

Commissioning Task and Finish Group

Report 1

Commissioning for outcomes in Sheffield' s VCF sector

Outcome based contracting is designed to;

'..shift the focus from activities to results, from how a programme operates to the good it accomplishes' (Plantz, Greenway and Hendricks 1999)

Background

This group is one of six work stream groups, part of the 'task and finish group' set up to enable the co-production of a joint programme of work between SCC and VCF sector to enhance and improve commissioning capability. The public sector is moving away from a grants based approach to a commissioning and procurement culture and this will have huge implications for both commissioners and the VCF sector. SCC have signalled their intention to move towards a co-commissioning process based on quality, outcomes and Value for money.

The Task and Finish Group recommend a move towards using a common methodology for developing and measuring outcomes across systems and organisations; the group recommend the use of the Outcomes Star- a well developed and tested approach across a range of service and client areas. The full set of recommendations can be found at the end of this report.

Problem/need

This work group addressed issues of commissioning for outcomes from both a VCF sector perspective and from the perspective of public sector commissioners. The following issues were seen to be key to achieving this transformational change:

- lack of understanding and agreement amongst commissioners and VCF sector of what an ‘outcome’ might be, how this can be measured and what indicators can be used to monitor progress towards outcomes. There is a need for an agreed framework. Some sectors (for example the advice sector) may already be using a variety of outcome measures that fit the needs of other funders. Wherever possible the commissioners will look at the information, schemes and databases already available to collect data to see what can appropriately be used to meet the Strategic objectives and requirements of the City Council.
- The problem of measuring outcomes where these may be long term and difficult to quantify (preventative services, addressing health inequalities for example)
- There is a need to monitor performance that is lean and proportionate to the level of contract in place (no need for ‘bean counters’!)
- There is a need to provide clarity on payment by results and to ensure that this strikes a balance between rewarding success at meeting outcomes and not deterring smaller organisations from tendering due to perceived financial risks
- There is a need to promote and integrate the use of SROI or ‘added value’ amongst commissioners and VCF sector as a means of providing additional value for money

Definitions

It is essential for commissioners and providers to agree on definitions of the terminology.

What is an outcome?	A measure of the ‘good’ that results from the service
What is an output?	A quantifiable measurement usually of the number s of people/groups/courses etc resulting from the service
What is an input?	The resources (money, people etc) that are provided for the delivery of the service
What is an ‘indicator’?	A step along the way to achieving/evidencing an outcome
What is ‘added value’	The added value (economic, social or environmental) that the service achieves

What is the 'impact' of a project or service? The combined 'outcomes' and any added value added together (these will include intended as well as unintended outcomes).

Example:

An output focussed contract may state that 'funding is provided to run training courses on social skills for young people who have committed offences'. An outcomes focussed contract may state 'this service will result in a reduction in offending within the target population'.

The service 'outcome' objective is a reduction in offending. The individual outcomes may include 'individuals are more integrated in their community', 'development of employment skills'.

Indicators of steps on the way to achieving these outcomes may include 'successful completion of a course, 'increased participation in community activities'. Outputs will also be important as an indicator of the desired outcomes.

The benefits of outcomes reporting

There are benefits to be gained by shifting the focus from outputs to outcomes. These include;

- By focussing on what is important, the end user will benefit from a better service
- Outcomes focused contracts should reduce transaction costs caused by unnecessary monitoring and recording of 'output' information for both providers and commissioners (counting beans)
- Outcomes – focussed commissioning should ensure greater flexibility in service delivery. If a service is not producing the desired outcome then it should be possible to change the service as necessary. With outputs focused contracts, the overall 'good' the project is achieving is not measured so as long as outputs are being achieved it is likely that a contract may continue and be deemed a 'success' even if it is not.
- Commissioners are more likely to work together with providers and co-design services based on agreed outcomes.
- Outcomes can be cross-cutting and be of benefit to a number of agencies. This will encourage a move away from a 'silo' mentality where the benefits of a service are only seen as relevant to a particular group.

Case studies (See Appendix 'A')

Appendix A provides an example from two Sheffield provider in the VCF sector. The examples reveal some of the issues involved in outcomes focussed and the negative impact of focussing on outputs.

Hierarchy of outcomes (see appendix B)

There is a recognition that commissioners do not currently specify outcomes-based contracts, with some limited exceptions. Nor do VCF sector focus primarily on the outcomes of their service provision (again with some exceptions). In recognition of the risks associated with moving from outputs to outcomes commissioning we have provided an example of how commissioners might work with providers in agreeing the most appropriate measures to put in place for a particular contract.

Outcomes tools

Key factors to consider when reporting on outcomes are:

- Outcomes need to be evidence based
- The methods for demonstrating outcomes need to be easy to use and implement to ensure evidence is captured in a way that is appropriate to the service/ client situation/resources and size of contract.
- The indicators (the steps on the way to achieving outcomes) need to be robust and (where possible taken from a set of agreed National indicators to ensure consistency.
- Case studies and other qualitative methods may be used to draw out and compliment additional evidence of outcomes

Example

The 'outcomes star'

An outcomes start can be an effective method of measuring distance travelled and outcomes achieved. The star can be designed for a particular project but will use outcome statements that are cross-cutting and can be linked to National or local objectives. This ensures that outcomes are consistent and are tied into the strategic objectives of commissioners.

www.outcomessat.org.uk

Measuring impact (SROI) (See Appendix C)

To ensure that commissioners are obtaining a good return on investment and that providers are demonstrating the value of the full value of the work they do, a method for analysing social return on investment will become increasingly important.

‘Social Return on Investment’ (SROI). SROI is an evaluation method which seeks to measure the broader concept of the value of outcomes including economic, social and environmental benefits and to quantify this ‘added value’ in monetary terms. The use of SROI enables providers to demonstrate the full value of the work they have undertaken and commissioners to incorporate this ‘added value’ into their commissioning process. If this added value is not captured, the real impact of the work cannot be assessed and the real strength of third sector providers ‘offer’ missed.

To ensure consistency of approach a ‘Sheffield’ model of SROI should be adopted. Sheffield well-being consortium has adopted the ‘selling added value’ model. Appendix ‘D’ provides an example of this approach using ‘Sheffield community health champions’ as an example.

Recommendations

The commissioning task and finish group advocates the following recommendations based on its findings:

1. **That commissioners and service providers should adopt the ‘outcomes star’** method of evaluation outcomes. The approach provides a simple and effective approach to measurement and reporting. This may require obtaining a license if the tools are to be used on-line.
2. The focus on the measurement of outcomes by commissioners should be commensurate with the length and nature of the contract and be realistic. Some short term contracts will not warrant the use of outcomes.
3. The evaluation of outcomes and added value will be more effectively undertaken by a lead organization or consortium ‘hub’ where a contract is delivered by a number of provider organizations. Commissioners should recognize the value of this approach in terms of efficiencies and consistency of approach.
4. VCF sector should adopt, and commissioners recognize, a method of measuring social return on investment. The tool used by Sheffield Well Being Consortium SWBC and other VCF organizations is one developed by the Social Enterprise Support Center ‘selling added value’. We recommend that the principles and methodology provided by this should be adopted by the VCF sector and recognized by commissioners. www.sesc.org.uk
5. Forecasting ‘added value’ and outcomes should be explicitly built into the procurement process. Tenders for contracts should include an assessment of the level of added value and wider outcomes that each bidding organization would bring to a contract. Commissioners need to work with procurement specialists to ensure the tenders enable the opportunity to set out ‘added value’ and projected outcomes- and that this can be taken into account when evaluating bids. Standardized documentation needs to be designed to take this into account.

6. Commissioners and providers will need support and training in developing understanding and application of Outcomes frameworks, and developing 'added value' . The pilot Commissioning Masterclass in July 2011 further revealed the need (and interest) in developing understanding and skills in this area. If the Outcomes Star is to be systematically developed and applied through the City, some external support may also be needed.

Appendix A

Case study examples

CASE STUDY 1

Advice, counselling and groupwork project

Title of project/Service

Advice, counselling and groupwork

Brief description:

Provision of a counselling and other therapeutic support for people with mental health problems, particularly targeted towards those unable or unwilling to access other services. Provision of advice and information for people approaching Sheffield Mind.

Funding body:

NHS Sheffield and Sheffield City Council

Type of funding agreement: Contract, Service level agreement, Grant, unsure...

Although the document calls it a contract it's content is more consistent with what you would find in a SLA.

When did the contract start?

September 2002

When is the contract due to finish?

NHSS have given notice that the contract will be terminated in March 2012 (though they have also indicated that it is likely to be extended for a further 12 months).

SCC have indicated that the contract will finish in March 2013.

Total value of funding:

Funding per year (ie 2011/12); NHSS = £65,108 SCC = £62,380. Total = £127,488

Outcomes and outputs

Does the funding require you to achieve certain outcomes?

If so, please describe: No outcomes identified. However, there are 8 service objectives.

Does the funding require you to achieve certain outputs?

200 people attending for counselling assessment per year. In addition there are 33 indicators.

Please provide a summary of each output

Output 1 200 people attending for a counselling assessment each year. This information is supplied with a demographic EOPs breakdown.

For each of the out outputs please describe the following:

- ***Whether they have been of value in helping you achieve outcomes***

They help to quantify the size of the service. As the contract fee does not fund achieving all the service objectives and there are no outputs attached to these objectives it is a fixed point.

They have not been helpful in achieving outcomes. Measuring assessments in isolation is also not helpful as it is not a measurement of the volume of service actually delivered i.e. counselling and other therapeutic activity. Measuring assessments does not help contribute towards the other objectives of the contract e.g. combating stigma and participating in local planning of mental health services

- ***Whether they have been of value to the end user***

No.

- ***Whether they have helped you focus on the client/end user***

It has helped focus on the volumes of assessments we need to undertake.

- ***Whether they have produced perverse incentives (for example numbers of people rather than quality of service)***

Yes. We can only provide a counselling service to about 70 individuals per year. This means that by undertaking 200 assessments we have to turn away 130 people. Some of these people are not suitable anyway, but generally it leads to long waiting times for counselling, signposting people to private counsellors or back to their GP .

- ***Are they flexible and helped your organisation to change in response to changing needs/environment***

We have moved away from offering everyone a full face to face assessment and now undertake telephone triages for all enquiries to establish whether a full assessment is needed and to be able to offer a more immediate intervention. This has reduced the number of face to face assessments to below 200. However, we count the triages as assessments, but do not have the same level of demographic/EOPS information.

Add any other comments that you feel may be relevant

The contract was written in 2002 and has not been significantly reviewed since. The services delivered have evolved and changed over time to respond to changing client need and priorities. Because the contract is so short on actual outputs there has been the flexibility there to change the service. 2001 was before the days of outcomes, all activity and interventions were counted in terms of outputs, so it is not surprising that no outcomes are included. There is nothing in the contract about measuring the impact of preventative work.

Individuals coming for counselling identify their own intended outcomes which form the basis of the counselling, but these are not systematically measured and used for reporting.

Alternative model – Outcomes focussed commissioning

Using the same project can you identify how an outcomes focussed process would be beneficial to the end user?

Outcomes help in determining the purpose of the service. This will help people self select whether the service is right for them. Outcomes also are a person centred way to identify goals and track progress towards meeting those goals.

Outcomes provide a way to measure the impact that the service has and is a way of describing how this impact contributes towards the more high level outcomes of funding bodies etc. For example, if becoming less socially isolated is an individual outcome, this contributes towards higher level social inclusion outcomes.

What outcomes would you want to achieve and why

Outcome 1 ; Clinical improvement.

Indicator; change in score on clinical outcome measurement tool (CORE). Moving below clinical cut of or move to recovery would be a positive outcome. However, for some people a smaller positive change in score would be a positive outcome also.

Indicator; Reduction in medication use (though this could be a positive or a negative indicator depending on the individual)

Outcome 2; improvement in health and wellbeing

Indicator; change in score on outcome measurement tool. Measuring health promoting activities and assessing likely impact on future health.

Outcome 3 improvement in relationships/social functioning.

Indicator; change in score on outcome measurement tool. Job retention/entry into education or training

Outcome 4 prevention of a deterioration in the condition/prevention leading to reduced service use

Indicator; comparing previous use of service (e.g. GP visits) to post intervention use. Comparing individuals outcome to what would be expected from research.

What indicators would you use to show progress/ achievement of the above outcomes? See above

Have you measured the impact/added value of the investment in your project?

We use CORE (a clinical outcome tool) and also measure wider impacts through a questionnaire devised in house. We have not measured added value.

Briefly describe the added value (volunteer input – training for volunteers etc) that you feel should be measured.

- Volunteer input. The counselling service and other therapeutic activities are delivered by a team of 20 volunteers – the equivalent of 1.6 WTE workers

Please use the space below to add any comments or suggestions.

Measuring outcomes in mental health is difficult as each individual is very different and their potential for change variable e.g. one small step for one person may make a huge difference but for another not so. Whilst there are some outcomes which are seen to be positive to everyone e.g. reducing social isolation, increased motivation etc., some are not e.g. reduced medication or reduced number of GP visits. In mental health outcomes can be

achieved across a wide range of domains which is a good thing for the individual. However, measuring this distance travelled in all domains can be difficult as it easily leads to an overload of monitoring forms. It is also hard to measure people's initial potential to change. E.g. someone with depression following a bereavement may see more marked results than someone with long term entrenched depression with its root causes in childhood. Monitoring methodology is also challenged when the people involved lack literacy skills or where English is not their first language. Measuring preventative work in mental health is also difficult.

Healthy Communities Programme, Manor, Castle and Woodthorpe

CASE STUDY 2

Title of project/Service

Healthy Communities Programme.

Brief description:

Delivering a range of activity to address key priorities identified through the Community Health Needs Assessment:

- Weight Management
- Physical activity, including Healthy Walks
- Confidence and personal development programmes.
- Access to ICDH course.
- Health promotion campaigns
- Men's health
- Street health
- Primary care access.

There is also a small amount for the coordination of MCDT's health programme overall.

Funding body:

NHS Sheffield.

Type of funding agreement: Although the document calls it a contract it's content is more consistent with what you would expect from grant funding.

When did the contract start?

April 2005 (the £20k management costs have been included as match funding for SRB and Lottery since 1997)

When is the contract due to finish?

We think March 2012

The contract for £20k match / management has been given notice to end March 2012. It is unclear whether the HCP will continue after 2012, even if HCP did continue and we lost the resource for coordination, the delivery of HCP would not be viable.

Total value of funding:

Funding 2010-11 £55k HCP, plus £19k for coordination and some delivery.

Outcomes and outputs

Does the funding require you to achieve certain outcomes?

If so, please describe: No outcomes identified. But we are seeking to reduce health inequalities and the improve health of local people who are disadvantaged and face worse health outcomes than other communities. So comments below are against the overall aims of the HCP.

Does the funding require you to achieve certain outputs?

Please provide a summary of each output

Output	Value in helping you achieve outcomes	Value to the end user	Helped you focus on the client/end user	Produced perverse incentives	Helped your organisation to change in response to changing needs/environment
500 contacts :Primary care access – work to increase the number of people registered with a GP and with an NHS Dentist	To some degree – people in disadvantaged communities use primary health care less effectively than other communities and / or later, with potentially costly results for them as individuals and the health care sector.	Yes	No – generic campaigns run universally.	We had to chase numbers – so it was quantity rather than quality of the contact.	No
500 contacts :Health Promotion events, including targeting men’s health specifically.	No – social marketing rarely works in disadvantaged communities. Word of mouth and / or specific project work is more effective.	No Limited impact on people with chaotic lives.	No – as above	Chasing numbers to achieve the contract – and having tangibles to ‘measure’ again quantity not quality.	No
208 contacts: Street Health	To a degree – this was focused on a particular street with high	No – limited impact.	Yes – we focused on a particular street – high number of families	We used a Living Street audit to engage people and then provided	Yes to a degree – we have a clearer idea of the ‘offer’ we bring that

	disadvantage.		and people living on benefits. We promoted other services – help to get into work for example as well as the health promotion messages.	information about support they could access. The issue for us is that lifestyle messages are limited for people living in real poverty and unless the wider issues are addressed alongside health promotion messages it becomes meaningless. We recruited a number of volunteers through this process and at least one is now in work.	includes services and experiences outside of the HCP offer.
5632 contacts: Ongoing physical activity sessions and weight management groups	Yes – people do have issues with weight , which impact on confidence and mental well being, which impacts on aspirations and ability to get work.	Yes – we have seen people’s lives transformed by a combination of activity – often an exercise class leads to accessing other services that improve the economic and social aspects of	Yes – we know what capacity we have to deliver .	No	Yes – we are always reviewing what we deliver, where and to whom and it changes accordingly in order to maintain the numbers.

		lives – and then health.			
864 contacts: Walking Group	Yes	As above.	Yes – we started with the traditional health walk – and developed a whole progression route to meet the needs of the people coming to maintain their motivation and interest– including a 24 mile walk for those who are able this year.	Raised lots of money for charities by doing sponsored walks in addition to the health walks. Staff do this in their own time as volunteers. The impact has been more on mental and emotional well being than physical health.	To a degree.
180 contacts: ICDH	Yes to a degree – confidence to think about volunteering and/ working in health and social care.	Yes	Not really – chasing outputs.	No	No
120 contacts: STEPS	Yes – raising confidence and self esteem and aspirations to achieve goals – work and training as well as health goals.	Yes	To a degree – the programme is tailored to meet individuals needs and supports them to set personal goals.	No	Yes – we are much more focused on delivering person centred approaches and whole household solutions.

Add any other comments that you feel may be relevant

The HCP was first commissioned as a pilot and grew from Wybourn to a wider area approach. The way in which it has developed is very organic. There has been a shift towards a more prescriptive approach from Public health leads towards lifestyle interventions because the outputs are easier to measure and account for.

We have to identify what we are to spend on each project and account for every penny – so it isn't a contract – its grant funding. Whilst we are adept at describing how we think interventions will deliver outcomes – it isn't long term enough to measure or achieve outcomes that relate to inequalities in health.

Alternative model – Outcomes focussed commissioning

Using the same project can you identify how an outcomes focussed process would be beneficial to the end user?

I would prefer to see a structure that set out clear aims and objectives that address the key priorities / gaps in services with a described set of outcomes that are required. The services would then be designed to achieve the outcomes and be person centred approach. The resources would be used flexibly to meet the needs of that person to achieve the outcomes.

An example :

Aim ; to tackle obesity and contribute to prevention of heart disease.

Objectives :

- to engage with vulnerable adults in Wybourn .
- To undertake a holistic needs assessment
- To provide a range of services that address the needs of that individual – supporting them to attend a weight management class and undertake physical activity, signposting to services that are not provided through the health team.

Activity :

- Health Development Worker (HDW) engages the individual and does a needs assessment.
- HDW encourages them to sign up to a STEPs course.
- Health Development Worker picks up the individual to attend a Zumba class and a weight management group.

- Signposted to a Key Worker to help them remove barriers to employment and write a good CV.
- HDW reviews the personal plan and suggests the individual might benefit from a HT.

Outcomes required : lifestyle changes leading to weight loss, reduction in probability of heart disease.

Outcomes reported : reduced social isolation and stress as a result of Steps leading to a reduction in comfort eating (chocolate) and the confidence to then attend a weight management class at which the person lost 12 lbs over 6 weeks, had the confidence to apply for a retail job which they got, saving the state £xx benefits and contributing £xx tax. A year later the probability of heart disease has reduced by 25%.

What outcomes would you want to achieve and why

Outcome 1; Improvement in health and wellbeing

Indicator; distance travelled over 12 months and a measure that provides a probability score of impact of interventions on future health. Measure of well being – baseline and follow ups at 3 month intervals.

Outcome 2 prevention of a deterioration in the health and well being

Indicator; comparing previous use of service (e.g. GP visits) to post intervention use. Reduction in use of medication.

Outcome 3 Engagement in social and economic activity.

Indicator; volunteering, employment and education and training.

What indicators would you use to show progress/ achievement of the above outcomes? See above

Have you measured the impact/added value of the investment in your project?

No , we have evaluated every activity and used the evaluations to shape service delivery. We always report case studies to NHSS as part of the quarterly monitoring.

Briefly describe the added value (volunteer input – training for volunteers etc) that you feel should be measured.

- Change in use of health services
- Volunteer input
- Reducing social isolation.
- Cost savings by people returning to work
- Value of other services accessed not paid for by the HCP.

Please use the space below to add any comments or suggestions.

Measuring outcomes needs to be flexible – we need some idea of what we are trying to achieve overall and what outcomes would be an indicator of that change. There needs to be a way of measuring distance travelled that is validated but un-bureaucratic.

We need a template for measuring social return on investment that is universally used and understood with some validated figures – e.g. a person going back to work – depending on the benefit they are on could vary – we need an average rather than have to try to work out each individual case.

The NHSS need to :

- Agree full cost recovery
- Contract rather than manage grants (unless it is grant funding they are passing down and needs to be accounted for in that way)
- Set some margins re outputs and outcomes – i.e allow for variances (e.g. 10% under / over) and narrative around reasons for variances.

Appendix B

Commissioning Task & Finish Group – Commissioning for Outcomes: May 2011

Current Hierarchy of Measurement - Characteristics

Inputs

- Very prescriptive approach that assumes commissioners know best
- No provider flexibility and innovation
- Easy and quick to measure and report from the outset
- Likely to require unsophisticated data collection and reporting requirements on the part of the provider
- Less resource intensive
- Low risk for commissioners (when reporting/accounting to senior management) as quantifiable

Outputs

- Allows for both qualitative and quantitative measurement
- Some flexibility for providers on delivery
- Most common form of measuring performance
- Requires providers to have more sophisticated data collection and reporting systems in place
- Tends to focus on what can be measured
- Can be measured and reported on from the outset
- Doesn't account for additional, wider reaching benefits
- Can be resource intensive
- Performance management needs to be proportionate to size of contract (although often isn't)

- Low risk for commissioners (when reporting/accounting to senior management) as quantifiable

Outcomes

- Measures the change or difference that is trying to be achieved
- Can be perceived as being more subjective than input or output measures therefore more difficult to achieve senior management buy-in
- Longer term approach so challenge for short (or even medium) term contracts to demonstrate success
- Measurement of outcomes can be resource intensive both for provider and service user
- Need to have clear understanding of the baseline and the change that needs to be effected
- Can be service user 'fatigue' i.e. responses drop off as time elapses
- Outcomes can be wide reaching going beyond departmental and organisational benefits so there can be a challenge to account for financial benefits if they do
- There needs to be consistency in the approach to measurement of outcomes (including tools) and the interpretation of the impact/benefits both within and across organisations
- High risk for commissioners as not as easy to quantify and account for investment benefits

Current Position

We have to recognise that commissioners do not currently specify outcome based contracts, with some limited exceptions. Amongst commissioners there is a lack of understanding and experience in defining outcome measures, and no local history in the use of appropriate tools and methodologies. Equally there is limited understanding and experience within providers, and there is a general need for education and development to be able to move to an outcome based approach.

In the context of significant financial pressures the use of outcome measures may be perceived as higher risk and a cultural challenge. Encouraging commissioners to move away from systems for accounting for expenditure and success based on established processes for measuring inputs and outputs, at a time when commissioners have to account for every penny spent and justify that expenditure to tax-payers and central government, has to be recognised as a 'big ask'.

Contracts are being let for shorter periods because of funding and organisational uncertainties. Shorter contracts do not allow time for the impact of interventions to be measured during the lifetime of the contract.

Conclusions

- Commissioners and providers need to be supported to move towards outcome based contracts. This should include agreeing a standard suite of outcomes measurement tools, and education on how to develop outcome measures.
- Outcome measures need to clearly link to the common strategic goals and vision for all Sheffield commissioners. This would allow outcomes to survive the end of a contract, service redesign, or change of provider, and also allow the benefits to be measured where they go beyond organisational boundaries.
- Outcomes and their measures need to be built in from the start of the commissioning process, and not as an add-on at the procurement stage or beyond.
- Accepting the previous statement, if there are opportunities to retrospectively agree outcome measures for existing contracts this would allow intelligence and baselines to be developed to inform future commissioning plans.
- To effectively measure outcomes generally requires a longer timescale, therefore definition and measurement of outcomes needs to be transferable across contracts and providers. Outcome measures need to be right first time and not subject to serial amendment.
- There is a challenge to commission more collaboratively – we have to recognise that in the context of financial constraints, organisations will have difficulties justifying their investment if it demonstrates greater benefit for another commissioner.

- In the context of short term contracts we need an approach to the development of proxies for outcome measures. The challenge is to identify appropriate and meaningful steps/pre-cursors.
- When we develop performance management frameworks we may need to have a transitional approach that recognises that different measurement approaches may need to be applied at different points in the life of a contract (or service) – see below.

		CONTRACT DURATION			
		SHORT (0-1 year)	MEDIUM (1-3 years)	LONG (3-5 years)	VERY LONG (5+ years)
INPUT MEASURES					
OUTPUT MEASURES					
OUTCOME PROXY MEASURES					
OUTCOME MEASURES					

Produced on behalf of the Sheffield Commissioning Task and Finish Group by David Qualter Director Sheffield Well-being consortium

July 2011