NHS England

The incentives framework for ICPs

Draft Integrated Care Provider (ICP) Contract - consultation package

August 2018

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Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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1. Introduction

1 This document was previously published in August 2017. This version has been updated with minor changes for the purpose of further clarifying how the incentives framework should be constructed in practice, updated terminology and to reflect that no NHS Standard Contract (Integrated Care Providers) ('ICP Contract') is expected to be awarded until the current consultation has concluded and NHS England has considered consultees' responses to it.[1]

2 The draft ICP Contract represents a new approach to contracting, including a wide scope of services for a population and a longer duration than an NHS Standard Contract. All current NHS contracts incorporate financial frameworks to incentivise particular activities, behaviours and quality improvements. As such, it is appropriate that the ICP Contract should also incorporate a financial incentive. In the longer- term, it is our intention that the incentives framework built into the ICP Contract will have a greater focus on long-term population and outcomes-based measures that reflect the longer-term and broader aims of new care models. In the shorter-term, the framework described in this document is aligned with relevant indicators from existing national reporting frameworks.

3 Currently, CCGs develop service specifications that often set out the details of individual services which providers are required to deliver and are prescriptive as to how those services are to be delivered. In an ICP context, contracts need to be sufficiently flexible to reflect long-term service development. This is because methods, technologies and best practice will change over a longer period, and defining in advance the precise details of services across the whole duration of the contract would be overly restrictive. At the same time, however, there needs to be a clear outline of, and commitment to, the individual, clinical, population and system outcomes the ICP is expected to deliver and the nature of the services the ICP must provide with others to do so. Together with the service specification and other national requirements of the contract, the incentives framework is a vital component of the ICP Contract, and will be essential to ensure commissioners can hold the ICP to account for delivering high-quality care. This document explains how we have developed a proposal for moving towards an outcomes-based incentives framework.

4 An ICP Contract will include a set of national indicators on which all ICPs will be expected to report, mirroring existing incentive payment schemes in NHS contracts. Payment would be attached to these indicators, to be earned by the ICP on achievement of national requirements.

5 In addition to national indicators, commissioners would have the opportunity to add new indicators into the ICP Contract on which they will require the provider to report. They may choose to attach additional payment from the ICP's available budget to these locally-added indicators, but any localised financial incentives over and above those required by national schemes will be subject to assurance by NHS England and NHS Improvement during the procurement of the ICP Contract.

1 Integrated Care Providers (ICPs) were formerly known as Accountable Care Organisations (ACOs).

2. Overview of the framework

6 The framework would provide commissioners and others with a view of the overall performance of the ICP and the contribution it is making to the wider health economy. More generally, commissioners should consider how they can ensure the performance and impact of an ICP is as transparent as possible.

7 The threefold purpose of the incentives framework for ICPs is to:

a. ensure that the ICP reports performance in a consistent way against existing national incentives frameworks relevant to the services it is required to deliver, to allow comparison against other providers

b. allow commissioners to add new system-wide indicators to ICP reporting requirements as these evolve, aligned to broader reporting requirements developed through work with Integrated Care Systems across the country

c. use payment to incentivise performance improvement in line with existing national schemes, and in some cases, to financially incentivise additional priority areas chosen by CCGs to reflect local circumstances.

3. Payment incentives for ICPs

8 The ICP would be required to report on existing payment schemes depending on which services are in scope. However, the service scope of ICP contracts will vary from one site to another. Commissioners would therefore be able to flex the ICP scheme to incorporate those elements most relevant to the ICP service scope. For example, if an ICP Contract incorporates community services, the commissioner will select relevant indicators from the Commissioning for Quality and Innovation (CQUIN) scheme, against which payment will be made. Where the scope includes primary medical services, because GP practices are fully integrated, the Quality and Outcomes Framework (QOF) will be relevant.

9 The total amount of earnable income in an ICP Contract can be constructed as below. Every ICP Contract incentives framework would be subject to the Integrated Support and Assurance Process (ISAP).[2]

Earnable Income Quantum Local Site =
Quantum Associated with National Incentive Schemes Applied to ICP
+ Incentive Quantum Associated with Local Priorities

2 Further information about ISAP can be found on the NHS England website: https://www.england.nhs.uk/publication/integrated-support-and-assurance-process/ (Information accessed 16 July 2018)

Nationally-mandated element of the payment scheme

CQUIN

10 The payment scheme incorporates the current national CQUIN scheme that applies to other NHS providers contracted through the NHS Standard Contract. This would ensure there is equity in standards across ICPs and other NHS contracts and that there is no additional administrative burden or changes to the principle of incentivisation for organisations holding both a generic NHS Standard Contract and an ICP Contract.

Care Quality & Innovation (CQUIN) Scheme
The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. The scheme is designed to support the ambitions of the Five Year Forward View and is linked to the NHS Mandate.

11 The CQUIN scheme would be worth 2.5% of the proportion of the Whole Population Annual Payment attributable to NHS-funded services for which CQUIN is applicable. This definition is in line with the existing CQUIN scheme and is designed to replicate the balance of financial risk and incentives that exist in the current national performance payment schemes. The overall minimum level of system funding used as an incentive payment in an ICP Contract would therefore mirror that in the current NHS Standard Contracts.

12 In the discussion below, we use the existing 2017-19 CQUIN scheme to set out an example of how the scheme would work in practice. Note however that this will be updated for ICPs when the national CQUIN scheme itself is updated.

Figure 1: CQUIN indicators from the 2017-19 CQUIN scheme for inclusion in the ICP incentive scheme.

	Incentive	Proportion of contract value (%)
Part A Commissioning for Quality and Innovation (CQUIN) potentially applicable to ICPs (commissioner to choose 6 most relevant)	1. NHS Staff Health and Wellbeing	0.25
	2. Proactive and safe discharge	0.25
	3. Child and young person mental health transition	0.25
	4. Wound care	0.25
	5. Reducing the impact of serious infections	0.25
	6. Physical health for people with severe mental illness	0.25
	8. Improving services for people with mental health needs who present to A&E	0.25
	9. Preventing ill health by risky behaviours – alcohol & tobacco	0.25
	10. Offering advice and guidance	0.25
	11. Personalised care planning	0.25
Part B Supporting Local Areas	Engagement with STP	1.0

13 There are two parts to the 2017-19 CQUIN scheme. Assuming all services to which CQUIN applies are in scope of the ICP (with the exception of ambulance services and NHS 111), then the indicator set that would apply to the ICP Contract is that set out in Figure 1. The specifications for these indicators are set out in the CQUIN guidance.

14 The current indicator in Part B would be mandatory and ICPs would therefore be expected to include this indicator and deliver on it as per existing guidance, demonstrating that the provider had been thoroughly involved in STP planning locally.

15 The Part A CQUIN indicators applicable to an ICP would be dependent upon service scope. However, commissioners are expected to select a minimum of six Part A CQUIN indicators. However, if more than six are applicable to ICP delivery, commissioners will be able to choose those which are most relevant for their population.

QOF

Quality and Outcomes Framework (QOF)
QOF is a voluntary reward and incentive scheme. It rewards providers of primary medical services in England for the quality of care they provide to their patients.

16 Within a fully integrated ICP model, some or all GP practices in the locality would have opted to suspend their contracts, allowing the core primary medical services previously contracted through GMS/PMS contracts to be in scope for the ICP. The ICP would therefore report on QOF measures for those primary medical services, and would earn QOF payments in line with national QOF payment thresholds.

17 Under a partially integrated ICP model, GP practices would continue to deliver primary medical services under their existing GMS/PMS contracts, and would therefore remain responsible for QOF delivery.

18 We are currently exploring how there might be changes to future QOF arrangements to better support collaborative working in an integrated care environment as part of the QOF review. NHS England has recently published a review of QOF, and discussions about its implementation are proceeding in parallel.

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Local flexibility in constructing the framework

19 Sites developing an incentives framework for a proposed ICP have advised us they would value flexibility to reflect local priorities and ambitions. The mechanisms by which commissioners can adapt the framework to meet their needs are as follows:

- Expanding the indicator set to be reported upon contractually without supplementing incentivised payment: Commissioners could choose to add locally-designed measures to the indicator set to be reported upon in the ICP Contract. This could include the examples listed in Annex 1 or other local indicators commissioners believe better reflect local ICP priorities. It will be useful to think through how performance reporting links to the four domains identified in Annex 1, developed through work with CCGs. The reporting requirements can be included without any associated payment.
  - Commissioners should consider how any additional proposed measures in their indicator set for the ICP could be designed to promote the desired level of collaboration between providers of primary medical services and the ICP and its services. For example, indicators could be aligned with the actions which the practices and ICP are taking to improve integration, as set out in an Integration Agreement.
- Supplementing incentivised payment with additional measures[3]: Commissioners could decide to increase the level of payment which could be earned through an incentive scheme (i.e. in addition to the 2.5% quantum associated with the nationally mandated element) by paying against additional chosen indicators. Such measures might include:
  - additional CQUIN Part A measures (i.e. in addition to the minimum of six) because the scope of the ICP contract is extensive; and/or
  - other non-CQUIN measures, such as those listed in Annex 1.

4. Managing the overall performance of ICPs

20 The draft ICP Contract is designed to signal and encourage change across a range of priority areas that meet the NHS ambition of closing the three gaps outlined in the Five Year Forward View: the health and wellbeing gap; the care and quality gap; the funding and efficiency gap, together with the transformation needed to address these gaps. Commissioners would need to ensure that all elements of the contract address local population needs, including those of marginalised and minority groups.

21 To support this ambition in the Five Year Forward View, we suggest commissioners develop a reporting structure and adopt measures that monitor improvements during the course of the ICP Contract and its impact, i.e. to ensure the population receives safe, effective, caring and responsive care through a well-led and sustainable care system.

3 The additional financial risk borne by sites choosing to include local metrics and assign additional contract value to them will be assessed through the Integrated Support and Assurance Process (ISAP) run by NHS England and NHS Improvement. Commissioners will be expected, as part of their ISAP submission, to establish a clear narrative setting out how financial risk to the ICP is managed. Please refer to further guidance on the ISAP. The ISAP documents can be found on the NHS England website: https://www.england.nhs.uk/publication/integrated-support-and-assurance-process/ (Information accessed 16 July 2018)

22 In the longer-term, we will support commissioners through identifying a set of core indicators that provide insight into the value of healthcare delivered by an ICP, taking account of outcomes and costs for individuals across the population. The intention is to develop this core data set to support benchmarking across different systems and providers. In the meantime, however, we have worked with local sites and subject matter experts to identify a number of indicators derived from existing national frameworks which commissioners could select for inclusion in their local indicator set (Annex 1), supplementing those required through the relevant national schemes. The measures in Annex 1 are divided into one of four domains based on closing the gaps in the Five Year Forward View, but commissioners could select an alternative structure for reporting.

23 An ICP Contract could be of up to ten years duration and, over this period, clinical best practice will change, new technologies will become available and the public's expectations will change. Different measures will be relevant over the duration of the contract, with population outcome measures only likely to be delivered in the longer term. Annex 1 therefore includes some longer-term population-based indicators alongside those derived from existing frameworks.

24 Many of the indicators in Annex 1 relate directly to the population the ICP is serving. However, it should be recognised that reporting on certain measures could be required at either CCG or local authority population levels. Local commissioners should consider this issue when selecting measures to incentivise local priorities as part of the payment scheme.

5. Example of how the ICP incentive payment scheme is constructed and its measures selected (indicative only)

25 An example of how a commissioner could construct the incentive payment scheme is shown in Figure 2 using the 2017-19 CQUIN scheme. In the example, commissioners have:

a). selected the most relevant Part A CQUIN measures they wish to incorporate, alongside the mandatory Part B measure, to form the nationally- mandated element of the payment scheme equating to 2.5% of the CQUIN-applicable proportion of the Whole Population Annual Payment (WPAP).

b). decided to supplement the CQUIN scheme and raise the proportion of the ICP integrated care budget used as an incentive payment by an extra 1%, creating a scheme worth 3.5% of the relevant proportion of the WPAP in total

c). decided to use a mix of additional indicators from Annex 1 as supplementary measures on which the ICP would be required to report, emphasising particular local priorities.

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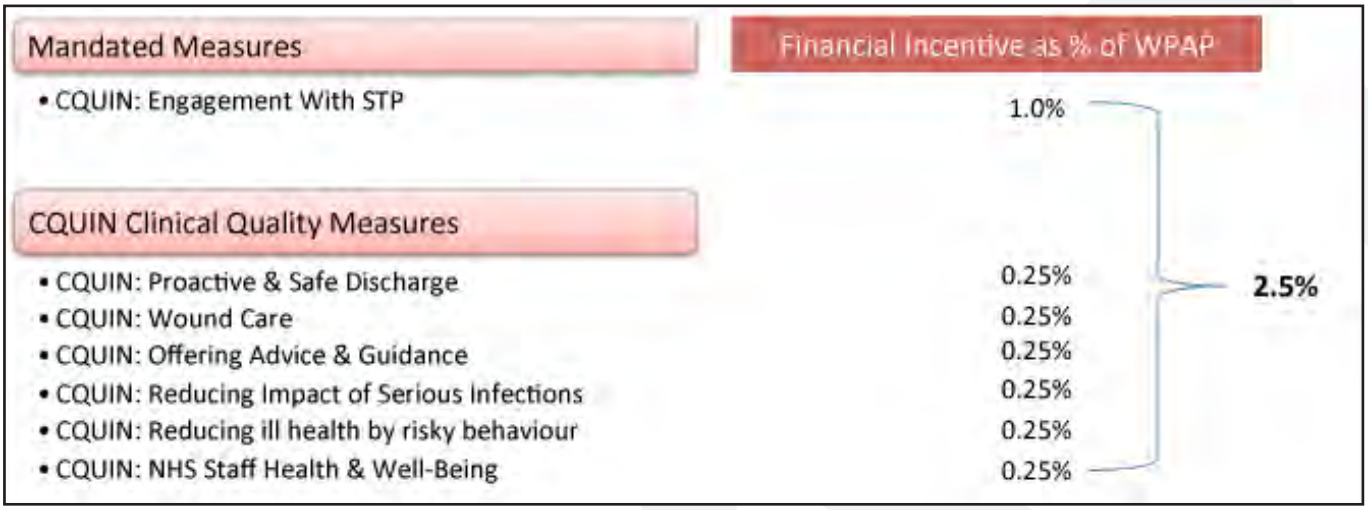
Figure 2: Example of how the payment scheme could work.

a). Nationally mandated element of the payment scheme (CQUIN): Commissioners selected six Part A CQUIN measures they wish to incorporate, plus the mandatory Part B CQUIN measure. The quantum associated with the nationally-mandated element equates to 2.5% of the CQUIN-applicable proportion of the WPAP. This example assumes no non-CQUIN applicable funding is included in the budget for the ICP (e.g. no primary medical services / social care services are in scope).



b),c). Local financial incentives: In this example, local commissioners wish to raise the proportion of the WPAP used as an incentive payment by an additional 1.0% to better reflect additional local priorities. They decided to use an additional three locally agreed incentive measures to make up this 1%. As this constituted an optional additional 1% on top of the nationally mandated scheme, both the amount and measures were decided by the commissioner and their plans assessed as part of the overall ISAP process.

Indicative total incentive scheme value as a percentage of WPAP: 3.5% = 2.5% CQUIN + 1.0% locally included at the discretion of the commissioner

6. Conclusion

26 The ICP incentives framework provides a consistent structure for commissioners to use when developing an ICP Contract. It is designed to evolve over time, but allows flexibility for commissioners to determine how payment for performance will operate. The annex to this document sets out supplementary measures which could be used to incentivise improvement and delivery of care, and commissioners may choose to use some of these additional measures (or other locally-identified measures) to create further payment incentives for the ICP.

27 We are committed to work with stakeholders, including regulators, local commissioners and providers, to ensure the ICP incentives framework reflects changing best practice around performance management, including updating this document after any change to the CQUIN scheme for April 2019 is published. We anticipate the framework evolving to allow benchmarking against a recognised set of system measures in due course, and this phased approach will allow us to both continue to work longer-term with stakeholders to improve measurement and payment mechanisms, and continue to reflect the increasing maturity of business intelligence systems to deliver improved population analytics.

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7. ANNEX 1
List of potential indicators for ICP reporting and financial incentive scheme

The table below is divided into four domains based on the Five-Year Forward View aims, in which selected measures from the indicator set have been identified. This framework is designed to provide a helpful starting point for commissioners who wish to ensure they are taking a full range of indicators into account in monitoring ICP performance, however the domains set out below are not mandated, and commissioners could choose their own alternative structure.

The domains are:

- Care Quality and Experience: This reflects the importance of high quality, person-centred care in line with the commitment to a nationally agreed definition of quality;
- Population Health and Wellbeing: Indicators linked to population health outcomes and lifestyle factors;
- Sustainability: Indicators focusing on the impact of the ICP on financial and clinical sustainability of services; and
- Transformation drivers: measures that will help to drive long-term improvements in the other outcome areas.

The measures in the table also take a tiered approach to the selected indicators:

- Tier 1 indicators relate to long-term outcomes and will last the full length of the contract, for example Potential Years of Life Lost. They signal a shared set of objectives for the system. Tier 1 indicators would not, as a matter of course, be financially incentivised for delivery (although commissioners could choose to do otherwise) but instead form part of the indicator set.
- Tier 2 indicators include indicators associated with NHS Constitution standards, national priorities and indicators from existing national schemes such as CQUIN.[4] The inclusion and definition of these indicators can be expected to change over shorter periods, including as part of changes to national reporting requirements, and could therefore be updated throughout the life of the contract.

This list of potential measures would be subject to change as new indicators evolve, or as policy around national reporting on ICP performance develops further.

Note:
Where "Core" is listed in the Service Scope column, this indicator is likely to be applicable to most ICPs.

4 It should be noted that CQUIN indicators listed in the table are taken from the 2017-19 scheme and are included here as examples to show how different measures could be used in combination.

List of 2017/19 CQUIN measures and examples of indicators commissioners might consider including in their ICP contract

Health and Wellbeing				
	Goal	**Indicator**	**Source**	**Service scope**
Tier 1				
H1.1	This indicator measures how successfully the ICP is supporting people with long-term conditions to live as normal a life as possible. This indicator helps people understand whether health-related quality of life is improving over time for the population with long-term conditions.	Health-related quality of life for people with long term conditions	CCG IAF 105d	Core
H1.2	This indicator seeks to capture how successfully the provider is supporting carers to live as normal a life as possible. This indicator helps people understand whether health-related quality of life for carers is improving over time.	Health-related quality of life for carers	CCG IAF 108a	Core
H1.3	This indicator captures gains in life expectancy at birth, which can be attributed to a number of factors, including rising living standards, improved lifestyle and better education, as well as greater access to quality health services.	Healthy life expectancy at birth	PHOF 0.1i	Core
H1.4	This indicator is a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation.	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles in each area	PHOF 0.2iii	Core

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Health and Wellbeing				
	Goal	**Indicator**	**Source**	**Service scope**
Tier 2				
H2.1	This indicator is a measure of whether the provider is effectively identifying and, where required, providing advice and offering referral to specialist services to patients displaying high use of alcohol and tobacco. Preventing ill health via smoking cessation and reductions in alcohol consumption can significantly reduce the burden on the NHS; premature mortality and morbidity; and will help to reduce health inequalities.	Preventing ill health by risky behaviours – alcohol and tobacco	CQUIN 9	Core
H2.2	This indicator aims to support NHS England's commitment to reduce the 15 to 20 year premature mortality in people with severe mental illness and improve their safety through improved assessment, treatment and communication between clinicians by measuring improvements in the identification and managing of physical risk factors for patients with severe mental illness.	Improving physical healthcare to reduce premature mortality in people with serious mental illness	CQUIN 3	MH, GP
Additional measures which could be applied locally				
H2.3	This is a measure of the number of respondents aged 16 and over, with valid responses to questions on physical activity, doing at least 150 "equivalent" minutes of activity each month as physical activity has a significant impact on overall health and well-being along with obesity rates.	Percentage of physically active and inactive adults – active adults	PHOF 2.13	Core
H2.4	This is a measure of smoking during pregnancy, which can cause a range of serious health problems, including placental complications and perinatal mortality and an increased risk of miscarriage, stillbirth, low birth weight, and premature birth.	Maternal smoking at delivery	CCG IAF 101a	Core

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Health and Wellbeing				
	Goal	**Indicator**	**Source**	**Service scope**
Additional measures which could be applied locally				
H2.5	This is a measure of the proportion of children aged 4-5 years classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile. Obesity is associated with increased risk of premature death.	Child excess weight in 4-5 and 10-11 year olds	PHOF 2.06	Core
H2.6	This is a measure of the percentage of working age people who have a long-term condition (includes learning disability and mental health) who are employed, compared to the percentage of all working age people employed. There is strong evidence of a link between employment and good health and wellbeing.	Employment of people with long-term conditions	PHOF 1.8	GP, Community, Mental Health
H2.7	This measure draws on self-reported levels of social contact as an indicator of social isolation for service users and carers. There is a clear link between loneliness and poor mental and physical health.	Proportion of people who use services, and carers, who reported they had as much social contact as they would like	ASCOF 1I (NHS Digital)	Social Care
H2.8	This measure reflects experience of access to information and advice about social care. Information is a core universal service, and a key factor in early intervention and reducing dependency.	Proportion of people and carers using services who find it easy to find information about services	ASCOF 3D (NHS Digital)	Social Care
H2.9	This is a measure of how able patients are to access therapies for common mental health conditions. These can lead to significantimprovements in physical health and overall health and wellbeing.	Increase the proportion of people with a common mental health problem accessing IAPT treatment.	IAPT data set	Core

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Care Quality

	Goal	Indicator	Source	Service scope
Tier 1				
C1.1	This indicator measures the proportion of people who feel supported to manage their long-term condition.	People with a long-term condition feeling supported to manage their condition(s)	CCG IAF 105d	Core
C1.2	This is a measure of premature mortality (under 75 years) that should not occur in the presence of timely and effective healthcare.	Potential years of life lost from causes considered amen-able to healthcare.	PHOF (4.04 to 4.07; 4.09 to 4.10 & 2.19)	Core
C1.3	This is a measure of the culture around safety reporting and how well the provider is able to learn from mistakes.	Fairness and effective-ness of procedures for reporting errors, near misses and incidents	NHS Staff Survey (KF30)	Core
Tier 2				
C2.1	This is a measure incorporating the timely identification and treatment for sepsis and a reduction of clinically inappropriate antibiotic prescription and consumption.	Reducing the impact of serious infections	CQUIN 2	Acute
C2.2	This indicator measures the number of full wound assessments for wounds which have failed to heal after 4 weeks. Failure to complete full assessment can contribute to ineffective treatment which delays the rate of wound healing.	Improving the assessment of wounds	CQUIN 10	Comm, GP
C2.3	This is a measure of people presenting at A&E with mental health needs, who could have these met more effectively through an improved, integrated service, reducing their future attendances at A&E.	Improving services for people with mental health needs who present to A&E	CQUIN 4	Acute, Comm, MH

Care Quality				
	Goal	**Indicator**	**Source**	**Service scope**
Tier 2				
C2.4	There is strong evidence that good staff wellbeing is associated with delivery of high quality care. This indicator measures staff engagement through staff survey results, food supplied on premises and improving flu vaccine uptake.	Improving staff health and wellbeing	CQUIN 1	Core
C2.5	The aim is to identify the groups of people who would benefit most from the delivery of personalised care and support planning and provide this support to them. This measure is about developing effective systems to deliver personalised support.	Personalised care and support planning	CQUIN 11	Comm
C2.6	This measure is constructed so as to encourage greater collaboration between providers spanning the care pathway. The aim is to improve the experience and outcomes for young people as they transition out of children and young people's mental health services.	Transitions out of Children and Young People's Mental Health Services	CQUIN 5	MH, Comm
C2.7	As set out in the NHS Constitution, patients have the right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.	Maximum 18 weeks from referral to treatment - incomplete standard	NHS Constitution	Acute
C2.8	As set out in the NHS Constitution (waiting time pledges), patients can expect to be treated at the right time and according to their clinical priority.	Maximum four hour waits in A&E departments Standard	NHS Constitution (Pledge)	Acute
C2.9	As set out in the NHS Constitution (waiting time pledges), patients can expect to be treated at the right time and according to their clinical priority.	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	NHS Constitution (Pledge)	Acute

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Health and Wellbeing				
	Goal	**Indicator**	**Source**	**Service scope**
Additional measures which could be applied locally				
C2.11	This is a measure of improvement in access to general practice, which is a fundamental component of new care models, as an enabler to a preventative model of care.	GP extended access - % registered patients with full provision	GP Forward View Dashboard	Core
C2.12	This measure reflects whether the proportion of deaths in hospital is reducing. It is common for patients to prefer not to die in a hospital, but this is currently a frequent outcome.	Percentage of deaths which take place in hospital	CCG IAF 105c	Core
C2.13	This is a key measure of early years' development across a wide range of developmental areas. Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life.	Children defined as having reached a good level of development at end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children	PHOF 1.02	Children Services
C2.14	Injuries are a leading cause of hospitalisation and are a major cause of premature mortality for children and young people. They are a source of long-term health issues, including mental health issues related to experience(s) of injury. Inclusion of this indicator is key for cross-sectoral and partnership working, including child protection.	Hospital admissions caused by unintentional and deliberate injuries in children and young people under 25.	PHOF 2.07	Children Services

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Sustainability

	Goal	Indicator	Source	Service scope
Tier 1				
S1.1	This indicator provides an indication of whether hospital bed usage following emergency admission is rising or falling, which will impact sustainability of services.	Population use of hospital beds following emergency admission	CCG IAF 127f	Core
S1.2	The measure provides an indication of whether there is successful co-ordination between hospitals, community and social care services in order to discharge patients.	Delayed transfers of care attributable to the NHS and Social Care per 100,000 population	CCG IAF 127e	Core
S1.3	This indicator provides a measure of acute activity that could be avoided through more effective management of ambulatory care sensitive conditions within the community.	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	CCG IAF 128a	Core
Tier 2				
S2.1	This indicator is a measure of whether patients are enabled to get back to their usual place of residence in a timely and safe way.	Supporting proactive and safe discharge	CQUIN 8	Acute, community, social care
S2.2	This indicator is a measure of whether GP has access to consultant advice prior to referring patients to secondary care, in order to effectively target resources.	Offering Advice and Guidance	CQUIN 6	Acute, GP

NB: In addition to the above measures, we are currently exploring whether we can develop a measure which seeks to measure the proportion of spend on prevention from care service funding, as opposed to treatment.

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Sustainability				
	Goal	**Indicator**	**Source**	**Service scope**
Additional measures which could be applied locally				
S2.5	Where care is provided in the most appropriate setting, the proportion of outpatient attendances resulting from a referral from A&E departments should be minimised.	Proportion of first outpatient attendances from A&E	Hospital Episode Statistics (HES)	Core
S2.6	This is a measure of growth in outpatient attendances from a sustainability perspective. Over the last few years, outpatient usage has grown significantly and this has not always represented best experience for patients or use of resources. It should be noted any increase in outpatient referrals might be clinically driven as result of earlier identification of, and better management of, potential condition(s) at expense of alternatives (which might include increased non-elective activity). Results should therefore be considered in conjunction with 2.7.	First outpatient attendances per registered patient, rolling 3 month growth rate relative to the same 3 month period in the previous year	General Practice Forward View Dash-board	Core
S2.6	High-level changes in local acute hospital comparative spend from unplanned to more planned care treatment and interventions for patients. This metric, and others in the Carter Headline Metrics compartment, focuses on high level data for each Trust to give an overview of activity and provide an indication of potential efficiency, productivity and quality. This will provide an indication of how efficient the Trust is compared with peers, including those within ICP scope. Results should be considered in conjunction with 2.6.	Comparative elective v. non-elective spending in acute Trusts: Carter Headline Metrics are split into three specific sub-compartments covering Trust level headlines, as well as pay and non-pay data.	NHSI Model Hospital	
NB: In addition to the above measures, we are currently working to explore development of an outcome-focussed indicator relating to polypharmacy to improve the effectiveness of prescribing for patients for whom this issue is relevant.				

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Transformation Drivers				
	Goal	**Indicator**	**Source**	**Service scope**
Tier 1				
T1.1	This indicator is a measure of staff engagement, as how well staff are engaged will impact on whether the provider can make successful changes to care delivery models.	The proportion of staff receiving good communication between senior management and staff.	NHS Staff Survey (KF7)	Core
Tier 2				
T2.1	This indicator stresses importance of providers to be part of extensive engagement with STP develop-ment which will include that of ICP.	Engagement with STP amongst providers involved in ICP	CQUIN Part B	Acute, MH, Community
Additional measures which could be applied locally				
T2.2	To demonstrate whether the ICP is contributing to increasing the number of patients with a personal health budget, as this is a key objective of the 5YFV.	Number of personal health budgets in place per 100,000 CCG populations	CCG IAF 105b	Mental Health, Community
T2.3	Designed to assess whether: a) The ICP understands the population's health needs through population segmentation, risk stratification/ case management /predictive modelling and actuarial analysis in accordance with relevant information governance. b) Understanding population's health needs feeds into planning and tailoring services. c) There is a focus on preventative services based on predictive modelling of the population's disease burden.	Planning and tailoring services based on population needs	Local measure	Commissioners
T2.3	Designed to assess ICP success in meeting people's ongoing care needs, particularly in the following: a) MDTs design and deliver shared care plans b) Team competencies are designed around the care needs of the group of people sharing similar characteristics c) MDT uses risk stratification tools and knowledge of registered patients to proactively identify those at greater risk of admission and complications	Multi-disciplinary teams for those with long term, life-limiting conditions	Local measure	GP, Community, Mental Health

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