

Transforming Community Services

Quality Framework: Guidance for Community Services



DH INFORMATION READER BOX

Policy	Estates Commissioning IM & T Finance Social Care/Partnership Working
HR/Workforce Management Planning/Performance Clinical	
Document purpose	Best Practice Guidance
Gateway Reference	12018
Title	Quality Framework: Guidance for Community Services
Author	Commissioning & System Management
Publication date	24 Jun 2009
Target audience	PCT CEs, SHA CEs, Care Trust CEs, Directors of PH, Directors of Nursing, Allied Health Professionals
Circulation list	NHS Trust CEs, Foundation Trust CEs, Medical Directors, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, PCT Chairs, Directors of HR, Directors of Finance, Communications Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs
Description	This guidance sets out how the seven elements of the Quality Framework applies in Community Services. It includes a set of proposed indicators of quality that will be developed and assured for publication. The Department will be seeking views from interested stakeholders on these indicators.
Cross ref	Transforming Community Services, Service Transformation Guides
Superseded docs	N/A
Action required	N/A
Timing	N/A
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Transforming Community Services

Quality Framework: Guidance for Community Services

Section 1: Introduction

- 1.1 *High Quality Care for All*, the final report of the Next Stage Review (NSR), envisages an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its centre. It introduced the Quality Framework as the national strategy for quality improvement. The NSR also outlined an ambitious future for primary and community health services, positioning them at the heart of NHS healthcare.
- 1.2 Lord Darzi defines quality of care as safe, effective and a good experience for patients. The vision for community care emphasises their key role in providing personal care, particularly for children and families, older people and carers, those requiring rehabilitative support, those with complex care needs and those at the end of life. They are also central to our drive for promoting health and wellbeing and reducing health inequalities.
- 1.3 The delivery of transforming community services sits alongside the transformation of adult social care laid out in the concordat paper – “Putting People First”. Primary and community care, together with social care, need to collaborate to achieve the desired outcomes for the health and wellbeing of the population. The focus of these outcomes should be to achieve independence, choice and control for people to live in the community. Likewise NHS community services are crucial to the delivery of the 2020 ambition of making England the best place for children to grow up, as set out in the *‘Healthy Lives, Brighter Futures’*.¹
- 1.4 The ambition to make ‘everywhere as good as the best’, delivering real improvements in quality, innovation and productivity is the over-arching goal of the Transforming Community Services (TCS) Programme.
- 1.5 The TCS programme supports the NHS to drive up quality by:
 - > Improving services – setting out clear ambitions, actions and achievements to be delivered
 - > Developing people – to design, deliver and lead the changes
 - > Reforming systems – to build the strong organisations and incentives needed to respond to the needs of people in their communities
- 1.6 To transform peoples’ experience of community services, we need to harness the energy and experience of all front line staff, whether working in health services or social care. We need to create the conditions for delivering high quality care whether in a home, hospital or other community settings. The Quality Framework will enable this to happen.

¹ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094400

Section 2: The Purpose of this Guidance

2.1 This best practice guidance sets the direction for implementing the Quality Framework within community services. It has been co-produced with the NHS, involving clinicians, commissioners and providers from over 50 PCTs. We have adopted the same seven elements of the Quality Framework as for all other NHS services, but adapted implementation to reflect the special circumstances of community services, and the need to accelerate progress.

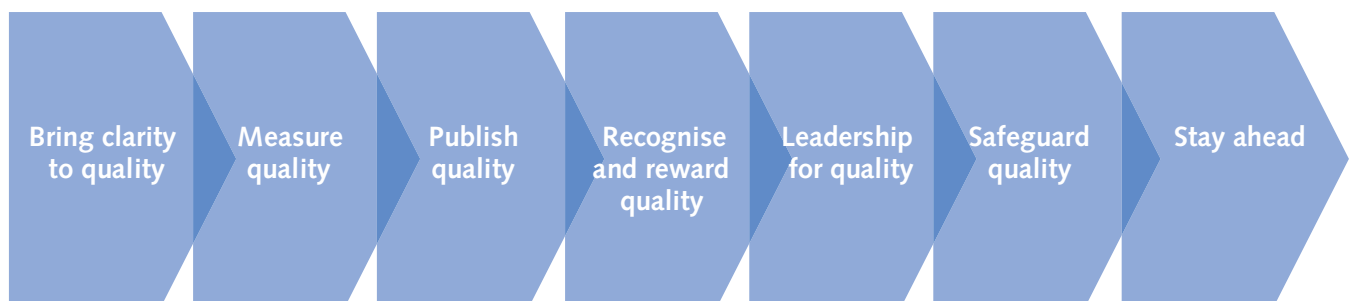


Figure 1: The Quality Framework

- 2.2 This guidance is aimed at all those who commission or have a role in providing community health services, particularly practitioners, lead clinicians and local delivery partners.
- 2.3 We recognise that the evidence base for community services is comparatively limited and that commissioning, contracting and information systems are under-developed in comparison with many hospital services. We have therefore adopted a pragmatic approach, initially focusing on the first two elements of the national quality strategy – *Bringing Clarity to Quality and Measuring Quality*.
- 2.4 In partnership with professionals across the NHS, the Department and the NHS Information Centre have identified an initial and evolving set of indicators to describe quality – the *Indicators for Quality Improvement*. We are continuing this process and have identified a list of **76** potential indicators (see Annex 1) of high quality care for community services, and we will be seeking your views on these.

- 2.5 Together with this guidance, we have published six service transformation guides, encompassing the majority of community services. These guides set out clear and challenging ambitions to transform all community services over the next few years, driving up quality and productivity, and improving outcomes. The guides describe evidence-based interventions, which will help make every service as good as the best. Whilst they are designed principally for front-line staff and clinical team leaders, commissioners will use them to inform service specifications, and with the indicators in the Quality Framework, track improvement.
- 2.6 The drive to improve quality is set in the context of wider reforms to the system within which community services work. The rules, payment systems, incentives and the new community contract, provide opportunities to meet the challenges ahead. The aim of these reforms is to ensure that improving the quality, productivity and effectiveness of community services is strongly incentivised and seen as everyone's responsibility.

Section 3: The Quality Framework and Community Services

- 3.1 *High Quality Care for All* called for the achievement of high quality care to become an obsession within the NHS. Building on good existing local clinical governance, it set out seven elements for achieving this ambition. It forms a strategy to implement quality improvement over a period of years, for all NHS services, including those in a community setting.
- 3.2 In working with clinicians, commissioners and providers of community services, we have heard a widespread commitment to the aims of the Quality Framework but some uncertainty about what it will look like and where to start for community services. The national programme described in the seven elements below, will apply to services provided in community settings. Certain aspects of the implementation timescales, will differ, e.g. Commissioning for Quality & Innovation ('CQUIN'), reflecting the time required to develop the necessary indicators. The development of the framework is described in more detail below.

Bring clarity to quality by asking NICE to develop quality standards and setting up NHS Evidence, a single portal allowing easy access to clinical and non-clinical evidence.

Support **measurement of quality** to enable improvement, through *Indicators for Quality Improvement* (IQI), which will allow clinicians to select indicators and facilitate benchmarking.

Require quality information to be **published** in **Quality Accounts**.

Recognise the role of **clinicians as leaders** and give them the **freedom** to drive improvements in quality of care.

Recognise and Reward quality including through the **CQUIN payment framework**.

Safeguard essential levels of safety and quality through the **Care Quality Commission's** registration system.

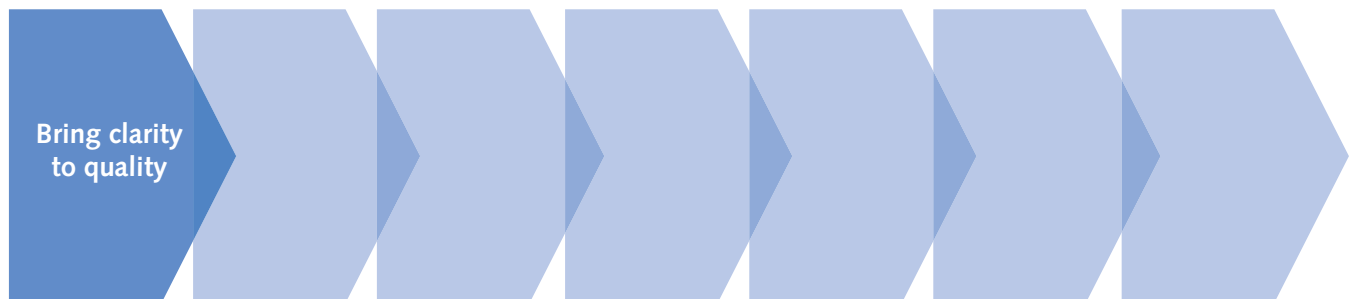
Stay ahead by ensuring that innovation in medical advances and service design is fostered and promoted.

- 3.3 In the community, services are delivered in uniquely local settings, often with families and over a long period, to people who may be vulnerable due to age, isolation or health status. Community services are proactive as well as reactive and in many cases will actively seek out their clients and engage the most disadvantaged in services, seeking shared outcomes with colleagues in general practice, social care and hospitals. In developing the Quality Framework, community services will need to take account of individuals with high needs and those from disadvantaged groups and areas, addressing health inequalities through increasingly personalised services. It will be important to be able to measure, as part of the Quality Framework, the effectiveness of these services in improving access, experience and outcomes for these individuals and groups.
- 3.4 Safety in a community setting is about safeguarding as well as addressing risks such as healthcare acquired infections and avoidable incidents. Effectiveness involves supporting people in maximising well-being and the ability to live an independent life as well as specific clinical interventions. Quality must be about the peoples' experience over time and using their feedback to ensure personalised care.
- 3.5 People expect competent and compassionate practitioners to deliver the best possible care and the TCS programme and this framework support practitioners in achieving this. In many cases, the isolated nature of the work in community settings means that quality has to emphasise each individual practitioner's responsibility and leadership role. For this reason the six community service transformational guides focus strongly on the development of community staff as 'practitioners, partners and leaders.
- 3.6 The approach to implementing the Quality Framework recognises that many developments need to take place in tandem to achieve high quality care. A year on from the publication of *High Quality Care for All*, progress is being made in implementing the seven elements. The newly established National Quality Board will provide strategic oversight and direction to guide the continued development of the framework.
- 3.7 We know that the evidence base for community services is comparatively limited and that commissioning, contracting and information systems are under-developed in comparison with many hospital services. For community services therefore, **the initial priorities are to:**

> **Set out what high quality community services look like – Bring Clarity to Quality**

> **Identify the indicators to monitor quality improvement – Measuring Quality**

Section 4: Bringing Clarity to Quality



- 4.1 **Publishing the evidence:** *Bring Clarity to Quality* aims to simplify access to guidance on good quality care. The National Institute for Health and Clinical Excellence (NICE) now hosts *NHS Evidence*², a website portal, providing access to a comprehensive evidence base for everyone in health and social care who makes decisions about treatments, health interventions and/or the use of resources. This includes clinicians, public health professionals, commissioners and service managers.
- 4.2 **Developing standards:** NICE will also work with the NHS to develop *NICE Quality Standards* – concise statements that will act as markers of high quality, cost effective care across a pathway or a clinical area. They will encompass community services. The National Quality Board will have a role in overseeing the development of quality standards.

“
The University of Birmingham has conducted a review of good practice in community services from over 18,000 studies from the UK and across the world. From this study a series of high impact changes across the six clinical areas have been identified. These studies are available at:
www.dh.gov.uk/healthcare/primarycare/tcs/index.htm
”

² www.evidence.nhs.uk/

4.3 **Service transformation guides:** Drawing on the University of Birmingham’s review, and working with over a thousand practitioners from community services across the country, we have identified a range of potential improvements in practice and systems, which – if applied in a co-ordinated and concerted way – could transform community services. Each guide sets out the evidence and professional user consensus on what should be achieved. The initial quality indicators in the Quality Framework will begin to enable achievement to be measured and demonstrated. The six Service Transformation Guides cover the following areas:

- > Health & well being and reducing inequalities
- > Services for Long Term Conditions
- > Services for Children, Young People & Families
- > Rehabilitation Services
- > Acute Care in the Community
- > End of Life Care

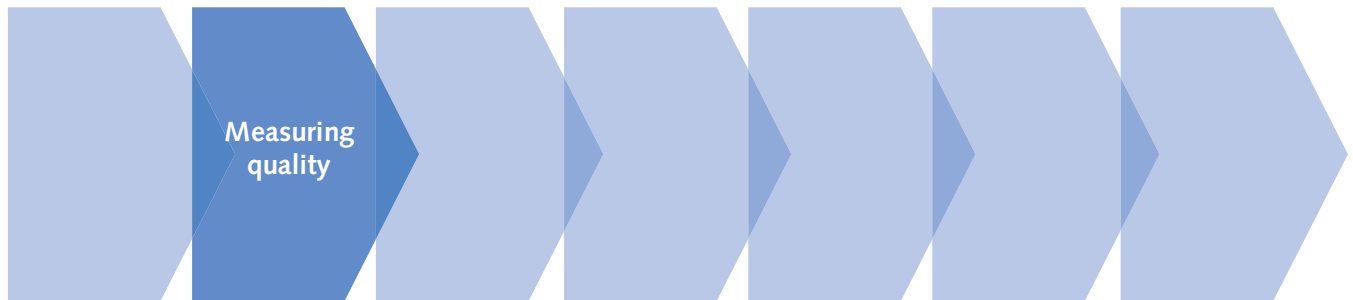
4.4 **Strengthening commissioning to bring clarity to quality:** Improved commissioning specifications for community services will add clarity to quality outcomes, as they develop out of the Joint Strategic Needs Assessment, with its focus on local population needs. Increasingly specifications will focus on pathways of care and will stratify to take into account the requirements of high needs and disadvantaged groups. To enable this, the Department will:

- > Support the development of skills in the commissioning of community services through the World Class Commissioning programme – we have already published a resource pack for commissioners;³
- > Develop and publish in September a set of commissioning packs, including outline service specifications, for End of Life Care, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Intermediate Care;
- > Continue to support the NHS to develop local and regional contract currencies to support commissioning and contracting. We have already published initial guidance on currencies and pricing.⁴

³ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093194

⁴ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093008

Section 5: Supporting Clinicians to measure quality



- 5.1 *High Quality Care for All* proposed that clinical teams should use a **menu of clinical indicators** to measure the quality of care they deliver, highlight areas for improvement and track the changes they implement.
- 5.2 The *Measuring for Quality Improvement* (MQI) programme, launched in late 2008, started the process of identifying and assuring indicators aimed at enabling clinical teams to improve the care they deliver. Earlier this year, the NHS Information Centre published the initial set of "*Indicators for Quality Improvement*".⁵
- 5.3 The "*Indicators for Quality Improvement*" are not targets for the NHS, nor are health economies expected to use all of the indicators. The menu of indicators will develop as a resource for clinicians and services to draw from as appropriate to local circumstances. It will encompass all sectors of healthcare, increasingly reflecting pathways of care rather than providers of care or single professional approaches. As they become adopted, they will offer consistency and support comparison and benchmarking across services. They may be used by commissioners and providers, incorporated into service contracts and specifications where they are considered to be relevant to local patterns of service provision.
- 5.4 As a starting point for community services and in consultation with over 50 PCTs, their clinicians, commissioners and providers, we have identified over 70 potential indicators (see Annex 1). The indicators will need further development and piloting to improve their fitness for purpose. Working within the emerging assurance processes being developed by the MQI programme, an initial set of piloted indicators will be published later this year, in time for contract revisions for 2010/11, with a second set published early in 2010.

⁵ www.ic.nhs.uk/services/measuring-for-quality-improvement.

- 5.5 Not all services areas are covered by these proposed indicators – there are gaps. We have worked with over a third of all PCTs in compiling this initial set but need to hear from more PCTs, as well as other interested stakeholders and patient/user representative groups. Following further development of the indicators over the summer, we will be seeking views about the priorities, gaps and other indicators currently helping clinical teams and services locally to monitor and improve quality. This will be co-ordinated by the NHS Information Centre.

“Following further refinement of these indicators, we will, with the NHS Information Centre conduct a survey of stakeholder views.

Your initial thoughts and comments can be sent to us at MQI.Community@ic.nhs.uk”

- 5.6 We know that clinical teams want to be able to deliver and demonstrate high quality care and thus need to be able to measure this. This initial set of indicators is a starting point. They are intended to complement rather than replace those already used by practitioners and services, many of which are recommended by professional bodies to demonstrate the impact of their interventions.
- 5.7 New indicators will emerge from local development, supported by the new regional Quality Observatories established by Strategic Health Authorities (SHAs) to support quality and innovation. Analysing the data across the dimensions of inequalities (such as gender, age, socio-economic group, ethnicity etc) will help focus attention on those with highest need.
- 5.8 We want to encourage and support local development of indicators by developing, testing and piloting a toolkit. It will be informed by existing best practice publications and will include information about:
- > [The principles underpinning good quality measurement](#)
 - > [Who should be involved in developing indicators, and examples of how to involve different stakeholders](#)

> The characteristics of a good indicator

> Examples of how indicators can be used by different stakeholders to support continuous improvement

> Guidance on developing and embedding a quality improvement culture

- 5.9 **Patient Experience:** The Next Stage Review promised to strengthen and maintain the focus on the patient's experience of healthcare. Structured questionnaires are the most common form of quantitative measure of patient experience, enabling the analysis, description and comparison of results. National patient surveys have been underway since 2002 and whilst they have not specifically focused on community services, many of the questions are relevant and could be adapted for local use by providers and commissioners of community care. A dedicated questionnaire for community services is being planned by the Care Quality Commission (CQC) and will be developed for testing over the next 12 months.
- 5.10 **Patient-Reported Outcome Measures (PROMs):** PROMs assess the effectiveness of care from the patient's perspective and are becoming more prevalent. Their use needs to be underpinned by a strong evidence base ensuring their appropriateness to the setting and the effectiveness of the data generated by them. There are a range of generic measures that could be used in primary and community care settings to assess the impact of services on self-reported health status. The Department of Health is exploring the extension of PROMs to the care of individuals with one of 6 long-term conditions (Asthma, COPD, Diabetes, Epilepsy, Heart Failure and Stroke).
- 5.11 **Performance Framework:** In April 2009, guidance for the NHS Performance Framework made clear that PCT provided services will be included from Autumn 2009, coinciding with their organisational development plans and the timetable set out in *Enabling New Patterns of Provision*.⁶ Providers will be assessed on Finance, Operational Standards and Targets, Quality and Safety and User Experience. As there are few Operational Standards and Targets that apply to PCT provided services, the Department will be working with key stakeholders to identify and develop a small set of meaningful indicators relating to service performance. These are likely to be drawn from the set of quality indicators identified in this publication.

⁶ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197

Section 6: Continuing the Journey



6.1 We have focused on *Bringing Clarity to Quality* and *Measuring Quality* to draw attention to important building blocks for the Quality Framework in Community Services. These building blocks are enablers for the remaining elements of the framework, which in the coming months and years will be the focus of further development for community services.

Publishing Quality Performance

- 6.2 **Quality Accounts:** There is evidence that making information about quality widely available is a powerful driver for improvement. Patients and the public require better information about the care they receive to enable them to make informed choices. Service planners and commissioners need information to ensure high standards and to improve their understanding of health inequalities. The Government is therefore introducing legislation to require NHS healthcare providers to publish an annual account of the quality of their services, which will include their plans for improving quality where the evidence shows that this is needed.
- 6.3 NHS community service providers will be required to publish Quality Accounts for the year 2010/2011, reporting on services measured against a mixture of nationally and locally set indicators, and setting out their plans for quality improvement. These plans should be developed in partnership with patients and other local stakeholders.
- 6.4 The Care Quality Commission has an important role to play in publishing quality performance on community services through its review functions. The Commission can carry out special reviews and studies to report on how services are commissioned or provided across organisations, areas or care pathways, across health and adult social care and to look at areas of particular interest or concern.

Further information on the Commission's future plans for its reviews is available at: www.cqc.org.uk/.

Recognise and Rewarding Quality

- 6.5 **The Commissioning for Quality and Innovation (CQUIN)** payment framework was introduced to support the aims of High Quality Care for All by placing quality at the heart of the commissioner-provider dialogue. It makes a proportion of a provider's income conditional on the achievement of locally agreed goals around quality.
- 6.6 For the current year 2009/10, commissioners are required to implement a CQUIN framework with their community providers, either as a full scheme with defined goals in the four domains of effectiveness, patient experience, safety and innovation or as an agreed quality improvement plan that establishes a baseline for measuring quality.
- 6.7 A full CQUIN scheme will be a mandatory part of the standard contract for community providers from April 2010.

Provide Leadership for Quality

- 6.8 The NSR emphasised the need for a high quality workforce to deliver high quality care and introduced the 'practitioner, partner and leader' health care professional for the 21st century. The Service Transformation Guides describe these key attributes for community practitioners in more detail including their role as champions of quality.
- 6.9 **Leadership:** A number of linked initiatives are underway to support the drive for leadership and quality improvement. As one of a number of enablers, the National Leadership Council, with its role to improve coherence and consistency, oversee curriculum and commission leadership development where there are gaps, will help to provide focus on the requirements of community services.
- 6.10 These initiatives build on the *Guidance for NHS Talent and Leadership Planning*⁷, SHAs will take action to ensure the right conditions for the development of regional plans that will facilitate talent and leadership improvement creating the right environment for quality, productivity improvement and contributing to transformation in culture.
- 6.11 These build on the existing tools available for the development of leadership, such as the well-established *NHS Leadership Qualities Framework*⁸ which sets the standard for outstanding leadership in the NHS.

⁷ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093395

⁸ <http://www.nhsleadershipqualities.nhs.uk/>

6.12 Supporting high quality care on the front line requires a focus on quality at Board level. Some providers of community services are already considering the use of Performance Dashboards to strengthen the focus on continuous quality improvement including tackling health inequalities. The Intelligent Board series is one source of guidance to trust boards on how the intelligent use of information can increase their effectiveness. For further information on the Intelligent Board series http://www.appointments.org.uk/docs/intelligent_board_report.pdf

Safeguarding Quality

6.13 **The Care Quality Commission (CQC)** is the independent regulator of health and social care in England. Through its new registration system, due to be introduced from April 2010, it will help to ensure better care, regardless of the care setting. It will operate a single regulatory system for health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations.

6.14 As of 1st April 2009, NHS healthcare providers are required to be registered with the Commission and need to comply with registration requirements relating to healthcare associated infection (HCAI). Further information on the HCAI registration requirements and the registration framework can be found on the CQC and Department websites.

“From April 2010, NHS providers will be registered against the full set of registration requirements.”

Staying Ahead

6.15 **Innovation:** Best practice shows that the most leading edge, effective and efficient organisations are those that innovate and encourage innovation. Earlier this year, we announced £1.5m of Innovation awards for community services. The winners of these awards reflected the local priorities of the SHAs regional visions to transform services and improve the quality of care for patients in their own communities, tackling health inequalities, giving people more say, more choice and more control over their own health care.

- 6.16 SHAs have been given the legal duty 'promote innovation for the purpose of securing continuous improvement in the commissioning and provision of health care.' Guidance on the promotion of innovation can be accessed at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098540
- 6.17 The creation of Health Innovation and Education Clusters (HIECs) will support this drive for quality improvement. HIECs will be partnerships between NHS organisations, the higher education sector, industry and other public and private sector organisations. Designed to enable high quality patient care, they will bring together the benefits of research and innovation, strengthening the co-ordination of education and training to build breadth and depth.⁹
- 6.18 **Never Events:** A recommendation in *High Quality Care for All* proposed that there should be a way of identifying and monitoring 'Never Events' in England. These are events that are serious and largely preventable. The National Patient Safety Agency has been tasked to take this work forward with key stakeholders. The purpose of developing a national set of Never Events is to strengthen the focus of commissioning on patient safety, in order to reduce serious incidents and improve transparency.

“We will explore their potential for use and learning in a community context and subject to initial feasibility testing, we will seek views on a set of Never Events for Community Services early in 2010.”

⁹ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098887

Section 7: Making it happen

- 7.1 The immediate next steps are to test and refine further the proposed indicators, and to invite as many views as possible on their value to measuring quality improvement, where the gaps are and what the priorities for indicator development should be. Later this year, the first set of piloted indicators will be assured and published on the Measuring for Quality Improvement website¹⁰.
- 7.2 Over and above this, it is for the NHS locally, to develop the quality landscape and to drive forward the achievement of quality for their patients and communities using the national menu of indicators and under the strategic oversight and leadership of the National Quality Board. SHAs will play a key co-ordinating and leadership role, encouraging innovation and best practice. The ownership and realisation of the quality improvement agenda rests with local commissioners, providers and clinical teams. Together with NICE, NHS Evidence, patients and service users and national and regional partners, the Department will ensure that there is a sharing of evidence, experience and basic consistency in the development of the Quality Framework in community services.

¹⁰ www.ic.nhs.uk/services/measuring-for-quality-improvement

Annex 1: Introducing the Indicators

- 1.1 We are introducing a set of potential indicators that have been co-produced with practitioners, providers, commissioners and other NHS stakeholders. They are drawn from several sources including a survey of what PCTs currently use, research from the allied health professions and good practice. Where appropriate, we have linked indicators to national targets and the "*Indicators for Quality Improvement*".
- 1.2 We recognise this is a starting point and we know it has gaps. The 76 indicators span the domains of effectiveness and experience but require further development in respect to indicators of safety. All six clinical areas are covered but the many are generic in application and require an increasing focused on outcomes.
- 1.3 To move towards '*Measuring what we value*' we need indicators that reflect measures of quality, innovation and productivity, addressing service and user priorities. We need a broader view of the indicators we have identified, suggestions on priorities for indicator development and substitutes for those that can be improved. We need the views of those who deliver and commission care, and importantly the perspective of people who receive care.

The 76 indicators are a starting point, and following further refinement during July & August, we will be seeking your views on the priorities for development, the gaps, and their value to quality improvement. Initial comments and suggestion can be sent to us at: MQI.Community@ic.nhs.uk

For further information, please see [Measuring for Quality Improvement](#)¹¹

¹¹ www.ic.nhs.uk/services/measuring-for-quality-improvement

- 1.4 We also want to take a pragmatic approach, recognising the need for robust indicators that can be adopted quickly. We will start the process of testing in July, with a programme of piloting from September. We will be working with SHAs to identify PCTs, the commissioners and their providers who want to take part in the piloting process.
- 1.5 Through this process, we anticipate that the list will evolve, as the definitions are refined, new indicators added in place of those that prove less valuable. This process will also enable continued alignment with concurrent work that may produce indicators appropriate to care in the community, for example, the Quality Markers and Measures being developed to support the End of Life strategy.
- 1.6 Following piloting and assurance, the indicators will be published on the menu of "*Indicators for Quality Improvement*" on the NHS Information Centre website. The first batch of assured indicators will be available later this year, with a second early in 2010.

Number	Clinical area	Dimension	Description	Links to a nationally defined priority (*Denotes a nationally defined indicator exists)	Links to Indicators for Quality Improvement
1	General	Effectiveness	% improvement in outcome scores following AHP intervention as measured by the Therapy Outcome Measures	No	
2	General	Effectiveness	Percentage of patients readmitted within 28 days following discharge from Community Hospital (for related medical condition)	No	RA 17/18/20/24/25/26
3	General	Effectiveness	Rate of non-elective admissions to hospital of people diagnosed with one of the following conditions (list to be inserted) (may need a readmissions indicator to interpret this one)	No	
4	General	Experience	% of patients reporting improved and sustained overall quality of life following AHP intervention using the WHO-QOL assessment	No	
5	General	Experience	% of patients who were satisfied with the length of time waited	Yes *	
6	General	Experience	% saying health professional(s) knew enough about their condition/treatment	Yes *	
7	General	Experience	% saying healthcare professional treated them with respect and dignity	Yes *	
8	General	Experience	% saying the healthcare professional listened carefully	Yes *	
9	General	Experience	% saying they had confidence and trust in health professional(s)	Yes *	
10	General	Experience	% saying they had sufficient time to discuss problem with healthcare professional	Yes *	
11	General	Experience	% saying they received clear explanations of treatments/actions	Yes *	
12	General	Experience	% saying they received comprehensible answers to their questions	Yes *	
13	General	Experience	% saying they were given appropriate information or advice on how to prevent illness and stay healthy	Yes *	

Number	Clinical area	Dimension	Description	Links to a nationally defined priority (*Denotes a nationally defined indicator exists)	Links to Indicators for Quality Improvement
14	General	Experience	% saying they were given appropriate information or advice on other services and available support	Yes *	
15	General	Experience	% saying they were given sufficient information about their care/treatment	Yes *	
16	General	Experience	% saying they were involved as much as they wanted to be in decisions about their care and treatment	Yes *	
17	General	Experience	% saying they were satisfied overall	Yes *	
18	General	Experience	N: Number of Appointments or contacts cancelled by Provider Services in the contract month D: Total number of Appointments or contacts in the contract month Expressed as a %	No	
19	General	Experience	N: Number of Appointments or contacts that were DNA'd in the contract month D: Total number of Appointments or contacts in the contract month Expressed as a %	No	
20	General	Experience	Overall level of patient satisfaction (Need to establish whether one of the current external surveys should be used and whether it will produce statistically significant information at provider level)	Yes *	
21	General	Experience	Percentage of home equipment delivered within 5 working days or time from referral for assessment of need for equipment at home	No	
22	General	Experience	Percentage of patients treated by a given service (to be defined) offered a time band for appointment or percentage use of choose and book system	Yes *	
23	General	Experience	Percentage of patients who overall felt that they were treated with dignity and respect	Yes *	PEAT 3

Number	Clinical area	Dimension	Description	Links to a nationally defined priority (*Denotes a nationally defined indicator exists)	Links to Indicators for Quality Improvement
24	General	Experience	Percentage of patients who reported that at least once in the previous 12 months they felt their needs had not been met	No	
25	General	Experience	Percentages of patients whose assessment to treatment time concluded within 18 weeks, 13 weeks, 10 weeks, and 8 weeks, as a proportion of the total number of completed pathways during the month	Yes *	TC01
26	General	Experience	Percentages of patients whose referral to assessment time concluded within 18 weeks, 13 weeks, 10 weeks, and 8 weeks, as a proportion of the total number of completed pathways during the month (to agree timescale)	Yes *	TC01
27	General	Experience	Proportion of complaints resolved locally within a given timescale (eg.25 days)	Yes *	
28	General	Experience	Proportion of patients satisfied on conclusion of complaint	Yes *	
29	General	Experience	Proportion of patients who reported that staff explained the purpose of the medicines they were to take at home in a way that they could understand	No	PE19
30	General	Safety	Percentage of reported SUI's, investigated and closed as per agreed processes	No	
31	General	Safety	Percentage of referral discharge letters meeting national guideline standards on diagnosis, contact details, medication and investigations within a specified timescale	No	
32	General	Safety	Rate of Community acquired MRSA bacteraemias and clostridium difficile cases	Yes *	LT28/VSA01
33	Health and well being	Effectiveness	Delivery of health promotion in schools (programmes to be specified)	Yes	
34	Health and well being	Effectiveness	Percentage of mothers smoking at booking who have quit by delivery	Yes	

Number	Clinical area	Dimension	Description	Links to a nationally defined priority (*Denotes a nationally defined indicator exists)	Links to Indicators for Quality Improvement
35	Health and well being	Effectiveness	Percentage of patients with alcohol intake pattern recorded	Yes *	
36	Health and well being	Effectiveness	Percentage of self-reported 4-week quitters (if they have been assessed 4 weeks after the designated quit date and declares that he/she has not smoked in the past two weeks)	Yes *	
37	Health and well being	Effectiveness	The percentage of the population aged 15-24 accepting a test/screen for chlamydia	Yes *	
38	Children and families	Effectiveness	Percentage of women sustaining breastfeeding to 6-8 weeks after delivery	Yes *	VSB11
39	Children and families	Effectiveness	Percentage of adults/children with an integrated care plan with the following minimum content (to be defined)	No	QOF MH 6
40	Children and families	Effectiveness	Percentage of all looked after children who have receive comprehensive health assessments every 6 months (0-4) and 12 months (4-16) (Comprehensive may need to be defined in the form of a minimum list)	No	
41	Children and families	Effectiveness	Percentage of children in reception year who are obese, as shown by the National Child Measurement Programme	Yes*	
42	Children and families	Effectiveness	Percentage of children in reception year with a recorded BMI	Yes *	
43	Children and families	Effectiveness	Percentage of children in Year 6 who are obese, as shown by the National Child Measurement Programme	Yes*	
44	Children and families	Effectiveness	Percentage of children in year 6 with a recorded BMI	Yes *	
45	Children and families	Effectiveness	Participation rate (proportion as a percentage) of eligible Reception Year pupils measured as part of the National Child Measurement Programme		
46	Children and families	Effectiveness	Participation rate (proportion as a percentage) of eligible Year 6 pupils measured as part of the National Child Measurement Programme		

Number	Clinical area	Dimension	Description	Links to a nationally defined priority (*Denotes a nationally defined indicator exists)	Links to Indicators for Quality Improvement
47	Children and families	Effectiveness	Percentage of children with LTC have a safe transition from children's to adult services (need to define minimum criteria for a "Safe" transition)	No	
48	Children and families	Effectiveness	Percentage of mothers offered post natal depression assessment between 6 to 12 weeks	Yes	
49	Children and families	Effectiveness	Percentage of parents signing up for take-up of childhood immunisations	Yes *	WCC 2.09/10/11
50	Children and families	Effectiveness	Percentage uptake of HPV vaccination	Yes *	WCC 2.09/10/11
51	Children and families	Experience	Percentage of under 15 year olds for whom the waiting time for initial assessment for NHS speech and language therapy is no more than 10 weeks	Yes	
52	Children and families	Experience	The percentage of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy	Yes*	VSB06
53	Acute	Effectiveness	Incidence of grade 2 or higher pressure sores in older people treated in a community setting	No	HES 1
54	Acute	Effectiveness	Percentage of wounds that heal in a specified time	No	
55	Acute	Effectiveness	Rate of admissions for short stay (1 – 2 days) due to provision of care at home (e.g. urgent care team for respiratory illness)	No	
56	Acute	Experience	Number of bed days lost due to patients whose discharge or transfer from community hospital is delayed, as a percentage of total bed days available	Yes *	
57	Acute	Safety	Number of patients falling in community hospital by severity of harm (as per NPSA definition)	No	
58	Long term conditions	Effectiveness	% of patients with depression demonstrating improvement as measured using the Beck Depression Inventory	No	

Number	Clinical area	Dimension	Description	Links to a nationally defined priority (*Denotes a nationally defined indicator exists)	Links to Indicators for Quality Improvement
59	Long term conditions	Effectiveness	Percentage of patients with a LTC who have a care plan of the following minimum content (to be defined)	Yes *	QOF MH 6
60	Long term conditions	Effectiveness	Percentage of all patients with a LTC that have been screened for anxiety and depressions (in a specified time period?)	No	
61	Long term conditions	Effectiveness	Rate of (non-elective?) admissions to hospital of people diagnosed with one of the following LTC (list to be inserted)	Yes *	
62	Long term conditions	Experience	% of carers who have completed a Caregiver Strain Index as part of the care planning and treatment programme	Yes	
63	Long term conditions	Experience	% of people with a LTC feeling independent and in control of their conditions	Yes *	VSC 11
64	Rehabilitation	Effectiveness	% improvement in independence of daily living as measured by the Nottingham Extended Activities of Daily Living Scale	Yes *	
65	Rehabilitation	Effectiveness	% of patients setting and achieving rehabilitation goals as evaluated by the Patient Evaluation Conference System	No	
66	Rehabilitation	Effectiveness	Percentage of patients on rehabilitation pathway/ with a neurological disease who have an integrated care plan of the following minimum content (to be defined)	No	QOF MH 6
67	Rehabilitation	Effectiveness	Percentage of people discharged from hospital and benefiting from intermediate care/rehabilitation enablement still living at home 3 months after discharge from hospital	Yes *	
68	Rehabilitation	Experience	% improvement in self-perceived occupational performance enabling patients to return to work (Canadian Occupational Performance Measure)	No	

Number	Clinical area	Dimension	Description	Links to a nationally defined priority (*Denotes a nationally defined indicator exists)	Links to Indicators for Quality Improvement
69	End of life	Effectiveness	% improvement in outcomes following AHP intervention associated with end of life care as measured using the Support Team Assessment Schedule	No	
70	End of life	Effectiveness	% of people dying at home	Yes *	
71	End of life	Effectiveness	Percentage of End of Life patients who have a care plan of the following minimum content (To be defined)	Yes	QOF MH 6
72	End of life	Experience	Percentage of carers reporting positive views on access to care, including pain control, information provided and respect shown	Yes	
73	End of life	Experience	Percentage of those on caseload who are dying on end of life care pathway	Yes	
74	Staff	Effectiveness	Percentage of staff (defined professions?) who have received health promotion training (define training) in a specified timescale (e.g the last 12 months)	No	
75	Staff	Experience	Percentage of staff reporting positive job satisfaction (based on the NHS staff survey scores-based measure of job satisfaction)	Yes*	
76	Staff	Safety	Numerator: Number of eligible staff who have completed statutory and mandatory training within the past 12 months as at the last of the contract month Denominator: Number of staff who are eligible to have completed all statutory and mandatory training within the past 12 months as at the last day of the contract month Expressed as a %, based on a rolling year a. % of eligible staff trained in Child protection b. % of eligible staff trained in adult protection c. % of eligible staff trained in Safeguarding d. % staff trained in infection control	Yes	CF06



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296785 1p 0.5k June 09 (CWP)
Produced by COI for the Department of Health

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