Equity and Excellence - Liberating the NHS:

Transparency in outcomes – a framework for the NHS
A consultation on proposals

Response from the Faculty of Pharmaceutical Medicine

04/10/10

Principles

1. Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework (page 10)?

Yes

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

In order to hold specific providers accountable it is not always possible to define responsibilities, especially when the care is delivered across many disciplines and different services. Therefore, definitions of responsibility and accountability would help in each domain.

A timetable for change should be described and a priority list according to importance and feasibility.

3. How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?

Removal of inequality and delivery of equitable outcomes is a complex process. There are no simple answers but one area where action could be both inexpensive and highly effective is provision of patient-centred information. The patient information on prescribed therapy and "over the counter" therapy is often written in technical language, which some groups of patients might find difficult to understand. An effective solution to ensure that patients understand how to use their prescribed therapy is to write patient information leaflets and instructions in plain English with illustrative diagrams to accompany the text if necessary.

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

In any complex organisation it is important to define the organisation/persons accountable and those responsible for the delivery of the process. Within the pharmaceutical industry, the practice is to break down the process into specific steps and then within each step define the accountabilities and responsibilities. This approach could be applied to where the work of caring is divided between NHS, public health and social care services. It is not sufficient to simply define the steps but also the roles and responsibilities of each provide within the step.

Five domains

5. Do you agree with the five domains that are proposed in Figure 1 (page 14) as making up the NHS Outcomes Framework?

The quotation from Florence Nightingale was apt. The Faculty would suggest placing safety as the first domain, as in the 21st century it cannot be acceptable that a public service is responsible for putting patients at risk.

Furthermore, mortality rates do not adequately reflect the suffering experienced in chronic disease. Here the PROMs have a great future in assessing the extent of the un-recognised and unrecorded suffering.

6. Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?

Yes

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

The structure looks feasible as a way of delivering improved care. The role of NICE to prepare Quality Standards is a useful benchmark but should not be a substitute for seeking excellence.

CHAPTER 3: What would an NHS Outcomes Framework look like?

Domain 1 - Preventing people from dying prematurely

***8.* Is 'mortality amenable to healthcare' an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?**

There is a significant number of deaths which are a result of inadequate or misuse of therapy. Low concordance with prescription of therapy contributes to premature death. Focus on methods to lessen these aspects of therapy failure would not simply reduce premature death but reduce cost of care.

Our theme for achieving a better understanding of use of prescribed medicines requires more than simply monitoring failure in correct use. We argue that there needs to be a change in behaviour that is under-pinned by an improved clinical pharmacology understanding by physicians and other prescribers. We argue that CPD should have a focus on clinical pharmacology learning for medical practitioners and other prescribers.

9. Do you think the method proposed at paras 3.7-3.9 (page 20) is an appropriate way to select improvement areas in this domain?

Just because a mortality rate is lower does not mean that there is appropriate utilisation of new technologies. Over interventional therapy can improve mortality rates but the benefit can be minimal or at great cost. Some GDP parameter benchmarking for similar countries should be used to ensure that we compare like with like, as well as examining

the infrastructure requirements and cost that this incurs. This can be compared with other interventions to ensure we address the most pressing issues through best use of health investment.

10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed in para 3.11 (page 21)?

Need for looking at the reasons for institutionalisation / hospitalisation in the first place.

The step back on the ability for maintenance of independence will make a bigger difference.

There is a danger that provision of a safe environment has not been adequately captured for the elderly.

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

Mis-prescribing for the elderly is a common error in medical practice. Measurements that include a selection of an inappropriate dose for an elderly patient should be included and the use of therapies that have not been approved for use in the elderly.

12. Are either of the suggestions at para 3.13 (pages 21) appropriate areas of focus for mortality in children? Should anything else be considered?

Mis-prescribing for the young is also common error in medical practice. Measurements that include a selection of an inappropriate dose for children should be included and use of therapies that have not been approved for use in children.

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

13. Are either of the suggestions at para 3.19 (page 24) appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?

Could another measure be the avoidance of hospital admission and ability to manage events or complications at home or in the community? A consideration of maintaining independence and reducing dependence will also reduce mistakes in prescribing / administration that may worsen problems for these patients.

14. Would indicators such as those suggested at para 3.20 (page 24) be good measures of NHS progress in this domain? Is it feasible to develop and implement them? Are there any other indicators that should be considered for the future?

PROMs have become a new and fast-developing tool in drug development for determination of efficacy of care and therapies. The science of these methods is sound and there are good illustrations for their sensitivity and specificity in demonstrating either presence or absence of benefit.

15. As well as developing Quality Standards for specific long-term conditions, are there any cross-cutting topics relevant to long-term conditions that should be considered?

The topic of communication between patient and health carer is an important new area in long-term conditions. There are frequent fluctuations in the severity of the condition that can require changes in care. Intermittent home visits and attendance in clinic cannot adequately tract these. Use of encrypted messaging devices that allow a non-telephone communication coupled with a trusted PROM could allow more effective responses and reduced costs.

As a measurement, it would be possible to quantify the time to respond to episodes of worsening care by the heath care provider.

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

16. Are the suggestions at para 3.28 (page 27) appropriate overarching outcome indicators for this domain? Are there any other indicators that should be considered?

Yes

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

We would agree that the outcomes may need to be assessed for specific acute illnesses with inclusions of PROMs.

18. Is the proposal at paras 3.30-3.33 (page 28-29) a suitable approach for selecting some improvement areas for this domain? Would another method be appropriate?

Yes

19. What might suitable outcome indicators be in these areas?

In Chronic Obstructive Pulmonary Disease two new PROMs have been developed to enable new drug development, one is called EXACT PRO and this provides a measure of severity and duration for the acute event, whether at home or in hospital. Subsequent events can also be recorded. As this is enabled to be used on a communication device like a blackberry patients can be linked to their GP, who will be able to follow their progress without necessitating a clinic visit.

Similar instruments are available for acute events in other chronic diseases. The caution is that these tools require time to validate and develop.

Domain 4 - Ensuring people have a positive experience of care

We recognize that outcomes measurement in this area has not been fully developed.

20. Do you agree with the proposed interim option for an overarching outcome indicator set out at para 3.43 (page 32)?

Yes

21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator set out at para 3.44 (page 32-33)?

Yes

22. Do you agree with the proposed improvement areas and the reasons for choosing those areas set out at para 3.45 (pages 33-34)?

Yes

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

Yes

24. Do you agree with the proposed future approach for this domain, set out at paras 3.52-3.54 (pages 36-37)?

It is not simply a question of communication with patients but detailed and carefully prepared integrated care. For example in US, *Kaiser Permanente* has focused on the integrated care in chronic diseases such as Chronic Obstructive Lung Disease and diabetes. In the UK these deserve further work.

A further area where there is a high priority is dementia sufferers and their family supporters.

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

25. Do you agree with the proposed overarching outcome indicator set out at para 3.58 (page 38)?

We agree with incidence reporting, extending the areas where incidences of harm are occurring.

However let us use as an illustration mis-prescribing of therapies. There is a need to be clear that the level of training of the prescriber is satisfactory and that they have access to drug use information. A measure of training in medical schools and level of attainment in prescribing skills needs to be recorded in the UK.

In addition, the adoption of effective therapies should accelerate, and the use of historical treatments where data is lacking should be actively stopped. We agree with the principles but this requires a huge culture change within the NHS to ensure that there is wide geographic learning and adoption of best practice.

26. Do you agree with the proposed improvement areas proposed at para 3.63 (page 39-40) and the reasons for choosing those areas?

Yes

27. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcomes for all patients and, where appropriate, NHS staff?

Literacy levels can be low in cases of poverty, disadvantage and societal disfunction. Many of the instruments that patients use require a reasonably high level of literacy. Direct and pictorial approaches may be needed for them, especially for PROMs, but also for directions for use of equipment and therapies.

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

In the pharmaceutical industry we have supported not just medical experts to develop care pathways but also to encourage greater patient involvement in design. This has in our experience led to more effective training of both patients and medical carers.

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

Yes

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

The reduction of waste, for example non-concordance of prescribed drug use has been estimated to account for up to 50% of drugs prescribed.

31. Is there any other issue you feel has been missed on which you would like to express a view?

Yes – to emphasise the correct use of drug therapy and prescriptions is an essential role of the NHS. Evidence suggests that mistakes in prescribing are frequent and put patients at risk. Drugs are wasted through poor concordance.

The adoption by medical schools of Pharmaceutical Medicine training on prescribing and adoption of standards in prescribing also needs greater emphasis.

Therapy for illness is most commonly by means of prescribing.

We would like to see a metric that includes the recording of mistakes in prescribing and that this is built into the process of re-validation.

32. What are the strengths and weaknesses of any of the potential outcome indicators listed in Annex A with which you are familiar?

In domain 5 we feel that there are too few methods to record all the medical errors in prescribing. We would argue for a focus on instruments to record errors and that these may be augmented by CPD re-enforced clinical pharmacology training and linkage of prescribing accuracy to re-validation.

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

There would be benefit in looking at both undergraduate training and CPD in relation to practice and delivery of the professional groups that staff the NHS.

34. How might we estimate and attribute the relative contributions of the NHS, Public Health and Social Care to these potential outcome indicators?

In many diseases the relative responsibility can be quantified for the NHS, public health and social care to the outcome. This could be used to apportion the relative contribution.

Principles for selecting indicators

35. Are the principles set out on pages 48 and 49 on which to select outcome indicators appropriate? Should any other principles be considered?

The responsibility for initial education and the continuing education needs to be considered as part of the total assessment of outcomes.