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Shaping health and care in Mid-Nottinghamshire

Mid-Nottinghamshire
Better Together Programme

DRAFT OUTCOME FRAMEWORK REPORT

December 2014

Introduction

Purpose of Framework and approach

Shaping health and care in Mid-Nottinghamshire

In mid-Nottinghamshire, commissioners are seeking to drive whole system change through a re-commissioning process that aims to realign risk and reward within the system.

The approach focuses on measuring and rewarding outcomes (end results) rather than inputs. This rewards both value for money and the delivery of better outcomes by discouraging unnecessary activity, supporting capitation payments (where inputs are not measured or paid for) and encouraging innovation (as the solution is not predefined). By aligning incentives it will also enable organisations to work together to achieve a common set of goals as well as to redistribute resources across the system as required.

Purpose of the outcome framework

The final contract will contain a single, integrated, outcome framework covering the population and services within scope. Achievement against the framework will be monitored and linked to the payment of providers. This will enable commissioners to incentivise providers to deliver improved patient outcomes as well as safe and effective services.

The Accountable Provider Organisation will be expected to deliver the agreed outcomes in addition to national and local and national quality standards, as well as adhering to the requirement to work with Commissioners to consult on service changes associated with delivering the outcomes.

The outcome design working group

A working group was established to oversee and contribute to the development of the framework. This group brought together a range of stakeholders including representatives from the CCG, Local Authority and Public Health, GPs, secondary care clinicians , HealthWatch and CCG quality leads.

The working group is accountable to the CCG commissioning committee and will ultimately recommend the framework to this group for adoption.

The development of the framework has brought together a range of perspectives including patients, clinicians and technical specialists. An overview of the approach is set out below. Throughout 2015 the framework will continue to be refined in dialogue with provider organisations in line with the formal commissioning process.

Steps to develop the outcome framework

Outcome Design: The outcomes against which providers are measured and rewarded should be grounded in what service users value and how health and care services can help them achieve their ambitions and goals.. To develop this understanding a review of the national literature and local public engagement was completed. From this work a number of outcome statements were developed and refined by the working group.

Indicator collation and selection: There is no single, integrated outcome framework for health and care services in the UK so a number of sources were used. A long-list of indicators were mapped to the outcome statements and were then considered and refined by the group. The indicators selected cover the whole pathway of care, combine existing and new measures and reflect different population groups.

Commercialisation: The next phase of work will focus on commercialising the framework. This involves prioritising and weighting the indicators, confirming baseline performance and considering performance trajectories for the duration of the contract. This process will link to the other work streams of the programme.

Structure of the framework

Structure and Domains

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Structure of framework

The Outcomes and Capitated Based contract will contain a single, integrated, outcome framework covering the population and services within scope of the contract. The outcomes and indicators within the framework will give Commissioners and Coordinating Providers a view of performance across pathways and population groups. An outcome framework is a collection of measures that are used to monitor and contract for services.

The framework is made up of three core elements:

Domains	The high-level grouping or classification of outcomes that are measuring similar things – for example, safety or patient experience.
Outcomes	Outcomes are the goals and results of providing health and care services and set out a definition for what Coordinating Providers should be aiming to achieve. Outcomes are grounded in the needs and wants of people who use the services. Many of the outcomes are related and can fit within a number of the domains.
Outcome Indicators	The measures selected to demonstrate the achievement (or not) of the outcome. These will be as outcome focused as possible but where there is a case a process/structure measure can be used as a proxy; for example, many people cite access to timely and responsible services as important. One of the ways to measure this is through process measures/standards. Where possible, existing indicators have been used but there will be a requirement to develop some new indicators.

The aim for the framework is to strike a balance between an appropriate number of measures to reward and recognise performance while not presenting an unnecessary burden on provider organisations or to constrain potential models of care. Through the contracting process these indicators can be refined through negotiation although the outcome statements will be kept the same.

Outcome Domains

There are a number of existing and emerging outcome frameworks. (Appendix 3). We have reviewed these and through the working group identified four 'domains' that are common across them. Outcomes within these domains will represent performance across the system and for different population groups. Indicators will be selected to demonstrate performance against the outcomes.

Outcome Domains

Population Health	The impact of health services on the health of the population such as preventing premature mortality and overall prevalence.
Quality of Life	The overall quality of life that patients and services users are able to have as a result of health and care services. This can include independence and the management of conditions
Quality of Care	The experience people have of health and care, the need to safeguard users and any unintended consequences of care.
Effectiveness of care	The results of or impact of care on services users. This includes immediate and long term recovery.

Structure of the framework

Incorporating outcomes into the contract

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Incorporating outcomes into the contract

The outcome framework will form a relatively small number of measures in the overall contract. Commissioners will get additional assurance from a range of other measures that are routinely collected and reported.

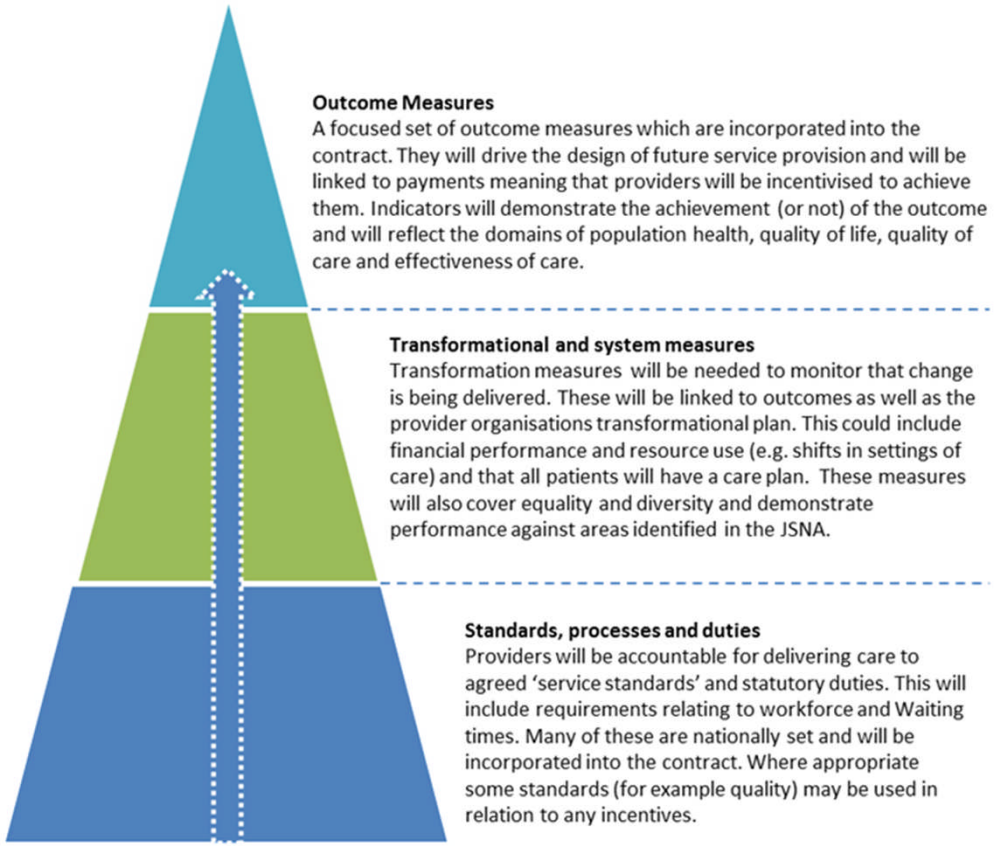
The diagram opposite sets out the different measures that will be measured and monitored. The outcome measures will be set by commissioners, transformational and system measures will be developed jointly with providers and the standards will predominately be set nationally . It is important that these additional measures reinforce the outcomes and do not constrain the potential delivery of new and innovative models of care. However, some standards, such as safeguarding, may be considered significant enough to patients and commissioners that it forms part of the payment mechanism.

The outcome framework also reflects the capitated payment approach. Capitation will incentivise providers to manage the quality and cost of provision meaning that they are more likely to invest in keeping people well and out of hospital.

Aligning services to the scope of the contract

The outcome framework has been developed in the context of the scope . This is because providers can only be held account for outcomes that they have a level of influence and control. Some measures have therefore been discounted where there is a clear distinction. However, the working group agreed to include some measures as they will drive integration and improved services . As the scope is confirmed the framework will continue to be refined. These considerations have been outlined below:

- **Maternity services**: There is currently a place holder for maternity services as this has recently been included in the scope of the contract.
- **Public Health**: While public health is out of scope there are a number of indicators within the Public Health outcome Framework that can be influenced by providers such as injuries from falls for people over 65. It is recognised that some upstream factors ,such as socio-economic, can not be directly influenced.
- **Primary Care:** Core primary care services are outside of the immediate scope of the contract. As such measures set out in QOF (Quality and Outcome Framework) have been discounted. These include some measures related to the management of long term conditions such as monitoring blood pressure.
- **Social Care:** Nottinghamshire Council are currently considering how their services are integrated into the scope. However, the group felt that many measures that traditionally relate to social care are influenced by health providers. The inclusion of these measure reflect the changes the better together programme is aiming to achieve.
- **Mental Health:** Acute Mental Health services are outside the current scope. As such indicators relating to these services have not been included.



Structure of the framework

Personalisation of outcome measures

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Personalisation is an important aspect of integration. The outcomes and indicators selected should therefore incentivise care providers to support service users to achieve their own personal goals and outcomes.

Personalising outcomes means focusing on people's individual goals and the lives they want to lead, rather than just the clinical outputs of their treatment. This means that models of care should be developed and organised around the patient and that service users have a say in what is important for them to achieve on a personal level.

However, at a population level it is not practical or feasible for commissioners to measure the personal outcomes for every patient and/or service user who enters the system. As such, organisations and users within the health and care system have a role to play to practically use to ensure that they personalise their outcome measurements.

- **Commissioners set outcomes and measures that facilitate personalisation:** Commissioners set broad outcomes that they will track that include a set of personalised outcomes. Such as 'people are able to remain independent' or 'service users are able to achieve their personal and social goals'. Other indicators may, for example, include the percentage of service users with a personal budget.
- **Individual care professionals and individuals work together to set personal goals:** Providers work with service users to capture personal goals and aspirations when delivering care.
- **Individuals are supported to track the achievement of personal goals:** Providers regularly check whether people are achieving their personal goals and identify how they can be realised and what, if any, additional support are required.
- **Service users take responsibility:** Service users have a role to play in achieving their own goals and will be expected to take a n appropriate level of personal responsibility.

The case study opposite provides an example of how co-ordinating providers can capture personal outcomes through the development of specific projects. This will, in turn, support the achievement of outcomes relating to independence and quality of life.

Case study: Translating and capturing personal outcomes

Wiltshire Council has established a 'Help to Live at Home Service' for older people and others who require help to remain at home. This approach has focused on the outcomes that the older people wish to gain from social care.

The Council will pay providers on the delivery of person-defined outcomes. These 'payable outcomes' express the goals of a person centred assessment – they must be the product of a person-centred planning process and they are the customer's outcomes.

The Council uses a prescribed set of payable outcome statements to translate individual customer outcomes. The difference from traditional services will be that the council will pay the Provider to help customers achieve outcomes that are defined in Support Plans and not to deliver a prescribed number of units of service – typically hours of domiciliary care – as we do now.

Example outcomes:

- I can manage my personal care (I can wash, dress/undress, shave)
- I can keep myself safe all of the time (Go for short walks, access the local community)
- I can eat, drink and prepare my meals (prepare cold/hot drinks)
- I can make decisions and organize my life (communicate with people independently)

While this service is directly commissioned by the Council it demonstrates how providers and care professionals could translate commissioner outcomes into person-centred delivery.

Source:

- http://ipc.brookes.ac.uk/publications/pdf/Wiltshire_Council_Help_to_Live_at_Home_IPC_Report_April_2012.pdf
- http://www.youtube.com/watch?v=uCretTNaCLg

Outcome Design

Service user and public engagement

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The outcomes against which providers are measured and rewarded should be grounded in what service users need and want. Throughout October and November we worked to understand what matters to patients and services users. This work was informed by:

- **Literature review:** There has been extensive research into the needs and wants of patients and services users at a national and local level. As such, existing literature was used as a starting point to develop insight to inform the development of the outcomes. This process reviewed national literature from organisations such as The Kings Fund , a review of national frameworks and, drawing on previous local engagement (a select list of sources is set out in appendix 1).
- **Local engagement:** To supplement and test the literature above we conducted a range of local engagement activities s that were focused on the development of outcomes. This process has involved over 400 people across Mansfield and Ashfield and Newark and Sherwood.

While some needs from health and care will be largely universal across different groups of service users, some will be related specifically to life stage and/or health and social care need; for example, people with a long term condition or the frail elderly. The same applies to the outcomes. For this reason, our work has distinguished between cross-population and population-specific needs, wants, and outcomes. While the final framework has not explicitly separated different population groups this work has informed the selection of indicators. Appendix 2 sets out the emerging themes at a population level.

Service users and the public often focus on their own needs and wants – such as speed and efficiency - rather than outcomes – to remain healthy. In addition there is often overlap between outcomes. This meant that it was necessary to filter and group these statements into a smaller set of measures so that the framework remained concise and the outcomes could be applied at a population level. The needs and wants of individuals will be used to inform some of the other measures that will be monitored.

The following page sets out the themes arising from the literature and local engagement and how they have been translated into outcomes within each of the domains.

Outcome design

Mapping themes and outcomes

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Domain	Themes from engagement an literature	Outcomes in framework
Population Health	• People are prevented from dying early • People are supported to stay well	• People are prevented from dying prematurely • People are able to stay well
Quality of Life	• Supported to live a healthy life and make positive lifestyle choices • Need for care is delayed and reduced • Can maintain their independence for as long as possible • Can stay in their own homes as long as is safe and appropriate • Quality of life is enhanced and not defined by their long-term condition(s) • Confident that their health is proactively managed • Carers maintain a sense of self and control • Have relationships that are important to them • Are able to participate in activities and to not become socially isolated	• People who use health and care services and their carers report a good quality of life • People can remain independent and are able to manage the risks associated with this • People are able to have choice and control over their condition and the services they receive • People can manage their condition and/or frailty to prevent complications • People are able to make a meaningful community and social contribution
Quality of Care	• Treated in a safe and appropriate setting and protected from avoidable harm • Treated with dignity and respect and without discrimination • People are able to access services and information when they need to • Services are joined up and people can access and navigate services with ease • Care is delivered efficiently and service users have the information they need, are listened to, and advised on the options available to them • Service users are supported to manage their own care • Carers' roles are respected	• People are safeguarded against potential harms • People have access to timely and responsive services • People who use services have a good experience of care
Effectiveness of Care	• Care designed for individuals and they have a choice about what treatment they receive and where this is delivered • Early diagnosis in order to stay 'well' and receive the appropriate treatment • Involved in decisions about what care they receive • To receive effective and appropriate care that alleviates their symptoms • Able to recover quickly from care, injury or episodes of ill-health • Avoid unnecessary hospital admissions • Carers are supported to provide high-quality care and support	• Services are effective and reduce the need for readmissions • Service users make their expected and sustained recovery following treatment • Maternity services effective to prepare mothers and babies for the best start in life • Carers are supported to provide high-quality support

Outcome design

Outcome rationale

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Domain	Ref	Outcome	Rationale
Population Health	1.1	People are prevented from dying prematurely	This outcome reflects the transition to a population based contract and premature mortality is a core overarching outcome. . All providers have a role is supporting people to live healthier for longer. Combined with other outcomes is it anticipated that this will promote improvements in preventative services.
	1.2	People are able to stay well	To improve population health people need to be supported to stay well and to avoid the onset of preventable conditions. The working group felt that measures of prevalence for key long-term conditions as set out in the JSNA would support 1.1 providing more of an 'upstream' measure.
Quality of Life	2.1	People who use health and care services and their carers report a good quality of life	Health and care services should support people who use those services to have a good quality of life. Service user reported measures are a central means to understand how successful services are at supporting them. Measures relating to this this have therefore been grouped into this outcome.
	2.2	People can remain independent and are able to manage the risks associated with this	Ultimately health and social care input should support people to live independently for as long as they are able to do so. It is identified that there are some risks associated with this and that there is a joint responsibility between providers and service users to manage these.
	2.3	People are able to have choice and control over their condition and the services they receive	Choice and control is a central dignity factor that cuts across all services and settings of care. The Social Care Institute for Excellence describes this as 'Enabling people to make choices about the way they live and the care they receive'. This outcome also relates to peoples choices relating to End of Life care.
	2.4	People can manage their condition and/or frailty to prevent complications	Central to the Better Together programme is the aim to prevent complications and problems before they arise. This outcome therefore reflects the need for services to support people to remain 'healthy' and balances against those which focus on treating people when they have an acute episode.
	2.5	People are able to make a meaningful community and social contribution	Social isolation and wanting to form part of a community was a theme that came through the literature and local engagement. It was recognised that being able to participate and be social has a strong link with both emotional and physical health.
Quality of Care	3.1	People are safeguarded against potential harms	Safeguarding against harms in all settings of care is a core requirement of health and care services. Many of these measures will form the standards of care that providers will be expected to deliver and to meet the statutory duties of commissioners. To reflect this the working group considered a summary indicator that would be linked to the incentives within the contract.
	3.2	People have access to timely and responsive services	Access to care was frequently raised through the local engagement as service users and the public think it is important that services are able to respond when they are needed. As with 3.1 many of these measures will be governed by national standards so a summary indicator for access has been included in the draft framework along with an additional measure aiming to improve the availability with primary care.
	3.3	People who use services have a good experience of care	Quality of care includes quality of caring. However, this can be inconsistent. This is central to improving patient-centred care.
Effectiveness of Care	4.1	Services are effective and reduce the need for readmissions	This is a short-term outcome that reflects the appropriateness of care as well as the ability of health and care services to work together to prevent unnecessary readmissions to hospital
	4.2	Service users make their expected and sustained recovery following treatment	Health and care services should support people to make a sustained recovery that meets the goals agreed before receiving treatment or the service.
	4.3	Maternity services effective to prepare mothers and babies for the best start in life	Maternity is a specific bundle of services within the contract and a range of indicators will be selected to demonstrate the effectiveness of these services.
	4.4	Carers are supported to provide high-quality support	Carers deliver a significant amount of care and can support the system to become more effective. However, they don't always have the support they need to deliver this care effectively.

Outcome design

Collating and selecting indicators

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Outcome Indicators are the measures selected to demonstrate the achievement (or not) of the outcome. The working group considered a range of indicators and selected those that best represent the outcomes in the framework.

Hundreds of measures and indictors exist across health and social care and the aim for this process has been to strike a balance between an appropriate number of measures. To achieve this the working group has attempted to develop a mix of:

- **Outcome focused**: Where possible indicators have been as outcome focused as possible but where there is a case or a need a process/structure measure can be used as a proxy; for example, many people cite access to timely and responsible services as important.

- **Outcomes across pathways**: People will interact with services at different points in time and with different needs. Each interaction will have its own related outcome. It is therefore important that outcomes reflect provision across a whole pathway from maintaining health and wellbeing through to end of life care.

- **Inclusion of both extrinsic and intrinsic indicators**: Extrinsic indicators can be measured consistently using data that is routinely collected and reported such as admissions to care homes. Intrinsic indicators are often reported by service users and capture experience or patient reported quality of live.

- **Indicators for different populations:** This is a single framework for a whole population. However, there are different population groups , such as older people or adults with long term conditions, which will have specific outcomes and indicators. The selection of these has been informed by the literature review and patient and public engagement.

- **Links to strategic plans**: Indicators have been aligned to local strategic plans including the Nottinghamshire Health and Wellbeing Strategy, Better Together Blueprint and Adult Social Care Stratregy. Where possible the aims of the Care Act have also been taken into account.

The majority of indicators that have been identified come from existing sources drawing on national frameworks, emerging frameworks from other parts of the country and local data sources. This has been to reduce duplication and the unnecessary development of new indicators which can be time consuming and costly. A number of placeholders have been included where indicators are being developed nationally.

Throughout the lifetime of the contract commissioners will continue to review and update the framework so that it remains relevant. A contractual mechanism will support this.

The outcome framework and next steps

The following page sets out the initial outcome framework that has been developed through consultation with the outcomes working group.

The next steps for the framework are:

- *Commercialisation*: To align the framework with the contract and consider how it will be linked to payments including which measures will be incentivised
- *Performance*: Agree baseline performance and trajectories
- Align with scope: Continue to iterate in line with developments in the scope of the contract
- *Engage providers*: Share the initial framework with providers in line with the formal re-commissioning process. While some indicators may be amended the outcomes should remain the same.
- *Language*: To work with residents to test language of outcomes so that it is meaningful to them
- *Coverage*: Sub-group to test against a current patient journey

Outcome Framework

Summary of domains, outcomes and indicators

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Population Health

People are prevented from dying prematurely
- Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
- Reducing premature mortality from the major causes of death
  - U75 mortality rate from CVD, Respiratory, Liver, Cancer, Heart Failure
- Excess Winter Deaths

People are able to stay well
- Impact on the prevalence of the main long-term conditions identified in the JSNA. These are hypertension, common mental health disorders, CKD, asthma, and diabetes

Quality of Life

People who use health and care services and their carers report a good quality of life
- Social care related quality of life
- Health-related quality of life for Carers, people with long-term conditions and, older people

People can remain independent and are able to manage the risks associated with this
- Permanent admissions to residential and care homes, per 100,000 population (both over 65 and 18-65). A) All admissions, B) Direct from Hospital, C) Other settings over than home (e.g. intermediate care service)
- Proportion of older people (65 and over) who where still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Return to usual place of residence following; Stroke, Fracture Proximal Femur, Dementia and Continence
- Delayed transfers of care from hospital

People are able to have choice and control over their condition and the services they receive
- Proportion of people who use services who have control over their daily life
- Proportion of people using social care who receive self-directed support, and those receiving direct payments
- EOL: % of patients dying in place of preference
- Proportion of patients and service users who feel that they were involved as much as they wanted to be in decisions about their care and support

People can manage their condition and/or frailty to prevent complications
- Proportion of people feeling supported to manage their (long-term) condition
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Examples include Infections, Nutritional, endocrine and metabolic, Diseases of the blood, Mental and behavioural disorders, Neurological disorders, Cardiovascular diseases, Respiratory diseases)
- Diabetes: Complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation

People are able to make a meaningful community and social contribution
- Employment of people with long-term conditions
- Proportion of adult social care users who have as much social contact as they would like
- Proportion of adult carers who have as much social contact as they would like

Quality of Care

Users are safeguarded against potential harms
- Providers are expected to comply with all national standards and duties in relation to safety and safeguarding. These will form part of the contract and a selection of measures may be used as a pass/fail for incentivisation.

People have access to timely and responsive services
- Overall satisfaction of people with accessibility and convenience to health and care services
- % reduction in attendances at A&E for primary care conditions including dental, minor injuries and minor eye conditions

People who use services have a good experience of care
- Patients experience of Integrated Care
- Patient experience of hospital care (composite measure of inpatient, outpatient and A&E)
- Overall satisfaction of people who use services with their care and support (Social Care)
- Overall satisfaction of carers with social services
- EOL: Bereaved carers' views on the quality of care in the last three months of life

Effectiveness of Care

Services are effective and reduce the need for readmissions
- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency readmissions within 30 days of discharge from hospital (fractured proximal femur; hip replacement surgery; hysterectomy; stroke and 'all readmissions')
- Summary Hospital Mortality Indicator (SHMI)

Service users make their expected and sustained recovery following treatment
- Proportion of service users achieving their personal and social goals agreed at the beginning of support or treatment
- Care hours required at the end of reablement and/or rehabilitation services
- Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months
- Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days
- Increased health gain as assessed by patients for elective procedures a) hip replacement, b) knee replacement, c) groin hernia, d) varicose veins
- Functional Mobility following stroke
- Cancer: One and five year survival rates for all cancers

Maternity services effective to prepare mothers and babies for an excellent start in life
- Maternity place holder (May need separate framework) - indicators could include (perinatal mortality rates, birth weight, % of babies admitted to Neonatal Intensive Care, experience and choice of maternity care and support, confidence to care for baby, % of women readmitted within 28 days of delivery

Carers are supported to provide high-quality support
- Carers feel they have access to expertise to be effective carers
- Carers reporting that they have had the support they need to stay well and manage their wellbeing

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DETAILED FRAMEWORK

Domain 1: Population Health

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Ref	Outcome	Ref	Indicator	Indicator Source
1.1	People are prevented from dying prematurely	1.1.1	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare	NHSOF 1a, CCGOF 1.1
		1.1.2	Reducing premature mortality from the major causes of death - U75 mortality rate from CVD, Respiratory, Liver, Cancer, Heart Failure	PHOF 4.3, NHSOF 1a
		1.1.3	Excess Winter Deaths	PHOF 4.15i
1.2	People are able to stay well	1.2.1	Impact on the prevalence of the main long-term conditions identified in the JSNA. These are hypertension, common mental health disorders, CKD, asthma, and diabetes	Existing data

Domain 2: Quality of Life

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Out Ref	Outcome	In Ref	Indicator	Indicator Source
2.1	People who use health and care services and their carers report a good quality of life	2.1.1	Social care related quality of life	ASCOF 1A
		2.1.2	Health-related quality of life for Carers	CCGOF 2.15
			Health-related quality of life for people with long-term conditions	NHSOF 2
			Health-related quality of life for older people	PHOF 4.13
2.2	People can remain independent and are able to manage the risks associated with this	2.2.1	Permanent admissions to residential and care homes, per 100,000 population (both over 65 and 18-65) A) All admissions B) Direct from Hospital C) Other settings over than home (e.g. intermediate care service)	ASCOF 2A, BCF (just over 65)
		2.2.2	Proportion of older people (65 and over) who where still at home 91 days after discharge from hospital into reablement/rehabilitation services	NHSOF 3.6i, ASCOF 2B
		2.2.3	Return to usual place of residence following; Stroke, Fracture Proximal Femur, Dementia and Continence	HSCIC Compendium, [Blueprint: FELTC2]
		2.2.4	Delayed transfers of care from hospital	ASCOF 2C
2.3	People are able to have choice and control over their condition and the services they receive	2.3.1	Proportion of people who use services who have control over their daily life	ASCOF 1B
		2.3.2	Proportion of people using social care who receive self-directed support, and those receiving direct payments	ASCOF 1C
		2.3.3	EOL: % of patients dying in place of preference	TBC
		2.3.4	Proportion of patients and service users who feel that they were involved as much as they wanted to be in decisions about their care and support	PIRU (app.C)
2.4	People can manage their condition and/or frailty to prevent complications	2.4.1	Proportion of people feeling supported to manage their (long-term) condition	NHSOF 2.1, BCF, CCGOF 2.2
		2.4.2	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Examples include Infections, Nutritional, endocrine and metabolic, Diseases of the blood, Mental and behavioural disorders, Neurological disorders, Cardiovascular diseases, Respiratory diseases)	HES, CCG 2.6, NHSOF 2.3i
		2.4.3	**Complications in relation to a diagnosed long-term condition** - Diabetes: Complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation - (See measure 1.1.2 for mortality from heart failure and CVD) - (See 2.3.2 for exacerbations relating to COPD and CVD)	CCG OF 2.8
2.5	People are able to make a meaningful community and social contribution	2.5.1	Employment of people with long-term conditions	NHSOF 2.2, PHOF 1.8, ASCOF 1E
		2.5.2	Proportion of adult social care users who have as much social contact as they would like	PHOF 1.18i
			Proportion of adult carers who have as much social contact as they would like	PHOF 1.18ii

Domain 3: Quality of Care

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Out Ref	Outcome	In Ref	Indicator	Indicator Source
3.1	Users are safeguarded against potential harms	3.1.1	Providers are expected to comply with all national standards and duties in relation to safety and safeguarding. These will form part of the contract and a selection of measures may be used as a pass/fail for incentivisation.	Link to NHSOF 5b
3.2	People have access to timely and responsive services	3.2.1	Overall satisfaction of people with accessibility and convenience to health and care services	IQI PEXIS1
		3.2.2	% reduction in attendances at A&E for primary care conditions including dental, minor injuries and minor eye conditions	NEW
3.3	People who use services have a good experience of care	3.3.1	Patients experience of Integrated Care	NHSOF and ASCOF (TBC) - currently under development
		3.3.2	Patient experience of hospital care (composite measure of inpatient, outpatient and A&E)	NHSOF 4b
		3.3.3	Overall satisfaction of people who use services with their care and support (Social Care)	ASCOF 3A
		3.3.4	Overall satisfaction of carers with social services	ASCOF 3B
		3.3.5	EOL: Bereaved carers' views on the quality of care in the last three months of life	CCG OF

Domain 4: Effectiveness of Care

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Out Ref	Outcome	In Ref	Indicator	Indicator Source
4.1	Services are effective and reduce the need for readmissions	4.1.1	Emergency admissions for acute conditions that should not usually require hospital admission	CCGOF 3.1, NHSOF 3.3a
		4.1.2	Emergency readmissions within 30 days of discharge from hospital (fractured proximal femur; hip replacement surgery; hysterectomy; stroke and 'all readmissions')	CCGOF 3.2
		4.1.3	Summary Hospital Mortality Indicator (SHMI)	HSCIC
4.2	Service users make their expected and sustained recovery following treatment	4.2.1	Proportion of service users achieving their personal and social goals agreed at the beginning of support or treatment	NEW
		4.2.2	Care hours required at the end of reablement and/or rehabilitation services	NEW (SCIE)
		4.2.3	Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months	NHSOF 3.4 (In development)
		4.2.4	Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days	NHSOF 3.5
		4.2.5	Increased health gain as assessed by patients for elective procedures a) hip replacement, b) knee replacement, c) groin hernia, d) varicose veins	NHSOF 3.1, CCGOF 3
		4.2.6	Functional Mobility following stroke	TBC
		4.2.7	Cancer: One and five year survival rates for all cancers	NHSOF 1.4 / CCG OF
4.3	Maternity services effective to prepare mothers and babies for an excellent start in life	4.3.1	Maternity place holder (May need separate framework) - indicators could include (perinatal mortality rates, birth weight, % of babies admitted to Neonatal Intensive Care, experience and choice of maternity care and support, confidence to care for baby, % of women readmitted within 28 days of delivery)	TBD
4.4	Carers are supported to provide high-quality support	4.4.1	Carers feel they have access to expertise to be effective carers	NEW
		4.4.2	Carers reporting that they have had the support they need to stay well and manage their wellbeing	ASCOF

APPENDICES

Appendix 1

Select sources for literature review

Shaping health and care in Mid-Nottinghamshire

National evidence base

- 'Measuring what really matters: towards a coherent measurement system to support person-centred care', The Health Foundation (2014)
- 'Outcomes-Based Commissioning for Mental Health services – consultation report', Oxfordshire CCG (2013)
- (https://consult.oxfordshireccg.nhs.uk/consult.ti/OBCMH/consultationHome)
- 'We've got to talk about outcomes – 1', Health and Social Care Alliance Scotland (2013)
- 'We've got to talk about outcomes – 2', Health and Social Care Alliance Scotland (2013)
- 'Improving Children and Young People's Health Outcomes: a system wide response, DH (2013)
- 'Framework for Action, 2013-17', Older People's Commissioner for Wales (2013)
- 'Measuring the social care outcomes of informal carers', Quality and Outcomes of Person-Centred Care Policy Research Unit (2012)
- 'Patient-centredness healthcare indicators review', International Alliance of Patients' Organisations (2012)
- 'Commissioning Maternity Services', NHSE (2012)
- 'What matters to patients?', King's Fund and King's College London (2011)
- 'A Better Life: what older people with high support needs value', Joseph Rowntree Foundation (2011)
- 'My name is not dementia: people with dementia discuss quality of life indicators', Alzheimer's Society (2010)
- 'Supporting carers – early interventions and better outcomes', The Princess Royal Trust for Carers and ADASS (2010)
- 'Commissioning better outcomes for carers – and knowing if you have', The Princess Royal Trust for Carers and ADASS (2010)
- 'Older people's vision for long-term care', Joseph Rowntree Foundation (2009)
- 'Contracting for personalised outcomes : learning from emerging practice ', Department of Health (2009)
- NHS Outcomes Framework (2014-15), Adult Social Care Outcomes Framework (2014-15), Public Health Outcomes Framework (2013-16)

Local evidence base

- 'Quality for all - Improving patient and carer experience at Sherwood Forest Hospitals NHS Foundation Trust' (2014)
- 'Involvement and experience report', Nursing, Quality & Patient Experience Directorate for the Trust Board of Nottingham Healthcare NHS Trust (September 2014)
- 'Patient voice report', Nursing, Quality & Patient Experience Directorate for the Trust Board of Nottingham Healthcare NHS Trust (September 2014)
- 'Report on Communications and Engagement Activity, November - December 2013', Mid Nottinghamshire Integrated Care Transformation Programme (2013)
- 'What you told us. What we did', Mid Nottinghamshire Integrated Care Transformation Programme (2013)

Appendix 2
Population overview

Shaping health and care in Mid-Nottinghamshire

Population Group	Common themes	Themes specific to patient groups
Older people (over 65)	*Quality of life* • Can receive care that supports them to meet their personal and social goals • Supported to live a healthy life and make positive lifestyle choices • Need for care is delayed and reduced *Quality of care* • Treated with dignity and respect and without discrimination • Can access and navigate services with ease • Services are joined up • Treated in a safe and appropriate setting and protected from avoidable harm • Care is delivered efficiently • Care professionals give service users the information they need, listen to them, and advise them on the options available to them *Effectiveness of care* • Receive care designed for them • Are involved in decisions about what care they receive • Receive care that alleviates their symptoms • Recover quickly from care • Avoid unnecessary hospital admissions	• Maintain their independence for as long as possible • Relationships that are important to them • Can make their desired contribution to their local communities • Can stay in their own homes as long as is safe and appropriate
Adults (18-64) with 1 or more LTC		• Quality of life is enhanced and not defined by their long-term condition(s) • Confident that their health is proactively managed • Supported to manage their own care
Adults with Mental Health Conditions		• Able to recover quickly from discrete episodes of mental ill-health • Avoid unnecessary hospital admissions
Generally healthy adults (18-64)		• Service users recover quickly from injury or episodes of ill-health
Carers		• Carers maintain a sense of self and control • Carers' roles are respected • Carers are supported to provide high-quality care and support
Women and Children		• Supported through pregnancy and to care for themselves and their babies after birth • Care and communication are appropriate to service users' ages • Service users recover quickly from discrete episodes of mental ill-health

Notes:
- Mental Health is currently outside the scope of the contract but was captured during the literature review and outcome design
- Maternity services have been included in scope and a place-holder has been identified
- Children's services are currently out of scope

Appendix 3

Select sources for outcome framework design

Shaping health and care in Mid-Nottinghamshire

Outcome Frameworks and performance measurement

- NHS Outcome Framework (https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015)
- Public Health Outcome Framework (http://www.phoutcomes.info/)
- Adult Social Care Outcome Framework (http://ascof.hscic.gov.uk/)
- HSCIC Indicator Portal (http://www.hscic.gov.uk/indicatorportal)
- Medicaid ACO Quality Measures and Performance Standards(http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html)
- Emerging frameworks: Cambridgeshire and Peterborough (older people), Oxfordshire (Older People), Croydon (Older People)
- Commonwealth Fund (2014): Aiming Higher Scorecard Report (http://www.commonwealthfund.org/publications/fund-reports/2014/apr/2014-state-scorecard)
- Department of Health (2011): Transforming Community Services (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215624/dh_126111.pdf)
- NHS TDA (2013): Delivering High Quality Care for Patients, The Accountability Framework for NHS Trust Boards (http://www.ntda.nhs.uk/wp-content/uploads/2012/04/framework_050413_web.pdf)

Academic and other literature

- Institute for Healthcare Improvement White Paper (2012); A guide to measuring the triple aim; population health, experience of care and per capita cost (http://www.ihi.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx)
- Health Affairs (2008): The Triple Aim: Care, Health, And Cost (http://content.healthaffairs.org/content/27/3/759.full.html)
- Michael Porter: The strategy that will fix healthcare (https://hbr.org/2013/10/the-strategy-that-will-fix-health-care)
- *The* NEW ENGLAND JOURNAL *of* MEDICINE (Michael Porter) (2010): What is Value in Healthcare?
- Institute of Public Care (2012) Wiltshire Help to Live at Home (http://ipc.brookes.ac.uk/publications/pdf/Wiltshire_Council_Help_to_Live_at_Home_IPC_Report_April_2012.pdf
- North West London Whole systems integrated care (http://integration.healthiernorthwestlondon.nhs.uk/)
- Commonwealth Fund (2014): Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally (http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror)
- IAPO (2014): Patient Centred Healthcare (http://iapo.org.uk/patient-centred-healthcare)
- The Health Foundation (2013), Measuring patient experience, http://www.health.org.uk/publications/measuring-patient-experience/
- The Health Foundation (2014), Helping Measure Patient Centred Care, http://www.health.org.uk/publications/helping-measure-person-centred-care/
- The Kings Fund (2010), Clinical and service integration. The route to improved outcomes, http://www.kingsfund.org.uk/publications/clinical-and-service-integration
- Monitor (2014), Complying with Monitor's integrated care requirements, https://www.gov.uk/government/publications/integrated-care-how-to-comply-with-monitors-requirements/complying-with-monitors-integrated-care-requirements
- Nuffield Trust (2013), (http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation_summary_final.pdf)
- Independent Commission on Whole Person Care for the Labour Party (2014), One Person, One Team, One System (http://www.yourbritain.org.uk/uploads/editor/files/One_Person_One_Team_One_System.pdf)
- HM Government (2014): Carers Strategy (https://www.gov.uk/government/publications/carers-strategy-actions-for-2014-to-2016)