

DELIVERING SOME OF THE BEST HEALTH IN EUROPE

OUTCOMES NOT TARGETS

Responsibility Agenda
Policy Green paper No.6





DELIVERING SOME OF THE BEST HEALTH IN EUROPE: OUTCOMES NOT TARGETS

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1. INTRODUCTION

OUR VISION FOR THE NHS

Eight years ago, in a famous interview on David Frost's sofa, the then Prime Minister Tony Blair committed the Labour government to matching European levels of health spending. Today, that pledge has been delivered. We now spend an amount equivalent to the European average on healthcare. But have we seen value for money for all this extra spending? That is what Labour's regime of top-down process targets and central bureaucratic control of the NHS was supposed to ensure. Instead, our health outcomes – measured in terms of the actual results of healthcare (for example survival rates for cancer) are amongst the worst in Europe. **Our vision for the NHS is to improve its performance so that our health outcomes are among the best in Europe.**

No public service matters more to people than our National Health Service. That is why the Conservative Party has made the NHS its number one priority. We share Britain's pride in the values which built our NHS, and we have made the unambiguous commitment to provide the funding it needs to deliver high standards of healthcare to all, free at the point of use, and according to need, not ability to pay.

Labour is letting down the NHS. Their bureaucratic approach, running our health service through perpetual political interference and the imposition of top-down targets, is failing patients and undermining hard-working doctors and nurses. Originally introduced to provide accountability within the system, Labour's bureaucratic regime has created a situation where sticking to arbitrary targets (which often focus on pre-determined processes with little medical benefit) has become more important than improving the health of patients. This target-driven approach diverts precious time and money from genuine clinical priorities, and is driven by political imperatives rather than patients' needs. It is one of the reasons why Britain's health outcomes – for example, five-year cancer survival rates – remain poor



compared with those of other European countries, despite the fact that we spend equivalent to the European average on our healthcare.

There is a wealth of evidence that targets distort clinical priorities, lead to worse outcomes for patients and have produced a demoralised workforce whose expertise in delivering healthcare is constantly second-guessed. Labour have tested the theory that the NHS can be improved through more bureaucracy, more central control, and more initiatives from the Department of Health.

We believe a new approach is needed if we are to improve the NHS for everyone, make sure it delivers people's rising aspirations for better healthcare and better service, and at the same time deliver value for taxpayers' money. As we explained in our NHS Independence and Accountability White Paper last year, this does not demand another massive structural change or reorganisation. But it does require a new focus on what matters most: a patient's health and the actual results of their treatment. As our White Paper emphasised, professionals need to be accountable, not to centralised bureaucracies interfering with their clinical judgements but to patients whose only interest is in being cured.

This Green Paper provides a new accountability mechanism for the NHS. Applied to existing NHS structures, we believe that our new accountability mechanism will lead to higher quality healthcare, higher patient satisfaction, and higher professional morale. In place of Labour's self-defeating top-down targets we will harness the power of information, publishing details of healthcare outcomes so that the professionals can see what works and what doesn't and patients can make informed choices about which services they want to use. Our outcome measures will be rooted in sound evidence and supported by meaningful information. Patients with the power to choose their care



provider will be able to use information about outcomes and results to hold services to account.

A focus on outcomes will replace Labour's idea of accountability – a top-down relationship between politicians and professionals – with modern Conservative accountability – a side-to-side relationship between patients and professionals. It is the right approach for an age in which centralised structures with a monopoly of information no longer work: the post-bureaucratic age. As we move towards decentralised, open systems where information and power are diffused and democratised, we believe it is both possible and right to replace the top-down central control favoured by Labour with a system where the collection, collation and publication of data on health experiences and outcomes makes the NHS truly accountable to patients, not the whims of politicians.

We believe that this new focus on outcomes instead of processes is the way to achieve the highest standards of care. And the benefits of a rise in standards could be dramatic: even if we only improve the NHS so it meets the international average, as many as 38,000 lives could be saved each year. **If we improve the NHS so our results are comparable to those of the best countries in the world, we believe at least 100,000 lives could be saved every year.** Nothing could be more important: it will add years to life, and life to years, for patients.

This policy paper sets out how the NHS will help us achieve this aim. Our new approach will allow us to replace Labour's top-down targets, which do so little to improve health outcomes, with information about results and outcomes which will instead empower patients and professionals to improve the quality of healthcare delivered.



At the heart of these proposals is a vision we share with all healthcare professionals: to deliver better care in a more patient-centred National Health Service.

We are inviting your views on these proposals, and a number of specific consultation questions appear at the end of this paper with details of how to respond.

2. THE TARGET-DRIVEN CULTURE IS FAILING PATIENTS

Labour's system of public service provision is based around the use of Whitehall-determined performance targets, which are then passed down to professionals to deliver. Priorities are driven by political imperative, and accountability is upwards to politicians, not downwards to users. The system involves the collection of small, specific and often unrepresentative amounts of information, often about processes rather than actual outcomes, and often made available only to politicians and bureaucrats. The people who deliver public services, and the people who use them, often lack the information to make accurate judgements about the effectiveness of a service because genuinely useful information – about results, not processes – is either not collected or not published. This has created a culture where the bureaucrat is king, and a public sector where the public service ethos is undermined.

Box 1

“One [example] was an elderly lady with a broken hip. Pain-relieving medications given earlier while we waited for her X-rays were only partially helping. She needed an injection of local anaesthetic into the joint to numb the pain. That takes time to do, but before I could start, without my say so, she was whisked off to the ward so she didn't breach the target.”

Dr Nick Edwards, A&E doctor, Daily Mail, 27 February 2008

Superficially, NHS targets can look sensible. No-one wants to wait a long time to be seen in Accident and Emergency (A&E); everyone would like to be able to get a GP appointment at short notice. But the trouble with these top-down targets is the same as the trouble with central planning through the ages: there are unintended consequences. Too often, the consequence of a top-down process target is worse patient care and a worse health outcome. If a patient is seen within the timeframe specified by the bureaucracy, but their health suffers because they have not been examined



for long enough or by the right person, clearly something is wrong. Yet this is what Labour's system encourages. Top-down targets often push healthcare professionals to make decisions purely to 'tick boxes' and meet paperwork guidelines, rather than because they judge them clinically necessary. This frustrates professionals, harms patients and erodes trust in the ability of the NHS to deliver the outcomes we all want.

A target that is often cited for creating major distortions of clinical priority is the four-hour A&E waiting time limit. This target has led to reduced average waiting times in A&E, but at the expense of patient care through:

- holding emergency patients in trolley waiting areas,
- increasing short-stay hospital admissions,
- making inappropriate admissions to other hospital units,
- moving critically ill patients from high dependency areas, when this may not have been in the patient interest,
- delaying treatment until nearer the time limit, and
- discharging patients earlier than desirable.

Unison recently reported incidents of patients being made to wait in ambulances outside A&E wards purely to avoid letting patients into hospital and thus starting the clock running on the four-hour waiting time limit for emergency admissions. This effectively creates 'waiting rooms' out of ambulances, putting them out of action for further emergencies.

BOX 2

"A 16-year-old terminally ill cancer patient died after waiting over an hour for an ambulance to transfer him. Three ambulances could have reached him but they were tied up waiting to hand over patients to A&E. It happens time and time again. It is an appalling waste of resources. We should not use ambulances as waiting rooms."

Unison Spokeswoman Mary Maguire, BBC News, 17 February 2008



The perverse effects of process-driven targets also extend to primary care. The system which links GPs' pay to performance (which we support in principle) measures their performance more on administrative processes than clinical ones. For example, GPs have been awarded more points for updating records and information systems than for looking after patients with chronic lung disease and stroke. Any system which prioritises box-ticking above the provision of life-enhancing care is unacceptable.

2.1 The long-term damage of political targets

There is little evidence to show whether Labour's bureaucratic approach is actually improving the nation's health. If anything, the evidence that does exist suggests that targets are having a direct and negative impact on the NHS.

2.1.1 Poor value for money

The NHS needs sustained investment, and the Conservative Party has pledged it will continue with the planned spending for the NHS. But while taxpayers want their money spent on the NHS, they expect value for that money, and they can see that under Labour there has been a huge amount of waste. For all Labour's targets, reorganisations, efficiency audits and reviews, the Office of National Statistics has showed declining productivity in the NHS under Labour: in other words we are getting less for more. Indeed, at the time of greatest increases in budgets and most intensive targeting, the productivity decline was 2.5 per cent a year – shocking evidence of Labour's mismanagement of the health service.¹ Despite the hard work of NHS staff, the service is delivering worse value for money because so much money and effort have gone into activities aimed at meeting targets rather than improving healthcare.

¹ Office for National Statistics, Public Service Productivity: Healthcare, January 2008



2.1.2 Professionals undermined

Labour's top-down target regime betrays a clear lack of trust in NHS staff. Their approach has demoralised many senior managers and eroded their capacity to lead. Targets are supported by a vast body of bureaucracy – the Department of Health demands from all NHS organisations in England each year a total of almost 250,000 data returns, many of which are used in the reporting of NHS targets.²

2.1.3 Patients lack accurate information

Labour's outdated approach sees patients as passive recipients of healthcare. It keeps health information in the hands of government officials, not the public. Because this approach focuses on activities rather than outcomes, there is a lack of good publicly available information on the results of treatment and care, so people cannot make informed choices about the care they need.³

BOX 3

Targets attacked by the experts

Labour's bureaucratic, top-down approach creates large and unnecessary burdens on the NHS, as healthcare managers are forced to reorganise activities away from genuine clinical priorities purely to meet the targets. This has been roundly criticised by a wide range of independent healthcare professionals and organisations.

Targets harm patients

“Pressure to meet the four-hour waiting time has had negative consequences for the quality of patient care. Three quarters of nurses say that patients were regularly admitted to inappropriate wards just to meet the target”.

Royal College of Nursing, ‘A&E staff under pressure to meet four hour target’, 28 April 2008.

12 ² Conservative Party analysis based on responses to Parliamentary Questions

³ Department of Health, Results of the National Patient Choice Survey - England, January 2007

BOX 3 continued

“We are concerned that where trusts are under severe pressure to meet targets relating to finance and access, concern for infection control may be undermined”

Healthcare Commission, Investigation into Outbreaks of Clostridium Difficile at Maidstone and Tunbridge Wells NHS Trust, October 2007

The British Medical Association reported that patients with eye conditions that could lead to blindness were being put behind patients in need of routine cataract operations on the waiting list

British Medical Association News, ‘Health targets could be risking patient safety, warn doctors’, 8 September 2006

Targets demoralise staff

“A target obsessed NHS means that the health system is failing to treat its own staff with dignity. There is no substitute for the direct involvement of frontline workers in service delivery and bureaucratic discretion for NHS senior managers is crucial.”

Professor Blacker, Lancaster University Management School, Press Release, 26 May 2006

“The downsides of targets are several: you get perverse outcomes – people focus on one target at the expense of others and that actually damages the services...A second problem is that people cheat – resources get marshalled behind a particular target; people find ways of meeting that target although actually perhaps not facing up to the things that are driving it. But perhaps the biggest problem of targets it that they deny autonomy to frontline managers”

Matthew Taylor, former head of No.10 Policy Unit, 15 July 2002



BOX 3 continued

Targets waste huge sums of money

A recent study by CHKS, an independent provider of comparative healthcare information, showed the huge unnecessary cost of attempts to avoid missing the four-hour target. A primary care trust pays as much as £1,000 per admission to move A&E patients to alternative wards to avoid the time limit, compared to £100 for being in A&E. So up to £900 can be spent per patient without any clinical necessity at all. Reporting the study, Dr Paul Robinson of CHKS said that over the past five years, the A&E target in England “has cost the taxpayer more than £2 billion”

The Times, 24 December 2007

3. OUTCOMES, NOT TARGETS, TO DRIVE UP STANDARDS

Labour's system of running the NHS through top-down process targets isn't working. Instead of using the technological advances which make it possible to collect, collate and publish huge amounts of sophisticated information for political ends, we believe it should be used to achieve outcomes which serve patients' needs. It will make the NHS accountable to patients, not politicians, and it will restore professional discretion over how to treat patients; discretion that over the past decade has been obliterated by Labour's management consultant-led target regime.

Our strategy for driving up standards involves:

- phasing out Labour's process-driven targets;
- a national focus on the health outcomes we want the NHS to deliver;
- collecting information about the results of people's treatment in the NHS, not the processes that produced those results;
- publishing those results, so we can see where we are making progress relative to other countries and where we lag behind, and can ensure continuing improvement in results;
- developing outcome measures which patients with chronic conditions themselves provide, reflecting their needs and what matters most to them;
- giving patients a choice of provider so they can use published outcome information to get the care they want; and,
- introducing payment-by-results within the system, to reward those doctors and hospitals that achieve good results and to incentivise improvement amongst those whose standards are falling behind.

3.1 Phasing out Labour's targets and introducing outcomes

Instead of Labour's top-down process driven targets we propose to move to a system where hospitals, trusts and other providers collect and publish information about the results – the health outcomes – they achieve. The technical definition of an "NHS outcome" is the recorded result from the care that a patient, or a group of patients, experiences, for



example long term survival rates from cancer. We believe these results, whether they relate to an individual hospital or a GP surgery, should be made publicly available to help patients and those who commission healthcare (primary care organisations and GP practices) choose the right care provider. There is considerable support within the health professions for moving to a system which measures results, not processes, and which uses the publication of this information to drive up standards (see Box 4).

Focusing the NHS on results instead of targets will not simply replace one set of government diktats with another. Results are clearly different from targets because they are not produced by specifying, in a top-down way, the procedures, processes or approaches taken by care professionals to achieve a good result for patients. What matters is the result itself, not how it is achieved. That must be left to the discretion of the professionals.

The removal of top-down targets will improve accountability and performance management in the NHS when accompanied by a new focus on outcomes. Focusing on outcomes will improve accountability as everyone will be able to see which parts of the service are doing well and which parts are performing less well. Combined with our plans to give every patient an open choice of provider, and our plans to introduce payment-by-results within the system, this focus on outcomes will provide a tough incentive to raise quality all the time. For example, waiting times and other measures of service and patient satisfaction will still be collected, but instead of servicing government bureaucracy and paperwork, they will be made publicly available to patients, so the incentive for achieving low waiting times will be stronger.

The process targets we propose to abolish are widely reported by healthcare professionals and independent analysts to be diverting precious NHS resources into activities that are of no tangible benefit to patients. This cannot be justified. Professionals estimate that the four-



hour A&E target alone is diverting £400 million of NHS money every year into the unnecessary and perverse practice of moving emergency patients out of A&E wards (or keeping them from entering them in the first place) purely to satisfy government time limits. We will abolish this burdensome target, along with a raft of others.

BOX 4

A focus on outcomes not processes

Many independent experts now believe that far better performance could be delivered by the NHS if only performance management focused on securing better patient outcomes instead of monitoring process targets:

“We need to radically overhaul the way that we measure success in the NHS, by putting patient satisfaction and outcomes at the heart of a new approach.”

Dr. Gill Morgan, former Chief Executive, NHS Confederation, BBC News, 22 January 2007

“Routine collection and use of outcomes measures in the NHS is both practical and essential. We expect it to lead to improved outcomes, performance and productivity, thereby providing significant benefits to patients.”

Office of Health Economics Commission, NHS Outcomes, Performance and Productivity, March 2008

“Patient reported outcome measures have been used extensively in clinical trials... they are urgently needed now as they were in Nightingale’s time.”

Professor Alan Maynard, The Guardian, 4 September 2007

“If we are going to have healthcare services that invest for health, we must find new ways of assessing their value and their productivity, or achievements in improving health.”

Healthcare Commission, State of Healthcare Report Summary 2004, 2004



BOX 4 continued

“The next step for healthcare is not about more reorganisation. It is about ensuring there is genuine support for healthcare professionals to measure and report clinical and patient-reported outcomes so that long-term improvements in the quality of patient care can truly be achieved.”

Stephen Thornton, Chief Executive, The Health Foundation, BBC News, 20 June 2007

3.1.1 Public health targets

Some of the targets outlined in the Government’s Public Service Agreements (the undertakings that departments of state give the Treasury about how they will spend the money they are allocated) do appear to focus on results, not processes. Examples include increasing life expectancy and reducing standardised mortality rates in under-75s from cancer and coronary heart disease. But in reality, these are general public health measures rather than measures for the results of individual treatment, and so it does not make sense to apply them to the NHS as a measure of its performance. Instead, they should be applied to the Government in general as a measure of its overall performance in improving public health. We will therefore maintain such public health targets, but apply them to Government as a whole, not the NHS.

3.1.2 A new culture within the NHS

With process targets abolished and patients exercising greater choice based on information about results, a whole new culture will emerge within the NHS. Instead of worrying about what politicians and bureaucrats think, NHS professionals will have powerful incentives to focus wholly on achieving better patient care. Any reason to structure activity around the interests of politicians simply falls away. Instead, NHS activity will be based around the needs and wishes of patients.



3.2 Principles behind our approach

There are many different types of information that can be collected about health and healthcare. Broadly, there are three categories of information about:

- diseases and remedies,
- the efficiency of services, and
- the quality and safety of health services.

The last of these three, information about the quality and safety of care, is the most important type of information for assessing the results of NHS treatment. It is this information that will do most to enable patient accountability and choice, and to create the incentives to improve standards.

In 2007, Shadow Secretary of State for Health, Andrew Lansley, and former Secretary of State for Health, Stephen Dorrell, started a period of consultation with healthcare professionals and hosted a seminar⁴ with leading policy-makers in the UK to explore the issues involved in the development of robust measures of these health outcomes. This process identified five principles from which best practice can be developed.

3.2.1 Outcome measurement must be professionally led

The Royal College of Surgeons has already started to use outcome measures. Their experience suggests that, to provide a full picture, both patient-reported outcomes and hospital-collated information are required. The part of the information that is provided by the hospitals themselves needs to be validated by the peer review, clinical audit and event analysis which is already routine in our centres of excellence. And the results need to be adjusted to reflect the different levels of risk attaching to different kinds of patient – so that there is no perverse incentive for the professionals selectively to treat low-risk patients.⁵

⁴ Seminar on the use of outcomes in healthcare, Policy Exchange, January 2007

⁵ Heart: <http://heart.bmj.com>, doi:10.1136/hrt2006.106393



3.2.2 Data collection is everyone's priority

Collecting, collating and publishing the right information is fundamental to achieving health outcomes that are among the best in Europe. Providing data on outcomes should be part of a clinician's commitment to both professional accountability and the development of the evidence base for future research.

The quality of outcome measures – and therefore of the decisions about future treatments and resource allocation taken on the basis of those measures – are dependent on the accuracy of the data provided by clinicians. The best person to report on a treatment episode is the clinician responsible for the care.

As commissioning becomes more sophisticated it will become progressively more important to ensure that the information submitted is accurate. That will require the active engagement of all clinicians in the process.

3.2.3 The NHS must have a robust information strategy

The Government published a commissioning guide in 2007 detailing the variety of sources in health and social care from which data are required to inform commissioning decisions. It found that the use of data in driving decisions is constrained, as the quality of information provided is often poor or inconsistent and it is often impossible to link episodes of patient care into the sequence of events which encompassed the patient experience.

Data need to be collected according to a standardised and audited protocol in order to ensure that these weaknesses are addressed. Independent providers such as BUPA and Nuffield Health have collected and collated patient-reported health scores and patient-reported outcomes for some time. This information allows for comparison of patient-reported outcome measures between hospitals.



3.2.4 The results must be published

The benefits derived from the collection of more and better information on NHS performance will only be fully realised if that information is published. In a post-bureaucratic age, public availability of accurate and sophisticated information has the power to put users in control of services and to drive up quality dramatically.

The principle that health information should be in the public domain is starting to become better established, but there is a long way to go. Cardiac surgeons, for example, publish league tables for mortality in heart bypass and valve surgery. The most telling point in reviewing the impact of publishing this information is the universally high quality of service that is now being achieved in this field.

There is an emerging body of evidence to suggest that, in addition to improved professional accountability, the process of publication itself acts as a stimulus to improve outcomes. For example, a recent study showed the death rate for coronary artery bypass graft patients after public disclosure was significantly lower than it had been before, falling from 2.4 per cent to 1.8 per cent. And this fall was not achieved by excluding complex cases or older patients.⁶

We believe that a culture of public accountability based around robust information would reduce the chances of scandals, such as that affecting the Bristol paediatric department, being repeated. In Bristol, a mortality rate double the national average was noted before the crisis, but public ignorance of the data allowed the original decline in service to be compounded by a lengthy period of inaction. Effective structures for professional accountability, focused on published outcome measures, should facilitate more effective and timelier intervention.

⁶ Bridgewater et al, 'Has the publication of cardiac surgery outcome data been associated with changes in practice in Northwest England?' Heart, January 2007



3.2.5 Public health measures should be reported

We have consistently argued the case for giving greater priority to public health objectives and have proposed that dedicated funding streams should be committed to joint Local Area Agreements with local authorities. This can be delivered if commissioners are required to publish their objectives and monitor their performance against those objectives. Commissioners should be familiar with the important measures of healthcare outcomes in their area, and the professionals involved in the delivery of care should be aware of the health outcomes for their treatments and procedures.

3.3 More and better information

Much of the clinical data required to measure outcomes, for example, five year cancer survival rates, is already collected. But patients are unable to gain easy access to it and use it to compare different care providers' results. An incoming Conservative Government will initially introduce outcome measures that draw on existing data sources, and mandate providers to make them public.

We start from the position that all data should be published unless it can be shown why this will cause harm. This is opposite to the Government's own approach to information provision, which is to publish only the data that it has selected and which reflects best on its own performance. In the first instance, this requires a change of culture rather than building a new system. The change will be to ensure that existing information is targeted at a new set of users – the public – instead of being used by Whitehall to monitor the NHS. Clearly some information can never be published (because it relates to private individual matters, for example) but we will ensure that the NHS publishes as much existing information as possible, and will allow the public to challenge any healthcare provider which holds back information without justification.

Box 5

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures, or PROMs, are used to help measure the benefits patients receive as a result of treatment. They are collected directly from patients through very simple questionnaires that ask for details about their particular condition, how long it has affected them, and how well they think the treatment they receive is working. Patients can complete this at home in their own time, or with their GP.

PROMs are already used by healthcare organisations like BUPA. By listening to patients' own views about the treatment they receive, doctors can better understand how to improve the quality of care they provide. PROMs also help patients and GPs to make choices over treatment, and help clinicians and managers get a more rounded picture of the quality of care they provide.

Surveys can distinguish between several dimensions of patient-centred care:

- accessibility and timeliness of appointment,
- respect for patients' values, preferences, and expressed needs,
- co-ordination and integration of care,
- information, communication, and education (including clinical status, progress and prognosis, processes of care, facilitation of autonomy, self-care and health promotion),
- physical comfort (including pain management, help with activities of daily living, surroundings and hospital environment),
- emotional support and alleviation of fear and anxiety (including clinical status, treatment and prognosis, impact of illness on self and family, financial impact of illness),



Box 5 continued

- involvement of family and friends (including social and emotional support, involvement in decision making, support for care giving, impact on family dynamics and functioning), and
- transition and continuity (including information about medication, coordination and discharge planning, clinical, social, physical and financial support).

The output could be made available openly to patients and their representative groups to allow comparisons of service excellence. Open publication of information will be crucial to realising the full benefits of using PROMs.

But we want to go further and provide new and more sophisticated information to patients and commissioners. We believe that comprehensive and effective measures of the health outcomes that patients experience as a result of treatment should include patients' own reported experiences as well as clinicians' data. Collecting patient reported outcome measures, or PROMs (see Box 5 for more details), will require new systems, but these can be delivered using existing infrastructure and expertise.

This data should be published in a standardised way and be open to the public to use in whichever way they see fit. Dr Foster Intelligence has published The Hospital Guide since 2000, as well as publications on infections and other specialised service areas. Websites also exist for patients to post comments on hospital experiences, from food to car parking. Recently, Microsoft, Google and AOL have created personalised health record spaces to assimilate such information. These represent social movements that could, with even better information provision about healthcare outcomes, bring about a transformation in the way patients use the NHS and help it achieve the highest possible standards of care.



3.3.1 Patients empowered with real choice

As with any service, expanding people's power of choice depends on the availability of information about the results of alternative providers. People need to be able to compare the performance of different providers to find the one that best suits their needs. Better information means more informed choice, and PROMs can help patients assess the quality of care with greater depth.

3.3.2 Better quality

Providers of health care, and the clinicians and other staff who deliver care, need information on outcomes to improve the quality of their care. As outcome measures become established there will be scope for far better analysis of both performance and management policies within the NHS itself.

3.3.3 Better value

The commissioners of care need information on outcomes performance to decide how to get the greatest benefit from the resources at their disposal. With commissioners having a better understanding of the outcomes that providers are achieving, rather than their success in meeting process targets, all providers will have better incentives to achieve good clinical results.

3.3.4 Better accountability

The Government also needs to determine the overall outcomes of the NHS to assess how much health benefit the NHS is producing for the public funds it receives. Better information on outcomes would allow, for example, the merging of long term outcome measures, such as five- or ten-year survival rates in cancer, with indicators of professional practice, such as the availability of different types of care and the uptake of professionally-set best practice.



3.4 Benefits and incentives

As well as providing better information to health professionals to enable them to improve the quality of care they provide, the development and publication of new and better measures of NHS performance will massively improve the ways in which patients and commissioners exercise choice in the system, and therefore dramatically increase the incentives for providers to improve their services.

Empowering patient choice will provide powerful incentives for professionals to innovate, in partnership with NHS managers, and provide the best care options for the local populations they serve. We want to consult further on how NHS monitoring and funding could be more focused on incentivising good clinical results.

3.4.1 Using outcomes to help deliver excellence for patients

Many customer service industries use 'outcomes'-type information to ensure that customers are satisfied with the service received and that it meets their specific needs. Service users also need this information to make genuinely informed choices between different providers, ideally ensuring they receive the highest quality service available. We believe the principle of ensuring accountability and choice to the patient is just as important in NHS-delivered healthcare.

Information about health outcomes, provided by both clinicians and by patients themselves, can create further incentives for high performance among health care providers – for example, by enhancing the reputation of good providers, thereby securing them more work, or even by rewarding successful providers through payments within the tariff system.

We envisage that the publication of outcomes and other data will deliver a better service for patients in a number of ways, as shown in Table 1.



Table 1

Managing performance using outcomes		
	Direct impacts	Indirect impacts
GOOD PERFORMANCE	<ul style="list-style-type: none"> ■ Financial rewards for exceptional performance ■ Evidence to inform care professional revalidation and appraisal ■ Key contractual indicators for commissioning contracts 	<ul style="list-style-type: none"> ■ Published outcomes assist professionals in directing patients to high quality providers ■ Patient information to inform high quality service providers ■ Enhanced provider reputations
POOR PERFORMANCE	<ul style="list-style-type: none"> ■ Long term trends will inform quality and safety governance ■ Evidence used in annual appraisal and revalidation 	<ul style="list-style-type: none"> ■ Patients and professionals move away from lower quality provision, incentivising low performers to improve and take on best practice

3.4.2 Better incentives for providers

Our public services must become more responsive to the needs of patients, their families and carers. Access to and delivery of care must be able to meet the changing demands of everyday living. Care is currently too often configured around the needs of providers rather than the needs of the public, and this situation has been perpetuated by endless centralised initiatives that have curtailed local leadership and constrained innovative local approaches.

In a speech earlier this year, David Cameron outlined how the use of PROMs and other information can be used to provide direct financial incentives to healthcare providers:



"It should be a basic rule of social policy that you don't pay for what you don't want more of. Money should attend success, not failure. So, for instance, I don't think hospitals should be paid – or paid in full – for a treatment which leaves the patient with a hospital-acquired infection like MRSA.

"So-called 'treatment following adverse events' should be the responsibility of the provider, not the purchaser – the hospital, not the GP or primary care commissioner. GPs can spend the money that they save in this way to improve care elsewhere.

"This is a means of hard-wiring infection control into the system. Rather than a top-down system of targets which encourages 'throughput' above all else, we propose a bottom-up system which prioritises quality as well as quantity. This will make managers concentrate on the effectiveness, not just the volume of treatment.

"In the same way, we want to explore new measures of patient-reported outcomes, which enables money to follow excellence in terms of the actual experience of people who use the NHS."⁷

We will further develop our proposals on payment by results, so that it is no longer payment by activity but payment for performance. The design of Healthcare Resource Groups (HRG), from which tariffs are derived, should incorporate national standards, linked to the commissioning guidelines being issued by the NHS Board. The tariff needs to be a maximum or standard price, but contracts must incorporate quality and value conditions.

4. OUTCOMES: IMPROVING THE HEALTH OF THE NATION

To achieve the dramatic improvements we want to see, we will publish new information on how healthcare providers are performing and on how patients judge the quality of the care they receive. A focus on outcomes will empower patients and commissioners by allowing them to choose better quality care, thereby providing a powerful financial incentive for providers to improve outcomes for their patients. Professionals within an independent NHS will have the right information about what works and what doesn't, and will be free to make the right clinical decisions they feel will achieve the outcomes we all want to see. The tariff regime, where providers are only paid for the procedures they deliver, will reward success and encourage under-performing providers to improve.

4.1 Key health outcomes

We want the success of the NHS under a Conservative Government to be judged against how it improves health outcomes in seven key areas, and expect the reforms we are proposing to deliver:

4.1.1 Five-year survival rates for cancer in excess of EU averages by 2015

A recent study of 20 European countries found that England has one of the worst five year cancer survival rates in Europe. Our outcomes are on a par with some Eastern European countries that spend less than one third of the UK's per capita healthcare budget.⁸

Our new independent NHS Board will be tasked by a Conservative Government with improving five-year cancer survival rates. Our separate public health strategy, to be published in due course, will support this, along with additional resources liberated from politically-driven targets. The data required for measuring five year outcomes is already collected by the Information Centre and National Cancer Registries. Instead of focusing on only part of a cancer patient's treatment, clinicians will be free to tailor all treatment around an individual's needs in order to achieve what matters most to patients – improved survival rates.

⁸ Lancet Oncology, 'Cancer survival rates continue to improve, but UK still lagging behind. 21 August 2007'.



4.1.2 Premature mortality from stroke and heart disease below EU averages by 2015

National targets exist to ensure patients do not wait for longer than three months for intervention, yet no clinician would signal this as an appropriate quality measure. The role of government policy is not to determine targets for the process of delivering care, but to measure the results in terms of survival rates and health improvements. The Government's process targets do not reflect best practice across the world and should be subject to clinical interpretation.

4.1.3 Premature mortality from lung disease below EU averages by 2020

Declining lung function causes a lower quality of life and premature death. Rates of chronic lung disease mainly reflect the legacy from smoking and certain occupational health exposures. Government targets do little for lung disease because they focus on process measures used solely in General Practice.

The NHS currently has no way of knowing whether treatments and services are helping patients, let alone which treatments or care pathways help the most. Under our system patient outcome measures would be recorded at regular intervals, judging patient perception of care and the quality of care across primary and secondary care as a whole. Healthcare commissioners would be free to design care packages around the needs of patients, rather than simply ensuring that certain processes are followed in order to hit Government targets.

4.1.4 Year-on-year improvement in patient-reported outcomes for patients living with long-term conditions

There are no current statistics or data for the great majority of those seventeen million patients living with a long term condition. And yet there are many disease-specific tools that measure the quality of life of



those suffering with heart or lung disease. These are increasingly important because the introduction of individual budgets (where the patient himself is given a budget with which to design his own care package) requires detailed outcome information to work effectively.

Care for these conditions is often fragmented between different care providers, leaving patients and their families confused about who to contact. Targets exist to deal with these problems, but they tend to measure the delivery of processes at one point in the health system – typically the administration of a test or treatment to a given demographic group over a given timeframe. We propose to replace these by collecting, collating and publishing patient-reported outcome measures for chronic diseases. We would consider using EQ5D – a 2-page patient questionnaire, developed and by EuroQoL. EQ5D been used in population studies over the past decade. The patient conducts a self-assessment that covers five dimensions: mobility; self-care; usual activities; pain/discomfort and anxiety/depression. EQ-5D defines 243 health states from the above and generates a single index score. We will consult on outcome measures for other common disease areas.

4.1.5 Year-on-year improvement in patients' satisfaction with their access to, and experiences of, healthcare

The past decade has seen targets applied to controlling specific services, with a narrow focus on casualty waiting times or access to see a GP. Evidence suggests these targets have been met by diverting attention or resources from other areas and in places by flexing the rules; they have had little effect on the reform of services.

We will ensure Primary Care Trusts (PCTs) commission independent samples to gauge patient satisfaction with a range of healthcare services. This will allow PCTs to make more informed decisions about the providers they contract with, and enable patients to see which providers deliver the best services.



4.1.6 Mortality amenable to healthcare brought down to the level of comparable countries.

Measures of avoidable mortality are used internationally to measure the extent to which healthcare services save lives and contribute to population health. Avoidable mortality refers to the number of deaths (under age 75) that should not occur in the presence of effective and timely healthcare.⁹ Causes of death are included in this indicator if there is evidence that they are amenable to healthcare interventions. Healthcare interventions include those aimed at preventing disease onset as well as treating disease.¹⁰

4.1.7 Year-on-year reduction in the number of adverse events

Over 6,000 patient deaths are reported every year as a result of healthcare-related events. Our view is that it is very rarely the case that one individual causes such an error; rather it is the system of care that contributes to these tragedies. We are therefore committed to an open and transparent approach to learning from failure. It is vital that patients understand the risks they face when submitting to health procedures delivered by a given provider.

We do not believe targets are the answer, and will consult on key outcome charts used in Australia, Germany and the USA where quality standards are often devised by experts and collected voluntarily.

A safety improvement environment can only be created by strong local clinical leadership informed by good information about care trends. We will bring forward measures to reward learning cultures, reinforce the importance of staff training, and provide event simulation and debriefing. We will consider contract penalties for the most serious adverse outcomes including Healthcare Associated Infections.



4.1.8 Additional outcomes

We are consulting on the outcome measures which we propose to introduce as soon as practicable. Over time, we will seek to roll out information about outcomes in further areas, including dentistry, maternity services and palliative care.

4.2 Saving lives through a focus on outcomes

Focusing the NHS on the range of outcomes outlined above will allow us to monitor its progress compared with systems elsewhere in Europe. Achieving average performance by European standard across the NHS could save nearly 38,000 lives a year. **Performing at the same level as the best health systems in the world could save at least 100,000 lives a year.**¹¹ We believe that the focus on outcomes we want to create in the NHS, along with the other policy proposals we have made elsewhere, will help us move towards achieving these ambitious goals.

4.2.1 Five-year cancer survival rates in excess of EU averages by 2015 would mean that between 4,600 and 34,500 lives could be saved

Every year around 230,000 people in England are diagnosed with cancer.¹² Only 45 per cent of cancer patients in England survive for five years after diagnosis. The European average is 47 per cent and the European best (in Sweden) is 60 per cent.¹³ Therefore, on the basis of current survival rates, 103,500 people would still be alive after five years; on European average rates 108,100 people would be alive after five years; and on European best rates, 138,000 people would be alive after five years. That means **between 4,600 and 34,500 lives could be saved every year.**

¹¹ These numbers of lives saved are calculated by adding together the lives that would be saved in each of areas 3.6.1 to 3.6.4 if the NHS were to perform to (a) average European standards or (b) the highest European standard. We have not included the lives saved from reaching these standards in area 3.6.5, a more general category, to avoid any risk of double-counting.

¹² Department of Health, Cancer Reform Strategy, 3 December 2007

¹³ Lancet, 21st August 2007, EURO CARE-4 study



4.2.2 Premature mortality from stroke reaching below comparable country averages by 2015 would mean that between 13,199 and 24,874 years of life could be saved

Every year approximately 110,000 people in England have a stroke.¹⁴ In the UK, 117 years of life below age 70 are lost to cerebrovascular disease per 100,000 of the population. This compares to just 91 in Germany, 83 in France and 68 in Australia.¹⁵ The population of England is 50,762,900, so England's population would lose 59,393 years of life to cerebrovascular disease, compared to just 46,194 in Germany and 34,519 in Australia. That means that **between 13,199 and 24,874 years of life could be saved every year.**

4.2.3 Premature mortality from heart disease reaching below comparable country averages by 2015 would mean that between 4,400 and 17,600 lives could be saved

275,000 people in England have a heart attack each year.¹⁶ 11.8 per cent of people in the UK die within 30 days, compared to just 10.2 per cent on average in the OECD and just 5.4 per cent in New Zealand, the best performing country.¹⁷ Therefore, 32,450 people currently die within 30 days in the UK. If OECD average rates were achieved then just 28,050 people would die; and if the best OECD rates were achieved then just 14,850 people would die. That means **between 4,400 and 17,600 lives could be saved every year.**

14 Department of Health, National Stroke Strategy, 5 December 2007

15 Sheila Leatherman and Kim Sutherland, The Quest for Quality: Refining the NHS Reforms, 20 May 2008

16 Department of Health website

17 OECD, Health Data 2007



4.2.4 Mortality from lung disease below EU averages by 2020 would mean between 15,737 and 23,860 lives could be saved

In the UK there are 78 deaths per 100,000 per annum from respiratory diseases, compared to just 47 on average in the EU15 and 31 in Austria, the best performing EU15 country.¹⁸ The population of England is 50,762,900.¹⁹ Therefore, 39,595 people currently die each year in England from lung disease, compared to just 23,859 if we achieved European average rates and just 15,736 if we achieved European best rates. That means **between 15,736 and 23,859 lives a year could be saved every year.**

4.2.5 Mortality amenable to healthcare to be brought down to the level in comparable countries.

In the UK there are 103 premature deaths per annum per 100,000 population from causes that are potentially preventable with timely and effective healthcare, whereas there are just 90 in Germany and 65 in France.²⁰ The population of England is 50,762,900.²¹ Therefore in England there are 52,286 deaths per annum from causes that are potentially preventable with timely and effective healthcare, compared to just 45,687 if we achieved German levels of care and 32,996 if we achieved French levels. That means **between 6,599 and 19,290 lives could be saved every year.**

18 British Thoracic Society, The Burden of Lung Disease, 28 June 2006

19 ONS website

20 Sheila Leatherman and Kim Sutherland, The Quest for Quality: Refining the NHS Reforms, 20 May 2008, p.109

21 ONS website



5. IMPLEMENTING OUTCOMES TO SAVE LIVES

Our focus on outcomes for the NHS involves making public information on a series of NHS outcomes that will allow patients and commissioners to compare the quality of care provision. The measures we want to publish are based on data that is already largely collected internally within the NHS, requiring only a change in focus towards a new set of users rather than having to construct any significant new systems. Collecting patient reported outcome measures, or PROMs, will require some new systems, but these can be delivered using existing infrastructure and expertise.

5.1 Measuring and publishing outcomes

Realising the ambitions described in this policy paper requires accurate information about NHS outcomes to be made accessible to patients and commissioners. The requirements are that providers produce data for their clinical outcomes, including morbidity, survival rates and patient experiences, including PROMs.

5.1.1 Working with the existing infrastructure

There is already a vast amount of data collected on all aspects of NHS activity, including outcomes for patients. This is typically used for management and clinical purposes rather than direct patient care: in areas such as strategic planning, benchmarking, clinical audits, research and clinical governance.

A wide range of bodies therefore already collect the outcomes data we require, or could be involved in its production and/or oversight. These include the National Clinical Audit Advisory Group, the Information Centre, the National Cancer Registries, PCTs, the GP QOF, the Secondary User Service, the Quality Management and Analysis System and the Office for National Statistics.

Our approach will make use of outcomes data already collected and allow it to be freely used by patients and commissioners of care. The Office of



Health Economics Commission (OHEC) has reviewed the evidence on measures of patient outcomes in several disease areas and demonstrates that this is a practical proposition across a wide range of health services.²²

Providers already have capability for the collection, collation and publication of outcome measures. Any transitional costs in areas such as IT and staff training will be minimal, if apparent at all, and more than absorbable given the freedom they will gain from a number of extremely bureaucratic government targets.

In fact, OHEC highlight the powerful market incentives for providers to proactively seek to develop and publicise outcomes information. In terms of who collects and publishes outcomes data, they note that “it seems reasonable for the responsibility to lie with providers as they are trying to inform commissioners and the performance managers of the benefits of their services.”²³ With greater patient choice being exercised, these incentives would become very powerful indeed.

5.1.2 Developing PROMs

We propose to collect PROMs from patients managing long-term conditions initially and, based on the evidence, look to roll them out in other areas. This would not be a new or untested exercise; there is already significant infrastructure and expertise in place which could facilitate the widespread collection of these PROMs. OHEC notes that, “private sector organisations, such as CHKS and Outcome Technologies have already implemented systems to collect and analyse PROMs... Such organisations, and no doubt other entrants to this market, can be called up for assistance.”²⁴

There is also some infrastructure already in place in GP surgeries. For example, computers are currently used in many areas for electronic check-in, and could very easily include outcomes questionnaires for patients.

²² Office of Health Economics Commission, NHS Outcomes, Performance and Productivity, March 2008

²³ Ibid, p.64

²⁴ Ibid p.63



OHEC have modelled the costs of collecting and producing PROMs, after reviewing evidence from a number of healthcare agencies and providers, as very modest and, again, more than absorbable given the targets that we will remove.²⁵

5.2 The cost of meeting process targets

The net financial effect of delivering the outcomes policy described here should be very positive for the NHS. It is difficult to assess the exact annual cost incurred by the NHS from the distortions of clinical priorities created by the targets we propose to abolish. But the evidence we do have points to a vast cost, not only in simple cash terms, but also in terms of clinical disruption, distorted resource allocation and huge administrative burdens.

Our own consultations with healthcare professionals showed NHS managers are spending large amounts of time reorganising activities, diverting funding from clinical priorities and using coping strategies such as employing extra temporary staff, purely to attend to government targets. Publicly documented evidence also shows clearly that the distortion of clinical priorities created by NHS targets has produced high costs and been a major factor driving the financial insecurity experienced within the NHS in recent years.

A recent survey of NHS chief executives published in the *Health Service Journal*²⁶ showed that 67 per cent of respondents said the NHS would not have faced such severe financial problems were it not for “inflexible government targets”. A similar study of NHS finance directors from the Healthcare Financial Management Association also highlighted widespread concern that the cost of meeting process targets is a key risk to the ability of trusts to achieve financial balance.²⁷

²⁵ Ibid p.63

²⁶ *Health Service Journal*, 19 January 2006

²⁷ Healthcare Financial Management Association, *Finance Director's Survey 2007*, December 2007



Perhaps the worst aspect of Labour's regime is that the targets placed on NHS staff are so-often politically-motivated rather than practical and professionally-led. A recent House of Commons Health Committee report²⁸ identified government targets as a principal pressure on NHS finances which is leading to significant increases in expenditure. It stated that, "in recent years the NHS has veered from one priority to the next as the political focus has changed. It has concentrated on meeting targets with too little concern for finance."²⁹

A survey of emergency medicine departments, commissioned jointly by the British Medical Association and the British Association for Emergency Medicine, found that 49 per cent of departments reported that they needed to use additional funding to help them meet the emergency access target, and 53 per cent reported that they had to employ agency or locum staff on short term contracts as a specific additional measure.³⁰

The nature of NHS accounting and reporting does not make it possible to quantify all this disruption in simple cash terms and with reference to the NHS accounts, since these additional costs are spread over various resource budgets, placing burdens on staffing, accounting, administration, budgeting, and many other areas. The total cost must, however, run into hundreds of millions of pounds; CHKS's annual estimate of the unnecessary cost of the four-hour A&E target is £400 million on its own.

5.3 Overall operational implications

Our policy generates significant value for the NHS that far outweighs any potential cost implications. The NHS will not be expected to do anything other than collect, collate and publish the required information.

Experience in other areas and other countries – such as crime mapping in the US – shows that third parties like Dr Foster, Google and others can creatively use this data and turn it into products that are available to patients and commissioners at zero cost to the user.

²⁸ Health Select Committee, NHS Deficits, 7 December 2006

²⁹ Ibid p.71.

³⁰ BMA / BAEM, Emergency Medicine: Report of national survey of emergency medicine, January 2007



The fact that our approach includes part of a strategy to rid the NHS of several process targets, and the vast cost associated with them, allows for significant efficiency gains as NHS professionals return to focus fully on achieving good clinical results for patients. In addition, enabling outcomes-based commissioning and facilitating greater patient choice will create powerful incentives to raise standards of patient care.

Removing key areas of national targeting and implementing an outcomes framework for NHS commissioning and patient choice will have the following direct financial and operational effects:

- a net positive financial effect across the NHS, as the costs of meeting government targets are reduced far further than the cost of implementing an outcomes framework;
- more efficient allocation of NHS resources, as clinical distortions resulting from activities aimed purely at meeting government targets are removed;
- more effective commissioning resulting from a more direct relationship with comparable providers' performance; and,
- clearer incentives for providers to raise standards, as patients exercise more informed choices based on information about different performance levels.

There will also be very important ancillary benefits. For example, the data itself will have a utility beyond its principal purpose to empower greater choice and more effective commissioning. It will be useful to patients with chronic conditions, who may be better able to track the progression of their disease over time and thus take a more active role in its management. There will also be better data resources from which to analyse the cost effectiveness of various treatments and other variables, which will be of interest to a wide range of people and institutions. Above all though, a more patient-centred culture will be fostered as the published results of patient care drive greater transparency and accountability throughout the NHS.



6. QUESTIONS FOR CONSULTATION

We believe that our proposals for improving NHS performance so that our health outcomes are among the best in Europe will give healthcare professionals the freedom they need to deliver higher standards of care, while providing robust bottom-up accountability to patients and commissioners instead of top down government control. Giving people access to quality information about care results can empower patients to choose between providers, and in turn make providers more accountable for their results and incentivised to raise standards.

The approach set out in this policy paper is intended to have a major and positive impact on the NHS. It aims to save large amounts of time and money, and far more crucially, we expect tens of thousands of lives to be saved from premature mortality across a number of major disease areas, including cancer.

We have outlined here a vision for helping the NHS to meet the challenge of achieving continuous improvement. We now invite your comments on these proposals.

You can send your responses to us by emailing:
jenny.parsons@conservatives.com

Or by post to:

Jenny Parsons
Conservative Campaign Headquarters
30 Millbank
London SW1P 4DP



6.1 Questions:

6.1.1 Removal of process targets

1. Do you support the phased removal of process targets and the move to a system of clinical and patient reported outcomes?
2. Do you consider central targets to have distorted priorities in the delivery of care services?
3. Which targets should we aim to remove as a matter of priority?
4. Are there important clinical areas that have been neglected as a result of central concentration on certain objectives?
5. Are there process measures that are currently fulfilling a purpose towards an aligned care pathway or that support a clinical outcome which should be retained?

6.1.2 Introduction of outcomes

6. Do you support the principles we have identified for the development of an outcome framework?
7. Do you agree that some data, e.g. referral-to-treatment times, should continue to be collected, but not have national targets applied to them?

6.1.3 Types of outcomes

8. Do you support the use of patient reported outcome measures in elective treatment?
9. Do you support the use of long term condition chronic disease scores for the longitudinal measurement of an individual's health status and the quality of care pathways or services?
10. Do you support the introduction of independently-sampled patient experience and outcome scores to rate the accessibility, responsiveness and quality of care provision; do you have views about existing patient-reported outcome measures and their suitability for national implementation?

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11. Do you support the specific outcome measures we have suggested to introduce at first, and would you recommend others?

6.1.4 Implementation

12. What are the main logistical barriers to the widespread collation of outcomes based information? How do we best sample, collect and validate patient reported outcome measures?
13. Are there hidden costs, benefits or pressures built in to the system which will aid or hinder the implementation of outcome measurements?
14. Do you support the publication of a wide range of anonymised aggregated outcome data to facilitate patient choice? Should we licence third parties to present this data to specific patient groups?

6.1.5 Alignment

15. Our stated objective is to ensure aligned objectives within a national health system. How do we ensure outcomes meet this objective across traditional boundaries of health and social care?
16. We also envisage movement towards more integrated pathways with total packages by episode treatment group for elective procedures and chronic diseases. What further development is required to identify outcomes to measure both episodic and longitudinal episodes of care?

NOTES



