Paper Five: Locally Commissioned Services (LCS) Outcomes Framework: proactive, integrated and extended primary care

Overview

The LCS contract framework includes the following overarching goals.

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Helping people recover from episodes of ill health or following injury
4. Patient experience outcomes - ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm
6. Improving health and wellbeing of children and young people
7. Delivering comprehensive, equitable and convenient care (right place, right time)

Goals 1-5 mirror the goals set out in the NHS outcomes framework, 6 and 7 are locally set overarching goals.

The LCS contract is offered to general practices working at Cluster level. Baseline assessment for each practice will be provided for the outcomes in the framework. The contracting approach will be one of a strategic partnership with the objectives of commissioner and providers fully aligned. The commissioner will set out the outcomes and invite clusters to submit costed action plans with targets using baseline assessment.

The table below provides details of the outcomes framework goals and specific outcome targets. Evidence and guidance will be available to support Clusters to develop the costed LCS Cluster Action Plans. There will be overall planning guidance as well as area specific evidence and guidance papers.

Framework Goals (based on priority health issues of Brighton and Hove)	**Specific outcome target areas** *[Measured by proxy indicators]*
NHS Framework Outcome: 1. **Preventing people from dying prematurely** • **<u>Reducing under 75 mortality rate from cardiovascular disease</u>**	**% reduction or maintenance of under 75 mortality rate for CVD considered preventable** This will be measured by: *[% increase in estimated percentage of <u>detected</u> CHD per cluster or practice per year]* *[% of CHD patient immunised against flu per year]* *[Increased % of those eligible living within the most deprived quintile and all other areas receiving an NHS Health Check per year. This will be measured by numbers of NHS Health Checks]* *[% reduction of smoking prevalence in 3 years]* *[% increase in number of patients screened that are identified as increased or high risk receiving an alcohol brief intervention]* *Reducing isolation - [% increase in referrals to the voluntary sector to address social isolation]* Reduction in % excess weight in adults and children in 3 years: *[% increase in GP/self-referrals to health improvement services for weight management and physical activity per year]*
NHS Framework Outcome: 1. **Preventing people from dying prematurely** • **<u>Reducing under 75 mortality rate from respiratory</u>**	**% reduction of under 75 mortality from respiratory disease considered preventable in 3 years** This will be measured by: *[% reduction of smoking prevalence in 3 years]* *[% increase in smoking cessation treatment and support offered (certain conditions) per year –reinforced by QOF]* *[X numbers of smokers quitting per year]*

Framework Goals (based on priority health issues of Brighton and Hove)	**Specific outcome target areas** *[Measured by proxy indicators]*
disease	*[% uptake of seasonal flu vaccine 65+ per year –reinforced by QOF]* *[% increase in number of patients screened that are identified as increased or high risk receiving an alcohol brief intervention]* *Reducing isolation: [% increase in referrals to the voluntary sector to address social isolation]*
NHS Framework Outcome: **1. Preventing people from dying prematurely** **Reducing under 75 mortality rate from liver disease**	**% reduction of under 75 mortality rate from liver disease considered preventable in 5 years** This will be only measured by: *[% increase in number of patients screened for alcohol use opportunistically who are existing patients]* *[% increase in number of patients screened that are identified as increased or high risk receiving an alcohol brief intervention]* *[% increase in patients with increased or high risk drinking levels referred / signposted to community recovery services per year]* *[% increase of patients with alcohol dependency referred / signposted to treatment alcohol recovery services for specialist support]* *[% reduction in the number of alcohol-related hospital admissions per 100,000 -* *Measured through the number of admissions involving an alcohol-related primary diagnosis or alcohol-related external cause.]* *[% reduction of smoking prevalence in 3 years]* *Reducing isolation: [% increase in referrals to the voluntary sector to address social isolation]*

Framework Goals (based on priority health issues of Brighton and Hove)	**Specific outcome target areas** *[Measured by proxy indicators]*
NHS Framework Outcome: **1. Preventing people from dying prematurely** **<u>Reducing under 75 mortality rate from cancer</u>**	% reduction of under 75 mortality rate per 100,000 from all cancers considered preventable in 3 years % increase in breast, lung and colorectal cancer survival rate (placeholder 1 and 5 years) These will be measured by: • *[% reduction of cancer diagnosis by emergency routes per year]* • *[% increase lung and colorectal cancer recorded at early stage of diagnosis per year]* • *[% improvement in Did Not Attend (DNA) rate for Two Week Referral appointments]* • *[% increase in women aged 25-64 with a record of cervical screening (last 5 years) per year]* • *[% increase in men and women aged 60-74 with a record of bowel cancer screening over 2 year]* • *[% increase in women aged 47-73 with a record of breast screening over 3 years]* • *[% reduction of smoking prevalence in 3 years]* • *[% increase in number of patients screened that are identified as increased or high risk receiving an alcohol brief intervention]* • *[% increase in GP/self-referrals to health improvement services for weight management and physical activity per year]* • *Reducing isolation: [% increase in referrals to the voluntary sector to address social isolation]*

Framework Goals (based on priority health issues of Brighton and Hove)	**Specific outcome target areas** *[Measured by proxy indicators]*
NHS Framework Outcome: **1. Preventing people from dying prematurely** **<u>Reducing under 75 mortality in adults with mental illness</u>**	% reduction in excess under 75 mortality rate in adults with serious mental illness (SMI) This will be measured by: % reduction in excess under 75 mortality rate in adults with common mental illness This will be measured by: *[% reduction of smoking prevalence in 3 years]* *[% increase in number of patients screened that are identified as increased or high risk receiving an alcohol brief intervention]* *[% increase in GP/self-referrals to health improvement services for weight management and physical activity per year]* *Reducing isolation: [% increase in referrals to the voluntary sector to address social isolation]*
NHS Framework Outcome: **1. Preventing people from dying prematurely** **<u>Reducing premature death in people with a learning disability</u>**	**% reduction in excess under 60 mortality rate in adults with learning disability** *(placeholder, no measures yet)* This will be measured by: *[% increase in the proportion of children and adults with a Learning Disability who have an annual health check and health action plan]* *[% reduction of smoking prevalence in 3 years]* *[% increase in number of patients screened that are identified as increased or high risk receiving an alcohol brief intervention]* *[% increase in GP/self- referrals to health improvement services for weight management and physical activity per year]* Reducing isolation: *[% increase in referrals to the voluntary sector to address social isolation]*

Framework Goals (based on priority health issues of Brighton and Hove)	**Specific outcome target areas** *[Measured by proxy indicators]*
NHS Framework Outcome: **2. Enhancing quality of life for people with long-term conditions**	***% improvement in health-related quality of life for people with long-term conditions*** This will be measured by: *[% reduction in exception reporting rates for cardiovascular disease per year (with a particularly focus on conditions with high exception reporting such as atrial fibrillation)]* *[% reduction in exception reporting for all conditions per year]* *[% increase in proportion of adults and children reporting that they feel supported to manage their condition per year]* *% increase in proportion of adults with a long term condition screened for depression* **COPD** *[% people with newly diagnosed COPD and medical Research Council Dyspnoea scale ≥3 referred to pulmonary rehabilitation programme per year]* *[% of patients with FEV1 < 30% referred to community respiratory service].* **Diabetes** *[% increase in the proportion of people with diabetes who have received nine care processes per year]* *[% increase in the proportion of people with diabetes diagnosed less than one year referred to structured education]* *[% increase in estimated percentage of detected diabetes per year]* *[% increase of people diagnosed with diabetes receiving an annual review per year as part of a shared care plan]* ***Carers*** *[Increase in identification of carers – narrowing the gap between reported and expected]*

Framework Goals (based on priority health issues of Brighton and Hove)	**Specific outcome target areas** *[Measured by proxy indicators]*
	[Increase in the number of carers signposted to carer support services] **Enhancing quality of life for people with mental illness** *[% reduction in exception reporting for SMI]* *[% increase in patients on SMI registers who have received an annual physical and medicines review]* *[% increase of patients on the SMI register who have a care plan]* *[% reduction in exception report for depression]* *[% of patients on the depression register and on prescribed psychoactive medication (benzodiazepine) received an annual medicines review]* *[% increased access of the wellbeing service by target groups - people living in deprived areas, LGBTQ, men, BME per year]* *[% increase in patient reported health related quality of life for adults with long-term mental health condition]* **HIV** *[% increase of people with HIV who have a personalised care plan and annual review per year]* **Dementia** *[% increase estimated diagnosis rate for people with dementia]* *[% increase in the proportion of people referred onto the Memory Assessment Service]* *[% increase of people diagnosed with dementia receiving an annual review per year]* **Substance misuse** *'Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months'*

Framework Goals (based on priority health issues of Brighton and Hove)	**Specific outcome target areas** *[Measured by proxy indicators]*
	<u>Reducing isolation</u> *[% increase in referrals to the voluntary sector to address social isolation]*
NHS Framework Outcome: **3. Helping people recover from episodes of ill health or following injury**	*Adults and children recovering well from episodes of ill health or following injury* *This will be measured by:* *[% reduction in A&E attendances]* [% reduction in emergency admissions that should not usually require hospital admission] *[% reduction in emergency readmissions within 30 days of discharge from hospital]* *[% increase in community short term services patients supported to remain at home]* *[% reduction in emergency admissions for children and young people with lower respiratory tract infections, diabetes, epilepsy & asthma]* *[% increase in the proportion of patients admitted to hospital with COPD exacerbation who are reviewed within 2 weeks of discharge]* *[% reduction of injuries due to falls in people aged 65 and over}* *Reducing isolation: [% increase in referrals to the voluntary sector to address social isolation]*
NHS Framework Outcome: **4. Patient experience outcomes - Ensuring that**	**<u>Improving patients' experience of primary care for GP and out of hours GP services</u>** This will be measured by: *[% increase in patients who would recommend practice]* *[Patient defined experience measures – to be developed with the Cluster's patients]*

Framework Goals (based on priority health issues of Brighton and Hove)	**Specific outcome target areas** *[Measured by proxy indicators]*
people have a positive experience of care	*[% increase in patients who know how to contact Out of hours GP services]* **Improving access to GP services** *[% increase in patient satisfaction with phone access found by the national survey]* *[Increase in % patient satisfaction with opening hours]* **End of Life / Palliative care** *[% increased patients on the palliative care register who have an out of hours form and / or entry on an electronic record]* *[% increase of people who are dying do so in their preferred place of care]* *[% increased of patients for whom an after death review takes place and lessons disseminated to the relevant Cluster team]* **Improving people's experience of coordinated care** *[% increase in proactive care patients who are satisfied with care]* *[% increase of patients (adults and children) satisfied with care and who report feeling that care is coordinated]* *[% increase of patients reporting their care was joined around their needs / patient service user experience of integrated care composite of 6 PIRU indicators]*

Framework Goals (based on priority health issues of Brighton and Hove)	**Specific outcome target areas** *[Measured by proxy indicators]*
NHS Outcomes Framework **5. Treating and caring for people in a safe environment and protecting them from avoidable harm**	**Reducing medicines related harms and avoidable hospital admissions** This will be measured by: *[% increase of complex patients who have had a medicines review delivered by Better care pharmacist or GP (with a view to reducing poly-pharmacy)']* *% increase in referrals to pharmacies for Medicine Use Reviews*
6. Improving health and wellbeing of children and young people	% **reduction of neonatal, infant and childhood mortality** **Improving health and wellbeing of CYP** This will be measured by: *[% reduction A&E Attendances - under 5s]* *[% reduction A&E Attendances - under 18s]* *[% increase identification of CYP up to 18 years with depression, anxiety, self- harm & eating disorders]* *% patient reporting improvement in emotional health and wellbeing* *% increase in young people attending sexual health drop in clinics per year* *% maintenance of Chlamydia diagnosis (15-25 year olds) rates per year* *% reduction / maintenance of under 18 conception rates* *% reduction of termination of pregnancy rates* *[Cluster agreement on defining characteristics of a child or young person with complex needs, implement a system to identify them and agree pathways of effective interventions to improve their health and*

Framework Goals (based on priority health issues of Brighton and Hove)	**Specific outcome target areas** *[Measured by proxy indicators]*
	wellbeing] *[% reduction of smoking prevalence in 3 years]* *[% increase in number of patients screened that are identified as increased or high risk receiving an alcohol brief intervention]* *[% increase in GP/self-referrals to health improvement, weight management services per year]* *Reducing isolation: [% increase in referrals to the voluntary sector to address social isolation]*
7. Delivering Comprehensive, equitable and convenient care (right place, right time)	**Improving comprehensive, equitable and convenient care for patients assessed by a primary care clinician as having needs which the following services could best meet in a primary care setting:** **Tissue viability / leg ulcer / wound care and suture removal needs** *This will be measured by:* *[Cluster agreement (including patients) on the description and delivery of an appropriate pattern of services for all their patients with tissue viability/ leg ulcer/ wound care needs. Agree with patients and CCG a plan to ensure this is delivered as locally as possible whilst meeting the standards set by commissioners.* **<u>Contraceptive needs</u>** *This will be measured by:* *[Cluster agreement (including patients) on the description and delivery of an appropriate pattern of services for all their patients with contraceptive implant needs.* *Agree with patients and CCG a plan to ensure this is delivered as locally as possible whilst meeting the standards set by commissioners.* *Number of long acting reversible contraceptive implants and Inter-uterine contraceptive devices fitted and*

Framework Goals (based on priority health issues of Brighton and Hove)	**Specific outcome target areas** *[Measured by proxy indicators]*
	removed *Numbers of appointments for follow ups by location]* **<u>Phlebotomy needs</u>** *[Cluster agreement (including patients) on the description and delivery of an appropriate pattern of services for all their patients with phlebotomy needs. Agree with patients and CCG a plan to ensure this is delivered as locally as possible whilst meeting the standards set by commissioners.* *[Number of blood samples taken per year by location*] **Other service needs:** Drug monitoring in primary care (flexible provision to enable growth over time) Ambulatory blood pressure monitoring Rabies injections *This will be measured by:* *[Cluster agreement (including patients) on the description and delivery of an appropriate pattern of services for all their patients with these needs. Agree with patients and CCG a plan to ensure this is delivered as locally as possible whilst meeting the standards set by commissioners.*