

## **Liberating the NHS: Transparency in outcomes – a framework for the NHS BMA response**

### **Executive summary**

This response highlights the British Medical Association's (BMA) position on the specific areas for reform contained in this consultation, building on the views set out in our response to the White Paper 'Equity and excellence: Liberating the NHS'. We hope this response will be useful.

Wanting to demonstrate the achievement of good quality is important and worthwhile. It is essential that these ideas do not become simply another series of targets and indicators which do not achieve the aim of providing meaningful information about healthcare outcomes. It is difficult to comment substantially on the proposals in the consultation until we understand the exact nature of all of the outcome measures that are going to be used, at which point we can see the potential impact on care.

The BMA supports in general the shift in emphasis from targets to outcomes. However, we would not support the wholesale replacement of process targets and indicators with clinical and patient reported outcomes measures. It is generally accepted that the quality of care received by a patient should be integral to the assessment of whether or not that care has been successful. Evidence indicates that the use of process measures is an effective tool for judging and rewarding quality, provided they are valid, have professional support, and are able to influence the process of care but without having total control over the outcome of that care.

The meaningful involvement of clinicians and the deployment of evidence-based decision making at every stage of service design and development is central to achieving successful change in the health service and to the delivery of high-quality care to patients. We believe that clinical decisions should take precedence over all others, and clinicians should be supported in making these decisions

The proposal that 150 quality standards be created, each with up to 10 outcomes within them, could produce up to 1,500 targets to achieve, which is a huge amount for clinicians to implement. When considered as a whole, 150 standards may be a challenge for providers to implement safely. We would like to see more emphasis when creating standards on an approach that can be quickly understood and implemented by all providers, including those that are relatively small.

There is a risk that the NHS Outcomes Framework may end up being so bureaucratic and risk-averse that value for money will not be achieved. Freeing professionals from excessive and unnecessary bureaucracy is essential.

## Draft FINAL

# Liberating the NHS: Transparency in outcomes – a framework for the NHS BMA response

## 1. Introduction

1.1 The BMA is an independent trade union and voluntary professional association, which represents doctors and medical students from all branches of medicine all over the UK. We have a membership of over 140,000 worldwide. We promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

1.2 The BMA supports in general the shift in emphasis from targets to outcomes. However we would not support the wholesale replacement of process targets and indicators with clinical and patient reported outcomes measures<sup>1</sup>. It is generally accepted that the quality of care received by a patient should be integral to the assessment of whether or not that care has been successful. Evidence indicates that the use of process measures is an effective tool for judging and rewarding quality, provided they are valid, have professional support, and are able to influence the process of care but without having total control over the outcome of that care.

1.3 It is important to highlight that, with devolution, healthcare policy has become increasingly divergent across the four nations of the UK, and the BMA's response to the policies and priorities set by each administration will vary according to the particular national context. The NHS in England has already moved further towards competition and marketisation in health than the devolved nations, and is now significantly different from the service in the rest of the UK. This response has been written to reflect the position of the BMA solely in the terms of the implementation of the consultations proposals in the English NHS, and should not be seen as representing the BMA's views more generally on the way forward for the NHS across the UK.

## 2. Scope, principles and structure of an NHS Outcomes Framework

- Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework?

### *Accountability and transparency*

2.1 We agree that accountability and transparency are essential to these proposals. The NHS Outcomes Framework should also have a strong evidence-base in order to engage the profession. Paragraph 2.8 of the consultation document states that the data for each of the outcomes that are presented in the NHS Outcomes Framework will be made publicly available. The way that the media reports these data is of concern and raises questions into how the information is likely to be used and presented once published. This is particularly worrying, as research has shown that patients view the internet as a potential way of finding out about local NHS services, but rarely go beyond browsing media stories<sup>2</sup>. The context in which the service provider is operating should be taken into account when producing reports on publicly available information.

### *Balanced*

2.2 Definitions of, and systems for measuring quality, do of course vary across different health systems. The three domains of quality set out by the Department of Health, comprising safety, effectiveness and patient experience, appear to be a good starting point for the NHS, provided

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<sup>1</sup> *An NHS constitution for England*. BMA, 2008.

<sup>2</sup> *Quality accounts patient and public engagement report*. Department of Health, 2009.

that an appropriate balance is struck between the emphasis put upon the three respective components<sup>3</sup>.

2.3 When measuring outcomes, it is important to note that there are many other factors, external to the care given, that can affect outcomes. The greater the time between the consultation and treatment, the less relevance any data obtained in assessing the quality of care will have.

#### *Focused on what matters to patients and healthcare professionals*

2.4 The meaningful involvement of clinicians and the deployment of evidence-based decision making at every stage of service design and development is central to achieving successful change in the health service and to the delivery of high-quality care to patients<sup>4</sup>. We welcome a focus on what matters most to patients and healthcare professionals, in particular the freeing of professionals from excessive bureaucracy and control. We believe that clinical decisions should take precedence over all others and clinicians should be supported in making these decisions<sup>5</sup>. As such, we welcome commitments to allow doctors the freedom to do what is clinically appropriate for their individual patients<sup>6</sup>.

#### *Internationally comparable*

2.5 The BMA notes the emphasis given in the consultation to comparing the performance of the NHS with healthcare systems from around the world. We would like to highlight that evidence from outside the UK is not always applicable for this sort of comparison and that sufficient investment in UK health research and a more coherent approach to investing in and designing long-term research programmes is required to ensure that robust evidence and recommendations can be obtained. International comparisons are difficult to quantify, sometimes simply due to concepts of illness and different cultures of diagnosis.

2.6 Although the importance of making intra-UK comparisons should not be underestimated, it may not be appropriate to state that it is a 'simpler' approach. Paragraph 2.3 of the consultation document suggests that making intra-UK outcome comparisons should be straightforward, and references recent work by the Nuffield Trust, which presented an analysis of the funding and performance of healthcare systems in the four nations of the UK before and after devolution<sup>7</sup>. An analysis by the BMA<sup>8</sup> of the Nuffield Trust report found that it did not tell the full (complex) story about the relationship between inputs and outcomes in the four nations post-devolution. Principal amongst these are staffing, funding, activity, waiting times and rurality. Furthermore, there was a relative absence of data relating to primary care – an area where there has been comparable investment across the four countries in recent years.

2.7 Comparing health outcomes across the four nations also raises the question as to which outcomes are to be compared. Different governments will have different priorities and it may be that one part of the UK performs comparatively well against indicators it has prioritised. We would welcome easier comparisons of the performance of the four UK health systems, but these

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<sup>3</sup> Response to 'The framework for Quality Accounts.' BMA, 2009.

<sup>4</sup> Caring for the NHS: A way forward. BMA, 2007

<sup>5</sup> Response to Department of Health consultation 'The NHS Constitution: A new consultation on new patient rights'. BMA, 2010. Available at [http://www.bma.org.uk/healthcare\\_policy/responses\\_consultations/newpatrightsfeb10.jsp](http://www.bma.org.uk/healthcare_policy/responses_consultations/newpatrightsfeb10.jsp)

<sup>6</sup> Revision to the NHS Operating Framework for the NHS in England 2010/11. Department of Health, 2010.

<sup>7</sup> Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution, Nuffield Trust, 2010.

<sup>8</sup> Funding and performance of healthcare systems in the four countries of the UK before and after devolution – A commentary. BMA, 2010

must be genuine comparisons based on reliable and compatible data and would require a consensus across the four nations on what outcomes should be compared.

#### *Evolving over time*

2.8 The consultation states that the NHS Outcomes Framework will evolve over time. Whilst we accept this in principle, over recent years the health service has been faced with continual change. A period of stability is vital if clinicians are to concentrate on delivering care and not setting up new systems.

- Are there any other principles which should be considered?

2.9 The BMA would welcome an NHS Outcomes Framework which places an emphasis on relevance. The framework should only measure outcomes for any given part of the system where that part is in a position to affect them.

2.10 We would also welcome an NHS Outcomes Framework that ensured equity of access, appropriately focusing on different socio-economic groups and recognising diversity within the population.

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

2.11 In order to ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities, it is important to focus outcomes on those who are most in need, to compensate for poorer health status and take into account the many factors which influence health experience, such as social determinants of health. For example, gender is recognised as one determinant which influences health status, as women are more likely to experience anxiety related conditions<sup>9</sup>. Therefore, it may be necessary to adopt a gendered approach towards the framework. This is also the case for the other diversity strands where care must be taken to collect necessary data such as ethnicity monitoring data. This will require inclusive grassroots consultation processes with diversity strands, identifying issues that affect health and desired health outcomes.

2.12 The BMA believes it is essential to measure process as well as outcomes, as promoting and resourcing good process has been repeatedly demonstrated to produce good outcomes. This is the approach currently taken in the Quality and Outcomes Framework (QOF) in general practice. The QOF is regarded as a world leader in primary care standards, and the BMA continues to support this approach.

2.13 We support the principle of ensuring equality of access to good quality care. However, it is important to recognise that patients have a right to make decisions about lifestyle or medical choices that may adversely affect their health outcomes. Clinical interventions can have a limited influence on lifestyle choices of patients (for example diet, exercise and alcohol). Often patients making such choices will come from disadvantaged groups and the BMA would not want to return to a directive style of consultation rather than the collaborative style which has developed in recent years.

2.14 It is also important to note the increasing accumulation of evidence that inequalities result in poorer health outcomes in the UK. Countries that have a narrower socio-economic scale have better morbidity and mortality figures across a range of diagnoses from cancer to diabetes<sup>10</sup>.

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<sup>9</sup> *Adult Psychiatric Morbidity in England 2007: results of a household survey*, The NHS Information Centre for health and social care, 2007.

<sup>10</sup> Wilkinson, R. G., & Pickett, K. E. 'Income inequality and population health: A review and explanation of the evidence'. *Social Science & Medicine*, 62(7), 1768-1784.

2.15 We have concerns that the outcomes which matter most to patients will be subject to political manipulation. It will be necessary to clearly set out the method for the evaluation of competing priorities when determining the most important outcomes to be included in the NHS Outcomes Framework.

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

2.16 Integrated care will not develop without appropriate encouragement, facilitation and direction. It requires the active participation of representatives of all elements of the system during the transition both locally and nationally. Representatives of all elements of the system must be involved in the development of a system.

### **3. What would an NHS Outcomes Framework look like?**

- Do you agree with the five outcome domains that are proposed as making up the NHS Outcomes Framework?

3.1 The BMA agrees with the five outcome domains that are proposed.

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

3.2 The BMA believes that the five outcome frameworks cover the range of healthcare outcomes that the NHS is responsible for delivering to patients. However, more extensive consideration of affordability and recognition of the fact that cost constraints may require prioritisation or limiting of outcomes is needed. Hospitals must also have the necessary coding systems in place for the framework to succeed.

#### *Structure*

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

3.3 It would be useful to have authoritative standards to ensure that there is a clear patient pathway and to avoid inequalities in care. However, a careful balance needs to be reached in order to allow clinicians to do more than follow protocols.

3.4 The proposal that 150 quality standards be created, each with up to 10 outcomes within them, could produce up to 1,500 targets to achieve, which is a huge amount for clinicians to implement. We would require clarification of the intention. We would also request further details on the number of indicators that each individual clinician or service would be working with. Taken in isolation, each indicator will be valuable, but when considered as a whole, 150 standards may be a challenge for providers, to implement safely.

3.5 The BMA would like to see more emphasis when creating standards on an approach that can be quickly understood and implemented by all providers, including those that are relatively small.

#### *Domain 1 – Preventing people from dying prematurely*

- Is 'mortality amendable to healthcare' an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?

3.6 For the range of conditions covered, mortality amongst the age groups concerned will only be low if interventions including prevention, are timely, and are of high quality.

- Do you think the method proposed is an appropriate way to select improvement areas in this domain?

3.7 Annex A of the consultation document illustrates the difficulties of selecting areas on mortality statistics. For example, while the UK has a higher death rate from chest infections, other countries routinely x-ray bodies which means they can ensure greater accuracy in death certification. Additionally, preventing a death in one category merely shifts it to another. Age-related mortality may be a more appropriate measure. International comparisons of performance are valid as long as the same measures are being compared and data on many factors are being compared as well as treatments to determine why there are differences.

3.8 It is also important to consider that lower mortality rates might relate to environmental factors in the populations themselves rather than the healthcare provided to them. Healthcare services are only one factor in mortality rates alongside profound environmental and socio-economic determinants of health and early mortality.

3.9 The use of survival rates may also be problematic, as it may not indicate a later death but an earlier diagnosis. This is why comparison of UK data with European data is often flawed.

- Does the proposed NHS Outcomes Framework take sufficient account of avoidable mortality in older people? If not, what would be a suitable outcome indicator to address this issue?

3.10 The BMA agrees that the NHS should not discriminate simply on age. We firmly believe that all patients are entitled to high quality care and for their wishes to be taken seriously, regardless of their condition or age. However, mortality in older people and healthy life expectancy at 65 are extremely difficult areas to quantify. The outcomes should not be restricted to only mortality and survival. Quality of life and measurements of independence may be considered more important to people as they age. Measures which evaluate independence and preserving function may be more appropriate. In addition it is difficult to obtain good data on people over 80 since most trials have an age range of 18-75.

- Are either of the suggestions appropriate areas of focus for mortality in children? Should anything else be considered?

3.11 This will require extensive consideration. Infant mortality must be corrected for different rates of congenital abnormalities, which can vary with the prevalence of consanguineous marriage.

3.12 Mortality statistics not linked to disability in survivors would not be fit for purpose.

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

- Are either of the suggestions appropriate for overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?

3.13 The BMA has reservations about the use of the GP patient survey in this area. The GP patient survey measurement of the 'percentage of people feeling supported to manage their condition' is a vague question which elicits highly subjective answers. It is therefore unsuitable for use as an outcome measure. It may be difficult to find any outcome measure for the management of a long-term condition that is specific and meaningful to a provider or service alone.

3.14 It should be noted that not everyone wishes to contribute to the collection of healthcare data that might be identifiable and retained, which it would need to be to measure sequentially in long-term conditions and demonstrate that deterioration had been prevented, rather than simply providing a short-term insight.

- Would indicators such as those suggested be good measures of NHS progress in this domain? Is it feasible to develop and implement them? Are there any other indicators that should be considered for the future?

3.15 The BMA is sceptical about the use of Patient Reported Outcome Measures (PROMs) in both primary and secondary care. Only a small number of PROMs have been properly validated at this time and as such, we do not believe that the use of PROMs should be expanded until there is peer-reviewed evidence to show how they benefit patient care. Any PROMs that are developed must focus on factors which can be influenced by clinicians and which can be changed and improved. They must be underpinned by robust methodology that ensures objective data and fair comparisons between services and providers. It is vital to avoid the risk of developing a system that places undue pressure on doctors to provide unnecessary treatment that fulfils the wishes of the patient, rather than providing the most clinically appropriate treatment.

3.16 The BMA does not believe that the suggested functional outcome for children – ‘Ability to attend school’ – is appropriate for inclusion as an improvement area for healthcare. The facilities and attitude of schools will determine whether a child with a long-term condition is able to attend. Further, seemingly simple measurable facts may not be immune from external confounding factors. This must be taken into consideration.

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

- Are the suggestions appropriate for overarching outcome indicators for this domain? Are there any other indicators that should be considered?

3.17 The reasons for avoidable hospital admissions are complex and not simply about whether care received in a primary care setting was of a good standard. Social factors, housing and the distance of patients from Accident and Emergency facilities are among the other factors which can have an effect on avoidable hospital admissions. It is also essential to remember that there can be a range of reasons why a patient is admitted, many of them beyond the control of the hospital<sup>11</sup>. The best outcomes are always likely to be achieved when primary and secondary care professionals are allowed to work together to achieve what is best for patients and the BMA supports models of healthcare and funding that encourage co-operation rather than competition.

3.18 A study explaining the differences in English hospital death rates took into account a significant number of socio-economic factors. Significantly, the study concluded that ‘the ratios of doctors to head of population served, both in hospital and in general practice, seem to be critical determinants of standardised hospital death rates; the higher these ratios, the lower the death rates’<sup>12</sup>.

3.19 The immediate discharge information about hospital diagnosis, investigations, management and subsequent treatment is crucial here, and a major source of readmissions, some of which are unnecessary. Good and safe IT linkage between secondary and primary care is extremely important for this to be successful.

3.20 With reference to paragraph 3.33 of the consultation document, there is currently an active campaign to admit patients with stroke to hospital. The BMA would require clarification as to how campaigns such as this are to be set against targets to reduce such admissions. Also, other

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<sup>11</sup> BMA comment on plans to reduce hospital readmissions, Tuesday 08 June 2010. Available at <http://web2.bma.org.uk/pressrel.nsf/wlu/RWAS-868HGH?OpenDocument&vw=wfmms>

<sup>12</sup> Jarman, B., et al. *Explaining differences in English hospital death rates using routinely collected data*, British Medical Journal, 1999; 318:1515-1520.

conditions require secondary care intervention at early stages so admissions will inevitably increase to avoid depriving patients of care. A more sensitive indicator needs to be developed. More appropriate tariffs for short-term stays for investigations should also be developed.

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

3.21 We would agree with paragraph 3.29 of the consultation document in that it may be possible to develop indicators that focus more explicitly on outcomes, and so reduce the risk of perverse incentives. This will require thorough and careful consideration.

- Is this a suitable approach for selecting some improvement areas for this domain? Would another method be more appropriate?

3.22 We would not agree with measuring emergency bed days as an improvement area. As stated previously, there are many complex factors that influence hospital admissions, and these would not be reflected in the measuring tool.

#### *Domain 4 – Ensuring people have a positive experience of care*

- Do you agree with the proposed interim option for an overarching outcome indicator?

3.23 The BMA agrees with the principle of asking patients for feedback. However, we do not believe that the current GP patient survey provides an accurate basis upon which to measure the quality of services in general practice. Research has found that ‘generic patient satisfaction questionnaires appear to be too broad in scope to capture the subtle and intimate nature of the therapeutic relationship’<sup>13</sup>. We do not believe that the survey should continue to be used as an interim measure. We agree with the importance of the themes being tested, but the survey is poor value when aiming to use the results for improvement.

- Do you agree with the proposed long-term approach for the development of an overarching outcome indicator?

3.24 The proposed core questions would need to be devised in a way that can facilitate meaningful feedback leading to improvement. For example, asking people to report back on care and services they received six months after treatment might result in inaccurate responses. Patient surveys must be linked to each episode of care in order to be meaningful.

- Do you agree with the proposed improvement areas and the reasons for choosing those areas?

3.25 In relation to end of life care, the proposed surveying of bereaved relatives could be very difficult and potentially be seen as very insensitive. The need for sensitive enquiries to be made and evaluated should be emphasised.

3.26 We would highlight that patient’s views can change as their disease progresses. For example, families may change their mind about receiving care in the home in preference for hospice based care. It is important that cultural differences are taken into account to avoid imposing a set idea of what is good and caring onto patients and families who may have different cultural backgrounds and wishes.

3.27 The BMA has some concerns about the validity of reported measures here because they are influenced by previous events. This is an area where alternative measures must be found.

- Do you agree with the proposed future approach for this domain?

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<sup>13</sup> Greenhalgh, T., and Heath, I. ‘*Measuring quality in the therapeutic relationship*’ The King’s Fund, 2010.

3.28 This approach appears to be sensible, however, we would welcome further details in order to develop our position fully.

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

- Do you agree with the proposed overarching outcome indicator?

3.29 The BMA has concerns about the suggestion that the number of incidents reported should be rising, as it is likely to result in providers simply reporting more trivial incidents, rather than addressing those that are more serious. A decrease in the rate of incidents judged to be serious needs to be measured rather than the average severity of all reports.

3.30 It is necessary to nurture a 'no-blame culture' first, in order for this indicator to operate successfully. The blame culture which currently exists in the NHS prevents honesty, clarity and problem solving. Accepting and learning from mistakes is a preferable approach.

3.31 A 2009 BMA survey of NHS hospital doctors in England and Wales showed that many doctors do report concerns of this nature, but it also revealed worrying trends in doctors' experiences of doing so. These included fear for career prospects, low awareness of official whistleblowing policies in the workplace and confidence in the outcomes of such processes<sup>14</sup>.

- Do you agree with the proposed improvement areas and the reasons for choosing those areas?

3.32 As stated previously, improvement in the safety culture and openness about mistakes will not be possible unless there is some measure of guaranteed immunity from punitive disciplinary action, as long as appropriate safety actions have been taken and reporting procedures have been followed.

3.33 The assertion in paragraph 3.61 of the consultation document, that safer care is generally less expensive may be true for major incidents, but in areas that have low adverse event rates and low severity of events the benefits resulting from change may be few. For example, increased costs will ensue if general practices, which have low infection rates, have to follow standards of hygiene designed for areas with higher risks.

#### **4. General consultation questions**

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

4.1 The BMA believes it is essential that the following must be avoided:

- Diversion of health professionals' attention and time from patients to the indicators;
- Diversion of resources from common problems to rare ones;
- Over-attention to areas with effective pressure groups; and
- Implementing changes based on flawed indicators.

4.2 To ensure that the NHS is appropriately implementing the non-discrimination aspiration set out in the NHS Constitution, all outcome indicators must include full demographic monitoring, including sexual orientation, disability, religion and belief, age, gender and ethnicity. These must be publicly accessible.

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<sup>14</sup> Whistleblowing: Advice for members working in NHS secondary care about rising concerns in the workplace. BMA, 2009. Available at [http://www.bma.org.uk/ethics/doctor\\_relationships/whistleblowing.jsp](http://www.bma.org.uk/ethics/doctor_relationships/whistleblowing.jsp)

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

4.3 This is presently unclear. Although the NHS has an expressed commitment to sustainable development it is almost impossible to discern what impact this policy has had on any area of service provision.

- How can the NHS Outcomes Framework best support the NHS to deliver better value for money?

4.4 There is a risk that the NHS Outcomes Framework may end up being so bureaucratic and risk-averse that value for money will not be achieved. We would like to reiterate that freeing professionals from excessive and unnecessary bureaucracy is essential.

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

4.5 Wanting to demonstrate and achieve good quality is worthwhile, and the consultation document goes some way towards setting an attitude and approach. However, it will be essential that the ideas do not become yet another series of targets and indicators, rather than guiding principles by the time they reach healthcare professionals. It is difficult to comment substantially on the proposals in the consultation until we understand the exact nature of all of the outcome measures that are going to be used, at which point we can see the potential impact on care.

4.6 The BMA has some concerns over the complexity of many of these proposals and the difficulty for clinicians in implementing them. In addition, the recording of the care must not create unnecessary work and become an unreasonable burden on clinicians' time. It is important that individuals are not blamed for failures of the system.

## 5. Other comments

5.1 This response should be viewed in the context of our continuing opposition to the commercialisation and active promotion of a market approach in the NHS and to the threats to national terms and conditions of service and education and training for doctors contained in the White Paper. We wish to see the NHS restored as a public service working cooperatively for patients. We are committed to an NHS that:

1. Provides high quality, comprehensive healthcare for all, free at the point of use.
2. Is publicly funded through central taxes, publicly provided and publicly accountable.
3. Significantly reduces commercial involvement.
4. Uses public money for quality healthcare, not profits for shareholders.
5. Cares for patients through cooperation, not competition.
6. Is led by medical professionals working in partnership with patients and the public.
7. Seeks value for money but puts the care of patients before financial targets.
8. Is fully committed to training future generations of medical professionals.<sup>15</sup>

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<sup>15</sup> *Look After Our NHS*. BMA, 2009. Available at <http://lookafterournhs.org.uk>

## **Annex A – Identifying potential outcome indicators**

- How might we estimate and attribute the relative contributions of the NHS, public health and social care to these potential outcome indicators?

We believe it will be difficult to work out which indicators are due to the actions of individual providers, even those that are related to healthcare. For example, a death from an aortic aneurism could be due to a genetic predisposition, poor blood pressure control, poor public health services, a slow ambulance response or poor hospital care.