Department of Health

The NHS Outcomes Framework 2015/16

What we heard and the Government's response

December 2014

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Introduction

1. This document provides a summary of views expressed during stakeholder engagement over summer 2014 on our proposed amendments to the NHS Outcomes Framework, and the Department's response.

2. Feedback from stakeholders came in the form of four discussion-style events held with the King's Fund, and through responses to the accompanying engagement document *Refreshing the NHS Outcomes Framework 2015/16: Stakeholder Engagement*.[1] This summary of stakeholder feedback and our response here has been published to accompany the refreshed NHS Outcomes Framework 2015/16.

Background

3. The NHS Outcomes Framework is a set of 68 indicators which measure performance in the health and care system at a national level. It is not intended to be an exhaustive list of health indicators. Rather, it has been designed to be a set of outcomes that together form an overarching picture of the current state of the NHS at a national level. This also means that the NHS Outcomes Framework must remain as clear and succinct as possible so as not to undermine the rationale for the Framework, as a whole, in providing a focus for accountability and improvement.

4. When the first NHS Outcomes Framework was published in 2010, the Department of Health indicated that there would be a review of the Framework within 5 years. As a result, after the publication of the 2014/15 NHS Outcomes Framework in November last year, the Department began to look at how we could improve the Framework. There were three key aims:
    - to update the existing set of indicators, making the Framework a more effective tool and aligning it further with the Mandate to NHS England;
    - to give an indication of the future direction of travel for indicator development in the NHS Outcomes Framework;
    - to increase alignment with the Public Health Outcomes Framework and the Adult Social Care Outcomes Framework, where appropriate.

5. Using these key aims, the Department formulated a number of proposed amendments to the Framework. As part of the review process, the Department engaged with stakeholders over the summer to seek feedback on these proposals, and to get an indication of what our priorities should be for the future.

[1] https://www.gov.uk/government/consultations/nhs-outcomes-framework-review

The process for refreshing the NHS Outcomes Framework for 2015-16

6. There were four main steps this year:

   i. **Planning**. Potential gaps in the Framework or problems with existing indicators were identified within the Department, informed by research evidence and views from stakeholders (for example, the report of the Children and Young People's Health Outcomes Forum).

   ii. **Design**. Once a potential gap or a problematic indicator was identified, policy and analytical teams within the Department worked to develop a feasible proposal for a new indicator or for changes to an indicator, identifying potential data sources, timescales for implementation and costs involved.

   iii. **Technical Approval**. All proposals were then considered by the Outcomes Framework Technical Advisory Group (OFTAG).[2] OFTAG is an independent group consisting of academic and clinical experts, who assess indicator proposals against the following criteria (for more details, see the Technical Appendix):

   Essential criteria

   a. *Outcomes-focussed*
   b. *Parsimony (i.e. keeping the total number of indicators to a minimum)*
   c. *Clarity of purpose*
   d. *Interpretable and actionable (i.e. providers and commissioners should be able to take action to address an adverse outcome)*
   e. *Affordable/value for money (i.e. indicator construction and data collection must be affordable)*
   f. *Additionality (i.e. whether an indicator fills an important gap)*
   g. *Feasibility (e.g. whether there will be available and reliable data)*

   Desirable criteria

   h. *Clear timetable for delivery*
   i. *Aligned with the Mandate and known ministerial priorities*
   j. *Supports alignment of the Outcomes Frameworks*
   k. *Potential to disaggregate by equalities / inequalities characteristics*
   l. *Supports robust international comparisons*

   iv. **Stakeholder Feedback**. Before any final decisions were made, we sought the views of key stakeholders. The Department set out its proposals and posed a series of questions about them, as well as about the NHS Outcomes Framework more widely, in *Refreshing the NHS Outcomes Framework 2015/16: Stakeholder Engagement*, published online. We also held events focussing on the four main areas in which changes were proposed. We received views from stakeholders from a wide variety of

[2] For more information about OFTAG, please see: https://www.gov.uk/government/groups/outcomes-framework-technical-advisory-group

backgrounds and organisations, including charities, patient groups and arm's length bodies, such as NICE (the National Institute for Health and Clinical Excellence).

Areas of focus of the review

7. This year, four areas were identified for improvement through the review of the NHS Outcomes Framework for 2015-16, because current indicators in the Framework are problematic or insufficient. However, it is important to note that for each specific proposal that has been made as part of this review, there are many that might be in a different stage of development, and were not considered ready to be included into the NHS Outcomes Framework at this stage. Below is a list of the four improvement areas, alongside some information on the work going on outside of the specific proposals made in this review.

8. **Mental health** – The Government's Mandate to NHS England includes an objective for the NHS to work towards parity of esteem between physical and mental health. In addition, the Government's mental health strategy document *No health without mental health*, published in 2011,[3] and the more recent paper *Closing the Gap: Priorities for essential change in mental health*, published in February 2014[4], set out the ways in which the three Outcomes Frameworks need to be improved in order to better contribute towards the Government's objectives on mental health. It is important that we seek to meet this commitment in the NHS Outcomes Framework to ensure that it continues to drive culture change within the NHS.

9. Within the Department, there is much work ongoing around improving how we measure outcomes for mental health, for example:

    - **dementia** - the Department is looking to develop a proposal for an indicator to measure the effectiveness of post diagnosis support in maintaining independence and improving the quality of life for people with dementia. At the moment, a robust measure of this is infeasible as data relies on patient surveys, and data from patients in an advanced stage of dementia can only be collected through face-to-face interviews, which is extremely expensive. However, we are commissioning research to find an alternative strategy.
    - **patient safety for people with mental health conditions** - this has been a very difficult area to develop indicators, as current methods rely on incident reporting, which is not a reliable measure. Mortality data would be a more reliable source of information, but including this would run the risk of punishing certain mental healthcare providers for whom high mortality rates are expected, for example, mental health hospitals and community treatment teams which specialise more heavily in old-age psychiatry or simply have an older population. However, we are researching the use of staff surveys to identify more robust ways of using this data. In addition, we are liaising with Manchester University to find ways to be

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

able to publish their mental health trust–level suicide and homicide data for patients who have been in contact with secondary care mental health services. This data is currently confidential due to the design of the data collection.

10. **Children and young people** – In 2012, the Children and Young People's Health Outcomes Forum published a report which outlines a number of areas where the outcome measures for children and young people could be improved across the NHS and Public Health Outcomes Frameworks. An important part of this NHS Outcomes Framework review has involved looking at how the suggestions in that report could be realised.

11. Within the Department, work continues to develop the proposals set out by the Children and Young People's Health Outcomes Forum, for example:

    - the Forum made a recommendation to extend the existing indicators on employment rates to include an equivalent for children - pupil absence from school for people with long term conditions/disability/mental health problems. The datasets for this have not been fully developed yet, so a feasible proposal is not yet possible. The Department is currently investing in new datasets for maternity and children's physical and mental health, but the data will not begin to be available until 2015. We are looking at how these datasets can be linked to the pupil database to construct indicators on pupil absence for children with long term conditions and mental health conditions.
    - the Forum also recommended improving data on children's mental health through the Mental Health Survey of Children and Young People. As well as investing in the children's mental health dataset, the Department has secured funds and is commissioning a new survey to be scoped over the summer, and put out to tender later in the year. However, as with the above example, it is not feasible at the moment to propose to include this in the NHS Outcomes Framework due to the current level of development of these surveys. We intend to consider these indicators for inclusion in the Framework as soon as feasible proposals are possible.

12. **Health inequalities** – The Secretary of State has set out that the Government's ambition is to make health inequalities a thing of the past. In support of this, the Health and Social Care Act 2012 introduced duties for the Secretary of State, NHS England and clinical commissioning groups (CCGs) to have regard to the need to reduce health inequalities. The duties are for NHS England and CCGs to seek to reduce inequalities in the access to, and outcomes from, NHS care for patients.

13. Within the Department, the Secretary of State has made his first assessments of how well the health inequalities duties for the Secretary of State and NHS England were carried out in 2013-14 and concluded that good progress had been made but there is more to do to address this challenging social issue. He has signalled that assessment will be based on outcomes measures when that becomes possible. The Department set out the importance of addressing health inequalities in the Mandate to NHS England and that success will be assessed in terms of inequalities as well as overall improvement. The Department has already committed to using the NHS Outcomes Framework and Public Health Outcomes

Framework to monitor health inequalities. Our review sought feedback from stakeholders on our proposed method of identifying priority inequalities measures to use for assessment and accountability, and the best ways of measuring inequalities based on NHS Outcomes Framework indicators.

14. **Patient experience and patient safety** – The challenge of improving the health and care system to prevent problems, to detect them quickly and act on them when they do occur, was highlighted in the Mid-Staffordshire NHS Foundation Trust public inquiry and the review into Winterbourne View hospital. The NHS Outcomes Framework is an important means of setting expectations and measuring outcomes.

What we heard and the Government's response

Introduction

15. The Department is grateful to all those who attended the events or provided a written response to the review of the NHS Outcomes Framework.

16. Broadly speaking, feedback, both from the stakeholder engagement events and in the form of written responses, was supportive of the changes proposed for the NHS Outcomes Framework this year. We received valuable feedback on the future direction of travel of the NHS Outcomes Framework, and how the NHS Outcomes Framework can best work with the Public Health and Adult Social Care Outcomes Frameworks. Stakeholders also emphasised a number of areas for improvement, concerning both our proposals and on how we can make the Outcomes Framework more accessible to all.

17. We received feedback about the need for greater clarity about the reasons for proposed changes to the NHS Outcomes Framework. The Department has sought to address this in this and the accompanying documents by describing more clearly the process for reviewing the NHS Outcomes Framework this year, the reasons for the final changes, and the ongoing work to develop indicators.

18. The following sections of this document describe what we heard, how we have tried to addess these points in the refresh, and how we will take them forward for any future reviews of the NHS Outcomes Framework.

Overarching questions:

General:

Question 1: *What are your views on the effectiveness of using outcomes measures to drive improvement in the health and care system?*

Question 2: *Do you agree with the proposed approach to refreshing the Outcomes Framework?*

Question 3: *What are you views on assessing NHS England's progress against the NHS Outcomes Framework?*

Robustness of indicators:

Question 22: *What views do you have on the removal of indicators if their data is deemed to be inaccurate or unreliable?*

Question 23: *Do you agree with the current indicator inclusion criteria?*

Question 24: *How do you think the indicator inclusion criteria could be adapted in future years?*

Alignment:

Question 25: *Do you agree with the Department's plans to work towards further alignment between the Outcomes Frameworks?*

Question 26: *What views do you have on alignment between Outcomes Frameworks?*

Availability and accessibility of data:

Question 27: *What are the biggest issues regarding accessibility to NHS Outcomes Framework data?*

Question 28: *What is your opinion on how the NHS Outcomes Framework can be made more accessible and available to all?*

General questions

What we heard

19. People supported the refresh of the NHS Outcomes Framework this year, and the general approach the Department was taking, including the areas for improvement that were set out in the stakeholder engagement booklet, which were seen as appropriate.

20. On the effectiveness of using outcomes measures to drive improvement, there was a strongly positive response from people and organisations. For example, the Imperial College Health Partnership said, "*Focusing on outcomes encourages a variety of approaches and innovations to achieving better care.*" The Royal College of Physicians said: "*The NHS Outcomes Framework is a vital tool in driving the quality of care and promoting efficient use of resources in the NHS. We welcome the drive to include a greater range of patient/service*

user outcomes, rather than relying on those traditionally derived by managers, or deemed easier to measure."

21. Some respondents questioned whether the Framework is a set of indicators that NHS England is expected to make a difference to at a national level (i.e. reducing mortality from certain conditions, improving patient experience), or whether it is a set of indicators that highlight issues of key policy interest (e.g. employment of people with long term conditions). Some stakeholders, such as Kingston CCG, thought it was important to ensure there are not too many indicators in the Framework.

22. The other question raised was with whether it is better to refresh the Framework often to ensure that indicators are as robust as possible and represent the full range of outcomes, or better for the Framework to remain stable, even if it means that it will include some indicators which may not be robust. This question was raised by a number of stakeholders including the Health and Social Care Information Centre. The Royal College of Physicians said: *"We agree that the range of clinical areas and topics needs to reviewed and expanded periodically."*

Our response

23. All indicators in the Framework must be amenable to NHS intervention. This is one of the seven essential criteria for inclusion of indicators in the Outcomes Framework (IV – interpretable and actionable). However, this does not mean that all indicators are only within the gift of the NHS – there may be a whole range of organisations that contribute towards a certain outcome in the Framework. This is one of the reasons that the Department is working towards having a greater number of shared and complementary indicators in the Framework – to highlight those areas where a more joined up approach may be needed.

24. Regarding whether it is better to refresh the Framework often or whether stability should be favoured, overall, our aim is to change as little as possible in the NHS Outcomes Framework in order to enable trends in outcomes to be reviewed over an extended period of time. However, where gaps in the Framework have been identified, we will continue to try and develop suitable indicators. Similarly, where absolutely necessary we will propose the removal of indicators if they are not robust.

Robustness of indicators

What we heard

25. Stakeholders were unanimous in their support of removing indicators in appropriate circumstances. However, there was a strong message from a large number of stakeholders who indicated that before the removal of an indicator it was important to have previously exhausted all possible avenues in terms of trying to improve the data source or method of data collection. For example, the NHS Confederation and NHS Clinical Commission wrote that "*where data on an indicator is considered poor quality or unreliable, efforts should be made to support the development of more reliable data. We must ensure that the focus on an important outcome is not lost as a result of a lack of good quality data to measure it. We*

welcome the approach put forward to ensure that proposed new indicators should be realistic and backed by funding, as well as being technically robust". In addition, many stakeholders felt it important that they were consulted on any potential indicators which were to be removed from the Framework.

26. Regarding the criteria for indicator selection, stakeholders were positive about the methodology as outlined in the Technical Appendix which accompanied the stakeholder engagement document.[5] In their response, the Health and Social Care Information Centre's Indicator Governance Board have commented "*in particular we welcome the systematic approach taken in indicator development as described in the "criteria for inclusion" in the Technical Appendix, and through the commitment to take proposals through the Indicator Assurance Service (also described in the Technical Appendix)*".

27. Comments on the indicator selection criteria suggested potential future points to explore regarding the indicator selection criteria. For example, Imperial College Health Partners commented that although getting rid of bad indicators was "*essential*", "*there should be an absolute overall limit on the number of indicators to avoid their proliferation to the point of uselessness*".

Our response

28. The Department is pleased by the high levels of support for the indicator inclusion criteria, and for the removal of indicators when data is misleading or otherwise poor at measuring the desired outcome. The removal of indicators from the Framework is something that requires a process which is as robust as the process for indicator inclusion. As such, every proposal to remove an indicator from the Framework this year has been recommended by the independent Outcomes Framework Technical Advisory Group, and has gone to stakeholders as part of the review process. Furthermore, concerning future refreshes, an indicator will never be removed from the Framework without a strong technical rationale and having considered views from stakeholders.

29. Regarding the suggestion to have a limit on the number of indicators in the Framework, the intention is to keep the number of indicators in the Framework manageable, and, as such, to aim to keep the Framework close to its current size. However, defining a limit to the number of indicators may be difficult due to the arbitrary nature of such a definition. For example, as part of this year's review we have sought to balance new additions with consolidating existing indicators where possible.

[5] NHS Outcomes Framework Stakeholder Engagement 2014 Technical Appendix p.7 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/341394/140730_Technical_Appendix.pdf

Alignment

What we heard

30. Feedback from stakeholders overwhelmingly welcomed further alignment between the NHS, Public Health and Adult Social Care Outcomes Frameworks, and for a stronger focus on alignment going forward. For example, Imperial College Health Partners supported further alignment "…*essentially because genuine outcomes are a product of the actions of all three agencies rather than one alone*" while Public Health England stated that they "*would welcome further discussions with the Department on how the refresh could increase alignment*". Kingston CCG "*would support further alignment as…integration of the governance structure should assist working relationships between adult social care, public health and the NHS".* A small number of stakeholders took this suggestion further, commenting that they would support mergers between the Outcomes Frameworks. Marie Curie Cancer Care commenting, "*we also welcome a stronger focus on alignment between the outcomes frameworks, though ideally they should be merged".*

31. Lastly, a few stakeholders wanted the Department to go further, and suggested the creation of new Outcomes Frameworks for policy areas such as children and young people and mental health.

Our response

32. The feedback we have received emphasises the importance of the Department's work on further alignment between Outcomes Frameworks, which is a key focus for the Department going forward. It is not clear what the extent of further alignment might be between the three Frameworks, but the Department will work towards assessing the best way for the three Frameworks to work together, and how that might look in the future. We would then expect to carry out a larger refresh of the Frameworks next year.

33. The three Frameworks work together to provide a national level outlook on the health and care system as a whole. They are designed be an effective, succinct list of outcomes that preserves the narrative of the Department's objectives for health, rather than a comprehensive set of outcomes for all possible conditions. In the interest of maintaining consistency of this approach, we will not look to develop new Outcomes Frameworks for mental health and children and young people at this time. However, there are other tools available that are related to these areas, such as the mental health dashboard,[6] and the Children and Young People's Health Benchmarking Tool. The latter is produced by the National Child and Maternal Intelligence Network (part of Public Health England), which brings together and builds upon health outcomes data from the Public Health and NHS Outcomes Frameworks.

[6] https://www.gov.uk/government/publications/mental-health-dashboard

Availability and accessibility of the NHS Outcomes Framework

What we heard

34. Some stakeholders expressed the need for greater clarity about the reasons for proposed changes to the NHS Outcomes Framework. Particularly, they felt the engagement document was insufficiently clear about the context and rationale for proposed new indicators, which meant that the true nature of what proxy indicators were trying to measure was lost. There was also feedback from stakeholders with an interest in children and young people that we should be clearer about the ages covered by each indicator.

35. Feedback was also received on the need for greater transparency on progress of the development of indicators that currently do not feature in the NHS Outcomes Framework, as well as on the work of the Outcomes Framework Technical Advisory Group (OFTAG). For example, the Teenage Cancer Trust commented: *"We do have concerns about the indicators which are still placeholders. We feel it would be beneficial to explicitly know the reasons from OFTAG for the rejection of any proposed indicators, and have the opportunity to know the position in the process where new indicators are and proposed times for entry into the outcomes framework*."

36. There was a strong sense among stakeholders that NHS Outcomes Framework data should be more easily accessible, and that at the moment it is not clear where the data is and how often it is published. In addition, the data available is not easily manipulated, and does not provide an accessible narrative to the public.

Our Response

37. The NHS Outcomes Framework has been designed to be a national-level outlook of the health and care system in England which is open and accessible to all. We have listened to stakeholder feedback.

38. The introduction section of this document aims to provide greater clarity around the process of reviewing the NHS Outcomes Framework this year as well as the feedback we have received and how we are responding. We have also changed the format of the NHS Outcomes Framework document, *NHS Outcomes Framework 2015-16*, compared to the *NHS Outcomes Framework 2014-15*. As well as setting out each amendment we have made, we have explained why the change has been made and, for new indicators, the affected patient group. We have also reflected the age range for each indicator in the Technical Appendix.

39. In addition, in early 2015 we will publish all OFTAG papers from this year's refresh, so that anybody will be able to see the process behind the development of indicators. There are no longer any placeholders in the NHS Outcomes Framework. All indicators are either 'live' or 'in development', and the Technical Appendix explains the progress of each indicator in development.

40. We recognise the importance of making the NHS Outcomes Framework data more accessible. Therefore, we are making a commitment to tackle this in the following ways:
    - reviewing how NHS Outcomes Framework data is presented on the HSCIC website, with a view to making it more accessible; and,
    - reviewing how we can make the data for each indicator easier to interpret.

Mental health

Excess mortality in people with common mental illness

Question 4: *Do you agree with the Department's proposal to measure mortality in people with both common and serious mental illness in the NHS Outcomes Framework?*

Quality of life in people with mental health conditions and long term direction of travel

Question 5: *What are your views on the Department's proposal to reflect quality of life for people with mental health illness in the NHS Outcomes Framework?*

Question 6: *What are your views on the importance of recovery of quality of life for those with mental illness?*

Question 7: *Do you agree with the long term direction that the Department is taking regarding mental health indicators within the NHS Outcomes Framework?*

Question 8: *What views do you have on the approach that the Department is taking towards more accurately assessing parity of esteem for people with mental health conditions in the NHS Outcomes Framework?*

Tentative proposal: alcohol related admissions to hospital

Question 31: *Do you agree with the Government's proposal to include alcohol related admissions to hospital in the NHS Outcomes Framework?*

Question 32*: What are your views on the potential for an indicator on alcohol-related hospital admissions to have an impact on primary care interventions?*

Question 33*: Are there ways in which this proposal could be improved?*

Area of interest: Care settings for mental health

Question 39: *What are your views on the most effective methods of capturing patient safety outcomes for people with mental illness within the NHS Outcomes Framework?*

Question 40*: Should care settings be used as a measure of safety for children and people with mental illness in the NHS Outcomes Framework?*

Question 41: *Specifically regarding appropriate care for people with mental health conditions, what are your views on how this can be measured?*

Question 42*: What are your views on the reliability of this indicator as a measure of patient safety?*

Question 43*: What are your views on how much NHS England will be able to influence the number of patients with mental illness who are taken to a police cell as a designated place of safety?*

Measuring mortality in people with common mental illness

What we heard

41. A substantial majority of stakeholders expressed broad support for this indicator, with the Imperial College Health Partners academic network stating "*Including premature mortality of this care group in the NHS Outcomes Framework will serve further to highlight the issue as a matter of concern and attention*". However, some stakeholders, such as Monitor, voiced concern over having separate indicators for people with Mental health illness in the Outcomes Framework, saying that this could detract from linkages that may be present between mental and physical health conditions. Otsuka Pharmaceuticals commented that "*including all forms of mental illness recognises the complexity of the condition and relationship with physical health*".

Our response

42. The Department is pleased with the level of support for an indicator which measures outcomes for people with common mental illness, to complement the existing serious mental illness mortality indicator. This indicator has, therefore, been included in the refreshed NHS Outcomes Framework.

Quality of life and recovery in quality of life for people with mental health problems

What we heard

43. There was support for the proposed quality of life indicators for people with mental health problems in both the stakeholder engagement events, and written responses we received. An example is the children's sexual health charity Brook, who commented that measuring quality of life for people with mental illness "*is particularly necessary given that there is still a stigma relating to mental health problems and better efforts should be made to understand and reflect the experiences of those people who drop out of treatment throughout the tiers of intervention including along with those receiving treatment*". Some questioned the extent to which this could be directly influenced by NHS England, with the Cambridgeshire and Peterborough CCG commenting "[we] a*bsolutely agree with the principle of looking at quality of life outcomes for people with mental health problems but much of this is out of the health sphere e.g. education, employment, housing, access to social networks*". However, others argued that it was important to highlight the role of the NHS here. For example the Association of Directors of Public Health stated: *"We support the Department's proposals to measure mortality in people with both common and serious mental illness and reflect the quality of life for people with mental health problems in the NHS Outcomes Framework. These proposals are key to supporting the role of the NHS in prevention, particularly with regards to the prevention of avoidable physical health."*

44. Some stakeholders raised concerns with this addition as regard to the complexity of gathering reliable outcomes data on these topics. Also of concern was the length of time that it would take for the research to create a final survey to be completed, the data from Professor John Brazier and his team at Nottingham University to be collected, and the indicators to go live. However, stakeholders were pleased that the Health of the Nation

Outcome Scales (HoNOS) would be used as an interim measure in one of the cases until the more suitable work of Professor Brazier is available.

Our response

45. The new measures of quality of life for people with mental illness as developed by Professor John Brazier will provide a far more robust interpretation of quality of life for people with mental illness than has previously been possible. We agree that it will need to look closely at the definition of recovery developed and communicate it clearly.

Alcohol related admissions to hospital

What we heard

46. Overall, stakeholders agreed with the principle of having a shared measure on alcohol in the NHS and Public Health Outcomes Frameworks. However, there was also acknowledgement among stakeholders this this was a complex issue, with the Cambridgeshire and Peterborough CCG commenting that NHS-related outcomes for alcohol are "*very difficult to measure*", and the Royal College of Surgeons of Edinburgh commenting that the complexity of measuring this would call for "*a raft of measures*" in this area. At the stakeholder engagement events, concern was also raised that the indicator is a process measure, with an argument of potential for perverse incentives to drive down the number of hospital admissions.

Our response

47. Given the mixed response from stakeholders, and the need to maintain the parsimony of the NHS Outcomes Framework and avoid introducing too many new indicators, the Department has decided not to include this indicator in the Framework at this stage. We believe there is a role for both the NHS and Public Health to address and help prevent alcohol-related health problems, but we would want to make sure the right shared indicator is identified. There will be an opportunity in the review of both the NHS Outcomes Framework and the Public Health Outcomes Framework next year to consider this again.

Care settings for mental health

What we heard

48. We received few responses to these questions, and there were mixed views. Respondents agreed that this was an important area, but identified a number of challenges in seeking to measure patient safety outcomes, particularly through patients held in police cells as designated places of safety. Cambridgeshire CCG, for example, suggested that the goal should be to improve patient safety in all settings. The Foundation Trust Network felt that measuring care settings was too process-based, rather than outcome-focussed.

Our response

49. The Department notes and agrees with the challenges identified in developing an indicator to measure appropriate care settings for mental health. The feedback received will be used to inform any future proposals for an indicator to measure age appropriate care to OFTAG.

The long term direction of travel for mental health in the NHS Outcomes Framework

What we heard

50. There was broad support for the move to improve the coverage of mental health outcomes in the Framework. Imperial Health Partners commented: "*Until there are measures (for both outcomes and access standards) robust enough to use for contracting, mental health service users will continue to be disadvantaged when compared to patients accessing services already using those measures and standards."* Similarly, the NHS Confederation and Clinical Commissioners welcomed the approach and the recognition that changes are needed to reflect the importance of parity of esteem between mental and physical health. However, they emphasised that further investment is needed to develop robust national level outcome measures on recovery, quality of life and physical health outcomes for those with mental health issues, so that these outcomes can be considered in parallel with physical health outcomes.

51. The Foundation Trust Network were also supportive of the approach overall, but noted that there remain challenges around the development of measures which also consider those who can't access services or have major waiting times, or who are attempting but failing to access services either in a timely way or at all.

Our response

52. We agree that being able to measure access and outcomes in mental health is vital to achieving parity of esteem. The Department is pleased to be able to add two new indicators measuring outcomes for quality of life for people with mental health conditions. As mentioned in the introduction section above, increasing the number of mental health indicators in the NHS Outcomes Framework has been a priority since the Government's mental health strategy, *No Health Without Mental Health,* was published in 2011.

Children and young people

Suicide occurring after contact with NHS services

Question 9: *What are your views on the Department's proposal to measure outcomes for suicide in the NHS Outcomes Framework?*

Question 37: *Should we include an indicator in the NHS Outcomes Framework measuring suicide occurring after contact with NHS Services? Are there other technical challenges?*

Question 38: *What is an appropriate length of time to use as a cut-off for contact with NHS services to ensure that this indicator remains as relevant as possible to NHS interventions, and what is your opinion on our approach to limit this indicator to recent contact with primary care, A&E and secondary mental health services?*

Tooth extractions in under-10s

Question 10: *What views do you have on the effectiveness of using the incidence of secondary dental procedures on under 10s to highlight issues with child safety?*

Care settings for mental health

Question 44: *What are your views on effective ways of measuring patient experience or safety outcomes related to access to appropriate care for children and young people?*

Question 45: *What are your views on the importance of including outcomes with a focus on children with mental health problems into the NHS Outcomes Framework?*

Question 46: *How can children with mental health problems be better represented in the NHS Outcomes Framework?*

Long term direction of travel

Question 11: *Do you agree with the long term direction that the Department is taking regarding indicators for children and young people in the NHS Outcomes Framework?*

A new indicator for suicide

What we heard

53. In general, there was support for an indicator to measure suicide. There was also support for this as a shared or complementary indicator between the NHS Outcomes Framework and the Public Health Outcomes Framework to emphasise the importance of partnership working to help prevent suicide.

54. Our engagement document proposed limiting the indicator to measure suicide only among those who had recent contact with NHS services. Such a proposal resulted in a variety of responses from stakeholders. For example, there were differences in opinion in how to define recent contact and which services to capture. More generally, some respondents questioned the extent to which suicide was amenable to NHS intervention, while other stakeholders believed, conversely, that such an indicator should not simply be limited to suicides amongst those who had recent contact with NHS services because the NHS (as well as local authorities and others) should take responsibility for proactively seeking to identify and support vulnerable people, particularly as access to CAMHS (Child and Adolescent Mental Health Services) is a significant ongoing issue.

55. Other technical challenges, in particular the extent to which coroners' verdicts underreport suicide, were also noted.

Our response

56. The Department welcomes helpful views on this indicator. The NHS has a role in preventing suicide and increasing access to mental health services for those at risk and we expect the NHS to work with local authorities and others in this area.

57. There is evidence that the NHS can influence outcomes in suicide when they have had contact with people beforehand. For example, around a quarter of people who die by suicide were in contact with secondary mental health services in the year prior to their death. 18% of these suicides occur within the first three months of their discharge from hospital. Reducing these deaths is amenable to NHS efforts in terms of effective care planning prior to discharge, early follow-up appointments and health professionals ensuring the adverse events that preceded the admission have been addressed. Furthermore, 63% of people who die by suicide had contact with a GP in the previous year. Therefore, we will proceed with an indicator for mortality from suicide and injury of undetermined intent among people with recent contact from NHS services and have considered feedback in defining the scope.

Tooth extractions in secondary care for children under 10

What we heard

58. Stakeholders such as the Faculty of Dental Surgeons agreed that it was important to include measures of dental health in the Framework, and noted that dental caries are almost entirely preventable. There were suggestions that this should be a shared indicator with the Public Health Outcomes Framework, given that public health has a role in preventing tooth decay. However, while it was suggested that this indicator "*would make sense as a warning sign of*

deprivation and potential neglect" (ICHP), they and many stakeholders did not feel it was an appropriate measure of children's safety more widely.

59. It was also identified that tooth extractions are not necessarily an indicator of a failure in care or even poor care - there are a number of reasons for children to receive secondary dental care appropriately, for example, injury, referral to a specialist dentist as a result of congenital/acquired problems, or because they have special needs meaning certain dental treatments must be provided in a hospital.

Our response

60. The Department acknowledges points made about the extent to which this indicator could be considered a wider measure of patient safety for children. It is important to include dental indicators in the Framework as an important NHS function, but dental indicators do not fit neatly into any domain within the NHS Outcomes Framework. The Department will explore the evidence for the suggestion that this indicator could be a potential measure of child neglect, and will also examine the size of any potential data skew arising from incidences of children receiving dental care in hospital. The next step would be to take a proposal to OFTAG detailing any changes to the indicator that would improve the robustness of the data.

61. The Department has also begun to explore how this indicator could be proposed for inclusion as a shared indicator into the Public Health Outcomes Framework when work on the first triennial refresh begins next year.

Removing indicator 5.6 'incidence of harm to children due to failure to monitor'

What we heard

62. Stakeholders were broadly content about removing this indicator, agreeing that it had the potential to be misleading, and the data has almost no relevance to the desired patient group. However, stakeholders indicated that the Department must make clear its plans to find a replacement indicator.

Our response

63. It is very much the Department's intention to develop a robust replacement for indicator 5.6, and have made this clear within the main refresh document. Work ongoing in this area is in the early stages, but includes looking at combining data from staff surveys with incident reporting data to create more robust patient safety indicators, and increasing the prevalence of Retrospective Case Record Review-based indicators.

Care settings for mental health

What we heard

64. There was strong support from stakeholders for an indicator which measures age appropriate care settings for children and people with mental illness. However, a number of

challenges were identified. The response by the Picker Institute Europe sets out some of the main concerns:

- *Indicator reliability* – The relatively small population sizes of children with mental health problems may make it difficult to create reliable indicators. Unreliable indicators which fluctuate widely will at best be unhelpful and at worst, misleading in highlighting problem areas and focusing resources.
- *Confidentiality* – Small population and/or sample sizes can also create confidentiality issues. For example, in the national patient survey programme, results based on fewer than 30 respondents are currently suppressed.
- *The complexity of CAMHS (Child and Adolescent Mental Health Services) service provision* – Moreover CAMHS service provision is complex, not least due to the number of professionals and other stakeholders involved, including schools, social workers, psychologists, occupational therapists, GPs, and of course, the families and service users themselves. This increases the complexity of indicator selection and development.

65. Additionally defining age appropriate care would be difficult as it is not a black and white issue. For example, the most appropriate care setting for a young person approaching transition from children to adult services would depend on the individual.

66. Also, at this summer's stakeholder engagement events, representatives from the Children and Young People's Health Outcomes Forum highlighted that a key issue behind measuring outcomes for this group is to minimise failures of care in the *transition* between child and adult care.

Our response

67. Given the many complexities with the proposals for measuring care settings, it is clear that although there is a strong need for an indicator measuring the outcomes associated with different care settings, there may be a need to revisit how this would be developed in a way that would not give rise to the issues described above.

68. The feedback will be used to inform any future proposals for an indicator to measure age appropriate care to OFTAG.

The long term direction of travel for children and young people in the NHS Outcomes Framework

What we heard

69. Stakeholders agreed on the need to increase the coverage of children and young people in the Outcomes Framework, and noted the lack of any new measures relating to children

apart from the indicator on tooth extraction which was separate from the recommendations made by the Children and Young People's Health Outcomes Forum. It was pointed out that the *Better health outcomes for children and young people pledge* had been launched in 2013 to "improve the health outcomes of our children and young people so that they become amongst the best in the world" to tackle issues such as child death rates that are among the worst in Europe. Stakeholders were keen to see greater progress in the work underway to develop measures for children and young people.

70. There was also a desire to see recognition of the wider determinants of outcomes for children and links to the Public Health Outcomes Framework.

71. Stakeholders felt that there should be a presumption that indicators cover all ages. Where they do not then they should clearly state the ages covered. Where indicators currently do not cover children and young people, and do not specifically cover conditions, for example, in old age, then they should be extended to do so (by extending data sources or by identifying/starting new data sources). Respondents felt that this was in line with taking a life course approach and in promoting early intervention to treat/prevent long term medical problems.

Our response

72. Some of the recommendations for new indicators made by the Children and Young People's Health Outcomes Forum were already included in the NHS Outcomes Framework where data was readily available. Further development is dependent on identifying or creating reliable data sources. It is very much the Department's intention to fill the gaps for children and young people in the NHS Outcomes Framework. The Department is keen to liaise closely with the Children and Young People's Health Outcomes Forum and other stakeholders in this area so that they are kept abreast of progress on developing new indicators.

Health inequalities

Identifying new inequalities indicators

Question 12: *What are your views on the proposed selection criteria? (Set out below.)*

We propose to select breakdowns of indicators that:

- *reflect major areas of inequality of outcome, either because a large number of people experienced inequality or because a smaller number of people experienced severe disadvantage, or because there is a significant adverse trend in equality of outcome;*
- *reflect areas where the NHS could make a significant difference to the inequalities people experience; or*
- *reflect areas of particular policy interest.*

And as a package:

- *cover all domains of the Outcomes Framework; and*
- *cover a range of inequalities dimensions (for example, sex, age, ethnicity, deprivation as data allow).*

Question 13: *What views do you have on how we are applying these criteria to identify inequalities indicators?*

Question 14: *What are your views on the most effective ways of assessing inequalities in healthcare?*

Question 15: *Do you agree with the Department's long term view on improving how we measure outcomes for inequalities and marginalised groups?*

Identifying new inequalities indicators

What we heard

73. Broadly, stakeholders were positive about our plans to identify a set of health inequalities indicators based on breakdowns of existing indicators, and about the criteria we proposed using to do so[7]. For example, the National AIDS Trust called it a "*positive first step*". National Voices commented: *"Addressing complex inequalities is not an easily achievable outcome but this does not make it any less of a priority."*

74. Imperial College Health Partners noted ambivalence between selecting breakdowns that NHS England has influence over, and selecting breakdowns that reflect an area of significant policy interest, and recommended restricting the Framework to measures of outcome that reflect the action of NHS England. Others, however, took the opposite view and were supportive of identifying health inequalities that required joined working to address.

[7] The full list, alongside the data we currently have on these inequalities dimensions can be found in the Technical Appendix to the stakeholder engagement document, pp.36-56 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/341394/140730_Technical_Appendix.pdf

For example, Kingston CCG said: *"Whilst some indicators (eg in access to health care) can be significantly impacted by the NHS, for many important ones the NHS does not affect inequalities in isolation…. the duty to tackle inequalities is shared - a coordinated and joined up approach will make the most difference."* In the same spirit, Cambridgeshire and Peterborough CCG recommended further joint working with Public Health England when developing inequalities indicators.

75. The NHS Confederation and NHS Clinical Commissioners recommended a focus on identifying areas where the most impact on overall health inequalities can be made. They also called for a commitment to reviewing and refreshing these priority areas regularly, to reflect any changes.

76. Concerns from a small number of stakeholders related to how outcomes for people who have multiple disadvantages could be adequately represented. We recognise that this is an important aspect of health inequalities to capture and will investigate what could be done on this through the analysis or improvements in data collection.

77. There were a number of suggestions from stakeholders as to how to measure health inequalities. Marie Curie Cancer Care suggested looking at inequalities caused by responses to different diagnoses, pointing to a recent study done in conjunction with the University of Edinburgh and NHS Lothian which found that only 20% of patients with a non-terminal cancer diagnosis were referred to palliative care services before dying, compared with 75% of patients with a terminal cancer diagnosis. The Picker Institute also suggested looking at inequalities of access.

78. At our engagement event a number of stakeholders commented on the difficulty interpreting survey response questions from different groups of the population. They emphasised the existence of response bias, whereby people of different backgrounds rated similar types of patient experience differently.

Our response

79. The Department is pleased with the positive feedback from stakeholders regarding our plans to improve how health inequalities are measured in the NHS Outcomes Framework.

80. Regarding the suggestion to capture outcomes for people with a combination of inequalities characteristics, this is an important issue worthy of attention from the health system. This is something we will investigate carefully, but the feasibility of including this in the NHS Outcomes Framework is limited at present due to constraints on data availability. Improvements in data collection may also need to be investigated.

81. We are exploring how we might link this work across the Public Health and Adult Social Care Outcomes Frameworks.

82. We will now move onto the next stage of research, which involves applying the criteria discussed to the outcomes data for different groups that is currently available. This will enable us to identify key inequalities on which the Department will need to be assured of progress. We will also investigate how to measure trends in these indicators in a meaningful way, taking into account issues such as response bias. We will publish the outcome of this work in due course, and before the updated Outcomes Framework takes effect from April 2015.

Comorbidities

Tentative proposal: Comorbidities

Question 16: *What are your views on the most effective ways of capturing outcomes for patients with comorbidities within the NHS Outcomes Framework?*

Question 34: *Do you agree with the Government's proposal to include comorbidities in the NHS Outcomes Framework?*

Question 35*: What are your views on the below comorbidities proposal in its current form?*

Question 36*: Are there ways in which the comorbidities proposal could be improved?*

Comorbidities

What we heard

83. On this tentative proposal, feedback from stakeholders at both the engagement events and from the responses we received indicated strong support for increasing the focus on people with multiple long term conditions within the NHS Outcomes Framework. In particular, the proposal to measure mental health conditions as comorbidities was welcomed by stakeholders, with a joint response by Mind, Rethink Mental Illness, the Mental Health foundation and the Centre for Mental Health commenting "*We strongly support the inclusion of a new indicator on co-morbidities. Physical and mental health problems frequently go together and people with one or more physical health problems are at risk of developing depression*".

84. Feedback also highlighted the difficulties in measuring outcomes for people with multiple morbidities, with several stakeholders such as Help the Hospices, Age UK and MSD Pharmaceuticals that recognising that there was more work to be done to refine this indicator. A number of stakeholders made suggestions about the long term conditions this indicator should capture.

Our response

85. There is very clear support for an indicator which measures outcomes for people with multiple long term conditions in the NHS Outcomes Framework. Despite the fact that there are clearly improvements that can be made to the indicator, there is also support for publishing it as soon as possible and refining it in the future, due to the importance of what it measures. The Department has heard this, and as a result we have pushed forward the

development of this indicator. In September, we took a proposal for this indicator to the OFTAG meeting which was approved. As such, instead of taking this forward as further research next year; we are including this as a full indicator in Domain 2 of the NHS Outcomes Framework this year, with a view to refining it as necessary in future years.

86. In practice, the new comorbidities indicator would initially work as was set out in the stakeholder engagement document, by measuring the quality of life for people with three or more long term conditions. We are currently reviewing the long term conditions captured by this indicator and will take account of the suggestions received as part of that process. More information about the specification of this indicator can be found in the Technical Appendix which accompanies the refreshed NHS Outcomes Framework.

The Francis Report and the NHS Outcomes Framework

Patient Experience

Question 17: *What are your views on highlighting negative experiences of care for patients rather than only focussing on positive ones?*

Question 18: *Do you agree on the Department's plans for the long term direction for improving patient experience?*

Patient Safety

Question 19: *What are your views on more effective methods to assess patient safety other than incident reporting?*

Question 20: *What are your views on the importance of hip fractures during hospital care as a measure for patient safety in the NHS Outcomes Framework?*

Question 21: *Do you agree on the Department's plans for the long term direction in terms of improving patient safety?*

What we heard: patient experience

87. Responses were supportive of our proposed Domain 4 indicator which would capture negative experiences of care for patients as well as positive ones. A small minority of stakeholders were not supportive of the indicator, citing concerns such as potential response bias from respondents and the difficulty in identifying the cause of poor experience.

88. A number of stakeholders emphasised that carer experience of care is an important area that is not currently in the NHS Outcomes Framework. Support from an indicator on carer experience was received from both the Royal College of Surgeons Edinburgh, and the All Party Parliamentary Group on Cancer. In addition, Carer's UK commented "*It is absolutely essential that as well as looking at the patient's experience of care, the experience of carers is also measured. In driving improvements and providing greater accountability carer experiences of care need to be part of the Outcomes Framework alongside patient experience*."

89. In addition, there were a number of comments from stakeholders on the importance of measuring children's experience of care in the NHS Outcomes Framework. The Teenage Cancer Trust commented: "*It's vital that patient engagement and experience measures are extended to those under the age of 16 to ensure the voices of young people are heard and responded to, and that young people up to the age of 24 are included in children and young people's specifically designed tools and surveys*".

Our Response

90. In the 2011 census, 5.8 million people in England and Wales identified themselves as carers, and people providing high levels of care are over twice as likely to be sick or disabled. The compelling support from a number of stakeholders for measuring outcomes for carer experience has brought into focus the need for the Department to explore this as a potential addition to the Framework as part of the next refresh, providing that a proposal satisfies the indicator inclusion criteria. Apart from this, analytical experts within the

Department have also identified an existing NHS Outcomes Framework data source which has within it data relating to carer experience. Therefore, in addition to exploring a potential future indicator for carer experience, this year we will also publish sub-analysis for carer experience within the existing Domain 4 overarching indicators which will be publicly available through the Health and Social Care Information Centre (although it will not be a full indicator in the Framework).

91. The Department also recognises the importance of progressing with measuring children's experience of care within the NHS Outcomes Framework. We have adapted indicator 4.8 to measure 'children and young people's experience of *outpatient* services' rather than inpatient services, as data for the former is more easily available, which will enable the indicator to be developed much sooner. At the time the indicator was first created, NHS England were planning to develop an outpatient survey of children's experience, but this is no longer being developed. There is, however, a CQC inpatient survey, which is soon to become live, from which we can develop an indicator in due course.

What we heard: patient safety (1) reducing the reliance on incident reporting in the NHS Outcomes Framework

92. Stakeholders were supportive of the move away from patient safety measures based on incident reporting (the National Reporting Learning System, or NRLS) as part of this year's refresh. Many recognise that it has its place, but, for example, the Imperial College Health Partnership commented that "*it is correct to say that the balance [of incident reporting safety indicators] is currently wrong and that other overarching measures must be adopted*".

93. A number of stakeholders suggested a future direction of travel around developing measures for 'near misses' in the NHS Outcomes Framework. Age UK remarked: "*Any method to assess patient safety should acknowledge that health services cannot be a completely risk-free environment."*

Our response:

94. Highlighting the issues around measuring patient safety outcomes using patient safety incidents reported through the NRLS has been an important part of this refresh, including the fact that its primary purpose is for learning and improvement for patient safety. However, any move away from the NRLS will make it even more important for the Department to adopt suitable replacement indicators that can measure avoidable harm and death at a national level as soon as possible. As such, we are working to develop the expansion of Retrospective Case Record Reviews as a more robust alternative in the future. While, at present it is limited to reviews of deaths in hospitals, there will be an active piece of research in 2015/16 that will look to extend the methodology for a new indicator on severe harm in hospitals, and in future it is planed that RCRR will be extended to cover children and non-hospital settings.

95. In addition, research is underway to assess whether incident reports can be supplemented with other indicators of a reporting culture, such as staff surveys, for more a more robust interpretation of the data.

What we heard: patient safety (2) hip fractures

96. There was strong stakeholder support for measuring incidences of hip fractures, and an appreciation of the impact that hip fractures can have on wider health outcomes. Regarding this indicator, the National Osteoporosis Society commented that *"We absolutely agree that measuring hip fracture incident during hospital care would be a good patient safety measure",* also commenting on the need for osteoporosis checks for all those who have hip fractures. Some raised questions about the choice of indicator, for example, Imperial College Health Partners commented that hip fractures in hospital are one measure of incidents of harm among many possibilities, and suggested that the frequency of falls may be a better measure.

97. In terms of the future direction of travel for this area, many stakeholders commented that hip fractures only represented a small proportion of fragility injuries which occur in hospital settings, with the Royal College of Psychiatrists commenting that "*only measuring hip fractures would present a limited, narrow picture of the wider subset of falls*".

Our response

98. Given the complexity of developing robust patient safety indicators, this is an important addition to Domain 5 as part of this refresh. In future, the Department will look to improve how we measure outcomes for older people by developing our existing measures of fragility further.

List of respondents

99. We are grateful to all those who attended events and provided written responses to the review of the NHS Outcomes Framework for 2015-16.

100. The following organisations were represented at the events:

Acorns Children's Hospice
Asthma UK
Barnet Voice for Mental Health
Barts Health NHS Trust
Bowel Cancer UK
Buckinghamshire Mind
Chelsea & Westminster Hospital NHS Foundation Trust
Children and Young People's Health Outcomes Forum
City and Hackney CCG
CLIC Sargent
Demelza Hospice Care for Children
Diabetes UK
ELFT
Foundation Trust Network
Great Ormond Street Hospital for Children
Guy's & St. Thomas' NHS Foundation Trust
Haringey Council
Health Education England
Imperial College Health Partners
Imperial Healthcare NHS Foundation Trust
Keele University
Kent Community Health NHS Trust
King's College London
Lambeth and Southwark Public Health
London Borough of Southwark
London Borough of Hackney
London Borough of Havering
London Borough of Hillingdon
Mind
Monitor
National Childcare Trust
National Children's Bureau
National Housing Federation
Newham CCG
NHS England
NHS Lambeth CCG
Norfolk and Suffolk NHS Foundation Trust
Northumbria Healthcare Trust
Oxleas NHS
Rainbow Trust Children's Charity
Redbridge Concern for Mental Health
Rethink Mental Illness
Royal College of Nursing
Royal College of Psychiatrists
Teenage Cancer Trust
The King's Fund
The Mosaic Community Trust
Tower Hamlets Council
UCL
UK Faculty of Public Health
University of York
Wessex AHSN
West London Mental Health NHS Trust
Whittington Health
YoungMinds

101. The following organisations provided written responses:

AbbVie Pharma
Age UK
Alliance for Providers of Specialist Children's Healthcare
All-Party Parliamentary Group on Cancer
Lundbeck
Marie Curie
MedConfidential
Mind, Rethink Mental Illness, Mental Health Foundation and Centre for Mental Health

Alzheimer's Society
Arthritis Research UK
Association of Directors of Public Health
Birmingham Children's Hospital
British Dental Association
British Specialist Nutrition Association
Brook
Cambridgeshire and Peterborough CCG
Cancer Research UK
Carers UK
Centreforum
Children and Young People's Mental Health Coalition

Diabetes UK
Foundation Trust Network
GSK
Guild of Healthcare Pharmacists
Health and Care Voluntary Sector Strategic Partnership Equalities Working Group
Help the Hospices
Hepatitis C Coalition
Hospedia
HSCIC analytical Services
Imperial College Health Partners
Independent Diabetes Trust
Indicator Governance Board
Janssen Pharmaceuticals
Kingston CCG
Lesbian & Gay Foundation
Lilly
MSD Pharmaceuticals
National AIDS Trust
National Children's Bureau
National Osteoporosis Society
National Voices
NHS Confederation and NHS Clinical Commission
Nottinghamshire Healthcare Trust
Optical Confederation
Otsuka Pharmaceuticals
Paediatric Continence Forum
Parkinson's UK
Pharmaceutical Mental Health Initiative Group
Picker Institute
Public Health England
Royal College of Dental Surgeons
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health

Royal College of Physicians
Royal College of Psychiatrists
Royal College of Speech and Language Therapists
Royal College of Surgeons Edinburgh
Sanofi (cf. sanofi pasteur)
Sanofi Pasteur MSD vaccines
Sustainable Development Unit
Teenage Cancer Trust
The Diabetes Think Tank
The National LGB&T Partnership
Together for Short Lives

102. A small number of individuals also responded, but we have not included their names.