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Measuring the performance of local health systems: a review for the Department of Health

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Summary of findings and recommendations

This report summarises the results of a rapid review of how to assess the performance of local health systems through the lens of clinical commissioning groups (CCGs). The review was commissioned by the Department of Health who asked The King's Fund to advise on the 'first principles' of a local health system scorecard for the NHS in England.

We have taken the performance of local health systems in this context to mean the performance of health services within a CCG area, including how well these services work with social care and public health services.

In undertaking the review, we were asked to consider the merits of basing the scorecard on five population groups (people aged over 75; people under 75 with long-term conditions; maternity services, children and young people; people with mental health conditions; and the generally well) and on a number of domains (prevention; access; effectiveness; efficiency; system resilience) as proposed in the terms of reference.

After discussion with the Department of Health and NHS England, it was agreed that our review would focus on the five population groups and the domains of access, prevention and effectiveness only. We also revised the effectiveness domain to include a wider focus on quality (and renamed the domain quality), including the three areas of quality defined by Lord Darzi: effectiveness, safety and patient experience (Department of Health 2008b).

A key part of our review has been to identify a large number of indicators from currently available sources that might be used to report on health system performance. These were narrowed down to about 200 indicators that could be relevant from a CCG perspective (although their technical feasibility has not been tested). The results show that the indicators mapped reasonably well to the domains of access, prevention and quality, but much less well to the five population groups proposed in the terms of reference.

The main difficulties were that several indicators refer to the whole population, many map to more than one population group, and the boundaries between groups is often unclear, making it difficult to know where to locate some indicators. It is also important to emphasise that presenting data by these five population groups does not easily encompass all areas of care – for example, where would data on cancer services and end-of-life care be included? Our conclusion is that while it would be feasible to work within this framework, it has some significant drawbacks.

In view of these drawbacks, we considered other approaches that might be used. The principal alternative would be to build on what already exists in the form of the national Outcomes Frameworks for the NHS, public health and adult social care and the CCG outcomes indicator set (COIS). Much work has gone into the development of these frameworks and supporting indicator sets and they are well embedded within the NHS.

There is also close and intentional alignment between the NHS Outcomes Framework and the COIS – which is used to measure how CCGs are contributing to progress in the domains of the NHS Outcomes Framework – with the COIS having been through a rigorous development process by National Institute for Health and Care Excellence (NICE). If this alternative were pursued, it would mean using the domains in the Outcomes Frameworks to assess health system performance, rather than the population groups proposed in the terms of reference. The challenge then is whether these domains are as meaningful to the public as the population groups proposed.

Our view is that it would be preferable to start with the three Outcomes Frameworks and the COIS. We recommend that data from these sources, supplemented by data from other sources, is presented at three levels as described below. The main purpose would be to provide patients and the public with information about the performance of local health systems. Commissioners and providers would also use the data to identify opportunities for improvement.

If this approach is chosen, we recommend a review of the three national Outcomes Frameworks with the aim of updating and consolidating them into a single framework covering the NHS, public health and adult social care.

In carrying out the review, we were struck by the number of different bodies involved in assessing performance (including the Department of Health, NHS England and the Care Quality Commission (CQC)), duplication in some of the work that has been done, and the competing frameworks that exist. Early on it became clear that there is a need for radical simplification and better alignment of this work. This is especially important at a time when the Department of Health is proposing a new framework to add to those that already exist.

We would particularly emphasise the need for alignment between the metrics used to assess local health system performance and those used in the CCG Assurance Framework developed by NHS England. The latter is the principal means for managing the performance of CCGs and includes metrics related to performance alongside information about other factors such as leadership, governance and planning capabilities.

NHS England is currently reviewing the CCG Assurance Framework and this provides an opportunity to align the metrics it uses with the metrics used to assess the performance of local health systems. It is particularly important that the metrics used in the Assurance Framework offer a balanced assessment of performance with an increased focus on quality and outcomes. This could be done by drawing on a wider range of indicators from the COIS in the revised CCG Assurance Framework.

Simplification and alignment would provide a clear line of sight from the Secretary of State and the Department of Health through NHS England and CCGs to the performance of local health systems, based on indicators that reflect what really matters to patients and the public. This would deliver the 'single definition of success' for local systems of care and CCGs that the Secretary of State has spoken of being needed for providers, as well as much greater transparency for patients and the public.

Our findings and recommendations have been influenced by experience in other countries in two respects: first, in proposing that data should be presented at three levels, adapting an approach used in Canada. At the first level would be a relatively small number of headline indicators that are of particular relevance to the public and that are agreed after engagement with the public, as happened in Canada. Indicators from the current Outcomes Frameworks could be used as the starting point.

Engaging with the public to determine what domains should be covered and what indicators should be used is essential as at present this is an evidence-free zone. The headline indicators should provide a high-level picture of overall performance for the population as a whole. These headline indicators might cover access, prevention and quality as suggested in the terms of reference, but alternatives like the Institute for Healthcare Improvement's (IHI) Triple Aim should also be considered.

At the second level, a wider range of data should be presented, and initially these could be based on the domains and indicators in the three Outcomes Frameworks and the COIS. The aim would be to provide a more granular understanding of performance in line with national priorities than is possible using the small number of headline indicators. The advantage of including the COIS is that it has been developed after thorough testing and covers a range of indicators considered important for delivering on national priorities in the NHS Outcomes Framework at a CCG level.

This data would be supplemented at the third level by indicators from other sources to provide as comprehensive a picture as possible of local health system performance. Inclusion of a larger set of indicators would enable the public to drill down into areas of care of particular interest and also would support commissioners and providers to benchmark their performance against others to facilitate improvement.

Second, international experience suggests the need to avoid producing aggregate scores for local health systems that risk hiding more than they reveal. These scores can mask good or poor performance on individual indicators and therefore may not provide a meaningful picture of performance. For these and other reasons, no government or official agency in other countries to our knowledge produces a single summary score to represent the performance of local health systems. The technical experts we consulted strongly advised against the use of aggregate scores.

If the Department of Health wishes to make use of aggregate scores, then it will be important to draw on the experience of CQC in producing provider ratings. CQC has found that its overall assessments need to be based on a combination of performance indicators and information drawn from inspections related to leadership, culture and other factors. This approach is similar to that used in NHS England's CCG Assurance Framework which in our view should be the principal means for managing CCG performance. We recommend that aggregate scores for CCGs – if they are to be used – are developed within that framework and not in the local health system scorecard.

Our final recommendation concerns the presentation of data to the public. There is huge scope for rationalisation and improvement of existing websites with varying content and formats that are not easy for the public to access or comprehend. We recommend a rapid review to tackle these weaknesses, again drawing on international best practice, with the aim of either producing a single website for all information intended for public use, or links to other websites such as CQC on provider ratings and Public Health England on local health profiles. Similarly there should be consolidation of the numerous websites directed at NHS organisations, with functionality that enables users to interrogate the data in multiple ways.

Throughout the course of our review, we have linked with colleagues from the Health Foundation who have been undertaking a parallel review for the Department of Health on indicators of general practice quality. There are a number of similar messages that can be found in both of these reviews, including our recommendations to:

- select a small set of headline indicators to present key performance information to the public
- avoid the use of aggregate scores based on performance indicators alone
- consolidate the disparate array of websites presenting information to the public and the NHS
- have NICE and others continue to play a leading role in indicator development and assurance for indicators relating to quality and outcomes.

The Department of Health has an opportunity to build on the findings of both of our reviews in promoting intelligent transparency in the NHS.

1. Our brief

This report summarises the results of a rapid review of how to assess the performance of local health systems through the lens of clinical commissioning groups (CCGs). It is a response to a commission from the Department of Health to The King's Fund to take stock of progress already made in this area by national bodies and other groups, and to assess what metrics are available.

The full terms of reference for our review can be found in Appendix 1, which set out the Department of Health's ambitions to develop a 'scorecard' of local health system performance. The Department of Health's stated aims for the health system scorecard are to:

- allow commissioners to assess the quality and effectiveness of local services and identify areas for improvement
- provide accountability to patients and the public, allowing them to compare local health services on the basis of objective information
- help NHS England identify areas where CCGs may need targeted support to improve quality of care and health outcomes.

To help the Department of Health understand how a scorecard might achieve these broad aims, we were asked to do the following in our review.

- Take stock of what progress has been made by national bodies and other groups to date to measure the performance of local health systems, and what metrics are available.
- Consider how the scorecard can align with other national work on measurement and metrics, in particular the integration and GP scorecards also in development, and build upon these ongoing developments.
- Consider the merits of basing metrics on five population groups: people over 75; people under 75 with long-term conditions; maternity, children and young people; mental health; and the generally well.
- Draw on international best practice of performance measurement from countries like Sweden, Canada and the United States, and international agencies like IHI, Organisation for Economic Co-operation and Development (OECD).
- Draw on past experiences of related initiatives in this country.
- Identify gaps in this work that would need to be filled to provide a rounded picture of local health system performance.
- Engage with a small number of key stakeholders to inform our work.
- Advise on the 'first principles' of a health system scorecard, including: clarity about the aims of measurement; the domains and population groups to be measured; the unit of measurement; the approach to measurement; and data and technical issues that need consideration.
- Advise on ranking and scoring using aggregated metrics.

This report sets out the findings from this review for the Department of Health.

This report was preceded by a report from Dr Foster, which was commissioned by NHS England to develop a CCG scorecard. Dr Foster was asked to review a list of 118 indicators to identify those that would be relevant for the scorecard and develop a methodology for compositing the results into summary scores for CCGs. Dr Foster reviewed the specified indicators, identified 27 as being suitable for this purpose, and developed an aggregate scoring model based on equal indicator weights. However, Dr Foster warned about the limitations of the indicators and the risks associated with using aggregate scores.

We agree with the issues flagged by Dr Foster as needing further consideration and with their recommendations. In our brief, we were able to take a broader view about the aims and audiences for information about CCGs in the context of the performance of local health systems, and we were not confined to the original 118 indicators. We were, therefore, able to be more inclusive in terms of the indicators that could be considered for use.

2. Our approach and methods

The review was undertaken between July and September 2015 by a small team at The King's Fund. It involved consultation with technical experts and stakeholders, within the limits of what was feasible in the timescale and the time of year it was undertaken. In undertaking this review, we have benefited enormously from the contribution of technical experts through our Technical Advisory Group (see Appendix 2 for a list of members), as well as stakeholders such as CCGs, professional societies, national bodies and patient groups. Considerable further work is needed to continue this engagement to understand more thoroughly what the public and other users of this data want and how it can best be presented to meet various needs. We liaised closely with the colleagues at the Health Foundation who were asked to review indicators of general practice quality.

We have drawn on current and historical policy and practice in this country and internationally, and the published literature. We also conducted a broad preliminary trawl of more than 1,500 indicators from currently available sources that could be used to report on performance. We narrowed these down to an illustrative list of about 200 indicators relevant from a CCG perspective, but have not tested their technical feasibility. We mapped this set of indicators onto the population groups and domains of performance proposed in the terms of reference. We have also offered some initial considerations about areas of performance where indicators are relatively lacking.

3. Context and background

Policy

In a recent speech at The King's Fund, the Secretary of State argued that intelligent transparency is needed in the NHS to improve care and outcomes for patients and the public. Intelligent transparency means being open about mistakes and failures of care and also being willing to share information about the performance of services. He went on to argue:

Self-directed improvement is the most powerful force unleashed by intelligent transparency: if you help people understand how they are doing against their peers and where they need to improve, in most cases that is exactly what they do. A combination of natural competitiveness and desire to do the best for patients mean rapid change – without a target in sight.

(Hunt 2015)

The opportunity offered by intelligent transparency, as described by the Secretary of State, is not only to stimulate improvements in care and outcomes but also to support greater devolution of decision-making. The logic here is that with more information about performance in the public domain, providers will have an incentive to use this information to understand how well they are doing and to take action when they identify opportunities for improvement. Patients and the public will also be able to understand how well local services are performing and make choices about where to seek care.

Intelligent transparency is, of course, not new. As we describe later in this report, in the past 15 years there have been successive attempts to publish data about NHS performance including star ratings, the annual health check and CQC's ratings of providers. Going further back, John Yates and colleagues led work in the 1970s to develop performance indicators for mental health services to identify and avoid failures of care. The Department of Health later extended these indicators to other services as part of the growing interest in measurement for performance management purposes (Ham 2009).

There have also been initiatives by private sector organisations to use available data to inform the public, for example in the pioneering work by Dr Foster to publish consumer guides to the quality of services, and the detailed assessments by the Nuffield Trust of the quality of care under the Blair government which served as an audit of how the NHS was performing (for example, *see* Leatherman and Sutherland 2008). More recently, the Nuffield Trust and the Health Foundation have joined forces in the QualityWatch programme to analyse and publish data about the quality of health and care services in England. In parallel, professional bodies have collected and published data about quality of care, as in the pioneering work of cardiac surgeons.

The opportunity now is to build on this experience and to use the government's commitment to intelligent transparency to change how the NHS is run. Put simply, transparency offers the prospect of relying less on targets and regulation and more on devolution and self-improvement as part of a commitment to reforming the NHS from within (Ham 2014). The challenge in doing so is to ensure that measurement focuses on the right issues and that the results are used to support improvements in care and outcomes.

It is also critically important, as we argue below, to simplify and align current approaches to performance assessment.

Current approaches

Since 2010, national priorities for the NHS and the supporting policy framework for performance measurement and improvement has been defined by the three Outcomes Frameworks developed by the Department of Health: the NHS Outcomes Framework, Public Health Outcomes Framework and Adult Social Care Outcomes Framework. With increasing priority being attached to prevention and integration between public health, health and social care services, the Department of Health has been moving towards greater alignment of the three Outcomes Frameworks. This has led to an increase in the numbers of indicators that are shared or complementary across the Frameworks.

In turn, the three Outcomes Frameworks are cascaded down to local organisations – the NHS Outcomes Framework to CCGs and the Public Health Outcomes Framework and Adult Social Care Outcomes Framework to local authorities. The NHS Outcomes Framework is supported by a CCG Outcomes Indicator Set (COIS) that includes the NHS Outcomes Framework indicators (where they are locally measurable) and additional indicators developed by NICE as being relevant for delivering the NHS Outcomes Framework priorities. In addition to the Outcomes Frameworks, national and local priorities for the NHS are defined in a range of other documents and frameworks, including but not limited to: *The Mandate* 2015–16, the *NHS five year forward view*, the Single Departmental Plan, the NHS Constitution, the CCG Assurance Framework, and the quality premium indicators for CCGs. Collectively, these define priorities for the NHS and the indicators that are used to measure progress nationally and locally.

This complex information and policy landscape and what it means for CCGs is illustrated in Figure 1.

Figure 1 Key policy priorities, performance frameworks, indicator sets and tools relating to CCG areas



For CCGs specifically, NHS England's CCG Assurance Framework uses performance indicators and a range of other information – including ongoing conversations between its local offices and CCGs – to assess the performance of CCGs in five dimensions: well-led; delegated functions; finance; performance; and planning. The 'performance' dimension of this framework includes indicators relating to quality and outcomes in the CCG delivery dashboard. This dashboard includes some metrics from the COIS, which is used to measure how CCGs are contributing to progress in the domains of the NHS Outcomes Framework, as well as other indicators from the NHS Constitution, the Better Care Fund, and a range of other sources.

Alongside these approaches, there is also an increasing amount of data available online about the performance of local health services and the health of local populations – for example, through Public Health England (on the health of local populations) and CQC (on the performance of providers). It quickly became clear to us that there is a need for radical simplification and better alignment of data about the performance of local health services to provide a clear and coherent picture for patients and the public as well as for commissioners and providers. Simplification and alignment would serve a further purpose in providing the Secretary of State with a clear line of sight from national priorities through NHS England to CCGs and the performance of local health systems. We explore what this might mean in practice in section 4.

Indicator development and content

Several groups are currently working on indicator development relevant for CCGs, including:

- Outcomes Framework Technical Advisory Group
- NHS England
- National Institute for Health and Care Excellence (NICE)
- Public Health England
- Care Quality Commission (CQC)
- Health and Social Care Information Centre (HSCIC)
- specialist groups working on indicators in specific areas, for example, mental health, children, diabetes and cancer.

The ongoing national work on indicator development includes the work on developing the Outcomes Frameworks and related datasets such as COIS, as well as public health and social care indicators for local authorities. Much work has also been done previously on developing performance indicators for primary care trusts (PCTs) and health authorities as commissioners. Current main sources of CCG indicators and other indicator sets that have been used previously for commissioners include:

- CCG Outcomes Indicator Set (COIS)
- Public Health England Fingertips
- Commissioning for Value toolkit
- HSCIC Indicator Portal
- Better Care Better Value indicators
- NHS Comparators
- NHS Atlases of Variation.

Taken together, there is a wealth of information from ongoing and previous indicator development initiatives to exploit for assessing the performance of local health systems.

The COIS in particular provides an appropriate basis to start from for gathering indicators of performance at the level of CCGs. COIS provides comparative information for CCGs, health and wellbeing boards, local authorities and patients and the public about the quality of health services commissioned by CCGs and associated health outcomes. The indicators are useful for CCGs and health and wellbeing boards in identifying priorities for quality improvement and to demonstrate the progress that local health systems are making on outcomes.

The COIS indicators are developed from NHS Outcomes Frameworks indicators that can be measured at CCG level, together with additional indicators developed by NICE in conjunction with the HSCIC. The COIS indicators have been chosen on the basis that they contribute to the overarching aims of the five domains in the NHS Outcomes Framework. The COIS does not in itself set thresholds or levels of ambition for CCGs but is instead intended to be used as part of the CCG Assurance Framework and as a tool for CCGs to set priorities and drive local improvement.

A robust process for producing COIS is already in place, with an indicator development committee run by NICE, including representatives from health professionals, commissioners and patient groups. NICE has statutory responsibility for developing evidence-based, cost-effective quality standards for public health, health and social care, and the supporting metrics. NHS England, NICE and HSCIC work together to ensure the fit of COIS indicators with the Outcomes Frameworks and to consult publicly on their indicator proposals, and HSCIC undertakes technical feasibility assessments of the proposed indicators.

Public reporting

There is a multitude of existing information sources including data about the performance of local health systems. All are publicly available, although some are directed primarily at NHS and local authority audiences while others are explicitly aimed at the public.

These include:

- the NHS Choices website, which is aimed directly at the public and provides information about health and local health services (see www.nhs.uk/Pages/HomePage.aspx)
- the MyNHS website, which aims to present performance information in a way that is comprehensible by and accessible to the public, while also encouraging the use of this data by those working in the health system (see www.nhs.uk/service-search/performance/search)
- the CCG outcomes tools, which provide interactive CCG data for COIS indicators grouped by the NHS Outcomes Framework domains, in addition to demographic and Quality and Outcomes Framework disease prevalence data. It allows users to view maps, charts, tables of individual indicators, a spine chart of all the outcomes for one or more CCGs, and to explore the relationships between different outcomes or between demographic information and outcomes (*see* www.england.nhs.uk/resources/resourcesfor-ccgs/ccg-out-tool/)
- Commissioning for Value tools, which provide maps and charts of CCG indicators categorised by programme budgets and pathways within them

 including spend, quality and outcome indicators drawn from a wide range of sources (see www.england.nhs.uk/resources/resources-forccgs/comm-for-value/)
- Public Health England's Public Health Outcomes Framework portal, which provides a wide range of indicators for local authorities grouped by the four Public Health Outcomes Framework domains, with options for

benchmarking by region, deprivation deciles and inequalities (*see* <u>www.phoutcomes.info/</u>)

- Public Health England's Fingertips website and Health Profiles, which contains benchmarking data for local authorities covering a wide range of public health areas, including: wider determinants of health such as environment, housing and deprivation; lifestyle risk factors such as smoking, alcohol, obesity; specific conditions such as cancer, mental health, cardiovascular disease and diabetes; and population groups including adults, older people and children. The website includes interactive maps, comparative charts and tables, and options for grouping areas by deprivation, ONS clusters, etc (see http://fingertips.phe.org.uk/andwww.apho.org.uk/default.aspx?RID=49802)
- Public Health England's website with adult social care indicators for local authorities grouped by Adult Social Care Outcomes Framework domains and the Better Care Fund (see <u>http://fingertips.phe.org.uk/profile/adultsocialcare</u>)
- HSCIC indicator portal, which provides local data for the Outcomes Framework indicators and many other indicators for commissioners (both local authorities and CCGs) and providers.

While this list highlights the wide range of information already available to the public about the performance of local services, it is worth noting that existing sources of data aimed directly at the public – such as NHS Choices and MyNHS – provide information primarily about providers rather than taking a broader health system perspective when reporting the data.

4. Our findings and recommendations

(i) A local health systems perspective

As we have outlined in the first part of this report, the focus of our review is the performance of local health systems through the lens of CCGs rather than a narrower consideration of the performance of CCGs themselves. We have taken the performance of local health systems in this context to mean the performance of health services within a CCG area, including how well these services work with social care and public health services.

The rationale behind this is that the public has an interest not only in how services are commissioned but also in the performance of providers, how effectively local services work together, and in the health of the population in the area in which they live. It also seems likely that most members of the public have little if any knowledge of CCGs and what they do – and nor should they be expected to.

Assessing performance in the way we propose has the potential not only to inform patients and the public about the performance of local health systems, but also to stimulate CCGs to work with providers and other partners like local authorities (who have responsibility for public health and social care services) to improve outcomes for the populations they serve. It is consistent too with the move towards place-based commissioning and provision of care. CQC is also currently working to develop assessments of the performance of local systems of care, and its indicators, when agreed, will need to be aligned with our work.

Focusing on local health systems also creates an opportunity to 'future proof' performance assessment at a time when commissioning is in a state of flux. By this we mean that the development of new care models following the *NHS five year forward view* is leading CCGs to work more closely with providers and in some areas is blurring the boundary between commissioners and providers. If, as seems likely, these developments gather pace – for example, through the emergence of accountable care systems – then an approach that focuses on the performance of systems and not just CCGs will become increasingly relevant.

Performance management of CCGs is already undertaken through NHS England's CCG Assurance Framework and this framework should continue to be used and developed for this purpose.

(ii) Organising and grouping performance data by domains of performance and population groups

The terms of reference proposed that the metrics used to assess the performance of local health systems should cover the domains of prevention, access, effectiveness, efficiency and system resilience.¹ Following discussions with the Department of Health and NHS England, it was agreed that The King's Fund would focus on the domains of prevention, access and effectiveness. We revised the effectiveness domain to include a wider focus on quality (and renamed the domain quality), including the three areas of quality defined by Lord Darzi: effectiveness, safety and patient experience (Department of Health 2008b).

We mapped the indicators that we included in our review (*see* Appendix 7) to these proposed domains of prevention, access and quality. In addition, we included indicators relating to inequalities because CCGs have a statutory responsibility to reduce inequalities in access to and outcomes of health care. The mapping worked reasonably well, as shown in Figure 2 below. However, some important indicators do not fit any of the domains neatly, such as indicators relating to life expectancy and inequalities.



Figure 2 Mapping the indicators to the proposed domains

¹ While out of scope for our review, we strongly recommend that a plain English alternative be found for the domain of 'system resilience' if this area of performance is to have any meaning to the public.

The terms of reference also proposed that the scorecard is presented according to five population groups: people aged over 75; people under 75 with long-term conditions; maternity, children and young people; people with mental health conditions; and the generally well.

We also mapped the indicators to the proposed population groups, as shown in Figure 3 below. This was challenging because:

- several indicators refer to the total population rather than sections of it for example, avoidable admissions, access to GPs, waiting times and patient experience data could be said to apply to all five population groups
- some indicators do not fall neatly into any category (such as cancer or inequalities)
- several indicators map to more than one population group for example, dementia indicators map to people aged over 75, people with long-term conditions and people with mental health conditions; child and adolescent mental health service (CAMHS) indicators map to mothers, children and young people and also to people with mental health conditions; while people with co-existing physical and mental health conditions could straddle people with mental health conditions, people with long-term conditions and people over 75
- the boundaries between the groups are often unclear for example, how is the transition from generally well to unwell or from childhood to adulthood defined?
- the five groups do not cover all aspects of care for example, indicators relating to carers, staff and end-of-life care
- the five groups do not reflect the total population that CCGs are responsible for.

Figure 3 Mapping the indicators to the proposed population groups



Overall, therefore, these population groups prove problematic in practice as a framework for categorising performance.

In view of the drawbacks in the approach proposed in the terms of reference, we considered other approaches that might be used. The main alternative would be to build on what already exists in the form of the national Outcomes Frameworks and the COIS. Much work has gone into the development of these frameworks and supporting indicator sets and they are well embedded within the NHS.

There is also close and intentional alignment between the NHS Outcomes Framework and the COIS – which is used to measure how CCGs are contributing to progress in the domains of the NHS Outcomes Framework – with the COIS having been through a rigorous development process by NICE. If this approach is pursued, it would mean using the domains in the Outcomes Frameworks to assess health system performance, rather than the population groups proposed by in the terms of reference. The domains in the NHS Outcomes Framework and the indicators in the COIS are illustrated in Figure 4.

Figure 4 The CCG Outcomes Indicator Set 2015/16

Annex	1 - CCG Outcomes Indica	tor Set 2	2015/16: Summary Table						
1	Preventing people from dying prematurely	- 2	Enhancing quality of life for people with long- term conditions	3	Helping people to recover from episodes of ill health or following injury				
Overarching indicators	Potential years of life lost from causes considered amenable to healthcare: adults, children and young people (NHS OF 1a i & ii) ^	Overarching indicators	 Health-related quality of life for people with long-term conditions (NHS OF 2) ^ ** 	Overarching indicators	Emergency admissions for acute conditions that should not usually require hospital admission (NHS OF 3a) ^ Emergency readmissions within 30 days of discharge from hospital (NHS OF 3b) *				
Improvement	areas	Improvement a	areas	Improvement a	reas				
Improvement areas Reducing premature mortality from the major causes of death Under 75 mortality from cardiovascular disease [NHS OF 1.1] ^* Cardiac rehabilitation completion Myocardial infarction, stroke & stage 5 kidney disease in people with diabetes Mortality within 30 days of hospital admission for stroke Under 75 mortality from repriratory disease [NHS OF 1.3] ^* Under 75 mortality from repriratory disease [NHS OF 1.3] ^ Emergency admissions for actooke eace [NHS OF 1.3] ^ Emergency admissions for actooh lerated tive reliasese Under 75 mortality from cancer (NHS OF 1.4] * One year survival from all cancers (NHS OF 1.4] * One year survival from breast, lung & colorectal cancers (NHS OF 1.4 iii) ^ Cancer: record of stage at diagnosis Cancer: cere of of stage at diagnosis Breast cancer: mortality Hig fracture: incidence Reducing premature death in people with serious mental illness People with severe mental illness who have received a list of physical checks Serious mental illness: any oung children Antental assessment < 131 weeks		Ensuring people 1 People feeling Improving functit People with dii People with dii People with dii education Reducing time sp Unplanned hos 2.3.ii) Å Complications ketoacidosia an Enhancing quality Health-related Enhancing quality Access to poyr Access to comr Access t	feel supported to manage their condition supported to manage their condition (NHS OF 2.1) * *** onal ability in people with long-term conditions SPD & Medical Research Council Dyspnoes scale = or >3 referred to shabilitation programme babetes who have received nine care processes babetes diagnosed less than one year referred to structured when in hospital by people with long-term conditions pitalisation for chronic ambulatory care sensitive conditions (adults) a sacciated with diabetes and epilepsy in under 19s (NHS OF associated with diabetes inc emergency admission for diabetic di lower limb amputation y of life for carers quality of life for carers quality of life for cares (NHS OF 2.4) y of life for cares socrewr/reliable improvement/reliable deterioration quality of life for people with mental illness munity mental health services by people from BME groups hological therapy services by people from BME groups togis rate for people with a long term mental health condition quality of life for people with a long term mental health condition y of life for people with a long term mental health condition y of life for people with a long term mental health condition y of life for people with a long term mental health condition y of life for people with a long term mental health condition y of life for people with a long term mental health condition y of life for people with a long term mental health condition y of life for people with a long term mental health condition y of life for people with a long term mental health condition y of life for people with a long term mental health condition y of life for people with a long term mental health condition y of life for people with a long term mental health condition y of life for people with dementia long term mental health condition y of life for people with dementia long term mental health condition y of life for people with dementia long term mental health condition y of life for people with dementia long term mental health cond	Improving outcomes from planned treatments • Average health gain as assessed by patients for elective procedures a) his preparament bits where replacement c) groin hernia d) varicose veins Preventing lower respiratory tract infections in children from becoming serious Emregency admissions for children with houver respiratory tract infections (NHS OF 3.2) ^ Improving recovery from injuries and trauma No CCG measure at present Improving recovery from tracke People who have had a stroke who are admitted to an acute stroke interventing lower associated at present Improving recovery from tracke and trauma receive a follow-up assessment between 4-8 months after initial admission section of their stay on an acute stroke are discharged from hospital with a join health and social care plan receive a follow-up assessment between 4-8 months after initial admission section of their stay on an acute stroke Acotol admissions and readmissions Mental health readmissions within 30 disys of discharge Proportion of patients receiving to their previous level of mobility or walking ability (NHS OF 3.5 i and ii) Hip fracture: collaborative orthogeriatric care, timely surgery, multifactorial risk assessment and care process bundle					
		4	Ensuring that people have a positive experience of care	5	Treating and caring for people in a safe environment and protecting them from avoidable harm				
		Overarching indicators	Patient experience of primary and hospital care Patient experience of GP out of hours services (NHS OF 4a ii) ^ Patient experience of hospital care (NHS OF 4 b)	Overarching Indicators No overarching indicator at present					
-	SAID.	Improvement a	areas	Improvement /	lreas				
NOTES & LEGEND Improvement areas Improving people's experience of outpatient care Patient experience of outpatient services (NHS OF 4.1) Improving hospital's responsiveness to bresonal needs NHS OF: indicator that is also measurable at local authority level Improving people's experience of accident and emergency services Patient		e's experience of outpatient care ence of outpatient services (NHS OF 4.1) all'responsiveness to personal needs s to in-patients' personal needs (NHS OF 4.2) e's experience of accident and emergency services nee of AAE services (NHS OF 4.3)	Patient safety i Reducing the inci Incidence of health No CCG measures Improving the safety	ncidents reported (NHS OF 5.6) dence of avoidable harm allicare associated infection: MRSA (NHS OF 5.2.1) htere associated infection: C difficile (NHS OF 5.2.11) at present for category 2, 3 and 4 pressure ulcers and incidence of medication errors causing serious harm ety of maternity services					
* NHS OF indicator shared with Public Health Outcomes Framework		Improving wome	n and their families' experience of maternity services (NHS OF 4.5)	Admission of full term babies to neonatal care (NHS OF 5.5)					
** NHS OF indicat	or complementary with Adult Social Care Outcomes Framework	Improving the ex Bereaved care	perience of care for people at the end of their lives rs views on the quality of care in the last 3 months of life NHS OF	Delivering safe care to children in acute settings No CCG measure at present					
Other indicators a collections.	re developed from NICE quality standards or other existing data	4.6) Improving experie Patient experie Improving childre No CCG measure	ience of healthcare for people with mental illness ence of community mental health services (NHS OF 4.7) en and young people's experience of healthcare of present						
		NHS OF indicator	e's experience of integrated care in development. No CCG measure at present						

Source: 2015/16 CCG outcomes indicator set: at a glance guide. Available at: www.england.nhs.uk/resources/resources-for-ccqs/ccq-out-tool/ccq-ois/

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If this approach is chosen, we recommend a review of the three national Outcomes Frameworks with the aim of consolidating them into a single framework covering the NHS, public health and adult social care. While the Outcomes Frameworks share a growing number of indicators, they currently include different domains. These are set out in the following table.

NHS Outcomes Framework	Public Health Outcomes Framework	Adult Social Care Outcomes Framework			
Preventing people from dying prematurely	Improving the wider determinants of health	Enhancing quality of life for people with care and support needs			
Enhancing quality of life for people with long- term conditions	Health improvement	Delaying and reducing the need for care and support			
Helping people to recover from ill health or following injury	Health protection	Ensuring that people have a positive experience of care and support			
Ensuring people have a positive experience of care	Health care public health and preventing premature mortality	Safeguarding adults			
Treating and caring for people in a safe environment and protecting them from avoidable harm					

Table 1 Domains in the three Outcomes Frameworks

Doing this would create a single framework defining the outcomes expected of local health and care systems, promoting joint accountability for improving services across the NHS, social care and public health. The advantages of this approach are not only that it builds on what already exists, but also that it offers the potential to achieve much greater alignment between national priorities and how performance is assessed at a local level.

For these reasons, we recommend that it would be preferable to start with the Outcomes Frameworks and the COIS as a basis for assessing the performance of local health systems, rather than the approach set out in the terms of reference.

(iii) International frameworks

In reviewing how these frameworks should be developed, we recommend that careful consideration is given to international approaches currently used to assess health system performance – many of which are underpinned by considerable research and experience. One well-known international approach is the Triple Aim developed by IHI in the United States (*see* Figure 5), which assesses how well systems perform in:

- improving the health of the populations served (including health outcomes like life expectancy and measures related to prevention)
- patient experience of care (which can include access, patient experience and clinical outcomes)
- per capita cost and the use of resources.

These aims seem to us to be at the core of what the NHS is currently seeking to achieve. They also consider the use of resources, which is likely to become increasingly important as funding pressures grow and greater attention is paid to efficiency in the NHS – for example, following the Carter review and plans to develop a provider efficiency index (Department of Health 2015).



Figure 5 The IHI Triple Aim

Source: The IHI Triple Aim framework was developed by the Institute for Healthcare Improvement in Cambridge, Massachusetts (<u>www.ihi.org</u>)

Other relevant frameworks include the performance framework used for the health care quality indicator project developed by the OECD, shown in the lower half of Figure 6, below. This framework subdivides performance by different stages along the lifecourse. It includes domains of access, cost and quality (using a definition of quality that aligns with the Darzi domains of effectiveness, safety and patient experience), and equity is included as a cross-cutting domain. Prevention is implicit in the staying healthy domain in the left-hand column. This framework for health care performance is embedded within a broader, overarching approach that includes the impact of the wider determinants of health and broader health outcomes.

Figure 6 OECD conceptual framework for Health Care Quality Indicator Project

		How health	HEALTH y are the citizens o	I STATUS If the OECD	member coun	tries?		
Health Cond	litions	Human Fun	iction and Quality of Life	Life Exp	ectancy and W		Mortality	
\bigwedge					>			
	Are the non-h	nealthcare fact	NON-HEALTHCA ors that also deterr and withir	RE DETER mine health n OECD me	MINANTS OF as well as if/ho mber countries	HEALTH	e is used	changing across
	Health B and Lif	ehaviors iestyle	Personal or Host Socio-ecc Resources Conditio Environ			nomic ns & nent	cal Environment	
V How does the	healthcare sy	H ystem perform	EALTHCARE SYS ? W hat is the level perform	of care acro ance cost?	ORMANCE oss the range of	of patient car	re needs?	What does this
	Dime	ensions of l	lealthcare Per	formance)	. The second second second		
Healthcare		Quality					ess	Cost / Expenditure
Neeus	Effect	tiveness	Safety	Respor / Pa cente	nsiveness atient- redness	Access	ibility	
Staying healthy								
Getting better								
Living with illness or disability								
Coping with end-of-life								
What are the imp	■ ortant design	HEA and contextua in	(Macro- an ALTH SYSTEM DE al aspects that may terpreting the qual	Efficie d micro-ed SIGN AND / be specific ity of its hea	conomic effi conomic effi CONTEXT to each health lthcare?	ciency) system and	l which ma	ay be useful for
Other cour	ntry-related d	eterminants of	performance		Health S	System Deliv	very Featu	ures

Reproduced from Arah OA, Westert GP, Hurst J, Klazinga NS. 'A conceptual framework for the OECD Health Care Quality Indicators Project'. *International Journal for Quality in Health Care*; September 2006, pp 5–13; DOI: 10.1093/intqhc/mzl024. By permission of Oxford University Press on behalf of the International Society for Quality in Health Care. Link to original article:

http://intqhc.oxfordjournals.org/content/intqhc/18/suppl 1/5.full.pdf

Whatever the approach adopted by the Department of Health, equity and health inequalities need to be factored into the framework. CCGs have a statutory responsibility to ensure equitable access to and outcomes of health care, and these are core components in NHS performance frameworks historically and internationally.

(iv) Alignment

It is important that metrics used to assess local health system performance are aligned with the Outcomes Frameworks, the NHS Constitution and The Mandate – documents that define the government's priorities for the NHS and pledges to the public that the NHS is committed to achieving – to provide a clear line of sight from the Secretary of State through NHS England and CCGs to the populations they serve based on indicators that reflect what really matters to the public.

This would deliver the 'single definition of success' for local systems of care and CCGs that the Secretary of State has spoken of as being needed for providers (Dowler 2015). It would also ensure much greater transparency for patients and the public. As we have argued, it would require radical simplification and much better alignment of existing policy and performance frameworks to serve this purpose.

Alignment with the CCG Assurance Framework (illustrated in Figure 7) is also essential to ensure that CCGs are not faced with conflicting priorities. As we have set out already, the Assurance Framework is used by NHS England to assess CCG performance, using a selection of performance indicators alongside information about other factors like the leadership of the CCG and how it is performing against its plans. This framework is currently being reviewed and developed by NHS England.

To achieve alignment, the indicators used to assess CCG performance in the Assurance Framework should align with the data used to assess local health system performance – in other words, the indicator sets should overlap in the areas where performance indicators are most attributable to CCGs – and should cover not just performance against key targets like waiting times and finance but also a wider set of indicators related to quality and outcomes of care. One way that this could be done is by drawing on a wider range of indicators from the COIS in the CCG Assurance Framework in the future.

Figure 7 CCG Assurance Framework 2015/16: domains and the components of assurance

Well led organisation	 Has strong and robust leadership; Has robust governance arrangements, including for the management of potential conflicts of interest and adherence to the CCGs' code of conduct policies; Involves and engages patients and the public actively; Works in partnership with others, including other CCGs; Secures the range of skills and capabilities it requires to deliver all of its commissioning functions, using support functions effectively and getting best value for money; and Has effective systems in place to ensure compliance with its statutory functions.
Delegated Functions	 Governance and the management of potential conflicts of interest Procurement Expiry of contracts Availability of services Outcomes
Finance	12. Financial performance 13. Financial controls 14. Financial governance, resources and processes
Performance	15. Performs against the range of measures in the delivery dashboard.
Planning	 16. Has an assured annual plan 17. Is performing to plan in year 18. Has an assured System Resilience Group plan 19. Has an assured Better Care Fund plan that complies with <u>Guidance for the operationalisation of the BCF in 2015-16</u> 20. Has a long term plan to implement the 5 year forward view

Source: CCG Assurance Framework 2015/16 operating manual, p13. Available at: www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/10/ccg-ass-op-man-2015.pdf

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(v) Three levels of data

Intelligent transparency focused on local health systems has a number of potential uses, as outlined in our terms of reference. At a minimum they include providing information to patients and the public about the services available to them and how they compare with services in other areas, supporting commissioners and providers to bring about improvements in care and outcomes by comparing their performance with that of peers, and enabling national bodies responsible for regulation and performance management to hold CCGs to account.

Given our view that the CCG assurance framework is the appropriate route to collect and analyse data about CCG performance, we focus here on what data is needed for patients and the public and to support improvement by commissioners and providers. Our recommendation is that data is needed at three levels.

At the first level would be a relatively small number of headline indicators – say 15 to 20 – that are of particular relevance to the public and that are agreed after engagement with the public, as happened in Canada (*see* Appendix 4). The views of the public on what data should be used might be tested using indicators in the current Outcomes Frameworks as the starting point.

The headline indicators should provide a picture of performance for the population as a whole. These headline indicators might cover access, prevention and quality as suggested in the terms of reference, but alternatives like the IHI's Triple Aim should also be considered. We illustrate how this could be done in the following section of this document.

At the second level, a wider range of data should be presented to provide a fuller picture of local health system performance in delivering national priorities – and initially these could be based on the domains and indicators in the Outcomes Frameworks and the indicators in the COIS. The advantage of using the COIS is that it has been developed after thorough testing and covers a range of indicators considered important for delivering on national priorities in the NHS Outcomes Framework at a CCG level.

The aim would be to provide a more granular understanding of performance on national priorities than is possible using the small number of headline indicators. Data at this level will be useful to the public to provide a more in-depth understanding of how their health system is performing, as well as for commissioners and providers in a local area to help them assess overall health system performance and identify areas for improvement.

This data would be supplemented at the third level by indicators from a range of other sources to provide as comprehensive a picture as possible of local health system performance. Inclusion of a larger set of indicators would enable the public to drill down into areas of care of particular interest to them, and also would support commissioners and providers to benchmark their performance against others across a wide range of areas to facilitate improvements in care.

To help provide information tailored to the needs of the public, one possibility would be for search options to be offered which would enable users to view indicators sorted by population groups or medical conditions of particular interest to them, recognising that there would be duplication of some indicators across the search options. Indicators at this level do not need to be as robust as indicators used for accountability purposes, as in the CCG Assurance Framework (Raleigh and Foot 2010).

Examples of indicators at this level might include data on specific population groups or conditions that do not lend themselves easily to reporting at the headline population level or to using the domains in the Outcomes Frameworks. Another example could be the range of indicators used to report on variations in quality and outcomes across the NHS developed through the various NHS Atlases of Variation (for example, *see* Right Care 2015).

The following figure illustrates how data might be organised across three levels, adapting the Canadian approach discussed earlier.

Figure 8 Assessing local health system performance: an approach across three levels



(vi) Providing a simple overview of performance

Aggregate ratings

If clarity and simplicity are important for public transparency, one option is to combine the chosen indicators into summary scores or aggregate ratings.

Summary scores are not new to the NHS. Aggregate performance ratings for both NHS providers and commissioners were first introduced in 2000/1 through a system of star ratings, awarded annually to all NHS trusts. CCGs currently receive an annual rating through the CCG assurance process. In the past, the world class commissioning programme rated PCTs' performance as commissioners against 11 core commissioning competencies. Appendix 5 summarises the rating systems used in the NHS over the past 15 years and the evidence on their impact.

Past experience shows ratings can improve quality in the areas they cover, although we do not know their impact on other areas of performance. For example, star ratings and the targets that they were based on contributed to the elimination of long waiting times in the English NHS (Bevan and Hood 2006).

It is, however, impossible to untangle the impact of ratings from the regulatory systems that underpin them and from other factors that affect health system performance. Extra funding helped NHS trusts meet waiting time targets, and the penalties associated with missing the targets were also a key driver of change. In this example of star ratings, the aggregate rating was just one part of the targets regime – a tool to highlight good or poor performance.

Ratings can also have perverse effects that are detrimental to both NHS patients and staff. In order to meet targets, there is evidence that NHS organisations have manipulated data, taken actions that are not in the best interests of patients and paid less attention to areas that are not covered by the rating (Bevan 2009). Both the star ratings and annual health check were criticised for distorting local priorities (Nuffield Trust 2013; Mannion *et al* 2005) and there is evidence that organisational culture, staff morale and recruitment can be negatively affected by a poor rating (Nuffield 2013; Mannion *et al* 2005; Horton 2004).

While an aggregate rating has the merit of being simple, economical in presentation, easily readable and easily comparable, there are many disadvantages and risks entailed in their use (see Appendix 6 for a full list). These include:

- Conceptual issues for example, the challenges involved in setting indicator inclusion and exclusion criteria, and the extreme sensitivity of a rating to the choice of the constituent indicators (and small changes in performance against these (Spiegelhalter 2005)); or the way that composites can mask good or poor performance on individual indicators when aggregated. In this way, while summary scores can be superficially clear and simple, they risk failing to provide a meaningful true picture of performance for the public because they mask the more complex reality that underpins them. This problem is particularly acute when a rating is applied to a CCG or local health system, as a result of its broad range of responsibilities.
- Technical issues for example, how to weight indicators covering a wide range of topics, set performance thresholds, or track performance over time when the indicators that underpin the rating change and evolve to reflect emerging priorities and new datasets.

• **Behavioural issues** – for example, unintended consequences like gaming and distortion of priorities, discrediting the ratings and undermining their impact. This is an issue experienced by NHS ratings systems in the past (Nuffield 2013).

Recognising these disadvantages, internationally no government agency to our knowledge produces a summary, single score to represent the performance of local health systems.

We strongly advise against a summary, aggregated score based on performance metrics, however it is calculated and presented – whether as a RAG rating or a percentage score or any other variant. It is unlikely to be a meaningful representation of performance to the NHS or the public or support improvement, and risks unintended consequences.

If the Department of Health wishes to make use of aggregate assessments, then it will be important to draw on the experience of CQC in producing provider ratings, as well as the evidence about the impact of aggregate scores in the NHS to date. CQC has found that its overall assessments need to be based on a combination of quantitative performance indicators and softer intelligence drawn from inspections related to leadership, culture and other factors. This approach is closer to that used in the CCG Assurance Framework and it may be that aggregate assessments – if they are to be used in future – are better developed within that framework rather than through analysis of indicators alone (which is where our work has focused).

Alternatives to aggregate ratings

As we outlined in the previous section, we recommend that a small number of headline indicators be presented to the public to provide a high-level summary of local health system performance and the health of the local population. We have said that this might include around 15 to 20 indicators that provide a picture of performance relevant to the whole of a local population.

To do this successfully, these indicators would need to be presented in a simple, accessible way, with clear messages that some indicators may not be direct measures of the performance of those involved in commissioning or delivering services. This is because indicators at this level will also be affected by issues such as the health status and deprivation of the local population.

While we have argued that summary scores fail to provide a comprehensive picture of health system performance and should therefore be avoided, there are a number of other ways that health system performance can be compared and reported. A summary of approaches used in a small number of other countries is set out in Appendix 4. Examples of approaches include:

- using diagrams to visually present comparative performance against selected indicators for example, by using 'dartboard'-style diagrams
- banding performance against individual indicators using categories like 'above average', 'same as average' or 'below average'
- using bar charts with confidence intervals to compare performance across selected indicators
- using dashboards to present a variety of data about providers an approach used previously in the NHS.

A number of different approaches can be used to visually present performance data in a way that is easy to understand and allows comparative judgements to be made. A good example is the 'dartboard'-style diagram, which can be used to outline comparative performance against a number of indicators. This has been done in Australia, where performance in a small number of indicators across four domains is presented this way to provide a one-page summary of local health system performance (*see* Figure 9 and Appendix 4 for more details). This approach was based on work developed in Pisa in Italy and has also been used by researchers in Dartmouth in the United States (for example, *see* Goodman *et al* 2013).

Figure 9 Summary of health measures for Southern New South Wales in 2011–12 relative to peer group results



Source: Australian government, My Healthy Communities website. Available at: <u>www.myhealthycommunities.gov.au/Content/downloads/ml-health-signatures/HC ADLE Report southern-nsw.pdf</u>

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The idea of rating comparative performance using categories like 'below average', 'average' and 'above average' is not new to England. Similar categories are used to indicate the health of local populations in Public Health England's local health profiles, for example. Figure 10 shows how this kind of approach is also used to compare the performance of local health services in Canada, as part of the Canadian Institute for Healthcare Information's 'in brief' summary of health system performance for the public (*see* Appendix 4 for details). This approach allows comparisons to be made between different areas while avoiding the potential issues associated with rankings.

Figure 10 Toronto's performance against two access indicators in the Canadian Institute for Healthcare Information's `in brief' health system summary



Source: Canadian Institute for Health Information, Your Health System website: http://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en#!/search/3/b7e31fe1791fdf0862019d14b0c6a15854ddb4 77

An example of using bar charts with confidence intervals to compare performance against areas can be found in Sweden, where regional comparisons of health care quality and efficiency in Sweden's 21 councils are published annually, using around 170 indicators (*see* Appendix 4 for details). Rather than being used as a yardstick by which to judge good or bad performance, the comparative data is intended to provide information for councils to identify potential areas for improvement.

Another example can be found in New Zealand, where a public-facing scorecard is published quarterly ranking regional health system performance against a small number of national targets (*see* Appendix 4 for details).

Closer to home, Public Health England's Fingertips website show various ways of viewing and comparing data, including benchmarking against deprivation peer groups when making comparisons (Figure 11). They also enable data to be viewed as a dashboard, along with functions allowing users to view maps and trends in the indicators over time.

Figure 11 Public Health England's Fingertips website: cardiovascular disease

Cardiovascular Disease Profiles									
Risk Factors D	iabetes			Heart			Kidney	S	troke
Overview Compare Map	└∠ Trends	Com	pare as	Area profiles	9 Defini) tions [Download		
Area type: CCG Area: ♦ NHS Bedfordshir Searc	▼ e CCG ▼ h for an area	Are Dep	as group privation	ed by: Depri decile: Seco	ivation de Ind least (cile deprived	T	Benchmark: Engla	nd 🔻
Compared with benchmark: Better Simila Not Compared * a note is attached to the value, hover over to see	r 🔵 Worse	🔵 Lower 🔘	Similar 🔘	Higher	W	orst/Lowest	25th Perc	Benchmark Value entile 75th Percer	tile Best/Highest
		Bedfordshire		Deprivation England decile				England	
Indicator	Period	Count	Value	Value	Value	Worst/ Lowest		Range	Best/ Highest
Hypertension: QOF prevalence (all ages)	2013/14	61,666	13.7%	13.9%	13.7%	7.9%		\diamond	18.0%
Model based estimate of the prevalence of hypertension	2011	106,784	24.1%	24.9%	24.7%	32.1%			15.6%
CVD-PP001: new hypertension patients, age 30-74, with CV risk assessment >=20% treated w. statins (den.incl.exc.)	2013/14	219	65.8%	63.3%	64.0%	43.0%			85.7%
CVD-PP002: Lifestyle advice for patients with hypertension (den. incl. exc.)	2013/14	9,102	79.2%	79.7%	79.0%	60.7%			97.1%
HYP002: Blood pressure ≤ 150/90 mmHg in people with hypertension	2013/14	49,449	80.2%	79.4%	79.2%	73.7%		\circ	84.6%
SMOK001: record of smoking status in last 24 months (15+ y), den. incl. exc.	2013/14	314,336	85.1%	86.3%	85.6%	79.5%		•	99.6%
SMOK004: record of offer of support and treatment (15+, last 24 mnths), den. incl. exc.	2013/14	52,922	78.1%	84.2%	84.3%	72.3%	•		91.5%
Estimated prevalence of adult healthy eating (adults who consume 5 or more portions of fruit and vegetables per day)	2006 - 08	99,533	30.5%	30.5%	28.7%	19.4%		0	46.0%
Cumulative % of the eligible population aged 40-74 offered an NHS Health Check	2012/13	29,461	23.6%	20.7%	18.4%	0.8%			44.4%
Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2012/13	15,384	52.2%	48.3%	49.0%	14.6%			100%
Percentage of people in the most deprived quintile	2010	22,662	5.4%	2.7%	20.4%	88.2%		0	0.0%
Proportion of people aged 65 and over	2013	71,218	16.7%	18.8%	17.3%	6.1%			27.9%
Percentage of people from minority ethnic groups	2011	46,292	11.2%	6.5%	14.6%	1.2%			72.2%
Estimated percentage binge drinkers in the resident population aged 16 years and over	2007/08	-	18.2%		20.1%	31.6%			7.5%
Percentage of adults classified as overweight or obese	2013	678	66.1%	63.4%	63.8%	74.4%		\bigcirc	47.2%
2.13ii - Percentage of physically active and inactive adults - inactive adults	2013	273	26.5%	25.8%	28.3%	40.5%		0	15.9%

Source: Public Health England Fingertips, Cardiovascular disease profiles. Available at: http://fingertips.phe.org.uk/profile/cardiovascular/data#page/0

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Another way to present performance information, which allows the inclusion of both qualitative and quantitative assessments of performance, is a dashboard approach (*see* Figure 11). This has been used in the NHS in the past to present the results of the then Healthcare Commission's annual health check assessment of NHS trusts. Information about the quality of services and financial performance was presented alongside a narrative assessment of performance. A dashboard can also offer access to more detailed information by allowing users to drill down to additional data on different themes.

Figure 12 The Healthcare Commission's annual health check performance dashboard for Northern Devon Healthcare NHS Trust



Source: Screenshot of 2007/8 annual health check results for Northern Devon Healthcare Trust. Available at: www.northdevonhealth.nhs.uk/annual-health-check/

Each of these approaches, of course, comes with inherent problems and weaknesses. Above all, ensuring statistical rigour in measuring and depicting variations in performance is of paramount importance for ensuring the quality and credibility of the data that is published. Such considerations should govern the whole process of selecting, producing and publishing performance data – including the analytical methodologies used, how statistically significant variations are identified, the choice of comparison groups, which indicators should be adjusted for context and how, and presentation formats themselves.

Alignment of websites and tools

In setting out the context for our review, we described the multitude of existing information sources including data about the performance of local health systems (*see* p 14). The growing, disparate and dispersed volume of material in the public domain, with its disjointed components and varying formats and
content, risks undermining the transparency agenda and could deter its use by both practised users and those less able to navigate their way around it.

Instead, public-facing information about the performance and outcomes of public health, health and social care services should provide an informed, integrated view of the whole local care system that is easy for people to navigate. We strongly urge that there is a consolidation of websites and tools aimed at providing performance information, rather than adding any additional alternative portals. Various information sources could complement each other and be brought together as a coherent whole, rather than sitting in a large number of standalone sites.

As shown in Appendix 4, the Canadian Institute for Healthcare Information hosts a single public-facing website called Your Health System, with different levels of information available for different aims and audiences. It includes:

- an 'in brief' summary of health system performance aimed at the general public, which sets out performance in 15 indicators across 5 dimensions (designed through public engagement)
- an 'in-depth' summary of health system performance aimed at the health system, which sets out performance in 38 indicators across 7 dimensions
- a secure-access tool called Insight that allows health care professionals to dig deeper into a wider range of indicators for performance improvement purposes
- a full indicator library.

This kind of approach could be adopted in England through the development of a single website, incorporating much of the content currently spread around a large number of systems while reducing duplication and increasing consistency of definitions. We would recommend that the focus of the new website should be local health systems, with public health, health care and social care data presented together to provide the public with a holistic view of the whole health and care system in their area. There could also be signposting to other sources of information of interest to the public, such as CQC's provider ratings.

(vii) Identifying indicators

In the limited time available, we trawled through readily available material to identify a shortlist of indicators that appear to be particularly relevant from a CCG perspective. Starting with an initial list of more than 1,500 potential indicators, we compiled a long list of around 200 from various sources of indicators that are already in use, under development or have been used historically to good effect (*see* Appendix 7). In seeking a broad local health system perspective, these indicators reflect:

CCG performance as commissioners

- provider performance within CCGs
- CCGs in their wider role working with partners to improve public health and social care services and to provide integrated care
- the health of local populations.

Not all the indicators therefore can be interpreted as unequivocal markers of CCG performance.

We used the origins of an indicator as a rough marker of its relevance and significance. For example, if an indicator is shared between two or all three Outcomes Frameworks, or appears in the COIS and NHS England's Delivery Dashboard used for CCG assurance, then we deemed it relevant for consideration here. We also considered some indicators published by Public Health England for local authorities as relevant at a CCG level too.

We were more, rather than less, inclusive, because the final choice of indicators should be informed by much more detailed assessment and development work – including wider consultation – than our deadline allowed for. This list should therefore be seen as illustrative of the sorts of indicators that, subject to feasibility and consultation, can be published for CCG populations.

We stress that this is not intended to be a definitive list. Indeed, we are aware that there are specialist groups working on indicator development in specific areas such as cancer, mental health, dementia, learning disabilities, children and end-of-life care, and that indicator possibilities therefore go much wider than the set of indicators we have compiled. For example, the 'cancer dashboard' proposed by the recently published cancer strategy includes a set of key metrics (some of which are included in our indicator list) that should be reflected in a comprehensive review of indicators (Independent Cancer Taskforce 2015). Another example is the latest NHS Atlas of Variation in Health Care, which provides a set of indicators showing national variations in the quality of care (Right Care 2015).

With these points in mind, the list of indicators presented in Appendix 7 was selected as seemingly relevant from a CCG perspective, in terms of reflecting on current NHS priorities, the local health care system, and the health of local populations.

This list of indicators is arranged as follows.

- Column A shows our reference number for the indicator.
- Column B shows the indicator title.
- Column C shows which of the Department of Health's five population group/s the indicator can be mapped to.
- Column D shows which of the Department of Health's three domains the indicator can be mapped to.

• Column E shows the source/s where the indicator originated.

Given that CCGs have a statutory responsibility to reduce inequalities in access to and outcomes of health care, we included some indicators (developed by others, including Public Health England and in Cookson 2015) that specifically measure these dimensions (such as inequalities in life expectancy and access to GPs per 100,000 population). While the measures we have included are direct measures of inequalities, it is equally possible to splice some other indicators on our list by inequality dimensions (*see* NHS Group, Department of Health 2015).

It is important to note the following caveats in this work.

- We were not able to perform many of the routine tasks that would normally be undertaken in reviewing, developing and assessing indicators against specific technical criteria.
- Given the voluminous breadth and spread of material available, there are many more relevant indicators and datasets that we were unable to review in the limited time available, and that need consideration, including those developed and under development by specialist groups.
- We were not able to explore the possibilities for developing relevant new indicators from existing data sources.
- We have not factored in the potential of data developments in the pipeline

 for example, in clinical audits, new datasets such as the Child and Adolescent Mental Health Services (CAMHS) dataset, maternity and children datasets, General Practice Extraction Service (GPES), care.data, and possibilities that become available through data linkage – all of which will greatly enhance the potential for developing new indicators.

If the Department of Health and NHS England were minded to adopt our recommended approach of providing a small set of high-level indicators on local health outcomes and health system performance to the public, some examples of the sorts of indicators that could be used are given below. We stress that these examples are illustrative and the choice of domains, indicators and presentation formats should be determined through a process of public consultation.

These high level indicators could include the following.

Prevention

- immunisation for children
- influenza vaccination for people aged 65 and over
- maternal smoking during pregnancy
- cancer screening rates
- obesity levels in the population

Access

• selected waiting times indicators (including for mental health services)

- GPs per 100,000 population
- access to GP services
- access to NHS dental services
- access to psychological therapies

Quality

- years of life lost from causes amenable to health care
- hospital re-admission rates
- emergency admissions for conditions that should not normally require hospitalisation
- patient experience of GP services
- patient experience of hospital services

Health outcomes

- life expectancy
- excess mortality among people with serious mental illness
- employment of people with long-term conditions including adults with a learning disability or in contact with secondary mental health services

(viii) Conclusions and next steps

The issues we have examined during this review are both important and complex. We welcome and support the drive to increase transparency and share the sense of urgency in making it happen. *Done well,* transparency will benefit both the public and the NHS but it must be based on a thorough appreciation of the opportunities and risks.

In the time available, we have gone back to first principles and outlined the options as they seem to us, with an emphasis on a tiered approach to indicators that might populate a local health system scorecard. We would reiterate the need for radical simplification and better alignment of the disparate performance assessment frameworks currently in use. This should include consolidating the three national Outcomes Frameworks into a single, coherent approach covering the NHS, public health and adult social care.

Intelligent transparency also demands a clear line of sight from the Secretary of State through CCGs to the populations they serve, based on indicators that reflect NHS priorities and what really matters to the public. This would deliver the 'single definition of success' for local systems of care and CCGs that the Secretary of State has spoken of as being needed for providers. Consultation with the public is needed on which aspects of performance should be covered in the scorecard and how information should be presented.

It is also important that there is close alignment between the local health system scorecard and the CCG Assurance Framework. The performance indicators in the

framework should align with those used in the scorecard to ensure clarity on what is expected of CCGs and how their performance is managed.

Below we summarise the recommendations of our review and outline a small number of areas for consideration in taking forward these ideas. Our recommendations are similar in a number of respects to those put forward by the Health Foundation in its review on indicators of general practice quality, and we have liaised closely during our respective reviews.

Summary of recommendations

- Intelligent transparency is a policy initiative that has the potential to support improvements in care and outcomes and to provide patients and the public with information about the performance of local health services.
- A number of national bodies are involved in assessing performance resulting in duplication of effort and unnecessary complexity. There is a need for radical simplification and much better alignment of this work.
- There is a strong case for consolidating the three national Outcomes Frameworks into a single framework covering the NHS, public health and adult social care.
- The CCG Assurance Framework used by NHS England should be the means for holding CCGs to account for their performance, and should align with the indicators used in the local health system scorecard we propose. It should incorporate a greater number of indicators relating to quality and outcomes from the COIS in future.
- The Department of Health should develop the scorecard starting from the national Outcomes Frameworks and the COIS, presenting data at three levels.
 - The first level would focus on a small number of headline indicators of particular relevance to the public and agreed after engagement with the public, with the aim of providing a picture of performance for the population as a whole.
 - The second level would be organised initially around the domains and indicators in the three Outcomes Frameworks and the COIS to signal national priorities.
 - The third level would include a larger set of indicators to enable patients and the public to drill down into population groups and medical conditions

of particular interest to them, and to support commissioners and providers in quality improvement.

- At all levels it should be possible to benchmark indicators against peer groups where contextual factors such as deprivation impact on performance.
- We do not recommend producing an aggregate score of performance using performance indicators alone. If the Department of Health wishes to develop aggregate scores for CCG performance it should make use of the CCG Assurance Framework which contains a wider range of data relevant to CCGs.
- NICE should continue to have the lead role, jointly with HSCIC, in developing CCG indicators on quality and outcomes for performance assessment and to support quality improvement by CCGs. Indicators should be validated by the HSCIC's indicator assurance service and comply with guidance from the UK Statistics Authority.
- To facilitate use of the data by both the NHS and the public, there should be a rationalisation of the disparate public-facing websites to provide an integrated view of health and care services in an area. This means consolidating the various websites that provide public health, health and social care indicators for local authorities and CCGs.
- We recommend that the implications of using registered versus resident populations for CCG indicator construction is reviewed and addressed in a way that ensures:
 - a) CCG performance indicators relate to the total populations they are responsible for
 - b) no individuals are excluded when considering CCG responsibilities for delivering health care.

This issue is discussed in detail in Appendix 8.

Next steps

Consultation and testing

We have benefited enormously in undertaking this review from the contribution of technical experts, stakeholders and others, but we are acutely aware of how limited our engagement has been within the time available. Further work needs to continue this engagement and to understand more thoroughly the information that the public and CCGs want, as well as how appropriate data could be presented and accessed to support the causes of transparency and improvement. Paramount in any plan to provide information to the public about local health system performance is wide and comprehensive consultation and testing with the public to identify the information that they want to see and how they want it presented. Such information needs to comply with guidance from the UK Statistics Authority about publishing information for the public. There is little direct existing evidence about what the public want to know about their local health system.

Similarly, other main users of the data, national clinical and policy leads, CCGs themselves, local authorities, health and wellbeing boards, professionals and others, need to be consulted and engaged both in the selection of indicators and in their presentation.

Data and technical issues

Detailed assessment of indicators, including data, specification and production issues, is a lengthy technical process, but one that is essential for ensuring the end products are reliable and credible. We were unable within the timeframe to assess the indicators listed in Appendix 7 for essential features such as:

- fitness for purpose
- ease of understanding
- allowing meaningful comparison
- attribution
- responsiveness, amenability to change
- feasibility
- unit of measurement (*see* section below on resident and registered populations)
- data quality
- frequency of data availability
- timeliness of data
- ability to measure both cross-sectional data and trends over time
- statistical rigour
- need for supporting contextual information, including for benchmarking against peers.

These characteristics are likely to differ between the indicators in Appendix 7, making some more suitable for further development than others, and showing some to be unworkable.

Given our broad perspective in selecting indicators, inevitably these reflect on CCG performance to significantly varying degrees. Some indicators will be within CCG control and reflect CCG performance much more than others, and some hardly at all. Some indicators will be highly context-dependent – for example, the proportion of low birth weight babies will be strongly associated with

deprivation, ethnic composition, and so on. In cases like this where indicators are highly context-dependent, a case can be made for benchmarking against control variables such as deprivation, ONS (Office for National Statistics) clusters, or regions to enable reliable interpretation of the data.

It is important to be able to show not just cross-sectional data for local populations but also changes over time. This is important to enable CCGs to track performance over time and also for the public to be able to see whether and how services are improving. Being able to show improvement is especially important for indicators where local contextual factors such as deprivation can have a negative impact on a local area's standing on an indicator.

Our review of health system indicators through the lens of CCGs has highlighted an important issue relating to the unit of measurement that could have significant implications for the choice of indicators and, more broadly, has implications for how performance is assessed. The issue relates to how 'CCG populations' are defined. This will determine data availability and can potentially impact on performance measurement across the wider health and care system.

Put simply, the Health and Social Care Act 2012 made CCGs responsible for people registered with GP practices within the CCG and for people living in the area who are not registered with any practice. Currently, both the Department of Health and NHS England aim to use indicators based on *registered populations*, which therefore exclude unregistered people from all performance data. This is clearly highly unsatisfactory for several reasons – most clearly because it does not measure CCG performance accurately and, more saliently, because it fails to reflect on the access to and outcomes of health care for people who are not registered with a GP practice who are often among the more disadvantaged residents of an area. There are also related technical issues that create inconsistencies between the rates for local authorities, CCGs and nationally for the same indicator.

We advise that the implications of using registered versus resident populations for CCG indicator construction is reviewed and addressed in a way that ensures:

- (a) CCG performance indicators relate to the total populations they are responsible for
- (b) no individuals are excluded when considering CCG responsibilities for delivering health care.

This issue is discussed in full in Appendix 8.

Addressing indicator gaps

Our review highlighted some notable gaps in the currently available indicators, which to some extent reflect the constraints of the datasets currently available.

For example, indicators relating to children and young people; care transitions (for example, the transition between adolescent and adult services); care pathways; community care; integrated care and care co-ordination; end-of-life care; carers; and staff are under-represented. We are aware that specialist groups are working on indicators for specific areas that will help to fill these and other gaps.

Information developments in the pipeline – in terms of new datasets, data linkage and IT developments – will enhance the potential for developing new indicators that provide a more rounded assessment of the performance of local health services. We recommend therefore that the CCG indicator set, especially COIS, is kept under review and continuous development to avail of these opportunities.

Indicator assurance and development

It will be essential to use the existing processes available to develop and assure the final selection of indicators, and to develop any new indicators in the future.

The current process for developing and producing COIS indicators on quality and outcomes led by NICE should be employed. It is a robust process, with clear links through to NICE's quality standards for public health, health and social care, as well as links with HSCIC for indicator feasibility testing. It also includes consultation with the public. The HSCIC's indicator assurance service provides an essential kitemark. We also advise compliance with the recommendations of the UK Statistics Authority on publishing patient outcome statistics for the public (UK Statistics Authority Monitoring Review 2014).

Both consultation and feasibility testing will be time-consuming and will need to precede final decisions about the choice of indicators. For these reasons, we would strongly recommend that the Department of Health and NHS England consider a soft launch or pilot of any initial set of metrics for the public and the NHS.

Appendices

Appendix 1 Terms of reference for this review

A key feature of high performing health systems across the world is the meaningful use of information about the quality of services to improve their performance. Transparent reporting of information has been shown to stimulate improvements in care quality, as well as providing patients and the public with information about their local services.

MyNHS brings together information on local health and care performance in one place. It allows comparison, for example, of the quality of care provided by local hospitals, GPs and mental health services. The Government, along with other national bodies, wants to develop MyNHS further to provide a fuller picture of local health system performance, notably by publishing information about quality of care and health outcomes for the local populations for which clinical commissioning groups (CCGs) are responsible.

To do this, the government is seeking to develop a scorecard to provide a comprehensive view of the quality of health services for different CCG populations. The new scorecard for CCG populations will be published on the MyNHS website and will be central to the Government's commitment to improve transparency across health and care. The intended purpose is that the new scorecard will:

- Allow commissioners to assess the quality and effectiveness of local services and identify areas for improvement
- Provide accountability to patients and the public, allowing them to compare local health services on the basis of objective information
- Help NHS England identify areas where CCGs may need targeted support to improve quality of care and health outcomes.

The Government would like to ask Chris Ham at The Kings' Fund to lead a review, working with the Department and NHS England, to set out how the scorecard might be constructed to achieve these broad aims. The review will:

- Take stock of what progress has been made by national bodies and other groups to date to measure the performance of local health systems, and what metrics are available
- Consider how the scorecard can align with other national work on measurement and metrics, in particular the integration and GP scorecards also in development, and build upon these ongoing developments

- Consider the merits of basing metrics on five population groups people over 75; people under 75 with long-term conditions; maternity, children and young people; mental health; and the generally well
- Draw on international best practice of performance measurement from countries like Sweden, Canada and the US, as well as international indicators used by bodies like OECD
- Draw on past experiences of related previous initiatives in this country
- Identify gaps in this work that would need to be filled to provide a picture of local health system performance
- Engage with a small number of key stakeholders to inform its work
- Advise on the 'first principles' of a health system scorecard, including: clarity about the aims of measurement, the domains and population groups to be measured, the unit of measurement, the approach to measurement, and data and technical issues that need consideration
- Advise on ranking and scoring using aggregated metrics.

This analysis is intended to provide input to the work of the Department and NHS England in developing the scorecard for CCG populations – part of the Government's commitment to improve transparency across health and care.

The review will require the support of the Department of Health and NHS England and will liaise with the parallel review on developing a scorecard for general practice. The review should report by end of September 2015 to allow the Department and NHS England to establish a new scorecard by March 2016. The review will be published by The Kings' Fund who will have full editorial control of content.

The review will also need to consider the Department of Health's plan, which will bring together the overall ambition of the government for health and care. It will encompass Government priorities and manifesto commitments and provides the basis for system governance and accountability. The ambition is to articulate the health and care system's objectives at national level and to align these with measures of success and performance used throughout the system.

Department of Health June 2015

Appendix 2 Membership of the Technical Advisory Group

Name	Job title	Organisation
Paul Aylin	Professor of Epidemiology & Public Health	Imperial College London
Nick Baillie	Associate Director: Quality Standards	NICE
Uma Datta	Head of Provider Analytics (Adult Social Care and Primary Medical Services)	CQC
Nick Black	Professor of Health Services Research	London School of Hygiene & Tropical Medicine
Richard Cookson	Reader and NIHR Senior Research Fellow	Centre for Health Economics, University of York
Gwyn Bevan	Professor of Political Analysis	London School of Economics & Political Science
Chris Dew	Clinical Indicators Programme Manager	Health and Social Care Information Centre
Julian Flowers	Head of Public Health Data Science	Public Health England
Peter Goldblatt	Deputy Director	UCL Institute of Health Equality
Shane Peel	Provider Analytics Manager	CQC (for Paul Bate)
Myer Glickman	Head of Life Events Modernisation	Office for National Statistics
Adam Roberts	Senior Economics Fellow	The Health Foundation
Martin Roland	Professor of Health Services Research	University of Cambridge
Peter Smith	Emeritus Professor of Health Policy	Imperial College
Robert Stones	Head of Analytical Services (North)	NHS England
David Spiegelhalter	Winton Professor for the Public Understanding of Risk in the Statistical Laboratory	University of Cambridge

Appendix 3 Indicator sources

- Direct from the Department of Health and/or NHS England
- NHS Outcomes Framework, Public Health Outcomes Framework, Social Care Outcomes Framework
- NHSE CCG Outcome Indicator Set (COIS)
- NHS Outcomes Framework inequalities report: <u>www.gov.uk/government/uploads/system/uploads/attachment_data/file/417</u> <u>899/EA_2015-16_acc.pdf</u>
- NHS Mandate
- NHS England's Delivery Dashboard
- Better Care Fund
- Mental Health Intelligence Network
- Dr Foster NHS England commissioned work
- NHS England indicators used for consultation
- Quality premium indicators for CCGs: <u>www.england.nhs.uk/wp-</u> <u>content/uploads/2015/04/qual-prem-guid-1516.pdf</u>
- Public Health England's indicator database for CCGs
- Public Health England's Fingertips website: <u>http://fingertips.phe.org.uk/</u>
- Public Health England's Local Health Profiles for local authorities: www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES
- Better Care Better Value Indicators
- NHS Comparators
- Sundry other sources, including suggestions from some specialist groups

Appendix 4 International examples

We have looked at a small number of international examples to help inform our review. We identified a handful of countries where regional health system performance is assessed and reported to the public – either by the government or national information agencies. We reviewed information on publically available websites to understand the kind of indicators used and the approach taken to reporting this information.

While health system and political context differ across each of these systems, we were particularly interested in understanding:

- the aims and audiences for the data
- the indicator framework used (ie, domains and population groups)
- the indicators used for public reporting
- the approach taken to comparing performance and whether rankings were used.

The table below summarises some of this information for the cases of Sweden, Canada, Australia and New Zealand. We have also included information about the United States, where a scorecard has been produced by an independent research institute rather than the government or related agencies.

Sweden

Sweden has a largely decentralised, publically funded health care system, with county councils responsible for most financing, planning and provision of services. The Swedish Association of Local Authorities and Regions and the Swedish National Board of Health and Welfare annually publish regional comparisons of health care quality and efficiency in Sweden's 21 councils. The reports use nationally available data to compare indicators relating to medical outcomes, patient experience, access and costs (*see* www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19072/2013-5-7.pdf/).

While these health care comparisons include some metrics related to population health outcomes (for example, mortality and life expectancy), public health comparisons are reported separately (for example, *see <u>www.socialstyrelsen.se/publikationer2014/2014-12-</u><u>3</u>).*

Regional comparisons of health care quality and efficiency:					
Aims and audiences	Indicator framework	Approach to ranking and comparison			
 To provide transparency to patients, the public and policymakers To support quality improvement efforts within the health care system To promote quality and availability of health care performance data 	 169 indicators, split between 'overall indicators' relating to outcomes across the whole population, and 'indicators by area' which focus on particular disease groups or service areas. These indicators sit within an overall framework measuring medical outcomes, patient experience, access and costs. Overall indicators, covering dimensions of: Mortality, avoidable hospitalisation, etc Drug therapy Confidence and patient experience Availability Costs Indicators by area, covering dimensions of: Pregnancy, childbirth and neonatal care Gynaecological care Musculoskeletal disorders Diabetes care Cardiac care Stroke care Kidney care Cancer care Surgical interventions Intensive care Other care (Full list of indicators on website) 	 They do not award a single aggregate rating to each region. All councils are ranked for each indicator along with confidence intervals. Results are not aggregated to form a total index of quality and efficiency; 'while the ultimate objective is to reflect the entire health care system to the extent possible, the indicators and outcomes should be regarded separately for the most part'. The report states that national averages should not be used as a yardstick for good or bad performance, but should simply be used to identify scope for improvement. 			



Canada

The Canadian health care system is funded largely by a universal public insurance programme, administered by provinces and territories responsible for organising and delivering services. The Canadian Institute for Healthcare Information (CIHI) collects data about the

health system and the health of Canadians, and reports this information on a website called Your Health System (<u>http://yourhealthsystem.cihi.ca/</u>).

This information is presented in a number of different ways, including:

- an 'in brief' summary of health system performance, aimed at the public, which sets out performance in 15 indicators across 5 dimensions
- an 'in-depth' summary of health system performance, aimed at health care professionals and policy-makers, which sets out performance in 38 indicators across 7 dimensions
- a secure-access tool called 'Insight' that allows health care professionals to dig deeper into a wider range of indicators.

An indicator library is also available which gives a full list of indicators in one place

(http://indicatorlibrary.cihi.ca/display/HSPIL/About+This+Tool). The CIHI's overarching framework for health system performance measurement is set out in Figure B.

Your Health System 'in brief': <u>http://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en</u>					
Aims and audiences	Indicator framework (including indicators)	Approach to ranking and comparison			
 To help the public learn more about the performance of their health system and the health of Canadians The public were consulted to understand which dimensions of performance matter most to them to inform the design of the indicator framework 	Access access to a regular doctor specialist waiting times cancer treatment waiting times joint replacement waiting times Quality of care hospital re-admissions hospital deaths repeat hospital stays for mental illness potentially inappropriate use of antipsychotics in long-term care Spending age-adjusted spending per person cost of a hospital stay Health promotion and prevention obesity rates 	 They do not award a single aggregate rating to each local health system Comparative performance against each indicator is rated as 'above average', 'same as average', or 'below average', and colour coded accordingly (for example, see Figure C) Trend data shows performance over time A short health profile of each area is included (eg, with % of people aged 65+, rate of unemployment and rural area population) alongside performance data 			

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Your Health System `in depth': http://y	 smoking rates Health outcomes life expectancy at birth avoidable deaths children vulnerable in early years of development 	=en#/
Aims and audiences	Indicator framework (including indicators)	Approach to ranking and comparison
 To provide decision-makers in health regions and local organisations with comprehensive information to help them assess local health services, facilitate sharing of best practice and to generate ideas for improvement 	 Access Emergency department wait time for physician initial assessment (hours, 90th percentile) Total time spent in emergency department for admitted patients (hours, 90th percentile) Have a regular doctor Hip fracture surgery within 48 hours Person-centredness Patient flow for hip replacement Repeat hospital stays for mental illness Safety In-hospital sepsis Obstetric trauma (with instrument) Falls in the last 30 days in long-term care Worsened pressure ulcer in long-term care Appropriateness and effectiveness All patients readmitted to hospital Surgical patients readmitted to hospital Obstetric patients readmitted to hospital 	As above

 Patients 19 and younger readmitted to hospital Ambulatory caresensitive conditions (per 100,000) Hospital deaths (HSMR) Hospital deaths following major surgery Influenza immunisation for seniors Breastfeeding initiation Low-risk caesarean sections Potentially inappropriate use of antipsychotics in long-term care Restraint use in long-term care 	
EfficiencyAdministrative expenseCost of a standard hospital day	
 Health status Life expectancy at birth (years) Life expectancy at age 65 (years) Perceived health Avoidable deaths (per 100,000) Avoidable deaths from preventable causes (per 100,000) Avoidable deaths from treatable causes (per 100,000) Avoidable deaths from treatable causes (per 100,000) Hospitalised heart attacks (per 100,000) Hospitalised strokes (per 100,000) Self-injury hospitalisations (per 100,000) Improved physical functioning in long-term care Worsened depressive mood in long-term care 	

 Experiencing worsened pain in long-term care Social determinants Heavy drinking Children vulnerable in areas of early development Obesity Smoking Physical activity during leisure time 	





 summary data for each area presented in a dartboard format (for example, see www.myhealthycommunities.gov.au/Content/downloads/ml-health-signatures/HC_ADLE_Report_southern-nsw.pdf).

My Healthy Communities: <u>www.myhealthycommunities.gov.au</u>

Aims and audiences	Indicator framework	Approach to ranking and comparison			
 To help the public make informed decisions To empower providers and clinicians to make improvements to services To increase transparency within the health system 	 A total of 110 indicators sit under six domains: health status and outcomes prevention use of health services experiences with health services expenditure on health services GP patient care (Full list of indicators on the website)	 They do not award a single aggregate rating to each region Regions are ranked for each indicator against their peer group (with peer groups defined based on remoteness, socio-economic status and distance to hospitals) (see example in figure D) 95 per cent confidence intervals are displayed for each area's performance The peer average is identified Statistically significant variation from the peer group result is highlighted where it exists A summary dartboard is available for each area, comparing a selected number of indicators against peers (for example see www.myhealthycommunities.gov.au/c ompare) 			

	2010-11	2011-12	60%	70%	80%	90%	100%
Peer group: Regional 2	83%	82%			F●H		
North Coast NSW	84%	85%			 - •		
South West WA	89%	85%					
Gippsland	85%	85%			•		
Hume	83%	84%					
New England	84%	84%			•		
Grampians	85%	84%					
Darling Downs-SW Qld	81%	83%					
Wide Bay	85%	82%			├ ──- 		
Tasmania	81%	82%			⊢●⊣		
Western NSW	83%	80%			•	_	
Murrumbidgee	83%	79%			•		
Goulburn Valley #	81%	79%			⊢-●		
Loddon-Mallee-Murray	82%	78%					
Country South SA	83%	77%					
Southern NSW	87%	NP					
Great South Coast	NP	NP					
		-	•		X!		4
	Nationa	al overviews	About the data	Downloa	d the data (XLS)	va View re	sults as PDI
	Nauona	aroverviews	About the data	Downioa	u the data (XLS)		suits as PDr
Statistically significant variation (at the 95% confidence	e level) from the peer	group result.					
Not available for publication							

Figure D Percentage of adults who reported excellent, very good or good health in 2011–12 in regional peer group in Australia



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New Zealand

New Zealand has a largely publically funded health care system, with responsibility for planning, providing and delivering health services devolved to geographically defined district health boards (DHBs). In 2014, the New Zealand Ministry of Health outlined a new framework for measuring health system performance in New Zealand and for improving the quality of health services, called the Integrated Performance and Incentive Framework (IPIF) (Ashton 2015).

When fully implemented, the IPIF will contain two levels of measures: (1) system-level measures which are set nationally and which apply to every DHB; and (2) 'contributory measures' developed by alliances of DHBs, primary health organisations (PHOs) and other stakeholders in local systems to monitor progress towards these system measures and which relate to their specific population needs and priorities.

In 2014/15, the IPIF will include only five system-level measures and will apply only to primary health services (including targets for heart and diabetes checks, help for smokers to quit, immunisation rates and cervical screening). Over time, a broader range of system-level measures will be added to the IPIF and the framework will be used to measure performance of whole health systems rather than just PHOs. A proportion of funding for health services will be linked to these performance indicators to align financial incentives behind system-level goals.

This new approach is being designed to provide continuity with existing approaches to measuring and reporting performance of PHOs and DHBs in New Zealand. DHB performance is currently reported quarterly against national health targets and ranked in a public-facing scorecard called 'how is my DHB performing?' (www.health.govt.nz/new-zealand-health-system/health-targets/how-my-dhb-performing. Rather than providing a full picture of health system performance, the scorecard focuses only on a small number of targets relating mainly to access and prevention (see below).

How is my DHB performing? <u>www.health.govt.nz/new-zealand-health-system/health-targets/how-my-dhb-performing</u>					
Aims and audiences	Indicator framework	Approach to ranking and comparison			
Public accountability, 'to help make the targets real for the community' (see www.health.govt.nz/new- zealand-health-system/health- targets/how-are-health-targets- reported)	 Six targets are reported, relating to: Length of stay in Emergency Dept Access to elective surgery Access to cancer treatment Immunisation rates in children Smoking cessation support rates Heart and diabetes check rates 	 They do not award a single aggregate rating to each DHB DHBs are ranked for each indicator (see example in Figure F) DHB performance against target is indicated DHB progress against target is indicated 			



United States The United States has a health care system that is predominantly based on private health insurance paid for by individuals or

employers. One third of health spending also comes from the federal and state governments who administer the Medicare programme for older people (federal) and the Medicaid programme for people with very low incomes (state).

There is no official government-funded system for comparing the performance of local health systems in the United States, however some independent research organisations have produced comparative reports that do this with publicly available data. One example is the Commonwealth Fund's scorecard on local health system performance, which compares performance across 306 local areas known as 'hospital referral regions', a geographical unit developed for the Dartmouth Atlas. The data is published in an overview report, which discusses variation and key themes and presents tables showing rankings for each region (*see*

www.commonwealthfund.org/~/media/files/publications/fund-report/2012/mar/local-

<u>scorecard/1578 commission rising to challenge local scorecard 2012 finalv2.pdf</u>) and an interactive tool allows comparison between local areas on individual indicators and an overall ranking score (<u>http://datacenter.commonwealthfund.org/#ind=529/sc=38</u>) (*see* Figure G below).

The first edition of the scorecard was published in 2012 and is described as the first step towards developing a comprehensive assessment of local health system performance. It was initially tested in two pilot areas where local stakeholders provided feedback on the report, data and benchmarking tools. To date no further editions of the scorecard have been published.

Commonwealth Fund local scorecard on health system performance					
Aims and audiences	Indicator framework	Approach to ranking and comparison			
 To help local health systems improve their performance The main audiences are health care providers and planners, rather than the public The scorecard allows local areas to assess their own performance and benchmark against others, helping them to establish priorities and set targets for improvement 	 43 performance indicators across four dimensions: 1. Access – includes insurance coverage for adults and children and three indicators of access and affordability of care 2. Prevention and treatment – includes 19 indicators that measure the quality of ambulatory care, hospital care, long-term care, post–acute care, and end-of-life care 3. Potentially avoidable hospital use and cost – includes six indicators of hospital care that might have been prevented or reduced with appropriate care, follow-up care, and efficient use of resources, as well as three measures of the spending on medical care by Medicare and private insurance 	 Local areas are rated for each indicator as either: Top quartile Second quartile Third quartile Bottom quartile Local areas also receive a summary score for each dimension and an overall rank based on the average of their dimension ranks. The Commonwealth Fund describes its methodology as follows. 'First, we derived a ratio for each indicator comparing the local area rate to a benchmark, the top 1 per cent of areas. Where higher rates would indicate a move in a positive direction, we divided the area rate by the benchmark. Where lower rates would 			

Commonwealth Fund local scorecard on health system performance

 4. Healthy lives – includes 10 public health indicators such as cancer mortality rates, suicide rates and others A full list of indicators is included in Appendix B1 of the overview report: www.commonwealthfund.org/~/media/files/pu blications/fund-report/2012/mar/local- scorecard/1578 commission rising to challen ge local scorecard 2012 finalv2.pdf 	indicate a positive direction (eg, mortality), we divided the benchmark by the area rate. The top ratio (best) was set to 100 per cent for scoring purposes. We then averaged the ratio scores for metrics within each of the four performance dimensions to calculate a dimension summary score for each local area. Local areas were then rank-ordered based on their dimension summary score. Dimension ranks were then averaged to derive an overall performance score.'



Appendix 5 The history of aggregate ratings in the NHS

Past NHS rating systems

Aggregate ratings – that combine a range of data sources to provide a single measure of performance for an organisation – are not new to the NHS (*see* Table 1). They first appeared in 2000/1 with the introduction of the star ratings system that awarded a rating of between zero and three stars to all NHS trusts annually. Ratings were awarded to NHS provider trusts and to primary care trusts, whose rating covered both their commissioning and their providing role (Commission for Health Improvement 2003a). The ratings were based primarily on performance against a small set of national targets for things like waiting times and ambulance response times, but also drew on a broader set of indicators that formed a balanced score on performance. High-performing trusts were given greater financial freedoms and were allowed to apply for foundation trusts status (Nuffield Trust 2013).

In 2005/6 the star ratings system was replaced by the annual health check (Healthcare Commission 2009). Like its predecessor this was a yearly assessment of NHS trusts, but it drew on a wider set of information sources and awarded an overall rating in two parts: a rating for the quality of services and a rating for the quality of financial management (*see* Table 1). Both parts used a four-point scale (excellent, good, fair, weak) chosen to align with the scale used by the Audit Commission for their comprehensive performance assessment.

The annual health check was part of the new, more targeted approach to regulation introduced by the Healthcare Commission, which had a statutory duty to rate all NHS providers annually (except learning disability providers, who were excluded due to a lack of robust data on which to base assessments) (Nuffield Trust 2013). In an attempt to move away from a top-down approach to performance management, NHS trusts were asked to assure their own performance against a set of core standards through a process of self-declaration. The assessment also incorporated performance against existing and new national targets and was presented alongside a narrative summary of performance. High-performing organisations earned greater freedoms and risk-based inspections focused only on areas of concern.

The final annual health check ratings were published in 2008/9 and for four years there was no system of aggregate performance ratings in the NHS. During that time, the Care Quality Commission (CQC) (that replaced the Healthcare Commission in 2009) focused its regulatory activity on registering health care providers and assuring compliance with standards set by the Department of Health, through trust self-declaration and risk-based, targeted inspections.

A new approach to regulating providers was introduced in September 2013 following a series of high-profile failures in the quality of care provided in NHS hospitals, in particular the failures detailed in the Francis reports of the public inquiry into the care provided by Mid Staffordshire NHS Foundation Trust (Care Quality Commission 2015a; Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). The ratings were initially introduced for NHS acute trusts and they have now been extended to cover all NHS trusts, GP practices and some other primary medical services (*see* Table 1). The new approach is based on an in-depth inspection by a team of experts that assesses a provider's performance on five domains of quality (safety, effectiveness, caring, responsiveness and well led) across a set of core services areas, which differ by type of provider. The domains are based on Lord Darzi's definition of quality that covers safety, clinical effectiveness and user experience (Department of Health 2008b). The inspections award an overall rating to each provider using a four-point scale developed by OFSTED (outstanding, good, requires improvement, inadequate).

The Department of Health's world class commissioning programme is another relevant assessment system from the NHS' past, particularly in terms of judging performance through the CCG lens. In 2009 and 2010 PCTs were rated against 11 core commissioning competencies using a four-point scale (see Table 1). The programme was designed to encourage PCTs to take a more proactive approach to commissioning that focused on improving the health and wellbeing of the local population and the quality of the services they received, rather than simply awarding provider contracts (Naylor and Goodwin 2010; Department of Health 2009). The assessment was based on a combination of metrics, local intelligence gathering, PCT self-declarations and a review day at which PCT board members were questioned by a panel. Although PCTs were not given a single aggregate rating of their performance (they were rated for each competency and some other factors), external organisations took the published data and used it to create their own league tables (see, for example, the Health Service Journal, www.hsj.co.uk/Journals/2/Files/2010/8/11/World%20class%20commissioning% <u>20league%20tabl1.pdf</u>). PCTs that achieved level 4 for all competencies were to be considered 'world class'.

Following the Health and Social Care Act 2012 and the creation of CCGs, a new process was developed for the ongoing assessment of commissioner competencies. The CCG assurance process is conducted by NHS England and assesses CCG performance against five dimensions: well led, delegated functions, finance, performance and planning. The assessment is based on a range of data sources that include ongoing conversations between NHS England local offices and CCGs, local intelligence gathering, CCG self-declarations and performance metrics (NHS England 2015). The performance domain is assessed using the NHS Delivery dashboard – a set of indicators that reflect CCG priorities relating to the NHS Constitution, outcomes and quality, Better Care Fund and finance. CCGs are awarded an overall rating and are also rated for each domain.

From 2015/16 onwards the CQC's performance rating scale will be used for the assessments, meaning that each CCG will receive a rating of assured as outstanding; assured as good; limited assurance requires improvement; or not assured.

	Star ratings	Annual health check	World class commissioning	CQC provider ratings	CCG Assurance Framework
When	2000/1-2004/5	2005/6-2008/9	2009/10-2010/11	2013/14-	2013/14-
Rating organisation	NHS Executive (2000/1-2001/2), CHI (2002/3), HC (2003/4-2004/5*)	HC (2005/6– 2007/8); CQC (2008/9).	Department of Health (via SHAs)	CQC	NHS England
Health care organisations rated	All NHS trusts**, including PCTs as providers and commissioners	All NHS trusts, including PCTs as providers and commissioners	PCTs	NHS trusts, GP practices, out-of- hours services, some other PMS	CCGs
Overall rating	Zero to three stars	Quality of services (excellent; good; fair; weak). Quality of financial management (same scale)	No single aggregate rating, although if PCTs achieved level 4 on all competencies they would be considered 'world class'	Outstanding; good; requires improvement; inadequate.	From 2015/16: assured as outstanding; assured as good; limited assurance requires improvement; not assured
Other ratings	Performance against a small set of national targets (achieved, underachieved, significantly underachieved) plus a broader set of performance indicators (significantly above average, above average, average, below average, significantly below average) that formed a balanced scorecard	A dashboard for each organisation showing overall scores for quality of services and financial management (see above); scores for the components of quality of services which included: core standards, existing national targets and new national targets (all using scale: fully met, almost met, partly met or not met) and a written	Rating of 1 to 4 each indicator of the 11 core competencies (3 indicators per competency), which were: act as the local leader of the NHS; work collaboratively with local partners; engage with public and patients; collaborate with clinicians; manage knowledge and evidence; prioritise investment according to local needs; stimulate the provider market to meet demand; promote continuous improvement and innovation; secure procurement and	A rating for each core service area (differs by organisation type) and for each domain of quality (safe, effective, caring, responsive, well led) using the scale above. Inspection reports also include a matrix showing performance for each service area on each domain	Performance is assessed for five core components using the four-point scale above. These are: well led; performance (based on delivery dashboard indicators); financial management; planning; and delegated functions (n.b. in 2013/14 only the overall assessment was published, data for 14/15 not yet available)

Table 1 Summary of past and present aggregate performance ratings in the NHS

		summary of performance	contracting skill; manage relationships and contracts with providers; make sound financial plans. PCTs also rated for health outcomes (inc. national and locally chosen indicators), governance (strategy, finance and board using RAG rating) and potential for improvement (narrative)		
Data	Rating based on performance in the previous financial year against a set of key national targets (eg, waiting times, hospital cleanliness) and a broader set of performance indicators (eg, re- admission rates, patient survey results) that formed a balanced scorecard. From 2002/3, the results of clinical governance reviews (periodic inspections of NHS trusts by the regulator) were incorporated into the rating via a set	Trust self- declaration of their performance against core standards across seven domains; performance against national targets; thematic/improvem ent reviews (although later withdrawn); investigations into service failures; financial management assessments by the Audit Commission or Monitor; developmental standards and local targets tested but not widely implemented	The annual assurance process combined self- assessments by PCTs, performance metrics, evidence gathered locally by the SHA and a review day at which board members were questioned by a panel	Based on inspection findings, local and national performance data, and information gathered from other organisations/ patients and the public	Ongoing risk-based assurance conversations between NHS England and the CCG, intelligence from local partners including CQC and Health Watch, COIS, patient feedback, 360 degree stakeholder survey, analysis of CCG documents, CCG self- assessments and performance against the delivery dashboard which includes indicators relating to the NHS constitution, outcomes and quality, Better Care Fund and finance

	of rules called `the Finsbury rules'				
Purpose	Primarily to improve the performance of providers on the areas measured (rather than to support patients' choice of provider)	3 core purposes: (i) assurance (of health care quality and safety) (ii) ensuring organisations focus on quality improvement and value for money (iii) transparency (to provide information for the NHS and the public to improve decision-making)	To improve PCT commissioning competencies and 'enables PCTs to commission high quality and value for money services, that meet the needs of their local communities'	To 'help people to compare services and will highlight where care is outstanding, good, requires improvement or inadequate'	'ensures that CCGs are commissioning safe, high quality and cost effective services, to achieve the best possible outcomes for patients'

*from 2003/4 the way that star ratings were presented changed so that performance against the balanced scorecard of indicators was rated as 'high', 'medium' or 'low' and performance against key targets was rated as 'pass', 'borderline', 'moderate'

** Learning disability trusts were excluded from 2003/4 due to a lack of data on which to base the assessments.

Sources: Care Quality Commission (2015a); Care Quality Commission (2015b); NHS England (2015); Nuffield Trust (2013); Naylor and Goodwin (2010); Department of Health (2008a); Commission for Health Improvement (2003a); Commission for Health Improvement (2003b); (2003b);

Abbreviations: CHI = Commission for Health Improvement; HC = Healthcare Commission; CQC = Care Quality Commission; PMS = primary medical services; SHA = strategic health authority
Evidence on the impact of NHS ratings

There is evidence from the United States that the publication of performance information – most famously, mortality rates for cardiac surgeons in New York – can stimulate quality improvement within hospitals (Shekelle *et al* 2008). Reputational effects drive performance improvements as providers seek to avoid being 'named and shamed', rather than market incentives created by patients using this information to choose between providers (Hibbard *et al* 2003).

There is far less evidence on the impact of published aggregate ratings (as opposed to performance data) on health care quality.

The various different ratings systems that have existed in the NHS over the past 15 years (*see* Table 1) have been difficult to evaluate. This is partly because approaches to rating are short-lived and frequent changes to the configuration of the organisations being rated make it difficult to track performance over time. In part it is also due to methodological difficulties that make establishing a causal link between the publication of a rating and an improvement in quality challenging.

We do know that ratings can improve performance in the areas measured. The star ratings system and the targets that sat within it contributed to the elimination of long waiting times for elective care in the NHS and improved performance in other areas subject to targets, such as the four-hour A&E wait and ambulance response times (Bevan and Hood 2006). At the same time, waiting time performance in Scotland and Wales, which had a very similar health systems but did not introduce a target regime, was significantly worse (Bevan and Wilson 2013; Propper *et al* 2008;).

However, the publication of a rating is not sufficient to deliver change. The context within which a rating is implemented and the structures in place to support improvement have a critical influence on its impact (Nuffield 2013; Bevan and Hamblin 2009; Smith et al 2009). The regime of 'targets and terror' in the NHS involved the public naming and shaming of poor performers with serious consequences for their leadership teams (Propper et al 2008). In 2000/1 the Secretary of State highlighted the 'dirty dozen' trusts that were awarded zero stars in that year's ratings, and six of their chief executives lost their jobs (Bevan and Hamblin 2009). The importance of a rating being linked to real consequences for trusts is underlined by the fact that where targets were implemented without this, they had little impact. The target that ambulance services respond to 75 per cent of category A (the most life-threatening) emergency calls within eight minutes was in place in both Scotland and England. It was only in England – where the target was linked to the star ratings system and resulted in reputational damage for trusts - that the target was met (Bevan and Hamblin 2009).

The annual health check put less emphasis on performance against national targets and it is more difficult to establish a clear link between the rating and changes in the performance of NHS trusts. Performance did improve over time: the proportion of trusts rated as 'good' or 'excellent' for the quality of their services increased from 54 per cent to 70 per cent between 2005/6 and 2008/9, despite some of the targets and standards getting tougher during the period (Nuffield Trust 2013). However performance did not improve in all organisations and many remained 'weak'.

Over the two years that PCTs received ratings as part of the world class commissioning programme, performance also improved by an average of 39 per cent across the 10 core competencies assessed in both years (NHS Confederation 2011). However there is no evidence to connect the publication of the PCT world class commissioning ratings with these improvements and the programme also included tools and guidance that provided support to help PCTs to improve.

Two important points can be taken from the past experience of ratings in the NHS.

Firstly context is key. It is impossible to untangle the impact of ratings from the inspection and data collection systems that underpin them. The success of the star ratings system in eliminating long waiting times was a result of the targets that underpinned them as well as other factors, such as the cash injection into the NHS during that period and the procurement of extra capacity from independent treatment centres. While performance on the annual health check assessment improved over time, we have no way of know what impact the publication of a rating had on that as opposed to the multitude of other factors that affect the quality of care in provider organisations. The rating was a tool that formed one part of the target regime and was used to highlight good and poor performance.

Secondly, we do not know how performance changed in areas not covered by the ratings and there is some evidence that ratings can lead organisations to focus on what is measured at the expense of other important areas of patient care.

When organisations are put under pressure to meet targets, they sometimes try to game the system, which can have negative consequences for patient care. For example, there is evidence that three types of gaming occurred under the star ratings system:

 manipulation of waiting and ambulance response time data in order to meet the targets

- organisations taking actions to meet targets that were detrimental to patient care ('hitting the target but missing the point' for example, cancelling follow-up appointments that were not subject to targets)
- organisations paying less attention to areas that were not subject to targets (Bevan 2009).

Both the star ratings and annual health check rating systems were criticised for distorting local priorities (Nuffield Trust 2013; Mannion *et al* 2005). There is also evidence that staff morale and recruitment can be affected by a poor rating and there have been accusations that ratings created a bullying management culture in some NHS organisations (Nuffield 2013; Mannion *et al* 2005; Horton 2004).

While systems can be put in place to minimise the opportunity for organisations to game the system, as the penalties for poor performance increase, the risk that a rating system creates perverse incentives also increases.

A more comprehensive review of the history and impact of performance ratings in the NHS was conducted for the Secretary of State by the Nuffield Trust in 2013. Their conclusion reflects the mix of potential positive and negative effects that ratings can have and the difficulty in attributing changes in performance solely to a rating system:

Ratings have had both a positive and negative impact, although on current evidence it is not possible to make conclusions on overall impact with confidence. The impact will depend not just on the rating system itself, but crucially on the prevailing set of policies and behaviours in play in health care, in particular the mechanisms used to encourage improvement.

(Nuffield Trust 2013)

Appendix 6

The pros and cons of aggregate ratings

Advantages of aggregate ratings

- Provide a simple, broad assessment of system performance.
- Allow comparison between different health systems and indicate which systems perform better or worse than others overall.
- Place system performance at the centre of the policy arena and draw attention to the underlying data.
- Offer policy-makers an opportunity to set priorities and seek out performance improvement in these areas.
- Can stimulate better data collection and analytical efforts.

Disadvantages of aggregate ratings

Conceptual issues

- Combine highly disparate components and may disguise failings in specific parts of the system. Ratings are therefore not appropriate for quality monitoring and can provide false assurance if used in this way.
- Can mask good or poor performance on one or more indicators, and therefore do not provide the detail required for the public or NHS to take an informed view of performance.
- Do not facilitate improvement as they reveal nothing about what actions organisations need to take to improve.
- The degree of attribution differs between indicators, and a summary rating does not take account of this. For CCG local area ratings in particular, it is difficult to link performance on a particular indicator directly to the actions of the CCG, as other health and social care organisations as well as demographic and cultural factors may have more influence than the commissioning organisation itself.
- Can be highly sensitive to the choice of performance against the constituent indicators and to small changes within these. For example, Addenbrooke's Hospital would have received three rather than two stars in the 2004/5 ratings if just four more junior doctors had signed up to the new deal on working hours.

Technical issues

- The choice of the weights given to the different elements that feed into the rating is ultimately an arbitrary judgement and can be contentious.
- The aggregation model may need revisiting if indicators change, get added to or are dropped. This constrains flexibility in the dataset that underpins the aggregate rating.
- Time trends are difficult to interpret as indicator content will evolve over time, and as new datasets emerge.
- Composites may ignore important dimensions of performance that are difficult to measure.
- Ratings can quickly become out-dated unless a methodology is developed to add new data into model as it emerges.

Behavioural issues

• There is a risk of political interference in the ratings process that affects their credibility and inhibits their ability to influence organisational behaviour. This was highlighted as a problem experienced during the star ratings process.

- As they do not give an informed view of performance, they may be poorly received by rated organisations leading to them being discredited and undermining the initiative.
- Indicator inclusions and exclusions can be contentious, and there can be pressures from vested groups to add or remove certain indicators.

Perverse incentives/unintended consequences

- Can distort local priorities for care, leading managers to focus on what's measured at the expense of what isn't.
- Staff morale and recruitment can be affected by a poor rating.
- Risk that organisations manipulate data in order to meet targets.

Sources: Nuffield Trust (2013), Smith et al (2009), Bird et al (2005), Spiegelhalter (2005)

Appendix 7 An illustrative indicator list

This list has been drawn from a quick review of CCG indicators (available and proposed) from various sources. The indicators have not been tested for feasibility, data quality or reliability. We are aware that there are potentially many more relevant indicators, so the list is illustrative and is not intended to be comprehensive or a recommended set. Please see the section on *Identifying indicators* for information on how the list was derived and associated caveats.

An illust	trative list of indicators relevant from a CCG perspecti	ve		
Serial number	INDICATOR TITLE	POPULATION GROUP	DOMAIN	INDICATOR SOURCE
No.	Indicator (indicators in italics are in development) (duplicates have been deleted, eg, if an indicator is in both the NHS Outcomes Framework (NHSOF) and COIS, we've retained the COIS indicator; so the NHSOF indicators shown are those that are not in COIS)	Generally well (GW); maternity, children and young people (MCYP); mental health and learning disabilities (MH); people with long- term conditions (LTC); older people (OP)	Prevention, Access, Quality (quality is defined as effectiveness, experience, safety)	INDICATOR SOURCE (some indicators are in more than one Outcomes Framework as 'shared' or 'complementary' indicators). MHEWG=MH Expert Working Group; DD=Delivery dashboard; BCF=Better Care Fund; QP=Quality premium indicator; CT=Cancer Taskforce; RC= Richard Cookson; PHOF=Public Health Outcomes Framework; ASCOF=Adult Social Care Outcomes Framework; BCBV=Better Care,

				Better Value indicators
1	1b.i Life expectancy at 75 – males	OP		NHSOF
2	1b.ii Life expectancy at 75 – females	OP		NHSOF
3	1.4.ii Five-year survival from all cancers	MCYP, MH, LTC, OP	Quality: effectiveness	NHSOF
4	1.4.iv Five-year survival from breast, lung and colorectal cancer	MH, LTC, OP	Quality: effectiveness	NHSOF
5	1.4.v One-year survival from cancers diagnosed at stage 1&2	MCYP, MH, LTC, OP	Quality: effectiveness	NHSOF, PHOF
6	1.4.vi Five-year survival from cancers diagnosed at stage 1&2	MCYP, MH, LTC, OP	Quality: effectiveness	NHSOF
7	1.5.i Excess under-75 mortality rate in adults with serious mental illness	МН	Quality: effectiveness	NHSOF, PHOF, NHSE, MH EWG
8	1.5.ii Excess under-75 mortality rate in adults with common mental illness	МН	Quality: effectiveness	NHSOF
9	1.5.iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services	МН	Quality: effectiveness	NHSOF
10	1.6.i Infant mortality	МСҮР	Quality: effectiveness	NHSOF, PHOF, NHSE
11	1.6.ii Five-year survival from all cancers in children	МСҮР	Quality: effectiveness	NHSOF
12	1.7 Excess under-60 mortality rate in adults with a learning disability	МН	Quality: effectiveness	NHSOF
13	2.2 Employment of people with long-term conditions	LTC		NHSOF, PHOF, ASCOF

14	2.6.ii A measure of the effectiveness of post-diagnosis dementia care in sustaining independence and improving quality of life	MH, LTC, OP	Quality: effectiveness	NHSOF, ASCOF
15	2.7 Health-related quality of life for people with three or more long-term conditions	MH, LTC, OP	Quality: experience	NHSOF, ASCOF
16	3.1.ii Total health gain as assessed by patients for elective procedures: psychological therapies	МН	Quality: effectiveness	NHSOF
17	3.1.iii Total health gain as assessed by patients for elective procedures: recovery in quality of life for patients with mental illness	МН	Quality: effectiveness	NHSOF
18	3.3 Survival from major trauma	GW, MCYP, MH, LTC, OP	Quality: effectiveness	NHSOF
19	3.4 Proportion of stroke patients reporting an improvement in activity/ lifestyle on the Modified Rankin Scale at six months	LTC, OP	Quality: effectiveness	NHSOF
20	3.6.i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services	OP	Quality: effectiveness	NHSOF, ASCOF, BCF, NHSE, DD38, Integration scorecard
21	3.6.ii Proportion of older people (65 and over) who were offered rehabilitation following discharge from acute or community hospital	OP	Quality: effectiveness	NHSOF, ASCOF, BCF
22	3.7.i Decaying teeth	МСҮР	Quality: effectiveness	NHSOF, PHOF
23	3.7.ii Tooth extractions in secondary care for children under 10	МСҮР	Quality: effectiveness	NHSOF
24	4a.i Patient experience of GP services	GW, MCYP, MH, LTC, OP	Quality: experience	NHSOF, NHSE
25	4.4.i Access to GP services	GW, MCYP, MH, LTC, OP	Access	NHSOF

26	4.4.ii Access to NHS dental services	GW, MCYP, MH, LTC, OP	Access	NHSOF
27	4.8 Children and young people's experience of inpatient services	МСҮР	Quality: experience	NHSOF
28	4.9 People's experience of integrated care	MCYP, MH, LTC, OP	Quality: experience	NHSOF, ASCOF
29	5a Deaths attributable to problems in health care	MCYP, MH, LTC, OP	Quality: safety	NHSOF
30	5b Severe harm attributable to problems in health care	MCYP, MH, LTC, OP	Quality: safety	NHSOF
31	5.1 Deaths from venous thromboembolism (VTE) related events	OP	Quality: safety	NHSOF, DD 57, NHSE
32	5.3 Proportion of patients with category 2, 3 and 4 pressure ulcers	OP	Quality: safety	NHSOF, NHSE
33	5.4 Hip fractures from falls during hospital care	OP	Quality: safety	NHSOF
34	1.1.i Potential years of life lost (PYLL) from causes considered amenable to health care: adults	GW, MH, LTC, OP	Quality: effectiveness	COIS, NHSOF, PHOF, NHSE, DD, QP
35	1.1.ii Potential years of life lost (PYLL) from causes considered amenable to health care: children and young people	МСҮР	Quality: effectiveness	COIS, NHSOF, PHOF, NHSE, DD, QP
36	1.2 Under-75 mortality rates from cardiovascular disease	MH, LTC	Quality: effectiveness	COIS, NHSOF, PHOF
37	1.24 Cardiac rehabilitation referrals	LTC	Access	COIS, NICE, NHSE
38	1.3 Cardiac rehabilitation completion	LTC	Quality: effectiveness	COIS, NHSE
39	1.4 Myocardial infarction, stroke and end-stage kidney disease in people with diabetes	LTC, OP	Quality: effectiveness	NICE
40	1.5 Mortality within 30 days of hospital admission for stroke	LTC, OP	Quality: effectiveness	COIS, NICE
41	1.6 Under-75 mortality rates from respiratory disease	MCYP, MH, LTC	Quality: effectiveness	COIS, NHSOF, PHOF

42	1,7 Under-75 mortality rates from liver disease	GW, MH, LTC	Quality: effectiveness	COIS, NHSOF, PHOF
43	1.8 Emergency admissions for alcohol-related liver disease	MCYP, MH, LTC, OP	Prevention	COIS, PHOF, NICE, NHSE
44	1.9 Under-75 mortality rates from cancer	MCYP, MH, LTC	Quality: effectiveness	COIS, NHSOF, PHOF
45	1.10 One-year survival from all cancers	MCYP, MH, LTC, OP	Quality: effectiveness	COIS, NHSOF
46	1.11 One-year survival from breast, lung and colorectal cancers	MH, LTC, OP	Quality: effectiveness	COIS, NHSOF
47	1.12 People with severe mental illness who have received a list of physical checks	МН	Prevention	COIS, NICE, PHE
48	1.13 Antenatal assessments within 13 weeks	МСҮР	Access	COIS, PHOF, NICE, NHSE
49	1.14 Maternal smoking at delivery	МСҮР	Prevention	COIS, PHOF, NICE, NHSE
50	1.15 Breast feeding prevalence at 6–8 weeks	МСҮР	Prevention	COIS, PHOF, NICE, NHSE
51	1.25 Neonatal mortality and stillbirths	МСҮР	Quality: effectiveness	COIS, PHOF, NICE, NHSE, DH
52	1.26 Low birth weight of term babies	МСҮР	Prevention	COIS, PHOF, NICE, NHSE
53	1.27 Proportion of pregnant women having planned caesarean sections after 39 weeks 0 days	МСҮР	Quality: effectiveness	COIS, NICE, NHSE
54	1.16 Cancer: diagnosis via emergency routes	MCYP, MH, LTC, OP	Quality: effectiveness	COIS, NICE, CT
55	1.17 Cancer: stage at diagnosis	MCYP, MH, LTC, OP	Quality: effectiveness	COIS, CT
56	1.18 Cancer: early detection	MCYP, MH, LTC, OP	Quality: effectiveness	COIS, PHOF, NICE, CT
57	1.19 Lung cancer: record of stage at diagnosis	MH, LTC, OP	Quality: effectiveness	COIS, NICE

58	1.20 Breast cancer: mortality	MH, LTC, OP	Quality: effectiveness	COIS, NICE
59	1.21 Heart failure: 12-month all cause mortality	LTC, OP	Quality: effectiveness	COIS, NICE
60	1.22 Hip fracture: incidence	OP	Quality: effectiveness	COIS, NICE
61	1.23 Serious mental illness: smoking rates	MH	Prevention	COIS, NICE, QP
62	2.1 Health-related quality of life for people with long- term conditions	MH, LTC, OP	Quality: experience	COIS, NHSOF, ASCOF, DD
63	2.2 People with a longstanding health condition who feel they are supported to manage their condition	LTC	Quality: experience	COIS, NHSOF, PHE, NHSE
64	2.3 People with COPD & Medical Research Council Dyspnoea scale = or > 3 referred to a pulmonary rehabilitation programme	LTC, OP	Access	COIS, NICE
65	2.4 People with diabetes who have received nine care processes	LTC	Quality: effectiveness	COIS, NICE, NHSE
66	2.5 People with diabetes diagnosed less than a year referred to structured education	LTC	Access	COIS, NICE
67	2.6 Unplanned hospitalisation for chronic ambulatory care sensitive conditions: adults	LTC	Quality: effectiveness	COIS, NHSOF, DD, QP, BCF
68	2.7 Unplanned hospitalisation for asthma, diabetes and epilepsy in under-19s	MCYP, LTC	Quality: effectiveness	COIS, NHSOF, DD, QP, BCF
69	2.8 Complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation	LTC	Quality: effectiveness	COIS, NICE
70	2.15 Health-related quality of life for carers	GW, MCYP, MH, LTC, OP	Quality: experience	COIS, NHSOF, ASCOF, NHSE
71	2.9 Access to community mental health services by people from Black and Minority Ethnic (BME) groups	МН	Access	COIS, NICE

72	2.10 Access to psychological therapies services by people from Black and Minority Ethnic (BME) groups	МН	Access	COIS, NICE
73	2.11a-c IAPT reliable recovery, IAPT reliable improvement, IAPT reliable deterioration	МН	Quality: effectiveness	COIS, NHSE, MH EWG, NICE
74	2.16 Health-related quality of life for people with a long- term mental health condition	МН	Quality: effectiveness	COIS, MHEWG, NHSOF, ASCOF, PHOF, QP, NHSE
75	2.13 Estimated diagnosis rate for people with dementia	MH, LTC, OP	Quality: effectiveness	COIS, NHSOF, PHOF, DH, NHSE, DD
76	2.14 People with dementia prescribed anti-psychotic medication	MH, LTC, OP	Quality: effectiveness	COIS, NICE
77	3.1 Emergency admissions for acute conditions that should not usually require hospital admission	GW, MCYP, MH, LTC, OP	Quality: effectiveness	COIS, NHSOF, DD, QP, BCF
78	3.2 Emergency re-admissions within 30 days of discharge from hospital	MCYP, MH, LTC, OP	Quality: effectiveness	COIS, NHSOF, PHOF, NHSE
79	3.3 a-d Average health gain as assessed by patients for elective procedures a) hip replacement b) knee replacement c) groin hernia d) varicose veins	MH, LTC, OP	Quality: effectiveness	COIS, NHSOF
80	3.4 Emergency admissions for children with lower respiratory tract infections	МСҮР	Quality: effectiveness	COIS, NHSOF, DD, QP, BCF
81	3.5 People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital	LTC, OP	Quality: effectiveness	COIS,
82	3.6 People who have had an acute stroke who receive thrombolysis	LTC, OP	Quality: effectiveness	COIS, NICE
83	3.7 People who have had a stroke who are discharged from hospital with a joint health and social care plan	LTC, OP	Quality: effectiveness	COIS, NICE
84	3.8 People who have had a stroke who receive a follow- up assessment between 4 and 8 months after initial admission	LTC, OP	Quality: effectiveness	COIS, NICE

85	3.9 People who have had an acute stroke who spend 90% or more of their stay on a stroke unit	LTC, OP	Access	COIS, NHSE, NICE
86	3.10 Hip fracture: proportion of patients recovering to their previous levels of mobility/walking ability at i) 30 and ii) 120 days after admission	OP	Quality: effectiveness	COIS, NHSOF
87	3.11 Hip fracture: collaborative orthogeriatric care	OP	Quality: effectiveness	COIS, NICE
88	3.12 Hip fracture: timely surgery	OP	Quality: effectiveness	COIS, NICE
89	3.13 Hip fracture: multifactorial falls risk assessment	OP	Quality: effectiveness	COIS,
90	3.18 Hip fracture care process bundle	OP	Quality: effectiveness	COIS, NICE
91	3.14 Alcohol: admissions	MCYP, MH, LTC, OP	Prevention	COIS, NICE
92	3.15 Alcohol: re-admissions	MCYP, MH, LTC, OP	Quality: effectiveness	COIS, NICE
93	3.16 Mental health re-admissions within 30 days of discharge	МН	Quality: effectiveness	COIS,
94	3.17 Percentage of adults in contact with secondary mental health services in employment	МН	Quality: effectiveness	COIS, NHSOF, PHOF, ASCOF, QP, MHEWG
95	Access to GP of choice	GW, MCYP, MH, LTC, OP	Access	
96	4.1 Patient experience of GP out-of-hours services	GW, MCYP, MH, LTC, OP	Quality: experience	COIS, NHSOF, NHSE, DD25
97	4.2 Patient experience of hospital care	MCYP, MH, LTC, OP	Quality: experience	COIS, NHSOF, NHSE, DD
98	4.4 Patient experience of outpatient services	MCYP, MH, LTC, OP	Quality: experience	COIS, NHSOF
99	4.5 Responsiveness to inpatients' personal needs	MCYP, MH, LTC, OP	Quality: experience	COIS, NHSOF

100	4.6 Patient experience of A&E services	GW, MCYP, MH, LTC, OP	Quality: experience	COIS, NHSOF
101	4.7 Women's experience of maternity services	GW, MCYP	Quality: experience	COIS, NHSOF
102	4.8 Patient experience of community mental health services	МН	Quality: experience	COIS, NHSOF, NHSE, MHEWG
103	4.9 Bereaved carers' views on the quality of care in the last 3 months of life	MCYP, MH, LTC, OP	Quality: experience	COIS, NHSOF
104	5.1 Patient safety incidents reported	MCYP, MH, LTC, OP	Quality: safety	COIS, NHSOF
105	5.3 Incidence of Health care-acquired infection (HCAI) – Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)	MCYP, MH, LTC, OP	Quality: safety	COIS, NHSOF, NHSE, DD
106	5.4 Incidence of HCAI – <i>C. difficile</i>	MCYP, MH, LTC, OP	Quality: safety	COIS, NHSOF, DD
107	5.5 Admission of full-term babies to neonatal care	МСҮР	Quality: safety	COIS, NHSOF, NICE, NHSE
108	1.9.i Sickness absence – Percentage of employees who had at least one day off in the previous week	GW, MCYP, MH, LTC, OP		PHOF, BCBV
109	1.9.ii Sickness absence – Percentage of working days lost due to sickness absence	GW, MCYP, MH, LTC, OP		PHOF, BCBV
110	2.04 Under-18 conceptions	GW/MCYP	Prevention	PHOF, NHSE
111	2.6 Excess weight in 4–5 and 10–11 year olds	МСҮР	Prevention	PHOF, NHSE
112	2.07. Hospital admissions caused by unintentional and deliberate injuries in children (aged $0-14$ years)	МСҮР	Prevention	PHOF
113	2.07.ii Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	МСҮР	Prevention	PHOF
114	2.12 Excess weight in adults	GW, MCYP, MH, LTC, OP	Prevention	PHOF, NHSE
115	2.13 Proportion of physically active and inactive adults	GW, MH, LTC, OP	Prevention	PHOF
116	2.14 Smoking prevalence – adults	GW, MH, LTC, OP	Prevention	PHOF,
117	2.20.i Cancer screening coverage – breast cancer	GW, MH, LTC	Prevention	PHOF, NHSE, CT

118	2.20.ii Cancer screening coverage – cervical cancer	GW, MH, LTC	Prevention	PHOF, NHSE, CT
119	Cancer screening coverage – bowel cancer	GW, MH, LTC, OP	Prevention	PHOF, NHSE, CT
120	2.22 Take-up of the NHS Health Check programme by those eligible (40–74 year olds)	GW, MH, LTC	Prevention	PHOF
121	3.3.i Population vaccination coverage in children (various indicators)	МСҮР	Prevention	PHOF, NHSE
122	3.3.xiv Population vaccination coverage – Flu (aged 65+)	OP	Prevention	PHOF, NHSE
123	4.10 Suicide rate	GW, MCYP, MH, LTC, OP		PHOF, MH EWG, Complementary indicator with NHSOF
124	4.12 Preventable sight loss (age-related macular degeneration AMD, glaucoma, diabetic eye disease)	LTC, OP	Quality: effectiveness	PHOF
125	4.15 Excess Winter Deaths	GW, MCYP, MH, LTC, OP	Quality: effectiveness	PHOF
126	0.1.i Healthy life expectancy at birth	GW, MCYP, MH, LTC, OP		PHOF
127	0.1.ii Life Expectancy at birth	GW, MCYP, MH, LTC, OP		PHOF
128	0.2.i Slope index of inequality in life expectancy at birth based on national deprivation deciles within England	GW, MCYP, MH, LTC, OP	Inequalities	PHOF
129	0.2.ii Number of upper-tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2.iii) has decreased	GW, MCYP, MH, LTC, OP	Inequalities	PHOF
130	0.2.iii Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area	GW, MCYP, MH, LTC, OP	Inequalities	PHOF
131	0.2.iv Gap in life expectancy at birth between each local authority and England as a whole	GW, MCYP, MH, LTC, OP	Inequalities	PHOF

132	0.2.v Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England	GW, MCYP, MH, LTC, OP	Inequalities	PHOF
133	0.2.vii Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area	GW, MCYP, MH, LTC, OP	Inequalities	PHOF
134	Dementia care has been reviewed in past 12 months	MH, LTC, OP	Quality: effectiveness	PHE, QOF
135	Deprivation score (IMD)	GW, MCYP, MH, LTC, OP	Inequalities	PHE
136	Rate of people receiving assertive outreach services: Rate per 100,000 population	МН	Access	PHE
137	New cases of psychosis served by Early Intervention teams: Rate (annual) per 100,000 population	МН	Access	PHE
138	Gate-kept admissions: % (quarterly) admissions to acute wards that were gate-kept by the crisis resolution and home treatment (CRHT) teams	МН	Quality: effectiveness	PHE
139	MH002: Patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan	МН	Quality: effectiveness	PHE, QOF
140	IAPT service referrals: Rate (quarterly) per 100,000 population aged 18+	МН	Access	PHE
141	Waiting > 90 days for IAPT: % of referrals (in month) waiting > 90 days for first treatment	МН	Access	PHE, NHSE
142	Spend (£) on CAMHS: Rate per 100,000 population aged <18 (mapped from PCT)	МСҮР, МН	Access	PHE
143	Proportion of people living with LTC who report having a care plan	MH, LTC, OP	Quality: effectiveness	NHSE
144	Controlled blood pressure indicator	LTCs	Quality: effectiveness	NHSE

145	Smoking cessation advice for smokers with selected conditions: percentage, 15+ years, annual, P	GW, MCYP, MH, LTC, OP	Prevention	NHSE
146	Percentage of GPs providing 3-month MDT case reviews for people on the Palliative Care Register. Or: regular (at least 3-monthly) MDT case review meetings where all patients on the palliative care register are discussed	MCYP, MH, LTC, OP	Quality: effectiveness	NHSE, QOF
147	Cancer experience survey	MCYP, MH, LTC, OP	Quality: experience	NHSE, CT
148	Placement of under-18s on adult wards (community failure/joint planning metric), part of CAMHS	МСҮР, МН	Access	NHSE
149	Number of people subject to the MH act per 100,000 population (18+)	МН	Quality: effectiveness	NHSE, PHE
150	Staff survey: (1) active use of patient feedback, (2) confidence in speaking up if concerns	GW, MCYP, MH, LTC, OP		NHSE
151	People presenting in acute service with a primary MH diagnosis	МН	Quality: effectiveness	NHSE
152	Rates of exclusions from QoF registers	MCYP, MH, LTC, OP	Access	NHSE
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153	Time spent in hospital during the last 6 months of life	MCYP, MH, LTC, OP	Quality: effectiveness	NHSE
153 154	Time spent in hospital during the last 6 months of life % mothers able to give birth in place of choice	MCYP, MH, LTC, OP MCYP	Quality: effectiveness Access	NHSE DH
153 154 155	Time spent in hospital during the last 6 months of life % mothers able to give birth in place of choice No. able to get routine appointments evenings and weekends	MCYP, MH, LTC, OP MCYP GW, MCYP, MH, LTC, OP	Quality: effectiveness Access Access	NHSE DH DH
153 154 155 156	Time spent in hospital during the last 6 months of life % mothers able to give birth in place of choice No. able to get routine appointments evenings and weekends Mental health waiting times	MCYP, MH, LTC, OP MCYP GW, MCYP, MH, LTC, OP MH	Quality: effectiveness Access Access Access	NHSE DH DH DH
153 154 155 156 157	Time spent in hospital during the last 6 months of life % mothers able to give birth in place of choice No. able to get routine appointments evenings and weekends Mental health waiting times % of people able to die at home	MCYP, MH, LTC, OP MCYP GW, MCYP, MH, LTC, OP MH MCYP, MH, LTC, OP	Quality: effectiveness Access Access Access Access Access	NHSE DH DH DH DH
153 154 155 156 157 158	Time spent in hospital during the last 6 months of life % mothers able to give birth in place of choice No. able to get routine appointments evenings and weekends Mental health waiting times % of people able to die at home % able to get same-day appts (who wanted one)	MCYP, MH, LTC, OP MCYP GW, MCYP, MH, LTC, OP MH MCYP, MH, LTC, OP GW, MCYP, MH, LTC, OP	Quality: effectiveness Access Access Access Access Access Access	NHSE DH DH DH DH DH DH, NHSE
153 154 155 156 157 158 159	Time spent in hospital during the last 6 months of life % mothers able to give birth in place of choice No. able to get routine appointments evenings and weekends Mental health waiting times % of people able to die at home % able to get same-day appts (who wanted one) CQC provider ratings	MCYP, MH, LTC, OP MCYP GW, MCYP, MH, LTC, OP MH MCYP, MH, LTC, OP GW, MCYP, MH, LTC, OP GW, MCYP, MH, LTC, OP	Quality: effectiveness Access Access Access Access Access Access	NHSE DH DH DH DH DH DH, NHSE DH

161	Dementia – number of patients/carers with care plan	MH, LTC, OP	Quality: effectiveness	DH, ASCOF?
162	Do all health and social care organisations have read/write access on care records?	GW, MCYP, MH, LTC, OP		Integration scorecard
163	Do you use risk stratification to drive the allocation of resources?	GW, MCYP, MH, LTC, OP		Integration scorecard
164	Total bed days for unplanned admissions for ambulatory care-sensitive conditions (ACSCs) per 100,000 population	GW, MCYP, MH, LTC, OP	Quality: effectiveness	Integration scorecard
165	Proportion of people with both personal health budget and social care direct payment who have been able to link the two	MH, LTC, OP		Integration scorecard
166	[New survey question] Do you think that the different people and services treating and caring for you work well together to give you the best possible care?	MH, LTC, OP	Quality: experience	Integration scorecard
167	Waiting times for new psychiatric referral for people with learning disabilities or Autism	МН	Access	DH
168	Current hospital inpatient stays per unit population with learning disabilities out of area	МН	Access	DH
169	Admitted patients starting treatment within a maximum of 18 weeks from referral	MCYP, MH, LTC, OP	Access	DD, QP
170	Non-admitted patients starting treatment within a maximum of 18 weeks from referral	MCYP, MH, LTC, OP	Access	DD
171	Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	MCYP, MH, LTC, OP	Access	DD, QP
172	Number of patients waiting more than 52 weeks on incomplete pathways	MCYP, MH, LTC, OP	Access	DD
173	Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	MCYP, MH, LTC, OP	Access	DD

174	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	MCYP, MH, LTC, OP	Access	DD, QP
175	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	MCYP, MH, LTC, OP	Access	DD
176	Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	MCYP, MH, LTC, OP	Access	DD
177	Maximum 31-day wait for subsequent treatment where that treatment is surgery	MCYP, MH, LTC, OP	Access	DD
178	Maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	MCYP, MH, LTC, OP	Access	DD
179	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	MCYP, MH, LTC, OP	Access	DD
180	Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	MCYP, MH, LTC, OP	Access	DD
181	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	MCYP, MH, LTC, OP	Access	DD
182	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patients (all cancers)	MCYP, MH, LTC, OP	Access	DD
183	Breaches of mixed-sex accommodation	MCYP, MH, LTC, OP	Quality: experience	DD
184	Percentage of people under adult mental illness specialities on Care Programme Approach who were followed up within seven days of discharge from psychiatric inpatient care during the period	МН	Quality: effectiveness	DD, MHEWG, NHSE, NICE COIS

185	A&E waits – percentage of A&E attendances where the patient spent four hours or fewer in A&E from arrival to transfer, admission or discharge	GW, MCYP, MH, LTC, OP	Access	DD, QP, NHSE
186	Cancelled Elective Operations – Number of elective operations that are cancelled at the last minute for non- clinical reasons and not re-booked within 28 days	MCYP, MH, LTC, OP	Access	DD
187	Access to psychological therapies (IAPT)– the proportion of people entering treatment against the level of need in the general population	МН	Access	DD, MHEWG
188	Friends and Family Test (FFT) – percentage who would recommend A&E	GW, MCYP, MH, LTC, OP	Quality: experience	DD, COIS, NHSOF
189	Friends and Family Test (FFT) – percentage who would recommend inpatient	MCYP, MH, LTC, OP	Quality: experience	DD, COIS, NHSOF
190	Medication-related patient safety incidents	MCYP, MH, LTC, OP	Quality: safety	DD
191	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population	OP		DD, ASCOF, BCF, NHSE
192	Delayed transfers of care (delayed days) from hospital per 100,000 population	OP	Access	DD, ASCOF, PHE, BCF, QP, NHSE
193	A&E trolley waits	MCYP, MH, LTC, OP	Access	DD
194	Cancelled operations – urgent	MCYP, MH, LTC, OP	Access	DD
195	IAPT access (comparison to plan)	МН	Access	MHEWG, DD
196	Mental Health Care Plan Approach (comparison to standard)	МН	Access	MHEWG
197	Proportion of people with learning difficulties on the GP DES (directed enhanced services) register receiving an annual health check	МН	Prevention	MHEWG, DH, NHSE
198	Proportion of population with learning difficulties accessing national cancer screening programmes vs proportion of general population	МН	Access	MHEWG

199	IAPT waiting times against 6- and 18-week standards	MH	Access	MHEWG, NHSE
200	Delayed transfer of care (mental health)	MH	Access	MHEWG
201	MH: availability and responsiveness of out-of-hours services	МН	Access	MHEWG
202	Rates of exclusions from CCG QoF registers (mental health)	МН	Access	MHEWG
203	People in contact with secondary mental health services in settled accommodation	МН		MHEWG, NHSE, PHOF, ASCOF
204	MH: Young people in full-time education, employment or training	МСҮР, МН		MHEWG
205	A&E data on outcomes for people attending with self harm and/or 4hr breaches involving mental health	МН	Access	MHEWG, QP
206	Friends and Family Test (mental health)	МН	Quality: experience	MHEWG
207	Mental health admissions (Public Health England indicator: admission of service users: Standardised percentage of people in contact with mental health services who are admitted)	МН	Quality: effectiveness	MHEWG, PHE
208	GP prescribing indicator (mental health)	МН	Quality: effectiveness	MHEWG
209	Reliance on inpatient care for people with learning difficulties	МН	Quality: effectiveness	MHEWG
210	CCG spend on mental health as a proportion of overall spend	МН	Access	MHEWG
211	Waiting times for Early Intervention in Psychosis (data will be available from Q3 of 2015/16 against the new waiting time standard)	МН	Access	MHEWG
212	Use of police cells/health-based places of safety for people detained under s136 – this is available by police force areas but needs to be mapped to CCG and trust areas	МСҮР, МН	Access	MHEWG, NHSE

213	Out-of-area treatment – some analysis is available via CCG from HSCIC – new indicator being considered for development	МН	Access	MHEWG, DH, NHSE
214	Children – new CAMHS dataset coming on stream from Q3 of 2015/16 and will mean there is comprehensive data across CAMHS services for the first time, including on access, experience and outcomes.	МСҮР, МН	Access, Quality	MHEWG
215	Liaison and psychiatry (building on the A&E 4hr wait) – further work to be considered as part of the work on implementation of the new access standard on liaison psychiatry	МН		MHEWG
216	Referral to treatment for Early Intervention in Psychosis services	МН	Access	MHEWG
217	Proportion of patients referred by a GP with symptoms receiving a definitive cancer diagnosis or cancer excluded within 2 and 4 weeks	MCYP, MH, LTC, OP	Access	СТ
218	Proportion of patients with patient-agreed written after- treatment plan	MCYP, MH, LTC, OP	Quality: effectiveness	СТ
219	Proportion of people who die who had a personalised end-of-life care plan	MCYP, MH, LTC, OP	Quality: effectiveness	СТ
220	Cancer patient survey data	MCYP, MH, LTC, OP	Inequalities	СТ
221	1. Inequalities: primary care supply: patients per full- time equivalent primary care physician a,b	GW, MCYP, MH, LTC, OP	Inequalities	RC
222	2. Inequalities: primary care quality: average clinical process quality, weighted by expected mortality benefit (based on UK primary care pay-for-performance data)	GW, MCYP, MH, LTC, OP	Inequalities	RC
223	3. Inequalities: hospital waiting time: days from outpatient decision-to-treat to inpatient admission-for-treatment	GW, MCYP, MH, LTC, OP	Inequalities	RC

224	4. Inequalities: preventable hospitalisation: proportion of people with an emergency admission for an ACSC (NHSOE 2.3 i list of ACSCs)	GW, MCYP, MH, LTC, OP	Inequalities	RC
225	5. Inequalities: Repeat hospitalisation: proportion of inpatients with one or more subsequent any-cause emergency re-admission the same year	GW, MCYP, MH, LTC, OP	Inequalities	RC
226	6. Inequalities: dying in hospital: proportion of people dying in hospital	MCYP, MH, LTC, OP	Inequalities	RC
227	7. Inequalities: amenable mortality: proportion of people dying from causes considered amenable to health care (ONS 2012 list of causes as per NHSOF 1a)	GW, MCYP, MH, LTC, OP	Inequalities	RC
228	8. Inequalities: mortality: proportion of people dying from any cause	MCYP, MH, LTC, OP	Inequalities	RC
229	Access to GP < 48 hrs	GW, MCYP, MH, LTC, OP	Access	DH
230	GPs per 100,000 population	GW, MCYP, MH, LTC, OP	Access	DH
231	Improved antibiotic prescribing in primary and secondary care. Composite Quality Premium consisting of three parts: Part a) reduction in the number of antibiotics prescribed in primary care Part b) reduction in the proportion of broad spectrum antibiotics prescribed in primary care Part c) secondary care providers validating their total antibiotic prescription data.	GW, MCYP, MH, LTC, OP	Quality: effectiveness	QP

Appendix 8 A technical issue relating to resident vs registered populations

Our review of CCG indicators has highlighted a technical issue relating to the unit of measurement that could have significant implications for the choice of indicators and measurement of CCG performance more broadly. The issue relates to how 'CCG populations' are defined. This will determine the availability of data and can potentially impact on performance measurement across the wider health and care system.

Currently, NHS England defines CCG populations as those (or as close to those as possible) that CCGs have responsibility for in the Health and Social Care Act 2012, which includes people registered with GP practices in the CCG, those resident in the CCG area but not registered with a GP practice and, for emergency care, anyone present in the CCG area. Currently CCG indicators like the CCG Outcomes Indicator Set are produced for populations registered with GP practices aggregated to CCG level, ie, not for local populations resident in geographically defined areas.

Based on our knowledge thus far, this issue could potentially create some challenges.

- a) Some NHS datasets cannot be reconfigured to populations registered with GP practices, which means that some indicators conventionally produced in the NHS – for PCTs, health authorities and currently for local authorities – cannot be produced for CCGs or the mapping to CCGs will be an approximation.
- b) It means that, locally, CCGs and local authorities are responsible for different populations. This raises various practical issues such as how they jointly commission and co-ordinate services, and how they deliver integrated care or public health services, if they are dealing with different populations, and how CCGs ensure care co-ordination for patients registered out of area. It is also unclear how indicators relating to care coordination or partnership with other local agencies – eg, prevention, integrated care, joint commissioning – are to be interpreted.
- c) It means that the CCG scorecard is not (strictly defined) about the health or health care system of local populations or areas, and cannot be presented thus to the public. Instead, the indicators relate to a geographically dispersed population defined only by the CCG practices they are registered with.
- d) Indicators based on GP-registered populations exclude people resident in the CCG area but not registered with a practice, and people requiring urgent care but not registered with a local practice. They therefore do not cover the total population that CCGs have responsibility for.
- e) CCGs are responsible for urgent/emergency care for everyone 'present' in their area. Thus for different services CCGs are responsible for different

segments of the population, and it is not clear how the available data and indicators map to these various populations. Seemingly people present in the area are excluded from indicators relating to emergency care if indicators are based on registered patients.

- f) The CCG-registered population is based on GP practice lists. The registered population aggregates to two million more people than the ONS registered population for England. The latter is used for all health and public health indicators at national and local level other than the CCG indicators. The use of these different population denominators makes for significant inconsistencies and differences to the national level rates for the same indicator, eg, premature mortality from cancer, and for differences between CCGs and local authorities in local rates for the same indicator.
- g) As an example, we show below data on the HSCIC Indicator Portal for the indicator on mortality under 75 years from cardiovascular disease for CCGs and local authorities aggregated to England level (*see* below). The data show a significant different in the rates for England, depending on which analytical method is used.

	Mortality <75 from cardiovascular disease, persons, 2013: England total for CCGs	Mortality <75 from all circulatory diseases, persons, 2013: England total for local authorities
OF indicator number	NHSOF indicator 1.1	PHOF indicator 4.4
Rate/100,000	64.9	76.56
Observed deaths	33,086	33,408
Numerator	Deaths registered by GP practice, source: Primary Care Mortality Database	Registered deaths by place of usual residence, source: ONS
Denominator	Registered population, source: NHAIS (Exeter) system	Resident population, source: ONS mid-year population estimates
Population used for standardisation	England, source: ONS mid- year population estimates for England	European Standard Population

In our view, the CCG scorecard should ideally be about the health of and health care system performance for local populations – ie, CCG performance as commissioners of health care for local populations resident in a geographically defined area. This is the conventional practice in the NHS – historically and currently with public health and social care – and internationally. Given the current practice, our view is that a review of this issue is urgently needed in order to understand the implications of not being able to measure performance for the populations that CCGs have legal responsibilities for, and in turn the implications of this for data availability, choice of indicators and indicator construction.

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