The coalition Government’s white paper *Equity and Excellence – Liberating the NHS*, published in July 2010, sets out a radical vision for the NHS. It proposes a significant structural reorganisation, challenging the location of power and making the move from quasi-markets to full market mechanisms with limited system management. It also sets out major changes to the NHS architecture.

Overall, our members are firmly committed to working positively with the Government to ensure its ambitions for the NHS are achieved. They have significant knowledge and experience which they are ready to contribute to making the new system work.

**The NHS Confederation**

The NHS Confederation is the only independent membership body for the full range of organisations that make up today’s NHS. We represent over 95 per cent of NHS organisations as well as a growing number of independent healthcare providers. We have a number of networks which represent specific types of organisations within, or working for, the NHS, including foundation trusts, primary care trusts, ambulance trusts, mental health providers, and independent sector providers of NHS services through the NHS Partners Network. We also have a steering group working on behalf of our acute trust members.

**Response to the consultation**

In preparing this response to the *Transparency in outcomes – a framework for the NHS* consultation, the NHS Confederation has drawn on feedback from and discussions with our members across all parts of the NHS in England between July and September 2010, including representatives of both commissioners and providers of services.

While we welcome the general principle behind the shift to measuring the NHS through its outcomes, particularly those which relate to people achieving independence in terms of employment and education, we have some concerns about the practical implementation of this.

Below is a summary of our views, followed by more detailed answers to the consultation questions.
Overview
The NHS Confederation supports the shift to measuring the NHS through its outcomes, particularly those which relate to people achieving independence in terms of employment and education. However, we are concerned that the white paper substantially overestimates the extent to which there is a reliable method for measuring outcomes that will be useful to providers, commissioners and patients. It also underestimates the substantial cost of data collection and is over-optimistic about the extent to which this information will be available in time to be useful to patients, and about the evidence that patients currently use the information that is available.

Process measures
- We think it is important to be clear that process measures are not being abandoned. Some process measures are of great value because they allow adverse outcomes to be predicted and intervention to be made much earlier.

Three outcomes frameworks
- During our consultation with members they frequently raised the potential for confusion, duplication and other problems that could arise from the development of three separate outcomes frameworks.
- 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.

Outcome indicators
- We understand that the first publication of the NHS Outcomes Framework will, as a starting point, use existing outcome indicators for which data can be collected. This will mean that the NHS Outcomes Framework for 2011/12 may not necessarily meet all of the principles set out in the consultation.
- Once set, it will be for the NHS Commissioning Board to determine how best to deliver improvements against the selected outcomes by working with GP consortia and making use of the various tools and levers it will have at its disposal such as payment mechanisms, commissioning guidance and the commissioning outcomes framework for GP consortia. This is not under consultation at present.
- We believe that outcome indicators should be considered at the earliest possible stage in designing the NHS Outcomes Framework because the design of the framework will determine how effectively commissioners will be
able to use the outcome indicators produced. If the framework is designed in such a way that it is of limited use to commissioners, or that makes it difficult, in practice, to assess performance against outcome targets for contract management purposes, this will be a wasted opportunity.

**Purpose**

- We need clarity on what the proposed outcome framework is trying to achieve. There are multiple possible purposes:
  - holding commissioners and/or providers to account
  - providing information to patients to promote informed choice
  - promoting self-improvement for clinicians
  - measuring population-level improvements in health.

- These purposes are not interchangeable. They are each likely to have different content and presentation. Therefore, the objectives must be made clear in order to inform the design of the framework.

**Commissioners and providers**

- We are concerned that the use of the outcomes framework for commissioners and providers creates confusion between population-based outcome measures, which could be used to hold the NHS Commissioning Board (and potentially GP commissioning consortia) to account, and quality measures for provider services.

- For example, cancer mortality rates are a good outcomes measure at national level and could be used to hold the NHS Commissioning Board to account. The NHS Commissioning Board could potentially use localised cancer mortality rates to hold GP consortia to account by taking account of variations in underlying need/demography/deprivation. But GP commissioners cannot use cancer mortality rates as a quality indicator for individual NHS providers because it would be impossible to assess the respective responsibility of different providers along the care pathway.

- It is not clear how NICE national quality standards will be used. We understand that it will not be mandatory for GP consortia to adopt these standards. However, we believe that GP consortia should be expected to adopt national quality standards (and other national commissioning guidelines) unless they have good reason not to. Where they choose not to adopt these standards, they should be required to publish their rationale for this.
Q1. Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework? That is,
• 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

We support the principles-based approach to developing the NHS Outcomes Framework, especially as this is described as evolving over time. The principles will provide a good reference for what we agree are the key things to achieve.

Accountability and transparency
We agree with accountability for the full spectrum of the comprehensive healthcare service and with enhancing this by measuring outcomes that focus on what matters to service users – this might be service users who are patients and intermediate users such as GPs. There are good reasons for greater transparency and we agree with the move towards this. Health service literature on patient safety improvements shows that transparency helps organisations to make the cultural shift to openness and improvement, and we know that clinicians respond to benchmarked feedback on their own performance. We also believe that patient groups are likely to see transparency of information as a critical element for consumer choice, and we expect this will be considered under the Government’s forthcoming choice consultation.

Balanced
The exact meaning of the principle of ‘balanced’ in this context is not clear. We would like the NHS Outcomes Framework to take account of the whole NHS, even though different categories might have different weightings, and balance some short-term outcomes with longer-term ones. However, we would need a clearer definition of balanced before we could agree or disagree with it as a key principle.

Promoting excellence and equality
We are in favour of excellence as a key principle. We think the NHS Outcomes Framework consultation substantially overestimates the extent to which there is a reliable method for measuring equality of health outcomes, especially given the great number of factors that affect them. We believe the NHS could be held accountable for equality of access and use of health services proportionate to need but this might require indicators that measure processes in order to keep track of performance in this area.
Focused on outcomes that the NHS can influence but working in partnership with other public services where required

We suggest in our wider response to the white paper that the eventual three outcomes frameworks: NHS Outcomes Framework, Social Care Outcomes Framework and Public Health Outcomes Framework, should overlap in order to support greater integrated working. For instance, the NHS Outcomes Framework should incentivise GPs and local authorities to work together to reduce health inequalities and improve outcomes for both mental and physical health across the population.

We believe the Government should consider how the three outcomes frameworks could be used to hold a wider range of government departments, including the Department for Education and the Department for Work and Pensions, to account for better health. The Government would need to determine acceptable levels of accountability for each, while minimising any barriers to innovation, collaboration and partnership. It will not be easy to attribute the relative contributions of the NHS, public health and social care to outcome indicators but in order to facilitate funding decisions for the allocation and redesign of services a clear methodology is required.

Outcomes for public health should include qualitative as well as quantitative measures. Patient case histories of a suitable sample size could be used to create a methodology for attributing costs and benefits per patient from different parts of the system. Peer review could also be incorporated into the system to drive improvements.

Internationally comparable

While international comparison is a useful benchmark for NHS performance we believe that it is less important than the other key principles, particularly those focusing on what matters to patients and healthcare professionals.

There will be limits on what comparable data is available - the pitfalls and problems of comparison data and underlying factors in Europe are well documented - and it may not always reflect the most important quality improvement challenges for the NHS. We believe it would be more beneficial to focus on comparisons within the UK, where there is more uniformity in the quality of data collection and where differences are more easily detected.

Recognising the differences between outcomes in our own country, determining what contributes to the variation, and working out how this can be addressed would be a significant step to achieving equity nationally.

Q2. Are there any other principles which should be considered?

Our members suggest equity should be included in its own right as a key principle underpinning the NHS Outcomes Framework.
Q3. How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?
We are concerned that there are examples of NHS work, for instance mental health services, where robust data is limited and outcomes are very hard to define, frequently relying on the performance of partnerships. The outcomes framework should incentivise the NHS to improve public mental health and prevent mental illness across primary and secondary care. We believe the Mental Health Strategy, to be published later this year, should aim to address this issue, synthesising the outcomes for mental health providers. The NHS Confederation’s Mental Health Network will be working with its members and key partners to influence the strategy.

Q4: How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?
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.

Q5. Do you agree with the five outcome domains, that is
- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

Q6. Do they appropriately cover the range of healthcare outcomes the NHS is responsible for?
We agree with the domains listed and believe that they cover the components of quality important in any healthcare system. We believe it will be important to have room to adjust them as the NHS Outcomes Framework evolves.

Outcomes are currently about national measures and development still needs to be done at a local level with patients and healthcare professionals to achieve something meaningful at the front line. It will be necessary to retain a focus on the process and structures of care because this is fundamental to good governance and high quality care.

We are concerned that the proposals in the white paper could be interpreted as abandoning process measures altogether and we do not think this should be the case. Some process measures are of great value because they allow adverse outcomes to be predicted and intervention to be made much earlier.

We believe that the new structure of the NHS Outcomes Framework should allow for local commissioners to set process measures locally, where GP consortia and other commissioners feel these would help towards the high-level national outcomes.
The loss of national targets has mixed implications – clearly it removes the fixation and perverse outcomes of chasing set time-based targets. However, it would be a backwards step if progress in terms of offering patients timely access to care is reversed, and where this matters to patients we would expect this to be incorporated in the ‘positive experience of care’ outcome domain.

We can see how a framework of outcomes can help provider organisations gauge their performance and drive improvements across their organisations and supply chains but it is unclear how adequately outcomes can be measured to support commissioning, and this will be critical.

Q7. Does the proposed structure of the NHS Outcomes Framework under each domain seem sensible?

The current hierarchy seems sensible and reasonable.

Q8. Is ‘mortality amenable to healthcare’ an appropriate overarching outcome indicator to use for DOMAIN1: PREVENTING PEOPLE FROM DYING PREMATURELY?

‘Mortality amenable to healthcare’ is an appropriate outcome indicator but we would like to see it used alongside an outcome that focuses on the quality of life that is retained. This would need further exploration. We would also like the Government to consider how to measure ‘dying with dignity’ when death is inevitable.

Q9. Do you think this is an appropriate way to select improvement areas in this domain?

Q10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed?

Q11. If not, what would be a suitable outcome indicator to address this issue?

We feel that insufficient account is taken of avoidable mortality in older people in this proposal. It is here that other factors, such as social care and support, and access to healthcare, are vitally important and can contribute to poorer outcomes, including avoidable mortality.

‘Quality of life’ or ‘Independence’ should be explored as alternative outcome indicators to address mortality in older patients.

Q12. Are either of these appropriate areas of focus for mortality in children? Should anything else be considered?

These are considered appropriate.
DOMAIN 2: enhancing quality of life for people with long-term conditions

Q13. Are either of these appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?

Q14. 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?

Q15. 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?

These are considered appropriate.

We support the proposals to narrow the inequalities in all the outcome indicators, with an initial focus on selecting some improvement areas where there are known inequalities in outcomes compared with the whole population. This is especially true for people with serious mental illness, and a focus on this would be welcomed.

The roles and interactions between the various parts of the service that have a significant affect on patients with mental health and long-term conditions should be considered as well. For example, primary and community care, GP and social care interventions.

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

Q16. Are these appropriate overarching outcome indicators for this domain? Are there any other indicators that should be considered?

Q17. What overarching outcome indicators could be developed for this domain in the longer term?

Q18. Is this a suitable approach for selecting some improvement areas for this domain? Would another method be more appropriate?

Q19. What might suitable outcome indicators be in these areas? Although patient-reported outcome measures (PROMs) and relayed experiences are useful, they are dependent on patient outlook and expectations, and should be balanced with other measures of the quality and success of an intervention.

Samples need to be large enough for valid judgements about outcomes to be made. This means a reasonable number of cases for each procedure and each surgeon will be needed. Inputs – the casemix of people seeing different consultants or teams – will also need to be the same. If one team specialises in difficult cases, their outcomes will be different to those handling easier cases and this will need to be
taken into account. The burden of work expected of patients participating and completing surveys in this scenario should not be discounted.

One longer term outcome indicator that could be developed might be ‘Unexpected complications following treatment’ and/or ‘Return to work or previous activities’ might also be considered. Mental health and public health organisations and professionals particularly welcome the opportunity to develop whole life outcomes, which could be supported and underpinned by the principles of recovery like stable housing, employment etc. Such outcomes would include being supported to retain or gain employment, or live independently, and educational gains for young people.

**DOMAIN 4: ENSURING PEOPLE HAVE A POSITIVE EXPERIENCE OF CARE**

Q20. Do you agree with the proposed interim option for an overarching outcome indicator?

Q21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator?

Q22. Do you agree with the proposed improvement areas and the reasons for choosing these areas?

Q23. Would there be benefit in developing dedicated patient experience Quality Standards for certain services or client groups? If yes, which areas should be considered?

Q24. Do you agree with the proposed future approach for this domain?

We agree with the four underlying principles about the necessity to have the systematic and validated collection of patient experience as part of the NHS Outcomes Framework. We understand that there is a lot of material under development in this area and, therefore, a need for an immediate interim approach and long term strategy.

We would welcome a focus on measuring the experiences of people who use mental health services. It might be more beneficial to focus on the experience of care pathways, as well as specific services.

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

Q25. Do you agree with the proposed overarching outcome indicator?

Q26. Do you agree with the proposed improvement areas and the reasons for choosing these areas?

We are supportive of a high reporting culture in healthcare organisations. However, our members tell us that the number of incidents reported is dependent on a number
of sometimes uncontrollable factors, such as organisational culture and bullying, and therefore may not be a reliable indicator. They suggest that mandatory reporting, and publication of “never events” might be a more reliable indicator.
4 NEXT STEPS – HOW CAN YOU BE INVOLVED?

Q27. 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?

Q28. Is there any way in which the proposed approach to the NHS Outcomes Framework might impact upon sustainable development?

Q29. Is the approach to assessing the likely impacts of potential outcomes and indicators set out in the Impact Assessment appropriate?

Q30. How can the NHS Outcomes Framework best support the NHS to deliver best value for money?

Q31. Is there any other issues you feel have been missed on which you would like to express a view?

It is important that the NHS plays its part in promoting equality of opportunity and outcomes. When the reasons and extenuating factors for poor outcomes lie outside of healthcare and health services, there should be support to make NHS interventions in concert with the other groups working for overall improvement.

During our consultation with members, they frequently raised the potential for confusion, duplication and other problems that could arise from the development of three separate outcomes frameworks. 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.

A quality service that is developed without sustainability in mind is a poor use of public money. Use of resources must be managed and monitored in a way that builds, rather than undermines, operative resilience for the future delivery of high-quality healthcare. Some representation of this should be made as part of the cross-governmental approach to outcome measurement and developing sustainable development metrics. In the broadest sense this is about best value for money.

The NHS Outcomes Framework should ensure that the development of indicators is research and evidence-based and that the Quality Standards are realistic and achievable. Alongside this, other measures that can impact on health, such as social circumstances, should be identified and taken into account and expectations should also be considered when developing standards and services.

Prevention outcomes that incentivise GP commissioning consortia to play a greater role in public health should be considered. Such domains may address deaths amenable to primary prevention, as well as avoidable hospital admissions.
ANNEX A POSSIBLE OUTCOME INDICATORS

Q32. What are the strengths and weaknesses of any of the potential outcome indicators listed below with which you are familiar?

Q33. Are other practical and valid outcome indicators available which would better support the five domains?

Q34. How might we estimate and attribute the relative contributions of the NHS, public health and social care to these potential outcome indicators?

Q35. Are these appropriate principles on which to select outcome indicators? Should any other principles be considered?

We see that the processes needed to achieve each outcome are broadly (1) collecting data for construction of the outcome indicator and (2) making the necessary changes (if we know the key drivers for improvement) to achieve outcome improvement over time. There is, however, a significant risk that we will not know what actions are needed to influence any given outcome. Sufficient evidence will be needed before the NHS should be expected to accept new areas of the NHS Outcomes Framework.

It is unclear whether the current method for producing NICE quality standards makes the connection between process interventions and expected outcome changes to assist the overall improvement journey.

We believe that the proposals currently underestimate the substantial cost of data collection, particularly if it needs to allow for the appropriate risk adjustment of outcomes that will be necessary if these data are to be clinically credible. There is a gap between what is available now and what is likely to be needed to realise the outcomes framework vision and it is hard to see how it will not increase bureaucracy. On the other hand, we want to ensure that the NHS Outcomes Framework does not focus disproportionately on those areas where it is easiest to develop measures.

The current PROMS programme requires significant patient effort and this time and energy cannot be discounted in decisions on wider use. We are not convinced that the PROMS-type tool can be streamlined and simplified without compromising its validity.

Ideally, outcomes should be designed so that it is possible for commissioners to use them as part of contracting for services and to hold providers to account where outcomes are not sufficiently good. We would urge the DH to share its thoughts about how to commission for outcomes using the NHS Outcomes Framework.

Finally, the proposals are overoptimistic about the extent to which information will be available in time to be useful. The view that this is simply a problem of poor presentation and accessibility is not supported by the evidence in this area. In
designing the system, the Government will need to be careful not to burden frontline staff and patients with additional data collection that would work against the objectives of reducing bureaucracy and minimising management costs.
The NHS Confederation
The NHS Confederation is the only independent membership body for the full range of organisations that make up today’s NHS.

We represent over 95% of NHS organisations as well as a growing number of independent healthcare providers.

Our ambition is a health system that delivers first-class services and improved health for all. We work with our members to ensure that we are an independent driving force for positive change by:

- influencing policy, implementation and the public debate
- supporting leaders through networking, sharing information and learning
- promoting excellence in employment.

All of our work is underpinned by our core values:
- ensuring we are member driven
- putting patients and the public first
- providing independent challenge
- creating dialogue and consensus.

The NHS Confederation
29 Bressenden Place
London SW1E 5DD
Tel 020 7074 3200
Fax 0844 774 4319
Email whitepaper@nhsconfed.org
www.nhsconfed.org/healthwhitepaper