

Setting Levels of Ambition for the NHS Outcomes Framework

A technical annex to support *Developing our
NHS care objectives: A consultation on the draft
mandate to the NHS Commissioning Board.*

Chapter 1: Executive summary

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Executive summary

- 1.1. This executive summary outlines the background and policy context to this technical annex as well as explaining its purpose.
- 1.2. *Developing our NHS care objectives: A consultation on the draft mandate* explains that the Government will hold the NHS Commissioning Board to account for delivering improvements in health outcomes. It will use the NHS Outcomes Framework as the basis for doing this, setting five broad outcome goals ('levels of ambition') for the Board to achieve. The Secretary of State will also set an objective to ensure continuous improvement of health outcomes, as measured by the individual indicators in the NHS Outcomes Framework. The draft mandate also proposes objectives to tackle health inequalities.
- 1.3. This technical annex provides more information on the NHS Outcomes Framework and the preparatory work underway for setting levels of ambition. The levels of ambition themselves will be included in the first mandate.
- 1.4. The purpose of this technical annex is to explain the proposed methodology for deriving levels of ambition, to present available data on the NHS Outcomes Framework indicators and to outline the assumptions that are being made in projecting future health outcomes expected from current NHS practice. It provides a partial assessment of the scope for improvement in NHS contributions to outcomes that will inform the setting of levels of ambition to achieve outcomes in excess of those projections.
- 1.5. As the consultation document explains, moving to measuring more health outcomes (such as reductions in mortality) rather than largely focusing on process measures (such as waiting times) is a radical shift in how NHS performance is measured. There are time lags involved both in determining the most appropriate measures and in gathering data. Therefore, it will take time to develop a full set of measures. A further challenge is to develop a greater understanding of the causes of improvements in outcomes, and to what extent they are attributable to the NHS, and over what timeframe.
- 1.6. This technical annex is a first step in a long term programme and is consequently presented as a 'work in progress'. For some of the 60 indicators in the NHS Outcomes Framework there are no data. For many more there are limited historic data. Therefore, this work is a starting point that will be developed and refined in the coming months and years.
- 1.7. For these reasons, the Department of Health considers it important to set out its assumptions transparently as it moves towards measuring outcomes.

Policy context: The NHS Outcomes Framework

- 1.8. The White Paper, *Equity and Excellence: Liberating the NHS*¹ explained how the improvement of healthcare outcomes for all should be the primary purpose of the NHS. This means ensuring that the accountabilities running throughout the system are focussed on the outcomes achieved for patients not the processes by which they are achieved.
- 1.9. The NHS Outcomes Framework 2011/12, published in December 2010, reflects the vision set out in the White Paper. The NHS Outcomes Framework is a set of national outcomes goals and supporting indicators. Its purpose is threefold:
- to provide a national level overview of how well the NHS is performing, wherever possible in a national context;
 - to provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board for the effective spend of some £80bn of public money; and
 - to act as a catalyst for driving quality throughout the system by encouraging a change in culture and behaviour.
- 1.10. The Framework, which has already been subject to extensive consultation, is structured around five “domains”, each intended to reflect a core aim of what the NHS should be doing. The domains were chosen to reflect the three elements of good quality care: effectiveness, patient experience and safety.

Domain 1	Preventing people from dying prematurely	Effectiveness
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill health or following injury	
Domain 4	Ensuring people have a positive experience of care	Patient experience
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	Safety

- 1.11. Appendix 1 provides an ‘at a glance’ version of the full framework

¹ Available at : http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

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- 1.12. The NHS Outcomes Framework will operate at a national level. The NHS Commissioning Board will develop a Commissioning Outcomes Framework which will, where appropriate, translate the NHS Outcomes Framework into indicators that are meaningful at a commissioning group level. The Commissioning Outcomes Framework will act as a mechanism for the NHS Commissioning Board to drive improvement and also to hold Clinical Commissioning Groups to account.
- 1.13. The NHS Outcomes Framework sits alongside similar outcomes frameworks for public health and adult social care. Assessment and mitigation of inequalities are integral to the frameworks.

Setting levels of ambition

- 1.14. As explained in the consultation document on the draft mandate, the Government intends to set the NHS Commissioning Board one broad 'level of ambition' for each of the five domains of the NHS Outcomes Framework. Setting ambitions at a domain level has several advantages, namely:
- This focuses attention, in a transparent way, on the ultimate outcomes of care that matter to patients and professionals: extending and improving lives, enhancing patients' experience, reducing harm.
 - It gives commissioners freedom to decide how to improve quality and outcomes in ways that are most important for their local populations. Setting prescriptive objectives for individual indicators would reduce local autonomy and risk distorting clinical priorities.
 - Healthcare is challenged by the rise in the number of people living with multiple long-term conditions. Increasingly, many people have complex needs, with more than one condition at once. Therefore, it is better for the mandate to take a holistic approach that looks at quality of life and quality of care as a whole, rather than focusing primarily on the treatment of individual clinical conditions.
- 1.15. Although these advantages exist, setting credible levels of ambition at a domain level is technically challenging. The level of ambition needs to be sufficiently broad to capture individual outcome areas covered by a particular domain. In the current economic climate, it is especially important that all of the ambitions set can be achieved within the NHS's financial envelope.
- 1.16. The Government's intention is to develop levels of ambition in time for the first Mandate to the Board, which are stretching but realistic. It intends to set these for 2, 5 and 10 years. The next section summarises the proposed methodology for doing this, which is subject to further development and refinement between now and the autumn, and for subsequent mandates.

Summary of methodology

- 1.17. In order to set a level of ambition for each of the five domains of the NHS Outcomes Framework, the intention is to follow a number of steps as outlined in figure 1 and explained below. It will be important to consider equality implications and how health inequalities can be tackled throughout the application of this methodology.

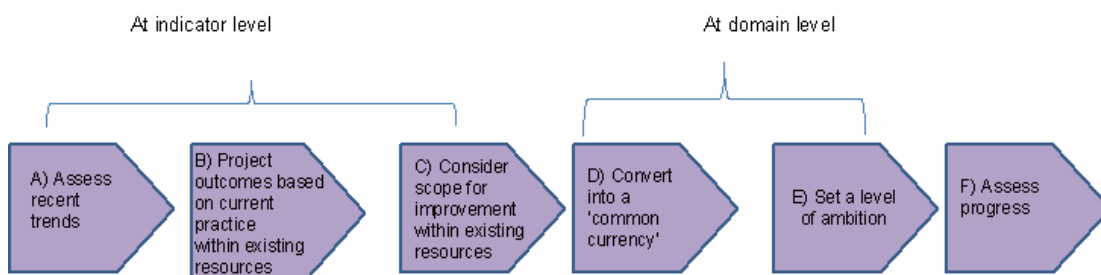


Figure 1: Steps to set level of ambition

A) Look at recent trends in outcomes (where known) for each indicator of the framework

- 1.18. For each indicator we review recent trends in outcomes, based on available data. Outcomes can be affected by many different factors, often acting in combination. In this document we refer to these factors as 'drivers'. In some cases these drivers are within the NHS's control. For example, providing treatment for illnesses; or providing advice to patients on how best to manage a long term condition such as asthma to prevent emergency admissions. In other cases, improvements or deterioration in trends are the result of much wider causes. These can be public health factors, for example, historic smoking rates, social determinants including socioeconomic factors such as deprivation; or demographic factors, such as an increasing prevalence of co-morbidities in an ageing population.
- 1.19. Where data are available, these have been disaggregated to show differences for example by age and gender. For many indicators this is not yet possible. However, more data will be available over time and it is an important function of the NHS Outcomes Framework to play its part in promoting equality and tackling health inequalities. Indicators are also presented to show differences by geography, again where data is available. This highlights regional variation – for example, the North West has higher mortality rates for liver disease, respiratory disease and cardiovascular disease than other regions.

- 1.20. It is important to note that variation in outcomes does not necessarily mean poorer health services are being provided. Variation can exist for a number of complex reasons. Nevertheless publishing such data can shine a light on areas of unwarranted variation – and increase the focus that local health economies place on tackling local challenges.

Illustrative example

We review trends on under 75 mortality from cancer, noting that there are a number of drivers including factors that the NHS can influence – such as earlier and more accurate diagnosis and providing appropriate treatment and support to patients. Other drivers include historic shifts in tobacco and alcohol consumption, and diet. Disaggregated data are presented to show mortality by age, gender and trends by region.

B) develop projections of what might happen based on the current quality of NHS practice

- 1.21. After considering the trends, we then estimate what might happen to each indicator in the next few years, holding constant the quality of NHS care. This estimate (which we term a ‘current practice projection’) is based on what has been happening to the drivers that affect the outcome, as well as an assumption that the NHS continues to provide the current quality of care within the current resource envelope. The NHS already has a challenging commitment to deliver up to £20bn of efficiency savings by 2014/15.
- 1.22. The default assumption is a flat projection – outcomes only change if there is a driver to make them change. In Domains 3-5 our assessment so far is that non NHS factors are unlikely to have significant impact on the outcomes. In these Domains, outcomes are largely determined by the quality of NHS care – so it is appropriate for a current practice projection to be flat.
- 1.23. Where data shows a trend (which is true of most of the indicators in Domain 1) and sufficient data is available, we model the different contribution of non-NHS effects, and project on the basis of those effects, holding the NHS contribution constant. Where data is insufficient for such modelling, a judgment is required as to whether the non-NHS drivers of any detected trend are likely to be sustained – in which case the recent trend is projected forward. However, where there is evidence of long-term improvement in the quality of services and this can be attributed to continuous incremental gains in effectiveness then this should be projected.

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- 1.24. Domain 2 presents a particular challenge: outcomes for people affected by long term conditions are affected by both NHS and non-NHS factors, and by stage and severity of condition, that are not well captured by available data. Here again, provisionally, what data there is suggests a flat projection – but more work is being commissioned to gain a better understanding of whether this is appropriate.
- 1.25. For some projections, we identify uncertainty intervals, but more work is necessary on sensitivity analyses to identify possible systematic biases in these projections.
- 1.26. The current practice projections are important both for setting the benchmark for assessing NHS contributions to overall domain outcomes and for understanding if outcomes for each indicator are meeting the objective of continuous improvement.
- 1.27. The commitment for improvement for each indicator is interpreted differently depending upon whether the current practice trend is improving or flat, or whether it is getting worse. Where it is improving or flat, improvement is reckoned relative to the outcome in 2012/13; where it is getting worse, improvement is reckoned relative to the projected trend. This interpretation preserves maximises flexibility for the NHS in meeting domain level ambitions whilst providing broad assurance that outcomes across the whole framework improve, recognising that it may not be possible to reverse a worsening trend.

Illustrative example

We project that under 75 mortality from cancer will continue to decline – ie an improving trend. The projection seeks to take account of some effects, such as the 5 year period in which people were born, which is likely to improve overall health outcomes even without further improvement in the quality of NHS care, probably because cohorts born more recently have smoked less.

C) consider if there is any scope for improvement, within financial resources

- 1.28. The next step aims to consider what scope there is for the NHS to improve outcomes against individual indicators, within the current resource envelope. This involves the NHS improving outcomes beyond the ‘current practice projection’. This document provides a partial assessment of what these scopes for improvement could be, in some case with some more or less tentative quantification, together with a provisional list of areas in which scope for improvement will be investigated over the summer.

Illustrative example

The Department of Health’s Cancer Outcomes Strategy promotes a number of interventions, including improved radiotherapy, screening and earlier diagnosis. We therefore consider these areas as scope for reducing cancer mortality.

D) convert those areas where we think there could be affordable improvement, into a 'common currency'

- 1.29. These 'scope for improvement' assessments can be converted into a common currency appropriate for each domain – such as life years (Domain 1), or quality-adjusted life years (Domains 2,3,5). This document provides some examples of what these scope for improvement could look like and our assumptions about converting into common currencies.

Illustrative example

Possible reductions in cancer mortality are converted into life years that could be saved.

E) Set a level of ambition in the common currency

- 1.30. We aim to base this upon the assessed scope for improvement of particular indicators in that domain, complemented by an overall judgement about the stretch that may be possible for the Domain. The overall judgment should take into account factors including: management capacity to bring about change over a shorter or longer time period; affordability, the scope for allocative efficiency; top-down assessment of outcomes relative to international comparators (where available); and scope for reducing variation in outcome at the Domain level.

F) Assessment of progress

- 1.31. Performance against the level of ambition will be assessed by considering the performance in the individual indicators against the current practice projections, and by aggregating this performance relative to projections to assess whether domain levels of ambition have been achieved. This assessment should be able to distinguish what has been reasonably achieved as a result of the NHS's efforts rather than other factors, but to do so it will be necessary to review the assumptions and modelling undertaken at step B above, in light of new evidence and improved modelling. We think this retrospective attribution will be easier to do having set out an assessment of the drivers of the indicator in advance.
- 1.32. There will also be a retrospective assessment of whether the obligation for continuous improvement for each indicator has been met.
- 1.33. As the consultation document about the draft mandate explains, the NHS Outcomes Framework forms part of a broader process of holding the Board to account. We envisage that whilst there will be ongoing conversations about performance against the indicators, as well as other objectives that the Board is charged with delivering.
- 1.34. We will need to update the current practice projections and underpinning assumptions on an annual basis to take account of emerging trends and new evidence in advance of the annual review of the mandate.

Other considerations – ensuring the level of ambition represents the domain

- 1.35. We want to set levels of ambition that represent each domain of the NHS Outcomes Framework. The above summary outlines how we will ideally set levels of ambition, considering issues at the level of the individual indicator and building up a picture. In principle, if we follow the above steps, we should produce a level of ambition that reflects the aim of the full domain.
- 1.36. However, each domain is at a particular stage of development and our understanding varies. For example, it will be important that a level of ambition for preventing premature mortality reflects what the NHS can do overall, within available resources, not just what it may be able to do in those areas such as cancer where an outcomes strategy has already been developed, and where data sources are rich. Similarly, for domain 3, some of the indicators are still in development. For domain 5 it is important to develop measures that more adequately indicate the overall level of avoidable harm. We will need to ensure that the level of ambition reflects what the domain is intended to achieve.
- 1.37. Therefore we expect that we may need to be pragmatic, particularly in the short term. A question that we are considering is whether we should set levels of ambition that are based on :
- quantified scope for improvement at individual indicator level (recognising that this may be based on a small number of indicators); or
 - if we make some broader assumptions about what might be feasible across a whole domain.

Structure of the technical annex and a note on content

- 1.38. This document is structured as follows:
- **Chapter 2** Proposed methodology for setting levels of ambition. This document provides an overview of the proposed methodology
 - **Chapters 3-7** These sections of the current document review trends, propose current practice projections, and partial assessments of scope for improvement. They are structured by each domain of the NHS Outcomes Framework and take each indicator in turn, where data are available. With further work over the summer, the final version of the mandate will include levels of ambition.
 - **Chapter 8** Drivers of outcomes. This section reviews trends in key factors such as smoking which have a bearing on many health outcomes.

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1.39. This material is presented as analytical work in progress. It is being published in the interests of transparency. We have tried to ensure that as far as possible, it is factually accurate. It should be noted that in some cases findings from literature are referred to, for example, in order to illustrate possible factors which are affecting outcomes. These references are not intended to be a guide to clinical practice and should not be taken as official endorsement by the Department of Health.

Link between this technical annex and the consultation on the draft mandate

1.40. This document supports but is not a formal part of the consultation on the draft mandate. It has been produced to provide more information on how the Department plans to set levels of ambition, which will form the outcomes objectives included in the mandate. It is a partial assessment based on data and analysis conducted to 22 June 2012.

1.41. Over the summer, we will be undertaking further work with the NHS Outcomes Framework Technical Advisory Group which has recently been established. We will also be conducting further analysis as data becomes available over the summer.

1.42. The consultation on the draft mandate asks three broad questions in relation to outcomes objectives:

- Do you agree that the mandate should be based around the five Domains of the NHS Outcomes Framework, and therefore avoid setting separate objectives for individual clinical conditions?
- Is this the right way to set objectives for improving outcomes and tackling health inequalities?
- How could our approach develop in future mandates?

1.43. In order to support these overarching questions, if readers of this technical annex would like to make comments, we would especially welcome views on:

- the assumptions and methodology we have employed in setting current practice projections, including implicit and explicit attribution of outcomes to specific drivers
- scope to improve NHS contributions to outcomes in particular areas including those listed, drawing attention to cost effective and evidence based practice? (Referenced work would be particularly helpful.)

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- 1.44. We would welcome early comments, to enable us to update work in the autumn. However, the development of the methodology and accompanying analysis will take place over a number of months and years. Therefore, any comments that cannot be taken into account as part of the first mandate will be considered to inform future work.
- 1.45. Please send any comments to nhsoutcomesframework@dh.gsi.gov.uk

1 Preventing people from dying prematurely

Overarching indicators

- 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
1b Life expectancy at 75 i males ii females

Improvement areas

Reducing premature mortality from the major causes of death

- 1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
Cancer
1.4 i One-and ii five-year survival from colorectal cancer
iii One-and iv five-year survival from breast cancer
v One-and vi five-year survival from lung cancer
vii under 75 mortality rate from cancer*

Reducing premature death in people with serious mental illness

- 1.5 Excess under 75 mortality rate in adults with serious mental illness*

Reducing deaths in babies and young children

- 1.6.i Infant mortality* ii Neonatal mortality and stillbirths

Reducing premature death in people with learning disabilities

- 1.7 An indicator needs to be developed

One framework

defining how the NHS will be accountable for outcomes

Five domains

articulating the responsibilities of the NHS

Twelve overarching indicators

covering the broad aims of each domain

Twenty-seven improvement areas

looking in more detail at key areas within each domain

Sixty indicators in total

measuring overarching and improvement area outcomes

The NHS Outcomes Framework 2012/13 at a glance

*Shared responsibility with the public health system and Public Health England and local authorities - subject to final publication of the Public Health Outcomes Framework.

** A complementary indicator is included in the Adult Social Care Outcomes Framework

***Indicator replicated in the Adult Social Care Outcomes Framework

Indicators in italics are placeholders, pending development or identification of a suitable indicator.

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

Overarching indicator

- 2 Health-related quality of life for people with long-term conditions**

Improvement areas

Ensuring people feel supported to manage their condition

- 2.1 Proportion of people feeling supported to manage their condition**

Improving functional ability in people with long-term conditions

- 2.2 Employment of people with long-term conditions*

Reducing time spent in hospital by people with long-term conditions

- 2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers

- 2.4 Health-related quality of life for carers**

Enhancing quality of life for people with mental illness

- 2.5 Employment of people with mental illness **

Enhancing quality of life for people with dementia

- 2.6 An indicator needs to be developed

4 Ensuring that people have a positive experience of care

Overarching indicators

- 4a Patient experience of primary care
i GP services ii GP Out of Hours services iii NHS Dental Services
4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care

- 4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs

- 4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services

- 4.3 Patient experience of A&E services

Improving access to primary care services

- 4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services

- 4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives

- 4.6 An indicator to be derived from the survey of bereaved carers

Improving experience of healthcare for people with mental illness

- 4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare

- 4.8 An indicator to be derived from a Children's Patient Experience Questionnaire

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

Overarching indicators

- 3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital

Improvement areas

Improving outcomes from planned procedures

- 3.1 Patient Reported Outcomes Measures (PROMs) for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia
iv Varicose veins

Preventing lower respiratory tract infections (LRTI) in children from becoming serious

- 3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma

- 3.3 An indicator needs to be developed.

Improving recovery from stroke

- 3.4 An indicator to be derived based on the proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

Improving recovery from fragility fractures

- 3.5 The proportion of patients recovering to their previous levels of mobility / walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury

- 3.6 Proportion of older people (65 and over) who were i still at home 91 days after discharge into rehabilitation*** ii offered rehabilitation following discharge from acute or community hospital ***

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

Overarching indicators

- 5a Patient safety incidents reported
5b safety incidents involving severe harm or death

Improvement areas

Reducing the incidence of avoidable harm

- 5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI) i MRSA ii C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services

- 5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings

- 5.6 Incidence of harm to children due to 'failure to monitor'