The NHS Outcomes Framework 2011/12

Department of Health

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning/Performance Clinical	Estates Commissioning IM & T Finance Social Care/Partnership Working
Document purpose	Policy
Gateway reference	15264
Title	The NHS Outcomes Framework 2011/12
Author	Department of Health
Publication date	20 Dec 2010
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of Nursing, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Allied Health Professionals, GPs
Circulation list	Directors of PH, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads
Description	The outcomes and indicators which make up the first NHS Outcomes Framework, following the consultation *Transparency in outcomes – a framework for the NHS*
Cross ref	*Transparency in outcomes – a framework for the NHS. Government response to the consultation*
Superseded docs	NA
Action required	NA
Timing	NA
Contact details	Quality and Outcomes Policy Department of Health Skipton House 80 London Road London SE1 6LH
For recipient's use	

Contents

Chapter 1 How will the NHS Outcomes Framework operate?

1.1 *Liberating the NHS*[1] set out a vision of an NHS that achieves health outcomes that are among the best in the world. To achieve this, it outlined two major shifts:

- a move away from centrally driven process targets which get in the way of patient care; and

- a relentless focus on delivering the outcomes that matter most to people.

1.2 The Government's plans for reform across the NHS, public health and adult social care are designed to enable services to deliver those improved outcomes. The cornerstone will be a framework of accountability that focuses squarely on how well services are improving outcomes for people. For the NHS, this begins with accountability at a national level focused on health outcomes.

1.3 The July White Paper explained that an NHS Outcomes Framework would be developed to provide that national level accountability for the outcomes that the NHS delivers. Its purpose is threefold:

- to provide a national level overview of how well the NHS is performing, wherever possible in an international context;

- to provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board; and

- to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a renewed focus on tackling inequalities in outcomes.

1.4 This document sets out the first NHS Outcomes Framework. It builds on the proposals published for consultation in *Transparency in outcomes – a framework for the NHS*[2] and the responses received to that consultation. The Department of Health ran a full public consultation between 19 July and 11 October 2010, receiving 773 responses in writing and capturing the views of interested parties at numerous engagement events, workshops and conferences across the country. A full government response to that consultation has been published alongside this document.[3]

[1] Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624
[2] Available at: www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117583
[3] Available at: www.dh.gov.uk/

1.5 Once the NHS Commissioning Board is formally in place, subject to parliamentary approval, the NHS Outcomes Framework will form part of the broader mandate that the Secretary of State for Health sets the Board. Once agreed, any levels of ambition attached to the indicators in the framework will also form part of the mandate.

Levels of ambition

1.6 This first NHS Outcomes Framework sets out the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board to account for the outcomes it secures through its oversight of the commissioning of health services from 2012/13. The indicators used to hold NHS organisations to account during 2011/12 were set out in *The Operating Framework for the NHS in England in 2011/12* which provided the financial, business and planning rules that support the delivery of NHS priorities.[4]

1.7 The purpose of the NHS Outcomes Framework will evolve over the next two years as the new NHS architecture emerges:

- **For 2011/12**, levels of ambition have not been attached to the indicators and the NHS will not be held to account for progress against these. Rather, the framework is intended to set the direction of travel, with the transition year ahead offering an opportunity for the NHS to begin to think through what an NHS focused on outcomes will mean for individuals, organisations and whole health economies.

- **During 2011/12**, we will work to refine the indicators in the framework and finalise precise definitions where necessary. Where data is available, 2011/12 will be used to identify baselines. This year will also be used to negotiate levels of ambition with the shadow NHS Commissioning Board, in light of the NHS settlement following the 2010 Spending Review.

- **In 2012/13**, the framework will be used by the Secretary of State for Health to hold the NHS Commissioning Board to account and for achieving levels of ambition where they have been agreed.

1.8 It is too early to set out a detailed process for negotiating levels of ambition, or confirm exactly what forms the levels will take, given that the NHS Commissioning Board does not yet exist. However, there are two elements which can be made clear. First, levels will be ambitious yet feasible and affordable. Where indicators are included which can be compared internationally, levels of ambition will work towards the goal of achieving outcomes which are among the best in the world.

[4] Available at: www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Planningframework/index.htm

Similarly, where improvement has been delivered in an outcome over recent years, levels of ambition will seek to increase the rate of improvement where that is a realistic proposition.

1.9 Second, the Secretary of State for Health and the NHS Commissioning Board will use a set of principles to underpin the negotiations about what the levels and pace of delivery should be. Levels of ambition should take into account:

- the current trajectory of each indicator as the baseline;
- the extent to which variations are attributable to NHS actions;
- the cost-effectiveness of the required improvements;
- the timeliness of the impact of NHS actions on healthcare outcomes;
- achievability and affordability as a whole – the required improvements should be consistent overall with the NHS funding envelope;
- the variation and inequalities in health outcome indicators, taking account of equalities characteristics, disadvantage and where people live; and
- any potential impact on behaviour and incentives.

Reducing health inequalities and promoting equality

1.10 Tackling health inequalities and promoting equality is central if the NHS is to deliver health outcomes that are among the best in the world. The social gradient in many health outcomes for people in disadvantaged groups and areas is a major driver of England's poor health outcomes in comparison to other similar countries.[5] For example, although infant mortality rates in England have fallen by almost two-thirds since 1978, we have the highest infant mortality rate in the EU15 and there is a 70% difference between the richest and poorest groups.[6]

1.11 Therefore, one of the underpinning principles when developing this framework has been the need to promote equality and reduce inequalities in health outcomes. As explained above, levels of ambition will take into account the variation and inequalities in outcome indicators, such as equalities characteristics,

[5] Marmot, M. (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010*, available at: www.marmotreview.org; QIPP/Right Care (2010). *The NHS Atlas of Variation in Healthcare*, available at: www.rightcare.nhs.uk/atlas/
[6] Equality and Human Rights Commission (2010) *How fair is Britain? Equality, Human Rights and Good Relations in 2010. The First Triennial Review*

disadvantage and where people live, where it is possible to do so. The framework will help the NHS Commissioning Board play its full part in promoting equality in line with the Equality Act 2010.

1.12 In selecting outcomes and determining how they should be measured, active consideration has been given to how the indicators can be analysed by equalities and inequalities dimensions to support NHS action on reducing health inequalities. In addition to the legally protected characteristics (age, ethnicity, religion or belief, gender, disability and sexual orientation), particular consideration has been given to socio-economic groups and area deprivation as these are key drivers of poor health outcomes.

1.13 Current data collections are limited in the extent to which this is possible, as **Annex A** demonstrates. Over time, we will work to improve data collections so that more indicators can be disaggregated in this way.

1.14 We recognise that there are certain groups or areas which the framework may not effectively capture at present, simply because the data and data collections available do not allow outcomes for these groups to be identified. One such group is people with a disability and particularly those with a learning disability. As we refine the framework and improve the data collection architecture, we will look to improve coverage of these groups and ensure that we are able to measure progress in improving their health outcomes.

Updating and reviewing the framework

Annually updating the framework

1.15 Measuring outcomes is not an exact science, and the NHS is relatively inexperienced at measuring progress from this perspective. Therefore, the NHS Outcomes Framework will be refined on an annual basis to make sure that the outcomes that matter most to patients are included and that the indicators being used best capture those outcomes. We recognise that, in order to measure progress over time, continuity of the indicators used in the framework is important, and so we envisage that only a small number of indicators will change or be refined in any one year.

1.16 **Annex B** explains the state of readiness of each of the outcomes and indicators in the framework. Twelve of the indicators have agreed definitions and available data to provide a baseline. Indicators exist for some of the other outcomes in the framework, but there is further work to do to agree their

definitions and to set baselines. This work will take place over the coming nine months, with the aim of having most definitions agreed for available indicators by autumn 2011. The next iteration of the framework will include a more developed set of indicators, with levels of ambition attached where baselines are available.

1.17 This first NHS Outcomes Framework includes several placeholders where consultation responses have suggested that outcomes need to be included but where appropriate or suitably robust indicators do not yet exist. These need to be developed but there is a necessary lead-in time for this process, and so it is likely that there will still be a small number of placeholders in the 2012/13 iteration of the framework.

Five-year review of the framework

1.18 The objective of creating accountability in the NHS based on outcomes means that it is essential to assess the extent to which the framework is meeting its objectives. Every five years, therefore, the Secretary of State for Health will commission an external review of the framework, looking at how it is operating as:

- a driver for improved health outcomes;
- an effective accountability mechanism; and
- a catalyst for cultural change and quality improvement.

Outcomes for the NHS, public health and adult social care

1.19 The framework has been based on the principles set out in the consultation, which were broadly supported by those who responded, and in accordance with the structure and approach proposed. The five domains proposed in the consultation were also broadly supported and have been used as the basis for the development of this first framework.

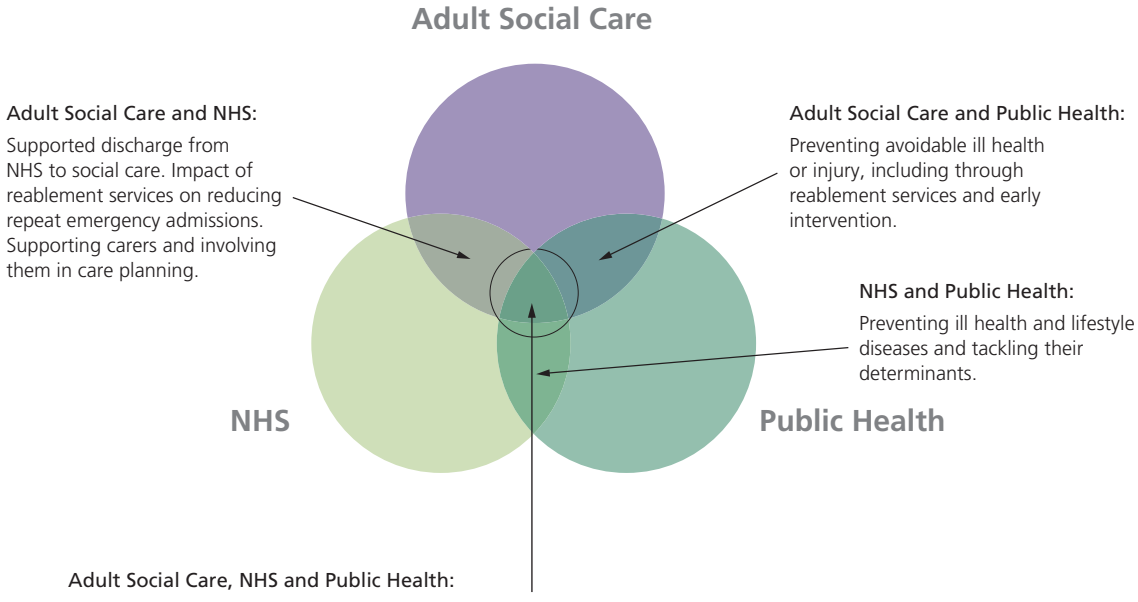
1.20 The outcomes and indicators in the NHS Outcomes Framework have been chosen with a view to capturing the range of activities that the NHS is responsible for delivering. Where appropriate, they are not condition specific, rather seeking to capture those outcomes that an individual with any condition would consider important.

1.21 As proposed in the consultation, the NHS Outcomes Framework will cover outcomes resulting from treatment activity for which the NHS is largely responsible.

1.22 However, if the outcomes that matter most to people are to be delivered, the NHS, public health and adult social care services need to be fully aligned and in some cases held to account for providing joined up or integrated services. A separate Public Health Outcomes Framework is being published for consultation and an Adult Social Care Outcomes Framework was published for consultation in November 2010.[7] In designing the NHS Outcomes Framework, for the outcomes that depend on integration and alignment, indicators are replicated across the three frameworks or complementary indicators are included.

1.23 Figure 1.1 below demonstrates how the three frameworks and sets of outcomes overlap. All three frameworks are brought together in the Department of Health's Business Plan, published in November 2010.[8] The overarching indicators in each domain of this framework are included as 'impact indicators' in the business plan, which forms part of the wider cross-government Public Services Transparency Framework.[9] The impact indicators within that framework provide the high level set of outcomes for the health, public health and adult social care sectors, and are currently out for consultation.

Figure 1.1: The three overlapping frameworks for the NHS, public health and adult social care services



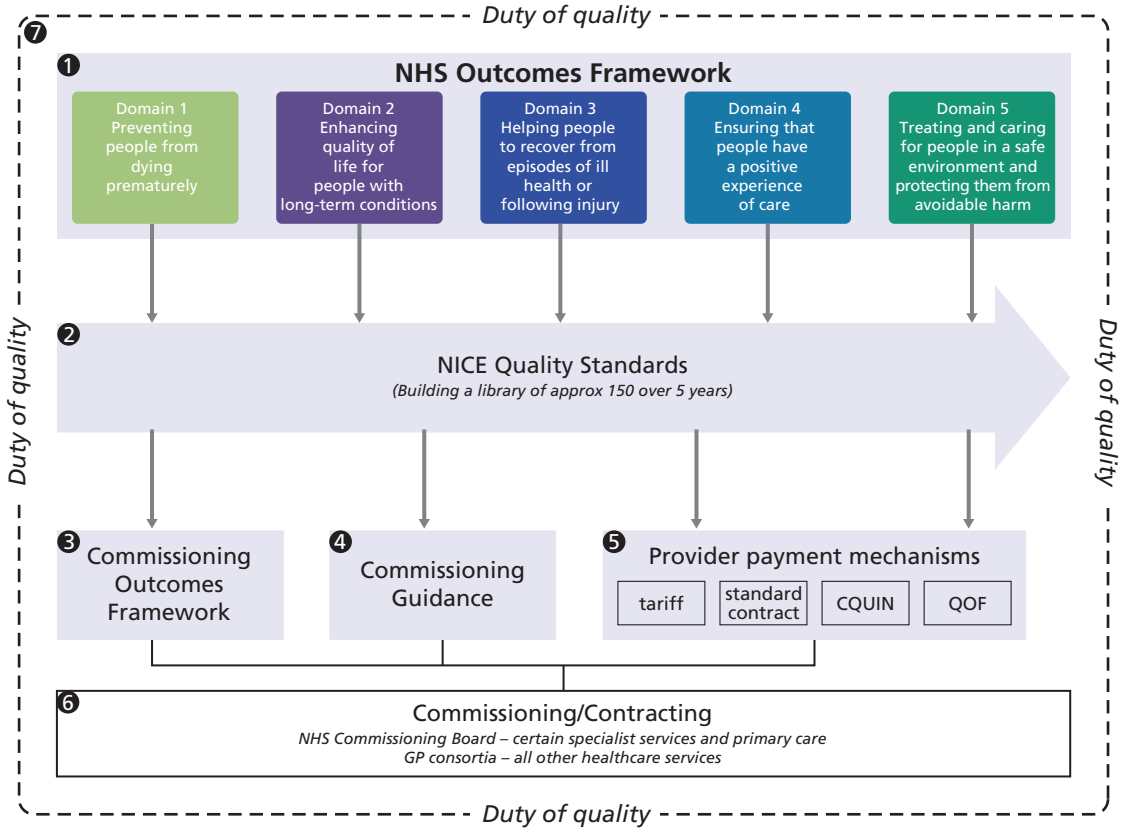
[7] Department of Health (November 2010) *Transparency in outcomes – a framework for adult social care*, available at: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_121509
[8] Department of Health (November 2010) *DH Business Plan 2011–2015: Consultation Transparency Framework*, available at: www.dh.gov.uk/en/consultations/liveconsultations/dh_122220
[9] Excluding 5c, 'number of similar incidents', the third part of the overarching indicator in Domain 5

The NHS Outcomes Framework and the wider system

1.24 The NHS Outcomes Framework sets out the national outcome goals that the Secretary of State for Health will use to monitor the progress of the NHS Commissioning Board. The Government, the Secretary of State for Health and the Department of Health will not be setting out how those outcomes should be delivered.

1.25 It will be for the NHS Commissioning Board to determine how best to deliver improvements by working with GP commissioning consortia and making use of the various tools and levers it will have at its disposal as Figure 1.2 below demonstrates.

Figure 1.2: The quality improvement system in the NHS



1.26 The NHS Commissioning Board will commission the National Institute for Health and Clinical Excellence (NICE) to develop Quality Standards (2) which will set out the evidence-based characteristics of a high quality service for a particular clinical pathway or condition. These standards will, where appropriate, look across several or all five domains of the NHS Outcomes Framework.

1.27 Drawing on these Quality Standards, the NHS Commissioning Board will translate the national outcomes into outcomes and indicators that are meaningful at a local level in the Commissioning Outcomes Framework (3), which it will use to hold GP commissioning consortia to account for their contribution to improving outcomes. A quality premium will be linked to certain outcomes in the Commissioning Outcomes Framework which will provide a financial incentive payment to GP commissioning consortia.

1.28 To support GP commissioning consortia in achieving improvements in outcomes and drawing on NICE Quality Standards, the NHS Commissioning Board will develop detailed commissioning guidance (4), alongside tools such as standard contracts and payment tariffs (5). These will support GP commissioning consortia to meet the commitments set out by the NHS Commissioning Board, as well as meeting the needs of their local population through the commissioning and contracting process (6).

1.29 In support of the new system's focus on improving outcomes, the Health Bill will propose placing a duty to secure continuous quality improvement in the NHS on the Secretary of State for Health, the NHS Commissioning Board, the economic regulator and GP commissioning consortia (7). This will ensure that quality runs throughout the whole system and, in practical terms, means that commissioners will be required to have regard to guidance produced by the Board, including NICE Quality Standards.

1.30 Other levers and incentives throughout the system will have an impact on quality and the delivery of the outcomes in this framework:

- the health and social care workforce are at the front line in improving outcomes for the individuals they treat and care for, and so the education, training and support they receive will need to reflect what is being asked of them; and

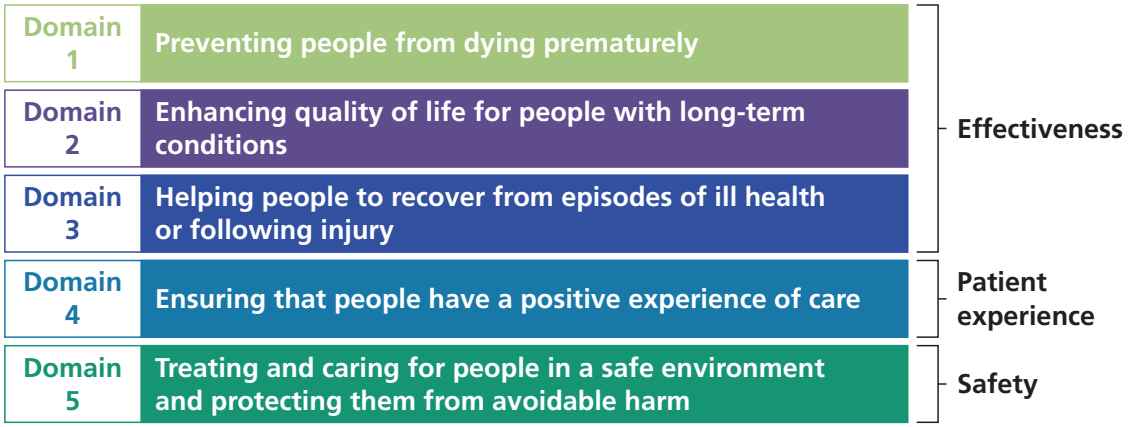
- continued research and the use of research evidence in the design and delivery of services at a local level will be vital.

1.31 The next chapter explains the structure of the framework and the outcomes and indicators that are included in this first NHS Outcomes Framework for 2011/12, including how gaps will be filled or indicators improved in coming years. Annexes A and B provide additional information on how indicators can be disaggregated and their state of readiness. Technical detail on all indicators is available separately in *The NHS Outcomes Framework 2011/12 – Technical details of indicators*.[10]

[10] Available at: www.dh.gov.uk/

Chapter 2 Outcomes and indicators for the first framework

2.1 This chapter takes each of the five domains of the NHS Outcomes Framework in turn, setting out the outcomes and corresponding indicators within each and explaining the rationale for why these have been selected. Encompassing the three parts of the definition of quality (effectiveness, patient experience and safety) the five domains are:



2.2 Each domain follows a similar structure with:

- a single or small number of **overarching indicator(s)**, allowing the Secretary of State for Health to track the progress of the NHS as a whole in delivering outcomes across the breadth of activity covered by the domain;
- a small set of **improvement areas** where the NHS Commissioning Board will be tasked with delivering better outcomes because the evidence suggests that significant improvement or health gain is possible; and
- a supporting suite of **NICE Quality Standards** setting out what high quality care looks like for a particular pathway of care.

2.3 Across the five domains there are 10 overarching indicators, 31 improvement areas and 51 indicators in total.

NICE Quality Standards

2.4 For each domain, the relevant topics on which NICE Quality Standards have been or will be developed are listed to demonstrate what that supporting suite will look like. These are also set out in full at **Annex C**. This list is not exhaustive, and represents only around a third of the eventual broad library of standards that will cover the majority of NHS activity. In many cases, the Quality Standards are applicable over more than one domain of the framework.

2.5 The National Quality Board (NQB) provides advice on topics for NICE Quality Standard development. For its most recent recommendations, the NQB drew on the proposals set out in the NHS Outcomes Framework consultation to suggest a limited number of topics that would enable NICE to accelerate its Quality Standard development programme. The NQB did not attempt to capture the most important clinical priorities for the NHS. Instead, it looked to recommend a set of topics that it was confident should be in the final library, the majority of which had, or will have, readily available evidence, meaning that they could be developed quickly.

2.6 A small number of the topics listed are still being considered by the NQB. They have been included because the Board identified them as important areas for Quality Standard development as part of its most recent selection process, but additional work is required to assess the feasibility and scope of these standards before they can be recommended for formal referral to NICE.

2.7 For the remainder, and vast majority, of the library the NQB are overseeing the development of a process for selecting topics that will integrate and build on the process for selecting NICE clinical guidelines. A particular strength of NICE's existing topic selection arrangements is its engagement with stakeholders and this will form an important part of the future approach to selecting Quality Standards. As part of this process, each of the topics suggested through the consultation will be considered for Quality Standard development. This selection process will be used by the NHS Commissioning Board, once it is in place, to commission Quality Standards from NICE.

2.8 The full NHS Outcomes Framework is set out at page 33 in this document. Pages 34–39 then provide the most recent data for those indicators where data is available. Where it is not possible, the document explains why, what further work is needed and when data will be available.

Domain 1 Preventing people from dying prematurely

Overarching indicators

1a Mortality from causes considered amenable to healthcare
(The NHS Commissioning Board would be expected to focus on improving mortality in all the components of amenable mortality as well as the overall rate)
1b Life expectancy at 75

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*
1.4 Cancer survival
- **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

Reducing premature death in people with serious mental illness
1.5 *Under 75 mortality rate in people with serious mental illness**

Reducing deaths in babies and young children
1.6.i Infant mortality*
1.6.ii Perinatal mortality (including stillbirths)

*Shared responsibility with Public Health England
Note: Indicators in italics are placeholders, pending development or identification of a suitable indicator

2.9 The objective of this domain is to capture how successfully the NHS is playing its part in reducing the number of avoidable deaths, recognising that the NHS Commissioning Board can be accountable only for the NHS contribution to this goal. Not all deaths can be prevented through healthcare; indeed, the major impact on reducing mortality will be by preventing people becoming ill in the first place.

2.10 The relative contributions of prevention activity and healthcare to delivering improved outcomes in relation to premature mortality is for the most part difficult to disentangle. Current measures of mortality allow causes considered 'amenable' to healthcare to be measured; however, this list itself is not perfect in its attribution and does not include some of the major causes of mortality. New measures need

to be developed which allow the contributions of the NHS in treating people and of Public Health England in keeping people well to be measured. In the interim, a number of national outcomes relating to mortality will be shared between the NHS Commissioning Board and the Secretary of State for Health as head of Public Health England. How these national level outcomes might be applied at a local level by the public health service is, however, subject to the separate consultation on the Public Health Outcomes Framework.

Overarching indicators

2.11 **'Mortality from causes considered amenable to healthcare'** ('amenable mortality') has been chosen to capture, at a high level, how successfully the NHS is meeting its objective in preventing people from dying prematurely where it can contribute. Rather than singling out several conditions where prevalence is particularly high, the Secretary of State for Health will track the progress of the NHS in reducing mortality across the full spectrum of causes considered amenable to healthcare. This will reduce the risk of commissioners focusing on specific conditions at the expense of others. This approach requires the definition of amenable mortality to be up to date in terms of the capabilities of current interventions. This work is currently being commissioned from the Office for National Statistics (ONS) and by autumn 2011 a systematic updating of the list of causes considered amenable to healthcare will have been completed, ready for use in the framework for 2012/13.

2.12 Experts in the area of amenable mortality have stressed the importance of using it as an indicator of potential weaknesses in healthcare that can then be investigated in more depth, and to gain insights into inequalities in access to care within populations. This will be taken into account by the Secretary of State for Health & the NHS Commissioning Board when interpreting the data.

2.13 The indicator 'mortality from causes considered amenable to healthcare' covers those aged 0–74. This is because there is general consensus that it is amongst this age group that most premature deaths occur. It is also more difficult to determine the cause of death in older people because they often have multiple conditions. However, to ensure that the NHS is held to account for doing all that it can to prevent avoidable deaths in older people, a second overarching indicator is included in this domain: **'life expectancy at 75'**. This indicator captures ages 75 and over and all conditions, not just those that are amenable to healthcare.

Improvement areas

2.14 In choosing shared mortality improvement areas, the conditions selected are those where it is clear that healthcare or public health interventions alone will not produce the required improvements in premature mortality.

2.15 On outcomes for cancer, **'one-year and five-year cancer survival rates'** are included. These indicators attempt to capture the success of the NHS in preventing people from dying once they have been diagnosed with the condition.[11] For the Public Health Outcomes Framework it is proposed as part of the consultation that mortality from cancer is more appropriate as it is driven by incidence (which is related to lifestyle factors) as well as the effectiveness of treatment.

2.16 For the other 'big killers' (**cardiovascular disease, respiratory disease** and **liver disease**), it is currently harder to calculate survival rates because, unlike for cancer, there are no comprehensive, nationwide disease registers measuring outcomes for people following treatment. For these diseases, shared improvement areas will use mortality rates in both the NHS and Public Health frameworks.

2.17 The outcome of reducing premature death in people with serious mental illness is included as a shared mortality improvement area in both frameworks as many of the risk factors that people with serious mental illnesses are particularly vulnerable to are related to lifestyle as well as to healthcare and access. The indicator that will be used is **'under 75 mortality rate in people with serious mental illness'**.

2.18 In using mortality figures to select improvement areas, there is a risk that mortality in children is not sufficiently reflected,[12] as the number of child deaths is so small. Therefore, two specific improvement areas are included in this domain relating to child mortality:

- **'infant mortality'** captures outcomes for children up to the age of one. It is influenced by both NHS and public health interventions and so is a shared mortality improvement area across both frameworks; and

- **'perinatal mortality (including stillbirths)'** relates to the outcomes of NHS care during pre-pregnancy, pregnancy, birth and immediately after birth. This is primarily an NHS responsibility so the indicator is not shared with Public Health England.

[11] It should be noted that cancer survival rates will still be driven to an extent by Public Health England through its role in overseeing screening and raising awareness of the signs and symptoms of cancer, which contribute to earlier diagnosis
[12] Four conditions in the amenable mortality definition are specifically relevant to children: all respiratory diseases (excluding pneumonia and influenza), intestinal infections, whooping cough and measles

Quality Standards – initial topics of relevance to Domain 1

2.19 A suite of NICE Quality Standards will be developed to support the NHS Commissioning Board, GP commissioning consortia and those providing NHS care to deliver the outcomes set out in this NHS Outcomes Framework. Several topics have already been or will shortly be referred to NICE for development which are relevant to the outcomes in this domain.

Quality Standards – initial topics of relevance to Domain 1	
• Acute chest pain • Alcohol dependence • Antenatal care • Bipolar disorder (adults) • Breast cancer • Chemotherapy* • Chronic kidney disease • Colorectal cancer • Diabetes (adults) • Diabetes (children) • Diagnosis and management of hepatitis B (all ages)	• Epilepsy (adults) • Epilepsy (children) • Intrapartum care • Lung cancer • Management of myocardial infarction • Ovarian cancer • Postnatal care • Prostate cancer • Schizophrenia • Specialist neonatal care • Stroke treatment and rehabilitation

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

Domain 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 (EQ-5D)**

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)
2.3.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 (EQ-5D)**

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness

** EQ-5D™ is a trademark of the EuroQol Group. Further details can be found at: www.euroqol.org
***Indicator also included in the Adult Social Care Outcomes Framework

2.20 Throughout this domain, we refer to long-term conditions as meaning any condition that cannot, at present, be cured but can be controlled by medication and/or therapy. This includes any condition that people live with over a period of time whether it is a physical or mental condition, or is associated with a disability.

Overarching indicator

2.21 Domain 2 seeks to capture how successfully the NHS is supporting people with long-term conditions to live as normal a life as possible. The overarching indicator **'health-related quality of life for people with long-term conditions'** allows the Secretary of State for Health to understand whether health-related quality of life is improving over time for the population with

long-term conditions. The indicator uses EQ-5D, which is a validated direct measure of health status or health-related quality of life that is used internationally. It asks individuals a set of five questions, which are looked at alongside information about the individual such as age and gender, and whether they consider themselves to have a long-term condition.

2.22 It is our intention that EQ-5D will be included in both the Health Survey for England, allowing health-related quality of life to be captured along with detailed health status information from a group of households representative of the national population, and, from 2011/12, in the GP Patient Survey, which will draw on a sample of 2.8 million people registered with a GP practice from 2011/12 onwards.

Improvement areas

2.23 In line with the consultation proposals, improvement areas in this domain do not take a condition-specific approach but focus on the generic outcomes that matter to people with any long-term condition. This approach was strongly endorsed through the consultation responses. The outcomes that matter most to people with long-term conditions have been identified, based on analysis of evidence and consultation responses, as follows:

- **Feeling supported to manage their condition**
  The indicator for this outcome (**'proportion of people feeling supported to manage their condition'**) measures how well the NHS as a whole is doing in supporting people to look after themselves and handle the consequences of their conditions. The indicator uses questions in the GP Patient Survey.

- **Functional ability**
  The indicator for this outcome (**'employment of people with long-term conditions'**) measures the extent to which people with long-term conditions are able to live as normal a life as possible by looking at their levels of employment. The indicator uses questions in the Labour Force Survey[13] and will be mapped against the number of people in employment in the general population to remove wider factors such as the state of the economy.

- **Time spent in hospital because of the condition(s)**
  This outcome is concerned with how successfully the NHS manages the condition(s) through looking at unnecessary hospital admissions. Separate indicators have been selected for adults and children. There are three conditions (asthma, epilepsy and diabetes) which account for 94% of emergency admissions for children (under 19s) with long-term conditions and so a dedicated indicator on these is included (**'unplanned hospitalisation for asthma, epilepsy and diabetes in under 19s'**).

[13] More information available at: www.statistics.gov.uk/statbase/Source.asp?vlnk=358&More=Y

For adults with long-term conditions, there is a far wider range of conditions that cause emergency admissions and so **'unplanned hospitalisation for chronic ambulatory care sensitive conditions'** is also included. Prior to full implementation of the NHS Outcomes Framework, work will be undertaken to identify the most appropriate definition for this indicator. The aim is to develop an indicator that looks at emergency admissions for all long-term conditions where optimum management can be achieved in the community.

2.24 Specific improvement areas have then been included for two groups where it is particularly important to track progress.

- **Those with mental illness:** to ensure that mental illness is not excluded due to an overriding focus on physical health. In seeking to capture the quality of life for this group, the indicator **'employment of people with mental illness'** has been selected as this provides an insight into how individuals are able to manage their condition. Clinical experts, including the Royal College of Psychiatrists, agree that this is an important outcome for people with mental illness. The indicator will measure how many people with mental illness are working, compared with employment rates in the population as a whole, to take into account wider economic factors on employment rates.

  It is recognised that looking at employment does not capture information about older people with mental illnesses, nor does it include children and young people. For older people, there are currently no suitable indicators to measure outcomes, and so we will look to develop these over time, particularly focusing on how well the NHS is playing its part in supporting those with dementia. For children and young people with mental illness, we will also look to develop an indicator to measure outcomes for this group, as well as examining the feasibility of using EQ-5D-Y[14] as a measure of health status for young people with long-term conditions in general.

- **Carers:** to recognise the vital role they play in supporting people who are ill. The role of the NHS in relation to carers centres on making sure that they remain in good health, or that their health-related quality of life does not deteriorate due to their caring responsibilities. Similar to the overarching indicator, the framework will include **'health-related quality of life for carers'**, which we intend to collect through the GP Patient Survey, using EQ-5D and a question on whether the individual has caring responsibilities.

[14] More information available at www.euroqol.org

Quality Standards – initial topics of relevance to Domain 2

2.25 A suite of NICE Quality Standards will be developed to support the NHS Commissioning Board, GP commissioning consortia and those providing NHS care to deliver the outcomes set out in this NHS Outcomes Framework. Several topics have already been or will shortly be referred to NICE for development which are relevant to the outcomes in this domain.

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

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

Domain 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 28 days of discharge from hospital***

Improvement areas

Improving outcomes from planned procedures
3.1 Patient-reported outcomes measures (PROMs) for elective procedures

Preventing lower respiratory tract infections (LRTIs) in children from becoming serious
3.2 Emergency admissions for children with LRTIs

Improving recovery from injuries and trauma
3.3 *An indicator needs to be developed.*

Improving recovery from stroke
3.4 *An indicator needs to be developed.*

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility/walking ability at **i** 30 days and **ii** 120 days***

Helping older people to recover their independence after illness or injury
3.6 The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services***

***Indicator also included in the Adult Social Care Outcomes Framework
Note: Indicators in italics are placeholders, pending development or identification of a suitable indicator

Overarching indicators

2.26 This domain focuses on helping people to recover as quickly and as fully as possible from ill health or injury. This can be seen as two complementary objectives: preventing conditions from becoming serious (wherever possible), and helping people to recover effectively. Each of these objectives is covered by an overarching indicator.

2.27 Progress in preventing conditions from becoming serious will be measured using the indicator **'emergency admissions for acute conditions that should not usually require hospital admission'**.[15] This indicator looks at conditions that should usually be managed without the patient having to be admitted to hospital. Where an individual has been admitted for one of these conditions, it may indicate that they have deteriorated more than should have been allowed by the adequate provision of healthcare in primary care or as an outpatient in hospital.

2.28 While some emergency admissions for these conditions might be unavoidable, and others may indicate inappropriate hospitalisation, a certain proportion will be linked to avoidable deterioration and this indicator is believed to be a suitable proxy measure for looking at this outcome.

2.29 Progress in helping people to recover as effectively as possible will be measured using the indicator **'emergency readmissions within 28 days of discharge from hospital'**. Healthcare, along with social care, is a major determinant of how well a patient recovers (including through rehabilitation) following illness or injury; if a patient does not recover well, then it is more likely that they will require hospital treatment again within the next 28 days. As a result, readmissions have been widely used as an indicator of the success of healthcare in helping people to recover. However, some questions have been raised about the interpretation of readmission rates, so work will be undertaken to look at how readmissions data should be interpreted and whether it can be used differently to give a better picture of recovery. We will also continue to examine outcomes around recovery and rehabilitation to understand how, in the medium to longer term, these can better be measured through existing information or new data collections.

Improvement areas

2.30 Improvement areas in this domain are based on specific causes of ill health that should be prevented from becoming serious, or from which the NHS should help people to recover as effectively as possible.

2.31 By focusing on the most common causes of serious acute illness for children, adults and older people, the improvement areas cover the largest possible number of people while being representative of the outcomes that the NHS is delivering for people of all ages. One way to consider the most common and serious causes

[15] There are a number of existing definitions of this indicator. Prior to full implementation of the NHS Outcomes Framework, work will be undertaken to identify which definition is the most appropriate

of illness is by looking at emergency bed days. The causes that lead to the most emergency bed days (excluding those relating to long-term conditions) for each age group are:

- injuries and trauma, and LRTIs for children;
- injuries and trauma, and stroke for adults; and
- fragility fractures and stroke for older people.

2.32 The following indicators have been chosen to measure outcomes in these areas for the relevant age groups:

- **'Emergency admissions for children with LRTIs'**
  For most of the improvement areas in this domain, the desired outcome is an effective recovery. However, LRTIs in children should not in general require hospital care, but are one of the top causes of hospitalisation. This implies that some cases are being allowed to become serious, and this indicator is a proxy for looking at how effectively the NHS is managing this condition.

- **Injuries in children and stroke in adults**
  The improvement areas on stroke recovery and injuries, and trauma, are placeholders, indicating that these are outcomes that matter to people and need to be measured in the NHS Outcomes Framework but that, at this stage, robust outcome indicators cannot be identified using existing data.

- **'The proportion of patients recovering to their previous levels of mobility/walking ability at (i) 30 days and (ii) 120 days'**
  Fragility fractures are the most common type of injury seen in older people, often resulting from falls. Suffering an injury such as this can have a serious impact on an older person's quality of life and ability to live independently, so effective recovery is hugely important. This indicator directly measures one of the most important functional outcomes for people with fragility fractures.

2.33 In addition to this, two further areas of interest are recognised:

- **Planned care**
  The causes that lead to the most hospital bed days do not include any elective procedures, so there is a risk that the issues that relate to elective care will not be covered by the NHS Outcomes Framework. PROMs currently exist for four elective procedures. They are included in this first framework, with a view to considering development of further PROMs in light of the NHS Outcomes Framework.

- **Independence in older people**
  Many older people never recover their independence following a spell in hospital for any cause. This is a key issue for this age group and is not picked up by a diagnosis-based analysis. This will be measured by an indicator looking at **'the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services'**.

Quality Standards – initial topics of relevance to Domain 3

2.34 A suite of NICE Quality Standards will be developed to support the NHS Commissioning Board, GP commissioning consortia and those providing NHS care to deliver the outcomes set out in this NHS Outcomes Framework. Several topics have already been referred to NICE or will shortly be referred to NICE for development which are relevant to the outcomes in this domain:

Quality Standards – initial topics of relevance to Domain 3	
• Bronchiolitis* • Cholelithiasis and cholecystitis (gallstones)* • Diverticular disease* • Fractures excluding head and hip* • Head injury • Hip fractures • Major trauma* • Meningitis in children under 16	• Migraine/headache (over 12 years of age) • Pain relief (to include young people)* • Perioperative care* • Pulmonary embolism • Safe prescribing • Stroke treatment and rehabilitation • Urgent and emergency care*

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

Domain 4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
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 inpatients' 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** 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 needs to be developed based on 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 needs to be developed.*

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

2.35 This domain reflects the importance of providing a positive experience of care for patients, service users and carers. It is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care. When analysed alongside a range of additional information sources (including complaints and operational data), this information provides local clinicians and managers with intelligence on the quality of local services from the patients' and service users' point of view, which means that patient feedback has an important role to play in driving improvements in the quality of service design and delivery.

2.36 In this domain, we have developed a core set of indicators for national accountability purposes and to support local benchmarking. These indicators are just one part of a wider set of measures and intelligence sources that are required by clinicians and managers to understand local priorities for improvement. The indicators have been chosen with a view to complementing locally led innovation, and supporting local activities for improving patient experience at the front line.

2.37 The approach to this domain is evolutionary. The initial focus is based on identifying indicators from existing nationally co-ordinated surveys. However, in parallel we will work closely with survey partners and wider stakeholders across the health and social care system to develop a full range of future options. This development work will be evidence-based, and focus primarily on the issues that matter most to patients, service users and carers. It will ensure that robust options are available for inclusion in future iterations of the NHS Outcomes Framework and support wider reforms for delivering a truly patient-centred NHS.

Overarching indicators

2.38 The initial overarching indicators have been chosen to capture, at a high level, the experience of patients using two of the main elements of NHS care.

- **Primary care, using the GP Patient Survey**
  The vast majority of the population visit their GP each year, and the average person will visit their GP more than five times a year whereas they will go to hospital for treatment once every five years. Often it is the experience people have of primary care – including GPs and dental services – that determine their overall view of the NHS.

- **Hospital care, using the Inpatient Survey**
  This indicator will capture the experience of patients who have recently received medical treatment in hospital – specifically those who have spent at least one night as an inpatient, and those who were admitted as an emergency or for elective treatment. The survey collects structured feedback by asking patients about their direct experience of different aspects of their treatment and care.

2.39 In the longer term, we propose developing a range of new measures for use as an overarching indicator, which can be included within all relevant surveys. This proposal was positively received in the consultation responses, and work will commence on developing this option for consideration in future frameworks.

Improvement areas

2.40 For this first NHS Outcomes Framework, improvement areas have been selected where there is a particular need to focus on specific aspects of care – for example, because the initial overarching indicators do not cover the issue, setting or patient group; responses to the consultation have indicated that this is a priority issue for patients; or where evidence suggests that the experience of particular groups of patients is of paramount importance given their individual circumstances.

2.41 The initial set of improvement indicators has been drawn from a range of existing surveys, or from surveys that are likely to be available in 2011/12. Collectively, they achieve wide coverage of the interactions people have with the NHS, and focus on different features of patient-centred care:

- **Improving people's experience of outpatient care** has been selected given the scale of activity within this setting (80% of hospital care), and that people's experiences in this setting are not captured through the overarching indicators. The indicator will be **'patient experience of outpatient services'** derived from the Outpatient Survey.

- **Improving access to primary care services** was frequently raised in the consultation process as a vital outcome for people in their interaction with the NHS.

  GP services in particular are the gateway into the NHS for most people and so their access to those services has a lasting impact on their overall experience of NHS care. The indicator **'access to GP services'** will be derived from questions in the GP Patient Survey.

  As part of its primary care responsibilities, the NHS is also responsible for delivering dental services to those who wish to use the NHS for their dental care. The desired outcome for NHS dental services is that everyone who wants to use an NHS dentist is able to do so. An indicator of **'access to dental services'** is included under this improvement area, also derived from questions in the GP Patient Survey.

- **Improving people's experience of accident and emergency (A&E) services** was also frequently raised in the consultation process as a vital outcome and determinant of patient experience. As with primary care, A&E is another crucial gateway into the NHS for individuals. With A&E it is about more than just how quickly people are seen by doctors or nurses but about their experience while in A&E care. The indicator **'patient experience of A&E services'** will be derived from questions on several aspects of experience, including access, in the A&E Survey.

- **Improving hospitals' responsiveness to personal needs** has been selected as consultation feedback indicated that personalisation and service responsiveness are important issues for inpatients. Results will be drawn from the existing annual Inpatient Survey.

- Outcomes have been included on **Improving women and their families' experience of maternity services** and **Improving the experience of care of people at the end of their lives** since experience issues are highly salient concerns for these groups, given the life-stage significance of this care episode. Consultation responses strongly supported the inclusion of both options within the framework. **'Women's experience of maternity services'**, will draw on questions from the Maternity Survey, which will be conducted every three years.

  For end-of-life care, a new survey of bereaved carers will be used to understand the experience of the person at the end of their life, and of their wider family. This survey is currently being developed, and so this improvement area is included as a placeholder at present. It is expected that an indicator will be available drawing on a nationally co-ordinated survey from 2012/13.

- **Improving experience of healthcare for people with mental illness** and **improving children's and young people's experience of healthcare** had strong support in the consultation. They have also been selected because, historically, it has generally been difficult to measure the experience of these different groups of patients. The mental health services indicator will draw on the new Community Mental Health Services Survey, although we will also review the previously developed Mental Health Inpatient Survey to assess the extent to which it is possible to include it in future frameworks. For children and young people, there are no survey options currently available, but development work is in hand which we expect to yield potential indicators in the future.

2.42 The maternity, A&E and outpatient surveys on which several indicators are based, are currently collected on a rolling basis, i.e. each is collected once every three years. This programme of surveys will continue on this basis, with levels of ambition set for the relevant outcomes for a three-year period. The Maternity Survey was carried out in 2010, data from which will be used to determine a baseline for improvement. The cycle will continue with the Outpatient Survey in 2011, the A&E Survey in 2012 and the Maternity Survey in 2013.

2.43 A number of additional survey projects are currently under way which cover a range of services and which may be able to produce options for future frameworks – these include surveys on cancer services, ambulance services and community care services.

2.44 In the medium to longer term, the infrastructure for collecting patient experience feedback will need to be further refined and developed, both locally and nationally. This will ensure that future indicators are fully fit for purpose, and that they focus directly on the issues that matter most to people using or needing to access services. In particular, there is a need to better cover the range of NHS services, and to develop a particular focus on capturing the views of people with specific clinical conditions and along care pathways.

2.45 We will work closely with survey partners and wider stakeholders on taking these new options forward. This is likely to require development of a range of new methodologies, approaches, instruments and indicators, but they must be developed in ways that build on and support the wide range of local measurement systems and approaches that have been developed and are being used across the NHS.

Quality Standards – initial topics of relevance to Domain 4

2.46 A suite of NICE Quality Standards will be developed to support the NHS Commissioning Board, GP commissioning consortia and those providing NHS care to deliver the outcomes set out in this NHS Outcomes Framework. Patient experience, as one of the three elements of quality, will be reflected in all Quality Standards. However, standards will also be developed specifically relating to delivering positive patient experience either generally, or in particular settings or for particular groups. Certain topics will also be of particular relevance to this domain given the improvement areas that have been selected. Several such topics have been or will be referred to NICE for Quality Standard development:

Quality Standards – initial topics of relevance to Domain 4	
• Antenatal care • End-of-life care • Intrapartum care • Nutrition in hospital, including young people	• Patient experience (generic) • Patient experience in adult mental health • Postnatal care • Urgent and emergency care*

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

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

Overarching indicators

5a Patient safety incident reporting
5b Severity of harm
5c Number of similar incidents

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 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'

Overarching indicators

2.47 This domain recognises that patient safety is of paramount importance in terms of quality of care and to delivering better health outcomes. There is a long history of efforts to embed patient safety more systematically in the NHS and recognition among clinicians, managers and policy makers has steadily increased over the last decade. However, it is also widely recognised across the health system that the pace of change is too slow and that there are still 'cultural barriers' to ensuring that patients are as safe as they could be.

2.48 These barriers are wide ranging and include fear of the 'blame game' in dealing with safety issues, health system design, human factors, training, resources, staffing numbers and leadership. Therefore improving safety is broader than just reducing the number of incidents – it includes having an understanding of how safety can be continuously improved and a culture that supports improvement.

2.49 The overarching indicator in this domain seeks to measure the broader outcomes resulting from the development of a patient safety culture across the NHS. It is not about ensuring that services or organisations are safe to practise – that is the role of the Care Quality Commission (CQC) through its registration and inspection regime. Rather, it is about measuring how well the NHS is adopting a safety culture and delivering improvements in safety as a result. As was proposed in the consultation, there are three overarching indicators, all of which will be derived from the National Reporting and Learning Service (NRLS):[16]

- **Patient safety incident reporting**
  This should be initially increasing, probably for several years, as the culture of reporting all incidents spreads more widely and deeply across the NHS, and then eventually remaining steady or even decreasing, as the habit of reporting incidents becomes routine and incidents are learnt from.

- **Severity of harm (measuring the number of incidents resulting in severe harm or death)**
  This should be decreasing as fewer serious incidents should occur if a patient safety culture is developing and lessons are being learnt.

- **Number of similar incidents**
  This should be decreasing as organisations learn from specific kinds of safety incidents and take action to ensure that they do not happen again.

Improvement areas

2.50 In this domain, improvement areas have been selected according to where there are particular safety issues or risks that need attention if the NHS is to achieve excellence in patient safety. The improvement areas come under two categories of outcome:

[16] More information on the NRLS available at: www.nrls.npsa.nhs.uk/

- **Reducing the incidence of avoidable harm**
  The specific incidents which have been selected are: hospital-related venous thromboembolism (VTE), i.e. those that develop as a result of being in hospital; the development of severe pressure ulcers while in NHS care; medication errors in acute, primary and community settings; and the incidence of the healthcare-associated infections MRSA and *C difficile*. These indicators can be measured using existing hospital episode statistics (HES), mandatory infection surveillance and data reported to the NRLS.

  Experience has shown that the NHS is adept at making real improvements on specific safety issues. Therefore it is envisaged that once progress on these areas has been cemented and best practice has become business as usual, the outcomes in this domain would evolve to include new areas which require improvement.

- **Keeping patient groups with particular needs safe**
  All patients deserve safe care, but specific improvement areas have been selected for two groups with particular needs within the safety domain: children and pregnant women.

  For children, a good indicator of how safe services are is **'incidence of harm to children due to "failure to monitor"'**, which is collected by the NRLS and will be included in the framework.

  For pregnant women, the outcome of maternity care is ultimately that the mother and baby are kept safe and avoidable complications are kept to a minimum. If care goes to plan and is safe, babies should not require specialist care where there is not a pre-planned need. Therefore an indicator of **'admission of full-term babies to neonatal care'** is included in the framework measured through HES. Older people's needs are also addressed through the pressure ulcer and VTE indicators outlined above.

2.50 We recognise that there is a bias towards acute care in this domain, partly because the most obvious risks to patient safety exist in acute settings, but also because the measurement of safety issues is less well developed in primary and community care. However, primary care organisations do report incidents to the NRLS and medication errors can be identified in primary care and community pharmacy. Over time we will improve the reporting and understanding of patient safety across all care settings and look to strengthen their coverage in this domain.

Quality Standards – initial topics of relevance to Domain 5

2.51 A suite of NICE Quality Standards will be developed to support the NHS Commissioning Board, GP commissioning consortia and those providing NHS care to deliver the outcomes set out in this NHS Outcomes Framework. Patient safety, as one of three elements of quality, will be reflected in every Quality Standard developed by NICE. However, there will be certain topics which relate to conditions, services or groups which are of particular relevance to this domain. Several such topics have already been referred to NICE or will shortly be referred to NICE for development:

Quality Standards – initial topics of relevance to Domain 5	
• Antenatal care	• Pulmonary embolism
• Chemotherapy*	• Safe prescribing
• Falls in a care setting	• Specialist neonatal care
• Intrapartum care	• Urgent and emergency care*
• Intravenous fluid therapy in hospitalised adult patients	• Urinary tract infections (in a care setting)*
• Nutrition in hospital, including young people	• Venous thromboembolism prevention
• Pressure ulcers (in a care setting, i.e. in a hospital bed)	

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

1 Preventing people from dying prematurely

Overarching indicators

1a Mortality from causes considered amenable to healthcare
(The NHS Commissioning Board would be expected to focus on improving mortality in all the components of amenable mortality as well as the overall rate)
1b Life expectancy at 75

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*
1.4 Cancer survival
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

Reducing premature death in people with serious mental illness
1.5 *Under 75 mortality rate in people with serious mental illness**

Reducing deaths in babies and young children
1.6.i Infant mortality*
1.6.ii Perinatal mortality (including stillbirths)

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 (EQ-5D)**

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)
2.3.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 (EQ-5D)**

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness

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 28 days of discharge from hospital***

Improvement areas

Improving outcomes from planned procedures
3.1 Patient-reported outcomes measures (PROMs) for elective procedures

Preventing lower respiratory tract infections (LRTIs) in children from becoming serious
3.2 Emergency admissions for children with LRTIs

Improving recovery from injuries and trauma
3.3 *An indicator needs to be developed.*

Improving recovery from stroke
3.4 *An indicator needs to be developed.*

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility/ walking ability at i 30 days and ii 120 days***

Helping older people to recover their independence after illness or injury
3.6 The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services***

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
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 inpatients' 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 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 needs to be developed based on 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 needs to be developed.*

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

Overarching indicators

5a Patient safety incident reporting
5b Severity of harm
5c Number of similar incidents

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 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'

One framework
defining how the NHS will be accountable for outcomes
Five domains
articulating the responsibilities of the NHS
Ten overarching indicators
covering the broad aims of each domain
Thirty-one improvement areas
looking in more detail at key areas within each domain
Fifty-one indicators in total
measuring overarching and improvement area outcomes

The NHS Outcomes Framework 2011/12 at a glance

**Shared responsibility with Public Health England*

***EQ 5D™ is a trademark of the EuroQol Group. Further details can be found at: www.euroqol.org*

****Indicator also included in the Adult Social Care Outcomes Framework*

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

Chapter 3 Current data for each domain

Introduction

This chapter contains illustrative data for the indicators in the NHS Outcomes Framework for 2011/12. Data has been provided for all indicators where it is available in the form in which it will be used for holding the NHS Commissioning Board to account from April 2012.

Data is also provided, where available, for indicators that exist but need further work. Such cases are marked as 'under development'. This data should be seen as illustrative only, and may differ from what is ultimately used to set a baseline for the indicators in the NHS Outcomes Framework.

Data sources and technical details

Sources of the indicative data are summarised for each domain. For indicators that are still under development, the data source referenced here may be different from that ultimately used.

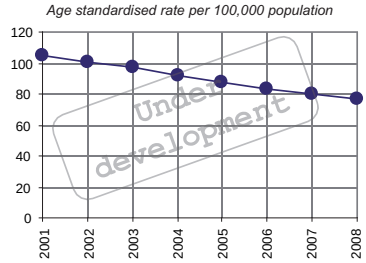
Further details of the sources of the data published here, as well as technical information about all of the indicators, can be found in *NHS Outcomes Framework: Technical details of indicators*, which is published on the Department of Health website[17].

[17] Available at: www.dh.gov.uk/

1 Preventing people from dying prematurely

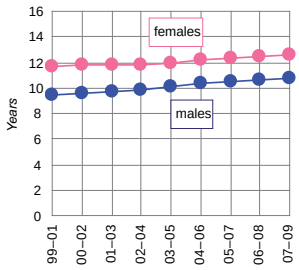
Overarching indicators

1a Mortality from causes considered amenable to healthcare



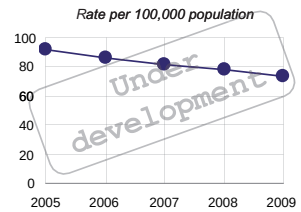
In future a breakdown of this indicator by its constituent conditions will also be monitored. This should be available from autumn 2011.

1b Life expectancy at 75

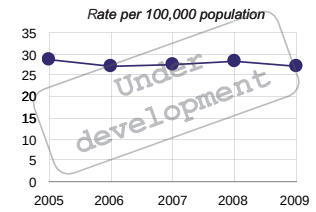


Improvement areas

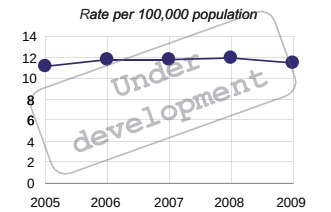
1.1 Under 75 mortality rate from cardiovascular disease



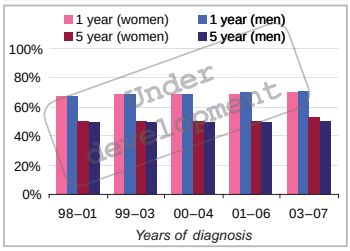
1.2 Under 75 mortality rate from respiratory disease



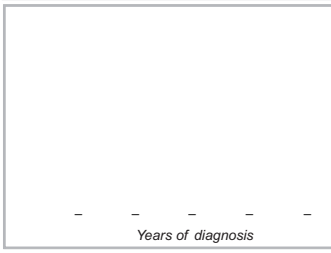
1.3 Under 75 mortality rate from liver disease



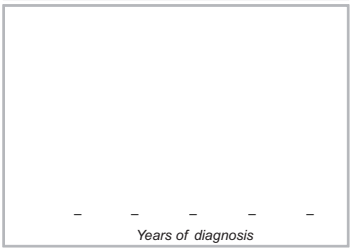
1.4.i One and ii five year survival from colorectal cancer



1.4.iii One and iv five year survival from breast cancer



1.4.v One and vi five year survival from lung cancer



1.5 Under 75 mortality rate in people with serious mental illness

Indicator under development

Data should be available from April 2012.

1.6.i Infant mortality

Rate per 1,000 live births

1.6.ii Perinatal mortality (including stillbirths)

Rate per 1,000 live and stillbirths

Illustrative data taken from: NCHOD, ONS

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 (EQ-5D*)

Indicator under development
Data should be available from January 2012.

Improvement areas

2.1 Proportion of people feeling supported to manage their condition

2.2 Employment of people with long term conditions

Indicator under development
Data should be available from autumn 2011.

2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)

2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Indicator under development
Data should be available from autumn 2011.

2.4 Health related quality of life for carers (EQ-5D*)

Indicator under development
Data should be available from January 2012.

2.5 Employment of people with mental illness

Indicator under development
Data should be available from autumn 2011.

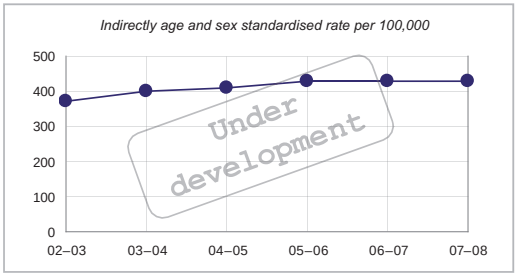
Illustrative data taken from: GP Patient Survey, National Centre for Health Outcomes Development (NCHOD)

* EQ-5D™ is a trademark of the EuroQol Group (www.euroqol.org)

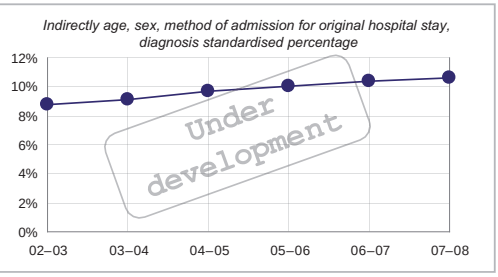
3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission

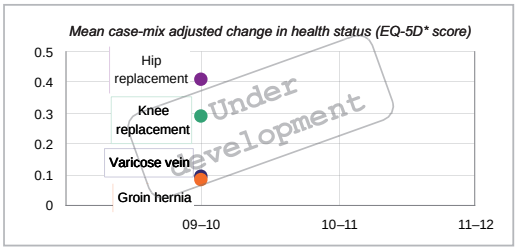


3b Emergency readmissions within 28 days of discharge from hospital

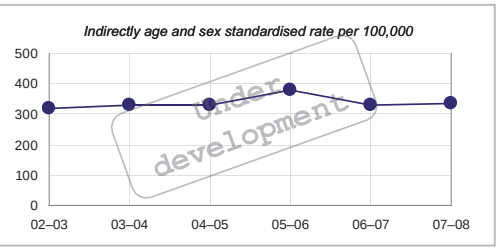


Improvement areas

3.1 Patient-reported outcomes measures (PROMs) for elective procedures



3.2 Emergency admissions for children with lower respiratory tract infections



3.3 *An indicator on recovery from injury/trauma*

A new indicator is required

Data may not be available for April 2012.

3.4 *An indicator on recovery from stroke*

A new indicator is required

Data may not be available for April 2012.

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

A new indicator is required

Data should be available from April 2012.

3.6 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services

Indicator under development

Data should be available from April 2011.

Illustrative data taken from: NCHOD, HES Online

* EQ-5D™ is a trademark of the EuroQol Group (www.euroqol.org)

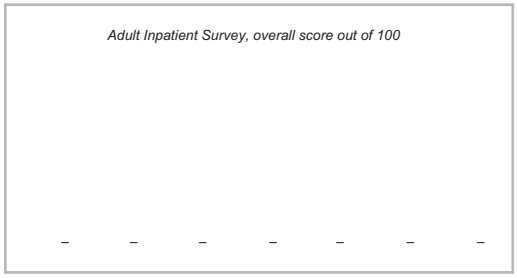
4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care

Indicator under development
Data should be available from autumn 2011.

4b Patient experience of hospital care



Improvement areas

4.1 Patient experience of outpatient services

Indicator under development
Data should be available from April 2012.

4.2 Responsiveness to inpatients' personal needs

This indicator is ready, but has not yet been collated at national level. Data should be available from April 2011.

4.3 Patient experience of A&E services

Indicator under development
Data should be available from April 2012.

4.4.i Access to GP services

Indicator under development
Data should be available from autumn 2011.

4.4.ii Access to dental services

Indicator under development
Data should be available from autumn 2011.

4.5 Women's experience of maternity services

Indicator under development
Data should be available from April 2012.

4.6 An indicator based on the survey of bereaved carers

Indicator under development
Data may not be available for April 2012.

4.7 Patient experience of community mental health services

Indicator under development
Data should be available from April 2012.

4.8 *An indicator on children and young people's experience of care*

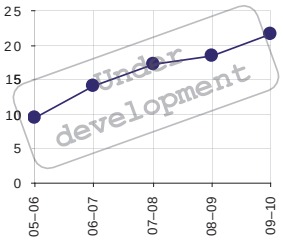
A new indicator is required
Data may not be available for April 2012.

Illustrative data taken from: CQC Adult Inpatient Survey

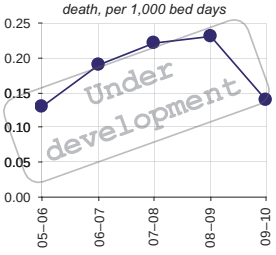
5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a Patient safety incident reporting



5b Severity of harm



5c Number of similar incidents

Indicator under development

Data should be available from April 2011.

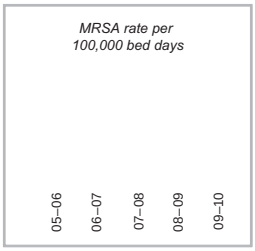
Improvement areas

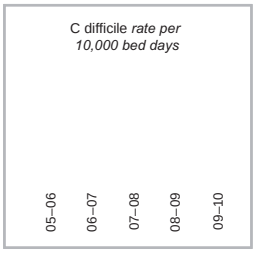
5.1 Incidence of hospital related venous thromboembolism (VTE)

Indicator under development

Data should be available from April 2012.

5.2 Incidence of healthcare-associated infection: i MRSA and ii *C. difficile*





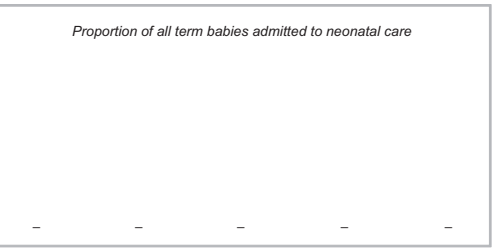
5.3 Incidence of newly acquired category 3 and 4 pressure ulcers

Indicator under development

Data should be available from April 2012.

5.4 Incidence of medication errors causing serious harm

5.5 Admission of full-term babies to neonatal care



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

Indicator under development

Data should be available from April 2011.

Illustrative data taken from: NRLS, HES, Health Protection Agency

Chapter 4 Next steps to 2012/13

5.1 This is the first NHS Outcomes Framework and, as explained in this document, it is intended to signal the direction of travel for the NHS in focusing on outcomes, and to set out the high level outcomes which the NHS as a whole will be aiming to deliver. Over the coming months and two years, the reforms set out in *Equity and Excellence: Liberating the NHS* and in *Liberating the NHS: Legislative framework and next steps* will be implemented, changing the NHS architecture and the way in which organisations operate and interact with each other.

5.2 In terms of the NHS Outcomes Framework, there is still a lot of work to do. Annex B makes clear where indicators are not yet finalised, or where they have not yet been identified.

5.3 The Department of Health will not take this work forward alone. It will work with partners such as the Office for National Statistics, the NHS Information Centre and leading experts in healthcare measurement to ensure that the best possible indicators are included in the next NHS Outcomes Framework for 2012/13. We will also issue a call to action to interested experts, academics and measurement specialists in the UK and elsewhere to help us to make this framework as effective as possible. We intend to explore the option of running a series of innovation competitions to identify new indicators in a few key areas, to stimulate novel approaches to measuring and reporting outcomes while minimising the costs and burden of associated data collections.

5.4 We have committed to updating the framework annually. This will not be done in isolation. We will work with our partners and with external experts to help us to review where indicators may have outlived their usefulness, and to identify where better measures of outcomes may subsequently have become available and where the substitution of alternative indicators might help to improve the comprehensiveness and inclusiveness of the NHS Outcomes Framework.

5.5 The box opposite sets out a summary of milestones in relation to the NHS Outcomes Framework, which are subject to the parliamentary process.

Milestones

- **December 2010** – publication of the first NHS Outcomes Framework
- **April 2011** – NHS Commissioning Board in place in shadow form
- **September–November 2011** – shadow NHS Commissioning Board negotiates levels of ambition with the Secretary of State for Health
- **December 2011/January 2012** – second NHS Outcomes Framework published for 2012/13, including levels of ambition where they have been agreed
- **April 2012** – subject to parliamentary approval, NHS Commissioning Board formally in place and held to account by the Secretary of State through the NHS Outcomes Framework which will form part of the broader mandate set for the Board
- **December 2012/January 2013** – third NHS Outcomes Framework published for 2013/14
- **2015/16** – five-year review of the effectiveness of the NHS Outcomes Framework conducted

Annex A Breakdown of indicators: international comparisons, local disaggregation and equalities

Introduction

International comparisons are necessary to identify where the UK is underperforming. This is useful in understanding where quality improvement may be possible. It is also essential in monitoring the goal set out in *Equity and Excellence: Liberating the NHS*, for an NHS which achieves results that are amongst the best in the world. However, only a limited number of outcomes are internationally comparable as this comparison relies on international agreement on and use of common definitions and data submission procedures.

An initial assessment has been made of the practicalities and desirability of **sub-national breakdowns** of the outcome indicators. The indicators were not chosen with this purpose in mind and, despite it being feasible to calculate sub-national comparisons, it may not be desirable. The concern is that it would be complex to calculate comparisons which reflect actual differences in performance between providers. It is known that socio-economic factors have an influence on outcomes; therefore, in order to use a sub-national breakdown – especially to compare NHS providers for accountability purposes – an assessment would need to be made as to whether an appropriate case-mix adjustment model could be produced. While this concern applies to some degree to all indicators, those where it is most pressing are indicated with an asterisk in the following table.

The Department of Health has made tackling health inequalities a priority and it is also under a legal obligation to promote equality across the equality strands protected in the Equality Act 2010. There is therefore both a legal requirement and a principle in designing the NHS Outcomes Framework that its introduction will not cause any group to be disadvantaged. We have used the **equalities and inequalities breakdowns** to assess data availability in order to monitor this commitment. Data collection is more complete for some of the strands than others; for example, there is better coverage (questions are asked as standard and patients provide the information) for age and gender than for religion or belief and sexual orientation.

The following assessment may change as further information becomes available.

Key

Y	Available
N	Unavailable
P	Not currently available but possible to construct
TBD	Not known/further work is required to determine if this is possible
N/A	Not applicable to this indicator
*	Starred items (i.e. Y* or P*) indicate that the breakdown should be treated with particular caution. In the case of sub-national breakdowns, this is because it will not be appropriate to make comparisons between areas without risk adjustment. In other columns, this is because there is concern about the reliability of some of the data or the statistical validity of this breakdown.

Indicator details

		Sub-national breakdown			Equality strands (national only)						Inequalities	
	International comparisons	Regional	PCT/ LA	Provider	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Socio-economic group (NS-SEC)	Deprivation (via postcode or area)
1. Preventing people from dying prematurely												
Overarching indicators												
1a Mortality from causes considered amenable to healthcare	P	P*	P*	TBD	P	N	N	P	N	N	P*	P
1b Life expectancy at 75	N	P*	P*	TBD	N/A	N	N	Y	N	N	P*	P
Improvement areas												
1.1 Under 75 mortality rate from cardiovascular disease	Y	Y*	Y*	TBD	P	N	N	Y	N	N	P*	P
1.2 Under 75 mortality rate from respiratory disease	Y*	Y*	Y*	TBD	P	N	N	Y	N	N	P*	P
1.3 Under 75 mortality rate from liver disease	Y	Y*	Y*	TBD	P	N	N	Y	N	N	P*	P
1.4.i One-year survival from colorectal cancer	N	P*	P*	TBD	P	TBD	N	P	N	N	TBD	P
1.4.ii Five-year survival from colorectal cancer	Y	P*	P*	TBD	P	TBD	N	P	N	N	TBD	P
1.4.iii One-year survival from breast cancer	P	Y*	Y*	TBD	P	TBD	N	Y	N	N	TBD	P
1.4.iv Five-year survival from breast cancer	Y	Y*	Y*	TBD	P	TBD	N	Y	N	N	TBD	P
1.4.v One-year survival from lung cancer	P	Y*	Y*	TBD	P	TBD	N	Y	N	N	TBD	P
1.4.vi Five-year survival from lung cancer	Y*	Y*	Y*	TBD	P	TBD	N	Y	N	N	TBD	P
1.5 *Under 75 mortality rate in people with serious mental illness (to be developed)*	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
1.6.i Infant mortality	Y*	Y*	Y*	TBD	N/A	N	N	Y	N	N/A	Y	P
1.6.ii Perinatal mortality (including stillbirths)	N	Y*	Y*	TBD	N/A	N	N	Y	N	N/A	Y	P

	International comparisons	Sub-national breakdown			Equality strands (national only)						Inequalities	
		Regional	PCT/ LA	Provider	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Socio-economic group (NS-SEC)	Deprivation (via postcode or area)
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	N	Y*	Y*	Y*	TBD	TBD	TBD	TBD	TBD	TBD	N	TBD
Improvement areas												
2.1 Proportion of people feeling supported to manage their condition	N	Y*	Y*	Y*	TBD	TBD	TBD	TBD	TBD	TBD	N	TBD
2.2 Employment of people with long-term conditions	N	P*	P*	N	P	TBD	TBD	P	TBD	TBD	P	P
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	TBD	Y*	Y*	Y*	Y	Y*	N	Y	TBD	N	TBD	Y
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	TBD	Y*	Y*	Y*	Y	Y*	N	Y	TBD	N	TBD	P
2.4 Health-related quality of life for carers	N	Y*	Y*	Y*	TBD	TBD	TBD	TBD	TBD	TBD	N	TBD
2.5 Employment of people with mental illness	N	P*	P*	N	P	TBD	TBD	P	TBD	TBD	P	P
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	TBD	Y*	Y*	Y*	Y	Y*	N	Y	TBD	N	TBD	Y
3b Emergency readmissions within 28 days of discharge from hospital	N	Y*	Y*	Y*	Y	Y*	N	Y	TBD	N	TBD	Y
Improvement areas												
3.1 Patient-reported outcomes measures for elective procedures	N	Y*	Y*	Y*	Y	Y	N	Y	N	N	N	Y
3.2 Emergency admissions for children with lower respiratory tract infections	TBD	Y*	Y*	Y*	Y	Y*	N	Y	TBD	N	TBD	Y
3.3 *An indicator on recovery from injuries/trauma (to be developed)*	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
3.4 *An indicator on improving recovery from stroke (to be developed)*	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
3.5 The proportion of fragility fracture patients recovering to their previous levels of mobility/walking ability at **i** 30 days and **ii** 120 days	N	Y*	Y*	Y*	Y	N	N	Y	N	N	N	Y
3.6 The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services	N	Y*	Y*	N	N/A	Y	N	Y	Y	N	N	Y

	International comparisons	Sub-national breakdown			Equality strands (national only)						Inequalities	
		Regional	PCT/ LA	Provider	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Socio-economic group (NS-SEC)	Deprivation (via postcode or area)
4. Ensuring that people have a positive experience of care												
Overarching indicators												
4a Patient experience of primary care	N	Y*	Y*	Y*	TBD	TBD	TBD	TBD	TBD	TBD	N	TBD
4b Patient experience of hospital care	N	P*	P*	P*	Y	Y*	N	Y	N	N	N	P*
Improvement areas												
4.1 Patient experience of outpatient services	N	P*	P*	P*	Y	Y*	N	Y	N	N	N	P*
4.2 Responsiveness to inpatients' personal needs	N	P*	P*	P*	Y	Y*	N	Y	N	N	N	P*
4.3 Patient experience of A&E services (from A&E Survey)	N	P*	P*	P*	Y	Y*	N	Y	N	N	N	P*
4.4.i Access to GP services (from GPPS)	N	Y*	Y*	Y*	TBD	TBD	TBD	TBD	TBD	TBD	N	TBD
4.4.ii Access to dental services (from GPPS)	N	Y*	Y*	Y*	TBD	TBD	TBD	TBD	TBD	TBD	N	TBD
4.5 Women's experience of maternity services	N	P*	P*	P*	Y	Y*	N	Y	N	N	N	P*
4.6 *An indicator on end-of-life care based on the survey of bereaved carers (to be developed)*	N	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
4.7 Patient experience of community mental health services	N	P	P	TBD	Y	Y*	N	Y	N	N	N	P*
4.8 *An indicator on children and young people's experience of healthcare (to be developed)*	N	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
5. Treating and caring for people in a safe environment and protecting them from avoidable harm												
Overarching indicator												
5a Patient safety incident reporting	P	P	P	Y*	Y	N	N	P	N	N	N	N
5b Severity of harm	P	P	P	Y*	Y	N	N	P	N	N	N	N
5c Number of similar incidents	N	P	P	P*	P	N	N	P	N	N	N	N
Improvement areas												
5.1 Incidence of hospital-related venous thromboembolism (VTE)	TBD	Y	Y	Y	Y	Y*	N	Y	TBD	N	TBD	Y
5.2 Incidence of healthcare-associated infection (**i** MRSA and **ii** *C difficile*)	P	P	P	Y*	Y	P	N	Y	P	N	N	TBD
5.3 Incidence of newly acquired category 3 and 4 pressure ulcers	P	P	P	Y*	Y	P	N	Y	P	N	N	TBD
5.4 Incidence of medication errors causing serious harm	P	P	P	Y*	Y	N	N	P	N	N	N	TBD
5.5 Admission of full-term babies to neonatal care	N	Y	Y	Y	Y	Y*	N	Y	TBD	N/A	TBD	Y
5.6 Incidence of harm to children due to 'failure to monitor'	P	P	P	Y*	P	N	N	P	N	N	N	TBD

Annex B Readiness of indicators

Summary of readiness

All indicators to be included in the NHS Outcomes Framework have been given a rating to indicate whether they are ready for use, and if not what is required to get them ready. Ratings are given according to the number/letter system shown in the table below.

The table also shows the number of indicators falling within each category. Thirteen out of the 51 indicators are ready to go without any further work. At the other end of the scale, there are four improvement areas for which completely new indicators will need to be developed.

		Data source		
		A	B	C
		Already exists	Exists but requires further work	New data source required
Definition 1	Already exists	**12**	**0**	0
2	Exists but requires further work	**19**	**5**	0
3	New definition required	6	5	4

Indicator scores by domain

	Data source	*Definition*
1. Preventing people from dying prematurely		
Overarching indicators		
1a Mortality from causes considered amenable to healthcare	A	2
1b Life expectancy at 75	A	1
Improvement areas		
1.1 Under 75 mortality rate from cardiovascular disease	A	2
1.2 Under 75 mortality rate from respiratory disease	A	2

	Data source	*Definition*
1.3 Under 75 mortality rate from liver disease	A	2
1.4.i One-year survival from colorectal cancer	A	2
1.4.ii Five-year survival from colorectal cancer	A	2
1.4.iii One-year survival from breast cancer	A	1
1.4.iv Five-year survival from breast cancer	A	1
1.4.v One-year survival from lung cancer	A	1
1.4.vi Five-year survival from lung cancer	A	1
1.5 *Under 75 mortality rate in people with serious mental illness (to be developed)*	B	3
1.6.i Infant mortality	A	1
1.6.ii Perinatal mortality (including stillbirths)	A	1
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	B	3
Improvement areas		
2.1 Proportion of people feeling supported to manage their condition	B	2
2.2 Employment of people with long-term conditions	A	3
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	A	2
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	A	2
2.4 Health-related quality of life for carers	B	3
2.5 Employment of people with mental illness	A	3
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	A	2

	Data source	*Definition*
3b Emergency readmissions within 28 days of discharge from hospital	A	2
Improvement areas		
3.1 Patient reported outcomes measures for elective procedures	A	2
3.2 Emergency admissions for children with lower respiratory tract infections	A	2
3.3 *An indicator on recovery from injuries/trauma (to be developed)*	C	3
3.4 An indicator on recovery from stroke (to be developed)	C	3
3.5 The proportion of fragility fracture patients recovering to their previous levels of mobility/walking ability at **i** 30 days and **ii** 120 days	B	3
3.6 The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services	B	2
4. Ensuring that people have a positive experience of care		
Overarching indicators		
4a Patient experience of primary care	B	2
4b Patient experience of hospital care	A	1
Improvement areas		
4.1 Patient experience of outpatient services	A	3
4.2 Responsiveness to inpatients' personal needs	A	1
4.3 Patient experience of A&E services	A	3
4.4.i Access to GP services	B	2
4.4.ii Access to dental services	B	2
4.5 Women's experience of maternity services	A	2
4.6 *An indicator on end-of-life care based on the survey of bereaved carers (to be developed)*	C	3
4.7 Patient experience of community mental health services	A	2
4.8 *An indicator on children and young people's experience of healthcare (to be developed)*	C	3

	Data source	Definition
5. Treating and caring for people in a safe environment and protecting them from avoidable harm		
Overarching indicator		
5a Patient safety incident reporting	A	2
5b Severity of harm	A	2
5c Number of similar incidents	A	3
Improvement areas		
5.1 Incidence of hospital-related venous thromboembolism (VTE)	A	3
5.2 Incidence of healthcare-associated infection (**i** MRSA and **ii** *C difficile*)	A	1
5.3 Incidence of newly acquired category 3 and 4 pressure ulcers	A	2
5.4 Incidence of medication errors causing serious harm	A	2
5.5 Admission of full-term babies to neonatal care	A	1
5.6 Incidence of harm to children due to 'failure to monitor'	A	2

Annex C NICE Quality Standards in development or already developed

For each domain, the relevant topics on which NICE Quality Standards have been or will be developed are listed to demonstrate what that supporting suite will look like. This list is not exhaustive, and represents only around a third of the eventual broad library of 150 standards that will cover the majority of NHS care.

In several cases, standards are applicable over more than one domain of the framework. Where the topic is marked with *, the topic has not yet been formally referred to NICE as more work is needed on the scope of the standard.

Quality Standard topic	Domain(s) to which topic is particularly relevant	Status
Acute chest pain	1	In development
Alcohol dependence	1, 2	Due for publication by June 2011
Antenatal care	1, 4, 5	In development
Asthma (including children and young people)	2	In development
Bipolar disorder (adults)	1, 2	In development
Bipolar disorder (children and adolescents)	2	In development
Breast cancer	1	Due for publication by June 2011
Bronchiolitis*	3	
Chemotherapy*	1, 5	
Cholelithiasis and cholecystitis (gallstones)*	3	
Chronic heart failure	2	Due for publication by June 2011
Chronic kidney disease	1, 2	Due for publication by June 2011
Chronic obstructive pulmonary disease	2	Due for publication by June 2011

Quality Standard topic	Domain(s) to which topic is particularly relevant	Status
Colorectal cancer	1	
Dementia	2	Published In June 2010
Depression (adults)	2	Due for publication by June 2011
Diabetes (adults)	1, 2	Due for publication by June 2011
Diabetes (children)	1, 2	
Diagnosis and management of hepatitis B (all ages)	1, 2	In development
Diverticular disease*	3	
Drug use disorders (over 16s)	2	In development
End-of-life care	4	Due for publication by June 2011
Epilepsy (adults)	1, 2	In development
Epilepsy (children)	1, 2	In development
Falls in a care setting	5	In development
Fractures excluding head and hip*	3	
Glaucoma	2	Due for publication by June 2011
Head injury	3	In development
Hip fractures	3	In development
Intrapartum care	1, 4, 5	In development
Intravenous fluid therapy in hospitalised adult patients	5	In development
Long-term conditions/ people with co-morbidities/complex needs*	2	In development
Lung cancer	1	In development
Major trauma*	3	

Quality Standard topic	Domain(s) to which topic is particularly relevant	Status
Management of myocardial infarction	1	In development
Management of ulcerative colitis	2	In development
Meningitis (under 16s)	3	In development
Migraine/headache (over 12s)	3	In development
Nutrition in hospital, including young people	4, 5	In development
Osteoarthritis	2	In development
Ovarian cancer	1	In development
Pain relief (to include young people)*	2, 3	
Patient experience (generic)	4	In development
Patient experience in adult mental health	4	In development
Perioperative care*	3	
Postnatal care	1, 4	In development
Pressure ulcers (in a care setting, i.e. in a hospital bed)	5	In development
Prostate cancer	1	In development
Pulmonary embolism	3, 5	In development
Reflux disease (gastro-oesophageal reflux disease)	2	In development
Safe prescribing	2, 3, 5	In development
Schizophrenia	1, 2	In development
Specialist neonatal care	1, 5	Published in October 2010
Stroke treatment and rehabilitation	1, 2, 3	Published in June 2010
Urgent and emergency care*	2, 3, 4, 5	

Quality Standard topic	Domain(s) to which topic is particularly relevant	Status
Urinary tract infections (in a care setting)*	5	In development
Venous thromboembolism prevention	5	Published in June 2010

© Crown copyright 2010
404063 1p 140 copies Dec 10 (Asset)
Produced by COI for the Department of Health

recycle
When you have finished with this please recycle it

50% recycled
This is printed on 50% recycled paper