Sussex Community NHS Trust – Agreed CQUIN Goals for the 2015/16 Contract

Goal No.	Indicator Name	National or Local Indicator	Weighting	Commissioner			
				CWS CCG	HMS CCG	Craw CCG	B&H CCG
1	Mental Health: Dementia and Delirium	National	0.25%	✓	✓	✓	✓
2	Urgent and Emergency Care	National	0.50%	✓	✓	✓	✓
3	Improve Transition Arrangements for Children and Young People transferring to Adult Services	Local – Pan CCG	0.25%	✓	✓	✓	✓
4	Mental Health Screening Matrix Tool	Local – Pan CCG	0.30%	✓	✓	✓	✓
5	Implementation of a Clinical Goal Setting tool (EKOS)	Local – Pan CCG	0.45%	✓	✓	✓	✓
6	Supporting Patients during End of Life Care	Local – CWS CCG	0.75%	✓	×	×	×
7	Supporting Patients during End of Life Care	Local – HMS & Craw CCG	0.75%	×	✓	✓	×
8	Integration – Frailty	Local – B&H CCG	0.75%	×	×	×	✓

Goal name	Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)
Indicator number	1a
Indicator name	Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)
Indicator weighting (% of CQUIN scheme available)	0.15% (60% of 0.25%)
Description of indicator	i. The proportion of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services; ii. The proportion of those identified as potentially having dementia or delirium who are appropriately assessed; iii. The proportion of those identified, assessed and referred for further diagnostic advice in line with local pathways agreed with commissioners, who have a written care plan on discharge which is shared with the patient's GP.
Numerator	i. Numbers of patients over 75 years old admitted or accepted for emergency unplanned care to hospital or community services, who are reported as having: known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question, excluding those for whom the case finding question cannot be completed for clinical reasons (e.g. coma); ii. Numbers of above patients reported as having a diagnostic (clinical) assessment including investigation; iii. Numbers of above patients who have a *plan of care on discharge* that is shared with general practice.
Denominator	i. Numbers of patients over 75 years of age admitted or accepted for emergency unplanned care to hospital or community services, with length of stay >72 hours, excluding those for whom the case finding question cannot be completed for clinic reasons (e.g. coma); ii. Numbers of above patients with a clinical diagnosis of dementia and a new assessment is indicated or who have answered positively on the dementia case finding question; iii. Number of above patients who have an existing/known/already recorded diagnosis of dementia or underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive.
Rationale for inclusion	This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia or delirium during episodes of emergency unplanned care.
Data source	UNIFY2 and local audits

	(i & ii) - Providers must collect and submit data on: • The total number of patients aged 75 and over, admitted or accepted for emergency unplanned care to hospital or community services and stayed more than 72 hours; • Of these, how many a) were asked the dementia case finding question; or b) had a clinical diagnosis of delirium using locally developed protocols in line with NICE Delirium Quality Standards 4 and 5 https://www.nice.org.uk/guidance/qs63/chapter/introduction; or c) had a known diagnosis of dementia; • Of those with a clinical diagnosis of delirium or who answered positively on the dementia case finding question, how many underwent a diagnostic assessment. (iii) - Commissioners must collect and submit data on a provider audit of all the patients notes from each provider (a census), where the patient underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive The commissioner should report aggregated data including all providers on: • the number of patients who underwent a diagnostic assessment for dementia on whom the outcome was either positive or inconclusive (denominator); • the number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners who have a *care plan on discharge* which complies with the criteria set out in this guidance for existing patients and for newly diagnosed (numerator).
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider - (i & ii) Commissioner - (iii)
Frequency of reporting to commissioner	Monthly
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	90%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Community Service Provider to achieve: • 90% or more for parts i & ii of the indicator from the start of Qtr 3: • 90% or more for part iii for the whole of Quarter 4.
Final indicator reporting date	March 2016

Are there rules for any agreed in-year milestones that result in payment	Yes
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Joint development with CCG Commissioners of a revised Plan of Care on Discharge to be shared with General Practice, to include as a minimum: • A diagnosis and READ code; • Current cognitive function and recommendations for re – testing; • A plan to modify/ stop any anti psychotics or sedative drugs (within 3 weeks); • Recommendations for patients with delirium in line with NICE Delirium Quality Standards 4 and 5 https://www.nice.org.uk/guidance/qs63/chapter/introduction • Recommendations for further assessment or onward referral in line with locally agreed care pathways; • A comprehensive communication plan to include all professionals/services involved; • Recommendations for liaison and communication if the usual place of residence is a care home or for carers; • Any further information to enable general practice to update plans of care for existing patients with a diagnosis of dementia;	31 Jul 15	20%
Quarter 2	Not applicable	31 Oct 15	0%
Quarter 3	90% or more for parts i & ii of the indicator at the end of Qtr 3	31 Jan 16	40%
Quarter 4	90% or more for parts i & ii of the indicator at the end of Qtr 4 90% or more for part iii for the whole of Quarter 4	30 Apr 16	40%
		Total	100%

Goal name	Dementia and Delirium - Staff Training
Indicator number	1b
Indicator name	Dementia and Delirium - Staff Training
Indicator weighting (% of CQUIN scheme available)	0.025% (10% of 0.25%)
Description of indicator	To ensure that appropriate dementia training is available to staff through a locally determined training programme.
Numerator	NA
Denominator	NA
Rationale for inclusion	This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia or delirium during episodes of emergency unplanned care.
Data source	Training programme to be determined locally. To ensure that appropriate dementia training is available to all staff. It is recommended that the commissioning and delivery of the training programme is a collaborative effort across the local health and care economy (including care homes).
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly report detailing: • Numbers of staff who have completed the training; • Overall percentage of staff training within each provider.
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	• Target %, agreed at Q1, of all staff identified in training plan trained by 31 March 2016 (target to be in line with Trust target for mandatory training). • Final report on actions taken as identified in Training Plan • Undertake audit of Q2 staff cohort and provide evaluation report on findings
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Achievement of agreed milestone measures.
Final indicator reporting date	April 2016
Are there rules for any agreed in-year milestones that result in payment	Yes – see milestone table below

Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Training Needs Analysis and development of Training Plan for each CCG and agree target %. Audit tool to be developed jointly to assess impact of training.	31 Jul 15	25%
Quarter 2	Roll out of Training Plan interim report to include % of eligible staff that have been trained.	31 Oct 15	25%
Quarter 3	Roll out of Training Plan interim report to include % of eligible staff that have been trained.	31 Jan 16	25%
Quarter 4	Target %, agreed at Q1, of all staff identified in training plan trained by 31 March 2016 (target to be in line with Trust target for mandatory training). • Final report on actions taken as identified in Training Plan • Undertake audit of Q2 staff cohort and provide evaluation report on findings	30 Apr 16	25%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Not applicable	

Goal name	Dementia and Delirium - Supporting Carers
Indicator number	1c
Indicator name	Dementia and Delirium - Supporting Carers
Indicator weighting (% of CQUIN scheme available)	0.075% (30% of 0.25%)
Description of indicator	Ensure carers of people with dementia and delirium feel adequately supported.
Numerator	NA
Denominator	NA
Rationale for inclusion	This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia or delirium during episodes of emergency unplanned care.
Data source	Carer survey
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Biannual
Baseline period/date	Q4 2014/15
Baseline value	NA
Final indicator period/date (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	NA
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Achievement of agreed milestones
Final indicator reporting date	March 2016
Are there rules for any agreed in-year milestones that result in payment	To be agreed locally - No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	To be agreed locally - No

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Carers' Audit/Survey tool to be developed jointly by CCGs and Provider. Audit/Survey cohort numbers to be based on agreed % of baseline value (should include Decliners).	31 Jul 15	20%
Quarter 2	Interim audit/survey report	31 Oct 15	40%
Quarter 3	Not applicable	31 Jan 16	0%
Quarter 4	Final audit/survey report to include evaluation report on carers concerns and remedial Action Plan for improvement as required	30 Apr 16	40%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Not applicable	

Goal name	Urgent and Emergency care 0.5% contract value
Indicator number	2a
Indicator name	Urgent and Emergency Care–Care of Deteriorating patients
Indicator weighting (% of CQUIN scheme available)	B&H CCGs Value for B&H CCG: 20% ; 0.1% contract value
Description of indicator	To ensure that clinical staff working in services that focus on admissions avoidance have the skills and confidence to identify signs of deterioration in patients at an early stage and have the appropriate skill set to maintain these patients safely at home
Numerator	N/A
Denominator	N/A
Rationale for inclusion	To ensure that patients with ambulatory care sensitive and similar conditions that do not normally require admission to a hospital bed receive highly responsive urgent care services outside of hospital. A 2014 audit identified that 40% of zero length of stay admissions and 16% of readmissions to BSUH we avoidable, and that of these 10-20% could have been avoided with community provision.
Data source	Provider Information
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	
Final indicator reporting date	March 2016
Are there rules for any agreed in-year milestones that result in payment	Q2: Identification of staff and development of training programme: 1. Numbers of staff per clinical team/ service to be agreed with each CCG

	2. Content of training programme to be agreed with each CCG Q3:Delivery of training programmes: 1. 80% identified staff to have completed training Q4: Evaluation of training programme 1. 75% of staff report feeling better equipped to identify/ manage deteriorating patients
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes: Q3 targets: 1. 50% payment if 60% staff have received training 2. 75% payment if 70% staff have received training Q4 targets 1. 50% payment if 55% staff feel better equipped to manage 2. 75% payment if 65% staff feel better equipped to manage

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 2	• Agree the staff cohorts to be included for training and evaluation • Develop and agree training plans for o Identification of the deteriorating patient o Identification and management of the deteriorating patient	31 Oct 15	30%
Quarter 3	• Deliver training programmes	31 Jan 16	40%
Quarter 4	• Evaluate training programmes	30 Apr 16	30%
		Total	100%

Goal name	Urgent and Emergency Care
Indicator number	2b
Indicator name	Urgent and Emergency care–Working with SECAMB
Indicator weighting (% of CQUIN scheme available)	B&H CCG Value for B&H CCG: 20%; 0.1% contract value
Description of indicator	To ensure that SECAMB colleagues follow clinical pathways for admissions avoidance by delivering training and raising awareness
Numerator	NA
Denominator	NA
Rationale for inclusion	To ensure that patients with ambulatory care sensitive and similar conditions that do not normally require admission to a hospital bed receive highly responsive urgent care services outside of hospital. A 2014 audit identified that 40% of zero length of stay admissions and 16% of readmissions to BSUH we avoidable, and that of these 10-20% could have been avoided with community provision.
Data source	Training programme to be determined locally. The commissioning and delivery of the training programme is a collaborative effort between SCT and SECAMB
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly report detailing: • Numbers of identified appropriate staff who have completed the training;
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Achievement of agreed milestone measures.
Final indicator reporting date	April 2016
Are there rules for any agreed in-year milestones that result in payment	See milestone table below. Quarter 2 1. Agreement of awareness/training programme with

	SECAMB and CCG (50%) 2. Agreement of teams and numbers of staff to be trained (50%) Quarter 3 1. 50% eligible staff to be trained Quarter 4 1. 80% eligible staff to be trained (50% payment) 2. Submission of evaluation report including remedial action taken if pathways not being followed (50% payment)
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Quarter 3 1. 50% payment if 35% staff trained 2. 75% payment if 40% staff trained Quarter 4 1. 50% payment if 60% staff trained 2. 75% payment if 70% staff trained

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 2	Agree content and methodology for training and awareness raising with CCGs and with SECAMB Agree numbers of staff to be trained	31 Oct 15	30%
Quarter 3	Roll out of Training Plan; interim report to include % of eligible staff who have been trained.	31 Jan 16	40%
Quarter 4	Continue and complete roll out of training plan; final report to include % of eligible staff who have been trained Evaluate training and audit impact on clinical pathways; report to include any remedial action required	30 Apr 16	30%
		Total	100%

Goal name	Urgent and Emergency care
Indicator number	2c
Indicator name	Urgent and Emergency Care–expediting discharge from acute care covering the front door and back door
Indicator weighting (% of CQUIN scheme available)	Brighton and Hove CCG Value for B&H CCG: 20%; 0.1% contract value
Description of indicator	To build on the experience of the SCT community frailty coordinator to target 80 discharges per month. To ensure that pathways are optimised for the speedy and safe discharge of patents from acute to community care.
Numerator	N/A
Denominator	N/A
Rationale for inclusion	To ensure that patients with ambulatory care sensitive and similar conditions that do not normally require admission to a hospital bed receive highly responsive urgent care services outside of hospital. A 2014 audit identified that 40% of zero length of stay admissions and 16% of readmissions to BSUH we avoidable, and that of these 10-20% could have been avoided with community provision.
Data source	Provider Information
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider: manual collection
Frequency of reporting to commissioner	Quarterly
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	
Final indicator reporting date	March 2016
Are there rules for any agreed in-year milestones that result in payment	Q2, Q3 and Q4: 80 patients on average per month identified for discharge

Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes: Q2, Q3 and Q4 targets: 1. 50% payment if 50 patients on average per month identified for discharge 2. 75% payment if 65 patients on average per month identified for discharge

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 2	Identify 80 patients on average per month for discharge, commencing 1/8/15	31 Oct 15	33%
Quarter 3	Identify 80 patients on average per month for discharge.	31 Jan 16	33%
Quarter 4	Identify 80 patients on average per month for discharge.	30 Apr 16	34%
		Total	100%

Goal name	Urgent and Emergency care
Indicator number	2d
Indicator name	Urgent and Emergency Care– Ibis care plans
Indicator weighting (% of CQUIN scheme available)	B&H CCG Value for B&H CCG: 40%; 0.2% contract value
Description of indicator	To ensure that the number of care plans from community services increases so that comprehensive clinical information is available to support patients.
Numerator	N/A
Denominator	N/A
Rationale for inclusion	To ensure that patients with ambulatory care sensitive and similar conditions that do not normally require admission to a hospital bed receive highly responsive urgent care services outside of hospital. A 2014 audit identified that 40% of zero length of stay admissions and 16% of readmissions to BSUH we avoidable, and that of these 10-20% could have been avoided with community provision.
Data source	Provider Information
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	
Final indicator reporting date	March 2016
Are there rules for any agreed in-year milestones that result in payment	Yes; see milestones table below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes: Q3 and Q4 targets: 1. 50% payment if 70% target reached 2. 75% payment if 85% target reached

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 2	Agree base line by measuring the number of care plans on Ibis, including duration of care plans on Ibis, new care plans being added etc Agree the percentage increase for quarter 3 and quarter 4	31 Oct 15	20%
Quarter 3	1. Report increase (20%) 2. Complete audit of quality of sample of care plans in conjunction with SECAMB (20%)	31 Jan 16	40%
Quarter 4	1. Report increase (20%) 2. Develop and implement action plan to improve the quality of care plans in conjunction with SECAMB (20%)	30 Apr 16	40%
		Total	100%

Goal name	Urgent and Emergency care 0.5% contract value across entire CQUIN
Indicator number	2a: 50% of this CQUIN (0.25% contract value)
Indicator name	Urgent and Emergency Care–Care of Deteriorating patients
Indicator weighting (% of CQUIN scheme available)	Coastal West Sussex CCG
Description of indicator	To establish the need for training in the identification, assessment and management of deteriorating patients in the community wards in the Coastal West Sussex locality. The provider will undertake a systematic audit of inpatients to assess the extent of the issue in relation to deteriorating patients. The provider will design the audit by 13 November and agree this with the CCG by 20 November. The audit will be undertaken from 30 November to 18 December 2015. The provider will analyse the results of the audit and present a report with recommended actions to the CCG by 8 January 2016. The action plans resulting from the audit will be agreed with the CCG by 22 January 2016. The provider will commence the implementation of the action pans from 1 February 2016. The provider will issue a progress report by 8 April 2016. The provider will implement any actions identified as being required urgently as soon as these are highlighted NB without waiting until the agreement of the action plan
Numerator	N/A
Denominator	N/A
Rationale for inclusion	To ensure that the community inpatient wards have sufficient skills to identify, assess and manage patients whose condition is deteriorating.
Data source	Provider Information
Frequency of data collection	See milestones below
Organisation responsible for data collection	Provider

Frequency of reporting to commissioner	See milestones below
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	November 2015 to March 2016
Final indicator value (payment threshold)	N/A
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Please see table below
Final indicator reporting date	April 2016
Are there rules for any agreed in-year milestones that result in payment	Yes, please see table below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 3	Agree content of audit and undertake prospective audit during November and December. Present audit findings and recommendations in report	31 January 2016	50%
Quarter 4	Agree action plan Implement action plan Produce progress report	30 April 2016	50%
		Total	100%

Goal name	Urgent and Emergency Care 0.5% contract value across entire CQUIN
Indicator number	2b: 50% of this CQUIN value (0.25% contract value)
Indicator name	Urgent and Emergency care – Care Homes working with SCT through One Call
Indicator weighting (% of CQUIN scheme available)	Coastal West Sussex CCG
Description of indicator	To review referrals received by the provider from care homes and care homes with nursing via One Call to ensure that the most appropriate care is being accessed. The provider will undertake a prospective audit of referrals from care homes to include the reason for referral and the outcome of the referral. This information will be triangulated with information that the CCG will collect over the same period from: • SECAmb: numbers and types of referrals from care homes to ED • WSHT: numbers and types of referrals from care homes and care homes with nursing to ED The provider will analyse the results of its audit alongside information from the CCG relating to SECAmb and WSHT above and will produce an action plan by the end of February 2016
Numerator	NA
Denominator	NA
Rationale for inclusion	To ensure that care homes are referring their patients appropriately and minimising referrals via SECAMB and to A&E as appropriate. To ensure that patients who do not require admission to a hospital bed receive highly responsive urgent care services outside of hospital and are admitted to a hospital bed promptly when this is appropriate
Data source	Provider reports
Frequency of data collection	See milestones below
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	See milestones below
Baseline period/date	Not applicable
Baseline value	Not applicable

Final indicator period/date (on which payment is based)	November 2015 – April 2016
Final indicator value (payment threshold)	N/A
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Achievement of agreed milestone measures.
Final indicator reporting date	April 2016
Are there rules for any agreed in-year milestones that result in payment	See milestone table below.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 3	• Complete a prospective audit of referrals from care homes to One Call from 1 November 2015 to 31 January 2016	29 February 2016	50%
Quarter 4	• Continue and complete audit and produce action plan by the end of February	31 March 2016	50%
		Total	100%

Goal name	Improve Transition Arrangement for Children and Young People transferring to Adult Services
Indicator number	3
Indicator name	Improve Transition Arrangement for Children and Young People transferring to Adult Services
Indicator weighting (% of CQUIN scheme available)	0.25%
Description of indicator	To ensure the smooth transition where required of children and young people with physical, learning disability or a complex health need from children's to adult health care services.
Numerator	Number of children and young people aged 16 years with: - Transitioning Plan - Identified/named SCT lead
Denominator	Total number of 16 year olds in SCT Care with a physical, learning Disability/complex health needs to be prepared for transition into adult health services
Rationale for inclusion	National Best Practice Guidance (Transition: Moving on Well, Dept of Health, Dept for Children Schools & Families 2008 states that young people with complex health needs/ physical disability should have a transition health plan in place. A recent CQC document 'From the pond into the sea' (June 2014) also highlights the need for good transition planning for this cohort.
Data source	Patient Caseload
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	For audit-Q4 14/15
Baseline value	To be confirmed post audit – baseline percentage of all 16 year olds who have a transition plan and a named care-co-ordinator.
Final indicator period/date (on which payment is based)	Quarter 4 2015/16
Final indicator value (payment threshold)	Performance threshold (%) to be agreed when baseline is determined of all 16 years olds who should have a transition plan and named care co-ordinator. Re-Audit to include evaluation of carers views.
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Yes, see table below
Final indicator reporting date	30/04/2016
Are there rules for any agreed in-year milestones that result in payment	Yes, see table below

Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	1. Evaluation of current transitioning planning practice through retrospective audit of Q4 14/15 to establish baseline for improvement. Audit to identify number of 16 year olds under SCT Care with a physical disability/complex health needs, of which how many of these had: • a transitioning plan in place; • a named care co-ordinator; and • a Carer's evaluation. 2. Develop format and content for transitioning plan. Plan should include the identification of a named (case manager) SCT Lead 3. Submit audit report with identified improvement plan for agreement with Commissioners. Improvement plan to include the following as appropriate: • Interface with MCA (2005) • Staff Training • Carers' Engagement.	31/07/2015	25%
Quarter 2	Engage with adult Specialist services Implementation of agreed improved plan Develop and agree Carers' Questionnaire for use in Q4 Interim report on progress against improvement plan	31/10/2015	25%
Quarter 3	Evidence of progress against improvement plan.	31/01/2016	25%
Quarter 4	Case notes audit to measure agreed improvement % of all 16 years olds should have a transition plan and named care co-ordinator: Carers Questionnaire to evaluate carers views on impact of transitioning planning on patient experience Final report on the whole CQUIN	30/04/2016	25%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Not applicable	

Goal name	Mental Health Screening Matrix Tool
Indicator number	4
Indicator name	Mental Health Screening Matrix Tool
Indicator weighting (% of CQUIN scheme available)	0.30%
Description of indicator	Improve Mental Health Assessments in community through the implementation of a Mental Health screening matrix  Mental Health and Wellbeing Screening T
Numerator	n/a
Denominator	n/a
Rationale for inclusion	1. To achieve parity of esteem between physical and mental health service provision 2. To facilitate timely identification of patients with MH concerns 3. Build confidence and ability in assessing and caring for patients with MH under SCT care 4. Provide standard and practical guidance on the appropriate action to take following assessment
Data source	1. Health Records Audit 2. Staff questionnaire 3. Training figures-training records
Frequency of data collection	Quarterly
Organisation responsible for data collection	SCT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	n/a
Baseline value	n/a
Final indicator period/date (on which payment is based)	Qtr 4 2015/16
Final indicator value (payment threshold)	• 90% staff trained and using tool in all services; • Final report outlining achievements in all areas including recommendations moving forward
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	See Qtr 4 milestone in table below
Final indicator reporting date	30/04/2016
Are there rules for any agreed in-year milestones that result in	Yes, see table below

payment	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	• Develop MH screening matrix that supports initial assessment and action triggers(potential RAG rating), such as onward referral, appropriate for the community • identify priority Service areas for each CCG where the MH matrix can be used • Develop Training and Implementation plan for the MH matrix **Evidence:** • Submit MH Screening Matrix, training and implementation plan for agreement with commissioners at the end of Q1	31/07/2015	25%
Quarter 2	• Train staff in identified area • Implement the MH screening matrix into practice • Develop staff questionnaire around confidence around MH screening (agree with Commissioners) **Evidence** to be provided at end of Q2-report detailing • numbers eligible for training and numbers trained • submit staff questionnaire	31/10/2015	25%
Quarter 3	• Continue roll out of MH screening matrix **Evidence** to be provided at end of Q3-report detailing • numbers eligible for training and numbers trained	31/01/2016	25%
Quarter 4	• continue rollout and embedment in practice • report on the staff Questionnaire on Q2 staff cohort • Undertake Health Records Audit **Evidence** • 90% staff identified in Q1 plan that have been trained and using tool in all services; • evidence of embedment in practice (health	30/04/2016	25%

	records audit of 100 records from various areas to include community nursing and UTC) • Final report outlining achievements in all areas including recommendations moving forward		
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Not applicable	

Goal name	Implementation of a Clinical Goal Setting tool (EKOS)
Indicator number	5
Indicator name	Implementation of a Clinical Goal Setting tool (EKOS)
Indicator weighting (% of CQUIN scheme available)	0.45%
Description of indicator	Implementation of outcomes scoring tool to improve quality standards within children's speech and language therapy services across Sussex Community Trust
Numerator	Number of children receiving intervention in SLT who have an EKOS form
Denominator	Number of children receiving intervention in SLT
Rationale for inclusion	CQC and Health Records Standards require a clear care plan to be available. EKOS is a nationally recognised goal setting tool to improve patient outcomes from therapy interventions
Data source	Patient case notes
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	For baseline Q1 15 - 16
Baseline value	TBC
Final indicator period/date (on which payment is based)	Q4 15 - 16
Final indicator value (payment threshold)	90% of children receiving intervention have an EKOS form
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	See table below
Final indicator reporting date	30/04/2016
Are there rules for any agreed in-year milestones that result in payment	Yes, see table below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	1. Baseline sample of 10 cases per SLT • % of cases that have an EKOS form or other type of goal setting form • Agree target % improvement for Q2 to 4 2. Develop Training and Implementation plan	31/07/2015	25%
Quarter 2	• Train staff in identified area • West Sussex: continue to embed into practice and provide evidence of this through audit • Evidence of continued rollout and embedment in into practice 1. repeat sample of 10 cases chosen at random per SLT 2. % increase of cases that have an EKOS form	31/10/2015	25%
Quarter 3	• Train staff in identified area • Commence training with Brighton and Hove staff • Evidence of continued rollout and embedment in into practice • Repeat audit in West Sussex x % increase on baseline	31/01/2016	25%
Quarter 4	• Continue training, roll out and embedment with Brighton and Hove staff • Repeat audit x% increase on baseline for both West Sussex and Brighton and Hove staff • 95% of children in West Sussex to have an EKOS form in place; and • X% (to be agreed after baseline audit in Q1 - TBC) of Brighton and Hove Children • Final report outlining progress against each element of the milestones set out in the whole of this CQUIN.	30/04/2016	25%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Not applicable	

Goal name	Supporting Patients during End of Life Care
Indicator number	6
Indicator name	Supporting Patients during End of Life Care
Indicator weighting (% of CQUIN scheme available)	0.75% -CWS CCG only
Description of indicator	Supporting patients by improving consistent levels of identification of those in the last year of life.
Numerator	• No of patients identified with EOLC needs to have/or have had a universal care plan in place whilst in receipt of SCT care.
Denominator	• No of patients identified with EOLC needs.
Rationale for inclusion	We currently see lower than expected levels of identification of those in the last year of life, and 90% of the local specialist End of Life care services are used by those with a diagnosis of cancer, despite cancer being the cause of 26% of deaths locally. Additionally residents aged 85+ are 10% more likely than the national average to have an acute admission that ends in death. Evidence identifies that locality End of Life care electronic registers (EPaCCS) improve care co-ordination and outcomes and NHS IQ state that by 2015 there should be a 70% roll out of EPaCCS across England. It is well documented that lack of staff confidence and skills has a direct effect on the patient and carer experience. A significant number of complaints around the experience at the EOL relate to poor communication and lack of knowledge can lead to inappropriate hospitalisation in the last year of life.
Data source	Register. Training plan and outcomes of training evidence
Frequency of data collection	Monthly
Organisation responsible for data collection	SCT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	
Baseline value	
Final indicator period/date (on which payment is based)	Qtr 4 2015/16
Final indicator value (payment threshold)	Minimum 90% for each measure below and evidence of increase in the number of people identified with EOLC needs
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied	• No of patients identified with EOLC needs to have/or have had a universal care plan (EOL Plan until this is available) in place whilst in receipt of SCT care.

to commissioner)	• No of staff who have received the following training:
	  • 'care in last days and hours of life';
	  • Sage and Thyme level 1 (communications skills); and
	  • Sage and Thyme level 2 (advanced care planning).

Final indicator reporting date	30/04/2016
Are there rules for any agreed in-year milestones that result in payment	Yes, see table below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes, see table below

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)

Quarter 1	• Undertake training needs analysis and development of a 2 year Training Plan to identify approach to delivery of training and appropriate cohort of staff to be trained. Percentage of identified staff to receive training over year to be agreed with CCG EOLC managerial and clinical leads to include the following training:
	  • 'care in last days and hours of life';
	  • Sage and Thyme level 1 (communications skills); and
	  • Sage and Thyme level 2 (advanced care planning).
	• Active participation in the EOLC redesign project.
		31/07/2015	25%

Quarter 2	• Evidence of rollout of training; • Work together and start to implement into practice the CWS Collaborative EOL model i.e. use of *'check list/ aide memoire'/ adapted SPICT tool* in proactive care MDT's and across SCT -RAIT/ community nursing / therapies teams to systematically identify those who are in the last year of life. • Active participation in the EOLC redesign project.	31/10/2015	25%
Quarter 3	• Evidence of rollout of training and embedment into practice. • Active participation in the roll out of EPaCCS register and start using/transitioning to and sharing the new CWS universal care plan (from existing EOL care plan as appropriate). • Number of people identified with EOLC needs reported in period and entered on the EPaCCS register (when available). • Active participation in the EOLC redesign project.	31/01/2016	25%

Quarter 4	• 90% of patients identified with EOLC needs to have/or have had a universal care plan in place whilst in receipt of SCT care.
	• 90% of staff identified within the training plan who have received the following training:
	  • 'care in last days and hours of life';
	  • Sage and Thyme level 1 (communications skills); and
	  • Sage and Thyme level 2 (advanced care planning).
		30/04/2016	25%

		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
80-89% of all patients identified with EOLC needs to have/or have had a universal care plan in place whilst in receipt of SCT care	50%
Below 80%	0%

Goal name	Supporting Patients during End of Life Care
Indicator number	7
Indicator name	Supporting Patients during End of Life Care
Indicator weighting (% of CQUIN scheme available)	0.75% - HMS & Craw CCG
Description of indicator	Strengthening the early identification of patients in the last year of life, through contributing to a shared platform and ensuring there is an MDT Care Plan in place.
Numerator	• No of patients with an MDT universal care plan in place whilst in receipt of SCT care.
Denominator	• No of patients meeting criteria for EOLC as assessed through the agreed Checklist or SPICT Tool
Rationale for inclusion	The Leadership Alliance for the Care of Dying People (LACDP) in its 'One Chance to Get It Right' recommends the development of personalised care plans and pathways for dealing with EOL care Evidence identifies that locality End of Life care electronic registers or shared platforms improve care co-ordination and outcomes and NHS IQ state that by 2015 there should be a 70% roll out of electronic registers across England. Additionally, it is well documented that lack of staff confidence and skills has a direct effect on the patient and carer experience. There is also evidence of a correlational link between a significant number of complaints around the experience at the EOL relate to poor communication and lack of knowledge and skills amongst staff. This CQUIN therefore aims to ensure compliance with EOLC care planning guidance. The training of staff will also improve the quality of the patient/carer experience through increased staff knowledge and confidence in EOL care in communicating and care plan formulation.
Data source	Risk Stratification tool MDT Meeting Minutes (to evidence collaboration with key stakeholders) Training plan and outcomes of training evidence
Frequency of data collection	Monthly
Organisation responsible for data collection	SCT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	
Baseline value	
Final indicator period/date (on which payment is based)	Qtr 4 2015/16

Final indicator value (payment threshold)	Minimum 90% for each measure below and evidence of increase in the number of people identified with EOLC needs
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	• No of patients identified with EOLC needs to have/or have had a universal care plan in place whilst in receipt of SCT care. • No of staff who have received the agreed training
Final indicator reporting date	30/04/2016
Are there rules for any agreed in-year milestones that result in payment	Yes, see table below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes, see table below

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Work collaboratively with the EOLC programme lead and CCG quality team to • Agree how many SCT teams will be included in this CQUIN work • Engage in already existing EOLC project work within Sussex (led by Coastal CCG) representing the North Sussex CCG population • Share and agree Checklist and care plan content (to be used in Q3) with the EOLC programme lead and CCG quality team from Crawley, Horsham and Mid Sussex CCGs • Provide end of Quarter report detailing achievement of above milestones	31/07/2015	25%
Quarter 2	• Undertake training needs analysis and develop a training plan identifying appropriate courses/modules as well as appropriate cohort of staff to be trained. *Percentage of identified staff to receive training to be agreed with CCG EOLC managerial and clinical leads * as a minimum, training will include the following elements; 'care in the last days and hours of life'; communications skills; and advanced care planning. • Collaboratively establish a shared platform for identifying End Of Life patients using existing processes such as the Proactive Care register • Continued engagement in the EOLC redesign project • Provide end of Quarter Evidence report detailing achievement of above milestones	31/10/2015	25%
Quarter 3	• Evidence of rollout of training and embedment into practice. • Roll out of the use of the agreed 'check list adapted SPICT tool' to identify EOLC patients and populate the register • Engagement with key stakeholders such as Hospices and Primary Care (GPs) via the MDT Meetings to ensure collaboration in formulating care plans. • Ensuring that agreed care plans are populated on the register. • Continued engagement in the EOLC redesign project • Provide end of Quarter Evidence report detailing achievement of above milestones and for this quarter in particular to give an update on the collaborative work with key stakeholders such as	31/01/2016	25%

	Hospices and GPs, minutes of MDT meetings to be included.		
Quarter 4	• Continue rolling out milestones outlined for Q3 • Provide final report on Q4, report should evidence • 90% of patients identified with EOLC needs to have/or have had a universal care plan in place whilst in receipt of SCT care. • 90% of staff identified within the training plan who have received the following training:	30/04/2016	25%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
80-89% of all patients identified with EOLC needs to have/or have had a universal care plan in place whilst in receipt of SCT care	50%
Below 80%	0%

Goal name	Integration - Frailty
Indicator number	8
Indicator name	Integration - Frailty
Indicator weighting (% of CQUIN scheme available)	0.75% (B&H CCG only)
Description of indicator	Supporting the scaling up of the frailty phase one programme and the development and roll out of proactive integrated care. This CQUIN will apply to both SCT and SPFT with the expectation they will work collaboratively and with adult social care and primary care in Brighton and Hove.
Numerator	n/a for components 1 to X X for flu
Denominator	n/a for components 1 to X X for flu
Rationale for inclusion	Partners across Brighton and Hove have signed up to the Better Care vision of a healthy and well population able to care for itself where possible, with joined up services that work together, provided around the whole person with a focus on early intervention and prevention. In response to this, a new model of working has been designed and developed iteratively with front line staff, within a phased approach. The model focuses on working with 2 specific cohorts of patients, those who require support due to their 'Frailty' or those who require support due to the needs resulting from homelessness. To move the programme to its next phase requires an increased focus on case finding, information sharing, and a client centred approach for holistic assessment and care planning. It will require the development and implementation of integrated processes and pathways across SCT, SPFT, adult social care and primary care. This CQUIN aims to support partner organisations to collaborate in the design of services and to identify the internal and external blocks and enablers to integrated working and coordinated care. The CQUIN introduces two key areas where partner organisations must come together to agree and establish cross organisational protocols and processes. Seasonal Flu vaccination uptake has been selected as a specific area to focus on as it provides an opportunity to identify clinical and process issues that need to be addressed as part of developing new ways of working between all organisations. It provides an opportunity for organisations to work together to increase uptake in at risk groups. The second area is establishing Key working arrangements for Multidisciplinary team working. Key working and coordination is important in ensuring good clinical outcomes for frail people, continuity of care throughout all stages of a patient pathway and across settings of care and a positive experience for patients and carers. The process of establishing these processes will provide organisations with an opportunity for joint operational planning, reaching agreement regarding changes in working practice and managing the implementation of change. It is also anticipated both of these areas will inform training and development needs.
Data source	
Frequency of data collection	Quarterly

Organisation responsible for data collection	SCT/SPFT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	Qtr 4 2015/16
Final indicator value (payment threshold)	To be agreed at end Qtr 1
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	
Final indicator reporting date	30/04/2016
Are there rules for any agreed in-year milestones that result in payment	Yes, see milestone table below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Milestones (only complete if the indicator has in-year milestones)

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	• Agreement of CQUIN • Sign up and participation at a senior level from clinical and management staff at all city wide proactive care related meetings (e.g. Integrated Provider Board, IMT/risk stratification group)	31/07/2015	25%
Quarter 2	**Data Sharing/IMT:** • Participation in the Brighton and Hove IMT/risk stratification group and • Provide clinical input to support discussions to ensure correct triggers/risk markers are identified for the patient cohorts. • Identify key service data based on agreed triggers/risk markers that will support case finding via risk stratification tool. • Inform the development of risk indicators and codes sensitive to identify increased risk of ill health, social isolation and loss of independence including for those with complex tripartite needs - homeless and DD. **Workforce:** • Map current staffing and how they align currently to GP cluster arrangements vs. city wide arrangements. Share with commissioners. • **For SPFT** -recruit additional MHHT team resource by 30/09/15 for interim year service. • **For SCT** - identify lead clinician in each cluster to manage	31/10/2015 By provision of quarterly progress report	25%

	MDT process, including preparation for meetings ensuring effective administration, collection of outcomes of meetings and communication with partners including GP practices. Establish and maintain a system to record at a patient level the interventions and pathways agreed at MDT meetings to monitor increased demand and unmet need. Share aggregated/non patient identifying findings with commissioners on a quarterly basis. **Development of joint processes and protocols to enable MDT working/Flu vaccinations:** • Continue to participate in fortnightly MDT meetings. • Contribute to an increase in the uptake of flu vaccinations in Cluster one by working with general practice and ASC to agree how at risk (of flu) clients will be identified and develop mechanisms to increase uptake in this cohort. Develop a plan for maximising flu vaccination uptake for 15/16 in the at risk population in cluster one by working together and identifying: target patients; responsibilities and process for improving uptake, processes and protocols to support inter-organisational working; risk/issues and potential enablers and blocks. • Commissioners to identify baseline and set target based on 14/15 flu vaccine uptake. **Key working:** • Develop draft key working and care coordination protocol identifying role/responsibilities, case holding, escalation and responsiveness. This must also include transfer of key working arrangements, how the key worker will work with acute care for planned and unplanned admissions and case closure arrangements. **Care planning:** • Develop a common suite of care plan tools and protocols, including contingency plans, which can be shared between organisations ensuring quality of care is seamless for the individual. • Establish where the care planning records will be held, for example Share my Care. • Develop and sign cross organisational information sharing protocol to support integrated working for identified patient cohorts that meets organisational IG requirements.		
Quarter 3	**Data Sharing/IMT:** • Participation in the Brighton and Hove IMT/risk stratification group and establish mechanisms for agreed data in Q1 to be made available for risk stratification on a monthly basis. **Homeless** - pilot Inform – milestones and timescales still in development **Workforce:** • Use staff mapping (Q2), JSNA and activity/demand data at a service level to identify gaps in provision. Identify and use patient cohort data where appropriate e.g. homeless. • In collaboration with commissioners draft action plan for	31/01/2016 By provision of quarterly progress report	25%

	how current staffing resources could be aligned to clusters and proposals to address any gaps, including input into any case of change. **SCT: Development of joint processes and protocols to enable MDT working/Flu vaccinations:** • Implement plan developed in Q2 to increase uptake of flu vaccine by x% in cluster one. • **Homeless** - Contribute to the evaluation of the pilot. **Key working:** • Implement key working protocol for all cases discussed at MDTMs. **Care planning:** • Develop Implementation plan for shared care planning processes including patient held contingency plans 31st October. • Implementation begins 1st November to be completed by the end of Q4.		
Quarter 4	**Data Sharing/IMT:** • Participation in the Brighton and Hove IMT/risk stratification group and involvement in programme to shape and test case finding through the risk stratification tool, refining data/markers: **Workforce:** • Working with commissioners finalise action plan and development implementation plan for alignment of staff to clusters vs. city wide arrangement. • Develop a training and development plan to support MDT working aligned to clusters, including person-centred care principles e.g. behavioural change; effective team working. **Integrated Care roll out:** • Full engagement with the roll out of the agreed integrated multi-disciplinary team model to go live in April 2016.	30/04/2016 By provision of quarterly progress report	25%
	SPFT: Dual Diagnosis: Improve performance against national pathway benchmark for following indicators: • Number and % of people in contact with mental health services when they access alcohol services • Number and % of people in contact with mental health services when they access drug misuses service	End of each quarter End of each quarter	
	SPFT: Dual Diagnosis: • Baseline - confirm no of current DD cases within mental health and cross reference with SMS Define pathway and joint work with SMS provider by:	Q2	

	• Number of % shared care plans as a percentage of total care plans for the cohort identified in Q2. • Participation in Hubs review and handover points, consultation and support, monitor, escalation. • Level of joint work quarterly	End of each quarter End of each quarter	

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Not applicable	

Goal name	Establishment of an activity base line for HWLH community services and an associated Data Quality Improvement Plan
Indicator number	1
Indicator name	Activity Base line
Indicator weighting (% of CQUIN scheme available)	100%
Description of indicator	Activity will be reported for each of the community services from contract commencement date. Activity information will be sense checked by senior clinical staff. A confidence rating will be allocated to each service's activity report by the performance analysis team through an analysis of Month 2 reports. Remedial action will be taken as necessary based on conclusions from Month 2 data. This will be developed onto a data quality improvement plan by 29/2/16 Activity for Month 4 will be reviewed in the light of gaps identified and remedial actions put in place at month 2. An action plan will be presented to the CCG based on agreed actions to ensure the final cut of activity is available by 31/10/16
Numerator	N/A
Denominator	N/A
Rationale for inclusion	Activity information for community services in High Weald Lewes Havens has historically been sparse. Conditions precedent within the contract requires the establishment of a first cut activity base line by 31/3/2016 with the final cut established by 31/10/16 Conditions precedent within the contract require a data quality improvement plan to be developed by 29/2/16
Data source	Provider information systems
Frequency of data collection	Outline reports to the CCG from Month 2 data and Month 4 date
Organisation responsible for data collection	SCT

Frequency of reporting to commissioner	End of January 2016 for month 2 data and end of March for month 4 data
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	31/1/16 and 31/3/16
Final indicator value (payment threshold)	N/A
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Please see milestones below
Final indicator reporting date	31/3/16
Are there rules for any agreed in-year milestones that result in payment	Please see milestones below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
31/1/16	A confidence rating will be allocated to each service's activity report by the performance analysis team through an analysis of Month 2 reports. Remedial actions will be determined as necessary based on conclusions from Month 2 data. This information will be presented in a highlight report to the CCG	5/2/16	33%
29/2/16	A data Quality improvement plan will be developed from the above for discussion with the CCG	29/2/16	34%
31/3/16	An action plan will be presented to the CCG	8/4/16	33%

	based on agreed actions to ensure the final cut of activity is available by 31/10/16		
		Total	100%