcomes and does not address the overall quality of care in certain areas; it is quite focused on secondary care. Additionally, there are a number of other indicators that may be beneficial to include, these being, length of stay and reason for a longer stay, unplanned returns to urgent care and more specific specialty indicators.

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

Individual Colleges and Faculties may comment on specific outcome indicators as they

see fit.

***Domain 4 - Ensuring people have a positive experience of care***

We recognize that outcomes measurement in this area has not been fully developed.

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

Yes – However, coordination of cross-cutting care is difficult to measure and there are a number of specific patient experience areas that are not covered here. For example this takes no account of children's experience of care which is extremely underdeveloped with respect to adult experience of care methodologies.

**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 – With the acknowledgement that age specific questionnaires are required to account for obvious differences.

**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)?**

Yes

**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 – Although it is our opinion that in segregating into services or client groups you run the risk of the system becoming overly complex and patients that span multiple groups being improperly evaluated. These patient experience measures should be incorporated into condition Quality Standards.

**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 there is a need to put some thought behind age stratification; those patients who cannot make themselves heard and have poor access to care and overlapping pathways.

***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)?**

Incident reporting itself is not a sound method of capturing patient safety unless the system works more effectively than at present as near misses are rarely recorded and feedback is often ineffective. We would want to see how this is operated with the other two indicators as an overarching indicator.

Additionally, medical errors through poor prescribing and poor patient concordance with the prescribed therapy represent an important outcome indicator. This is amenable to training and enhanced patient doctor communication.

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

Yes – Again, there is a distinct secondary care focus

**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?**

It is vital to be alert to the fact that any measurement that is done may have unintended consequences and that there will be gaps in those patient groups that are covered under this framework. Subsequent documentation needs a more substantial focus on the acknowledgment of which measures are clearly attributable to those that are being measured and which areas/patient groups have been excluded based on the outcome measures chosen. In the case where evidenced based measures are not available expert opinion should be exercised to ensure the proper methodology and justification.

There is a need for patient involvement in the development and usage of indicators and the framework. For instance, many of the instruments that patients are being asked to use in outcomes measurement require a reasonably high level of literacy. Investigation into direct or pictorial approaches could prove beneficial.

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

We are unclear of the thrust of this question.

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

Yes – In many areas better quality and better productivity go hand-in-hand, however there are also areas where costs will increase. It is important to be aware of the inter-relationship between indicators and the possible resulting effect of achievement in one area on success in another.

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

The best value for money can be achieved through the collection of accurate and relevant data from which to derive actions, the proper testing of outcomes measurement and increased flexibility surrounding the framework, so as not to impact clinicians own priorities. There is the additional issue of how outcomes are identified and the compromise between information that is already available and that which requires new costs.

Additionally, increasing value for money could be achieved by making more effective use of prescribed therapies through avoidance of misuse of prescribed therapy and poor patient's concordance with prescribed instructions.

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

Definitions of responsibility and accountability would help in each domain. It is difficult to provide any further comment until it is known how this framework will be presented at a local level.

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

There would be benefit in looking at both undergraduate training and CPD in relation to practice and delivery of the professional groups that staff the NHS.

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

A pilot program for testing said indicators is an obvious course of action.

***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?**

These principles are sufficient, but require extension into the areas of public health and social care. Again, there is a need here to differentiate between those outcomes that can be directly related to these principles and those that are intermediate.

Additionally, it is vital that the need for measurable outcomes is emphasized and that pure experience measures, (e.g. quality of food, friendliness), whilst important, are not inappropriately conflated with clinical outcomes. This is not to negate the relevance of specific Patient Reported Outcome Measures.

There exists a need for a clear transparent process for deciding and including new indicators - and removing old ones.

Before the outcome measures are put into practice, there is a need for clarity as to their exact usage. Are these measures intended primarily to inform patient choice or for service improvement, or for both? Are all the measures appropriate for both purposes? When indicators are finalized the possibility of bringing together these measures into some form of a 'dashboard' should be explored.

Overall, while improving performance remains the central focus of these principles, it is important not to lose the quality of personal care in efforts to reach a certain level of performance.