Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

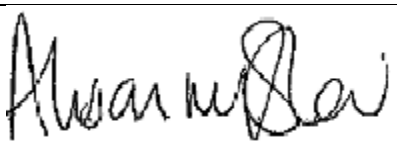
CONTENTS

1) PLAN DETAILS

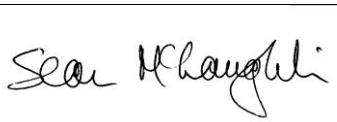
a) Summary of Plan

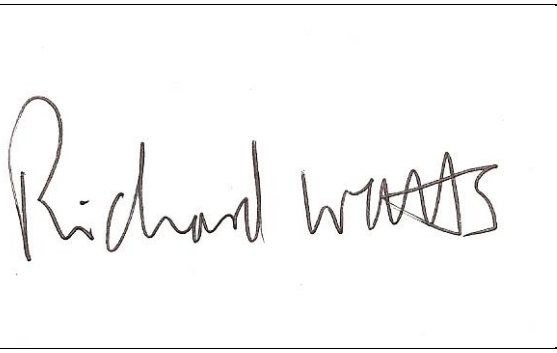
Local Authority	Islington
Clinical Commissioning Groups	Islington CCG
Boundary Differences	Co-terminus
Date agreed at Health and Well-Being Board:	19 September 2014
Date submitted:	19 September 2014
Minimum required value of BCF pooled budget: 2014/15	£5,894,000.00
2015/16	£18,390,000.00
Total agreed value of pooled budget: 2014/15	£5,894,000.00
2015/16	£18,390,000.00

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Alison Blair
Position	Chief Officer
Date	19 September 2014

Signed on behalf of the Council	

	
By	Sean McLaughlin
Position	Corporate Director Housing and Adult Social Services
Date	19 September 2014

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Richard Watts
Date	19 September 2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Islington Joint Strategic Needs Assessment	Sets out the needs of the local population. http://www.islingtonccg.nhs.uk/about-us/jsna
Islington Joint Health and Wellbeing Strategy	Islington's joint strategy to improve health and wellbeing outcomes for our local population. http://www.islington.gov.uk/publicrecords/library/Public-health/Business-planning/Strategies/2012-2013/(2013-03-01)-Joint-Health-and-Wellbeing-Strategy-2013-2016.pdf
Adult Joint Commissioning Strategy	Islington's Joint Commissioning Strategy setting out the strategic direction from 2012-2017 http://www.islington.gov.uk/services/social-care-health/contacts-news-feedback/Pages/Joint-Commissioning-Strategy-Consultation.aspx
Islington Primary Care	Islington's Primary Care Strategy focuses on driving up

Strategy	the quality of primary care to meet the health needs of the population. It looks at making real improvements in: • GP services – working with the primary care teams • Dental services – general dental practitioners and community dentistry • Community Pharmacy Services – local pharmacists • Optometry Services – local opticians. http://www.islingtonccg.nhs.uk/about-us/strategies/primary-care-strategy.htm
Islington Urgent Care Strategy	This refreshed Urgent Care Strategy again aims to continue to improve urgent care provision from hospital emergency and ambulance services, but also strengthen patient access to urgent care from primary and community services. http://www.islingtonccg.nhs.uk/about-us/strategies/urgent-care-strategy.htm
Islington Care Closer to Home Strategy	The Care Closer to Home Strategy demonstrates the group's holistic approach to achieving this vision through integrated care commissioning. The strategy will support areas where care closer to home initiatives have already been implemented and areas identified for further opportunities. http://www.islingtonccg.nhs.uk/about-us/strategies/care-closer-to-home.htm
National Collaboration for Integrated Care and Support (May 2013) "Integrated Care and Support: Our Shared Commitment"	Presents a shared vision for integrated care and support to become the norm over the next five years. https://www.gov.uk/government/publications/integrated-care
"The NHS belongs to the People: A Call to Action" NHS E (July 2013)	Sets out the challenges facing the NHS and sets out that the NHS needs to change to meet that challenge. http://www.england.nhs.uk/2013/07/11/call-to-action/

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our vision for the Integrated Care Pioneer has underpinned our submission for the Better Care Fund. That is:

"To deliver a step change improvement in health and social care outcomes for our population, by taking a whole system approach to service planning and delivery and supporting the population to better manage their health through mobilising their own abilities and the assets of the community."

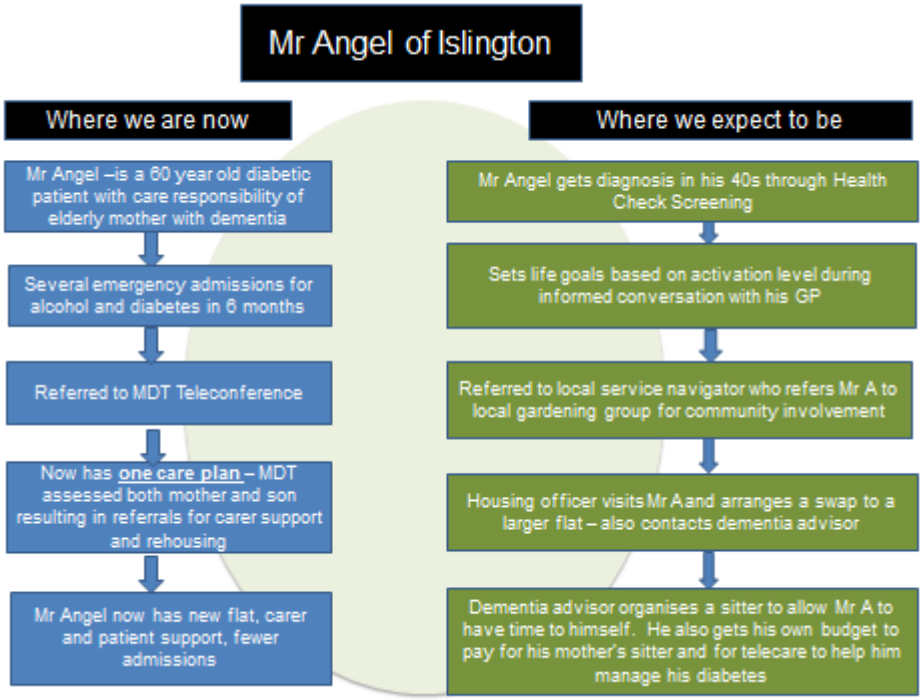
Over the next five years we expect to have a health and social care offer that provides access to care at the right time, in the right place, in a co-ordinated and personalised way. Systems will be stream-lined, with pathways that reduce duplication, avoid unnecessary hospital admission and act swiftly to get people home and re-abled after illness. We also expect people to have a better experience of care and to feel like they have been given the information and advice they need to be informed of their condition and better able to manage by themselves or for those for whom they care

We have identified the key ingredients of our transformed service offer as:

- An offer of **early intervention and prevention** for the whole population
- Health and care systems and pathways that are **co-produced** with patients and users
- Strong **clinical leadership** shaping and supporting change
- Hospitals that **plan and support discharge** from the first day of admission
- Better access to voluntary and community based services through **better information and advice**
- **Joined up care** delivered through **four localities** based around GP practices
- Better **identification and co-ordination** of patients/users at **high risk** of hospital admission
- A programme of **supported self-management** for children and adults with long term conditions
- More personalised service offers through the roll out of **personal health budgets** and increasing numbers of those who opt for a **personal budget**
- Services that are more easily understood and accessed through **single point of access, single assessment processes** and **7 day services**
- Better alignment of physical and mental health services
- A **skilled workforce** that delivers care with dignity and compassion, is motivated to make a difference and is rewarded for its efforts
- **IT systems** that support joined up care by becoming interoperable
- **Patient held** records

The experience of Mr Angel of Islington set out below demonstrates how we wish to

transform and improve care for our residents.



We have developed this vision for health and social care through listening to what patients and users have told us. They have said they want to be listened to and heard, to be treated as a whole person and for professionals to understand how disempowering being ill is. They want their care to be co-ordinated with better access to healthcare through social services and vice versa and they want to be supported to help them-selves. We have also heard how people don't always have positive experiences of our care services; that they can be confused by who is doing what and that care isn't always delivered in a way that shows compassion and maintains dignity. In addition to this we have worked with over 250 patients to develop our own set of "I statements" and have used these as a basis of our Pioneer programme.
We have also taken note of wider partnership strategies, in particular the Joint Health and Wellbeing Strategy which has four priorities:

- Ensuring every child has the best start in life,
- Preventing and managing long term conditions to extend both length and quality of life and reduce health inequalities,
- Improving mental health and wellbeing, and
- Delivering high quality, efficient services within the resources available

These were developed in response to the needs identified within the JSNA.

Our JSNA is now an online, public-facing interactive web-based resource called the

Evidence Hub, allowing us to share more timely and accessible information about Islington's needs[1]. We have looked at our population to understand the health and care needs so that we can prioritise resource to make greatest impact.

Islington is the 5th most deprived borough in London and the most densely populated borough in England. There is an unusual spatial distribution of affluence and poverty with rich and poor living cheek-by-jowl. The high level of deprivation is reflected in substantial inequalities in health and outcomes. In addition Islington also has high rates of social housing (nearly 50% of housing stock) and large numbers of single households.

Life expectancy has increased over time in Islington, but it remains low compared to other London boroughs and the country as a whole. Men in Islington have the lowest life expectancy in London, and women one of the lowest. Many other London boroughs with similar levels of deprivation have managed to successfully reduce the gap in life expectancy between their local area and the national average, but in Islington the gap has not closed. The key cause of the inequalities gap in life expectancy between Islington and England is premature or early death, particularly amongst men living with long-term conditions such as cardiovascular disease, cancer and chronic obstructive pulmonary disease. Nearly half of all deaths in the borough are in people under the age of 75.

Our programme of work is focusing on integrating long term condition pathways as well as improving physical health outcomes for vulnerable residents and those with mental health conditions and providing a more co-ordinated approach to those with complex needs. The programme of work looks beyond health, and focuses on promoting health, wellbeing and independence through the delivery of programmes that address the wider determinants of health (such as safe housing, sufficient income and social contact) and contributes towards preventing emergency admissions. A focus on supported self-management and personalising services will further strengthen the community response to long term condition management.

Islington has a long history of joint working and already has over £60m invested in pooled budgets across adult and children's services. We welcome the Better Care Fund as an enabler to our work and to quicken the pace of change.

We want to see an improvement, not only in the outcomes of care but crucially in the experience of care that is received and perceived by our residents.

Our plan mirrors the intention of the Integrated Care Programme in that it will support health and care integration across children's and adults.

b) What difference will this make to patient and service user outcomes?

Through our joint efforts we want to see a population that has a better experience of health and social care services, feels more involved in decision making and is

[1] http://evidencehub.islington.gov.uk/Pages/HomePage.aspx

supported to manage their own care better.

We want to see a continued improvement in key metrics that measure health inequalities so that we know care is reaching all those that need it.

We also want:

- Improved reported quality of life for both carers and those who use social care services
- Improved patient reported outcomes and improvement in patient experience measures
- A reduction in long term admissions to care homes
- A reduction in preventable emergency admissions
- An increase in the proportion of older people at home 91 days after discharge from hospital
- Improved physical health outcomes for adults with a mental health diagnosis
- Retention of our excellent track record in delayed transfers of care
- Fewer hospital readmissions within 30 days
- Improved mortality from preventable causes
- Improved take up of NHS health checks, particularly by those with mental illness and learning disabilities
- Increase in the uptake of personal budgets across health and social care
- Improved physical outcome measures which indicate a more "joined up" system including fewer falls, fewer pressure ulcers and improved flu, pneumococcal and shingles vaccination rates

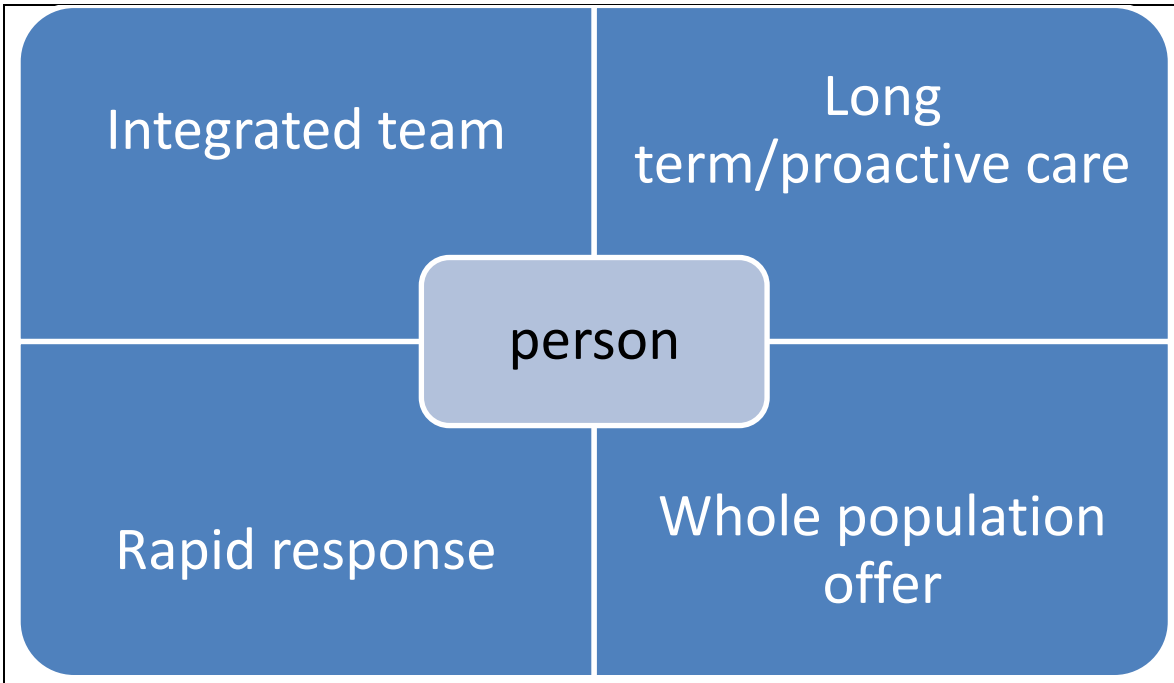
c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Although we already have integrated services in a number of areas including intermediate care, adult mental health and stroke discharge as well as a carer offer across health and care we know that residents don't always receive care that is joined up and delivers the best outcome.

Much work is already underway to make improvement and the BCF provides an opportunity to accelerate the pace through investment. To focus the BCF we have agreed a number of priorities:

1. **The development of a locality offer across community, social care and mental health services to support primary care capacity**

Our locality offer is the lynchpin to our integrated care programme and the BCF will mean that we can pump prime investment to support change. It describes at a high level how community based health and care services are structured within each of the four Islington localities. It has four components:



- Integrated Teams
  Locality based, multi-disciplinary teams, structured around primary care, who provide co-ordinated care to those with the highest level of need.

- Long term and proactive care
  Ongoing case management and care for patients not held by the MDT ("business as usual") This will include social care clients who are stable but have long term care needs, patients who are stable yet have regular community nursing visits as well as patients who are supported by primary care but are stable.

- Rapid response
  A borough wide rapid response service to the whole population, with close links to the two approaches above

- Whole population offer
  Supporting population wide health improvement by mobilising local assets focussing on early support and prevention

By redesigning community services to deliver **joined up care** around **four localities**, aligned to GP practices our aim is to be able to **identify and coordinate care** for users at risk of hospital admission.

We want to streamline access and develop **seven day services** that are more efficient and free up capacity. We also see that by working differently we can transform communication and relationships between GPs and specialists. This would support provision of comprehensive disease management and preventive services to our population. We are likely to see some co-location of health and social care professionals to support more co-ordinated ways of working and opportunities for other partners such as housing and the voluntary sector to have space in which

to operate.

Staff within the integrated health and care teams will also be trusted to undertake a broader range of **assessments** on behalf of others and will be able to mobilise care packages when people need support to remain at home. Intrinsic to all care will be the ethos of **supported self-care** and **personalisation** so that users and patients can participate in planning their own care.

2. **Enhancing primary care capacity**

Primary care will have developed new ways of working that is able to meet demand in a planned way, with opportunities for proactively planning and managing of care particularly for those with higher needs and long term conditions. Working within MDT's they will be able to support healthier communities through signposting to non-traditional services in the voluntary sector. This will support the **prevention** function where we want to see better integration of our preventative offer and more proactive care, ensuring multiple risk factors can be addressed following a single interaction with a resident.

Our new offer is likely to mean that acute hospital provision reduces over time as care is provided in different settings and seven day access to primary and social care becomes available

3. **IT and inter-operability to ensure patient information can be shared across integrated services and along care pathways**

A fundamental enabler for improved joint working is the development of IT systems that are **inter-operable** so that clinicians and others can view and input information in "real time". Specialist services will remain borough wide but all health and social care professionals will be able to access information about patients and users more easily within an ethos of holistic, compassionate care co-ordinated around the individual rather than reliant on current structures and professional boundaries. We are working at a national and local level to develop IT systems that are inter-operable, this will be supported explicitly by the BCF. Similarly we are working to develop a **patient held integrated digital care record** so that patients and users can have better access to information. Service developments already in place include DOCMAN for electronic transfer of referrals and discharge letters, GP portals at UCLH and Whittington Health to allow GP's to view test results, Adaptor pilot at Islington Council to allow referrals to be sent between social care and health (Whittington and UCLH) and Medically Interoperable Gateways to allow UCLH and Whittington Health to view primary care records.

4. **To meet demographic pressures in social care, and across health and care services for older people and people with learning disabilities**

Islington has a high and increasing number of people living with learning disabilities. The needs of this group are planned for and funded via a S75 pooled budget between Islington CCG and the Council. There has been an increase in the numbers of people with a learning disability who meet NHS continuing healthcare criteria with a £1m pressure on the pooled budget. The BCF is being used to

support this demand.

There is also a lesser, but still substantial demographic demand for the care and support of older people. Again, this has also led to an increased pressure on continuing healthcare budgets which are there being supported by the BCF.

5. **To maintain social care eligibility**

Islington is proud of its history in protecting social care for those who need it and maintaining eligibility levels to ensure those with moderate needs and above are supported to live independently at home.

Demand is rising at a time of unprecedented budget pressure and work is being undertaken in partnership with the CCG, local NHS Trusts and the voluntary sector to ensure that adult social care services can be successfully sustained in Islington. This builds on existing initiatives to support pooled budgets that bring greater flexibility across health and care for new ways of working.

6. **To incentivise providers to support integrated care**

The Whittington, as the main provider of community services in the borough will have transferred staff and resource from the hospital into a broader offer of community provision with higher numbers of community and specialist nurses and therapists able to care for people at home. Consultants will be accessible to patients in new ways through an increased use of technology and will be outward facing providing support to primary and community colleagues. This has already started in the frail older people's pathway with a newly commissioned community geriatrician service that is providing clinical support, advice and assessment to patients and professionals in the community.

Services will be designed to work proactively with patients and users able to mobilise quickly to avoid unnecessary emergency attendance at hospital and to reduce hospital admission. That means joint teams will work at the front line and in services like A&E to be able to put packages of care in place for people to avoid deterioration in condition or hospital admission. We will also have a renewed focus on **planning and supporting discharge from the first day of admission** through the primary care discharge arrangements. The rapid response function is being built up with the use of the BCF and additional nurse capacity to support discharge to primary care is also being funded explicitly through BCF.

Mental health professionals too will work more actively to support primary care in managing people's physical health needs and we want to see a reduction in health inequalities across the population as those that find it harder to access the right care are supported to do so. We have already made an investment in 2014/15 contracts with Camden and Islington Foundation Trust to deliver a new offer from mental health professionals into primary care. The intention is that these will form part of the integrated health and care teams that are due to be piloted from September 2014.

We also want to see a higher uptake of NHS Health Checks by people with learning

disabilities so have commissioned a liaison nurse to support primary care – this work will be complemented through the development of individual health action plans.

Finally, access to information will be more streamlined with fewer telephone numbers and skilled staff able to triage and sign post effectively.

We believe our track record in delivery puts us in a strong position to succeed with this scale of change. We are London leaders in delayed transfers of care, national leaders in dementia diagnosis and our projects have already led to a reduction in COPD admissions and a decrease in the life expectancy gap for CHD.

We worked with the Whittington to develop an ambulatory care pathway as part of their 30 day readmissions programme and the pathway is now being designed to come out into the community to link with the hospital at home initiatives.

Similarly, we have commissioned CIFT to provide the “RAID” model in the Whittington as part of our investment programme and this is already improving the quality of response to adults with mental health problems, having around 200 referrals per month. RAID are co-located in the emergency department and are seeing patients within 60 minutes of referral. In addition they are supporting early discharge through identifying patients at ward rounds.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Although Islington has a reputation as a wealthy borough with some of the highest house prices in the country it is a borough of contrasts, with rich and poor living side by side.

It is in fact the 5th most deprived borough in London and 14th most deprived in England, leading to some poor health outcomes for our population, for example,

- 28,000 people in Islington (13% of the population) are living with 1 or more long-term conditions
- More than 30,000 adults experiencing some form of mental health problem
- 7-year gap in life expectancy between men in the highest income group and those in the lowest income group
- 10% gap in attainment between the most affluent and least affluent children by the time they leave primary school
- 22% of people living in areas with high levels of social housing have a long-term condition compared to 9% of people living in areas with low levels of social housing
- The highest incidence of people with psychotic disorders in England
- Highest rates of male suicide and alcoholic mortality in London
- One of the highest levels of child poverty in the country

What we know from our analysis from the Evidence Hub that has driven our case for change is:

1. **Our population of older people is growing and becoming more diverse.**

Greater London Authority population projections show that in the next 10 years there will be a 10% increase in those aged 65 and a 23% increase in those aged 85 years and older. The aging of the population in Islington over the next 10 years will lead to a growing number of people living with long-term conditions including dementia and mental health, **indicating an increasing need for health and care services to identify and manage these conditions earlier and more effectively**.

Age group	2014	2024	Change (2014 to 2024)	% Change (2014 to 2024)
65 - 74	10400	11100	700	6%
75 - 84	6100	6800	700	10%
85+	2300	3000	700	23%
65+	18800	20900	2100	10%

We think that by providing a **locality offer (BCF1 and BCF2)** we will be able to identify and manage conditions earlier, co-ordinate care to deliver better outcomes and that through supporting self-management programmes we can give our residents the tools to manage their conditions more successfully.

2. **We have high rates of A&E attendances**

Although Islington has a relatively young population, the demand for and use of health services by the 85+ population is significant. Islington has the fifth highest rate of A&E attendances and the seventh highest rate of emergency admissions in London. The rate of emergency admissions is greater than the London and England averages and has increased over time (a 14% increase between 2009/10 and 2010/11). Overall, 17% of A&E attendances lead to a hospital admission, but this rate increases to over 60% for people aged 85+. In addition, people aged 85+ are more likely to present at A&E multiple times, thus highlighting the high usage of A&E services and acute hospital beds amongst this population group.

In the 85+ population, the main reasons for emergency admissions were external causes (including accidents), circulatory diseases, respiratory diseases and genitourinary diseases (such as urinary tract infections). In the 85+ group, admissions for “flu and pneumonia” ended in significantly more “in hospital” deaths than other diagnosis groups (24%).

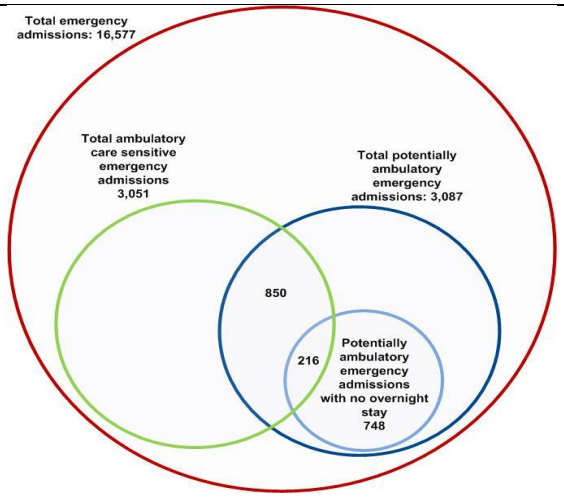
The percentage of people attending A&E three or more times in a year varies, ranging from 1% in people aged 30-39 to 9% in people aged 85 years and over. People aged 80 years and over have the highest percentage of people attending more than once (46%), while children aged 5-9 have the lowest (26%).

We have some schemes in place already that are aimed at reducing A&E attendances for older people, for example, our community geriatrician service and CareLink that provides rapid response reablement services to support discharge. In addition though the new **Integrated Rapid Response function (BCF2)** should provide timely clinical assessment and treatment, including rapid access to domiciliary care to prevent A&E attendance.

3. **The percentage of attendances leading to hospital admissions increases with age with almost 70% of attendances in people aged 85 years and over leading to admission**

Young and middle aged adults (aged 15-59) have the highest percentages of A&E attendances where the patient left without treatment whereas older people are more likely to be admitted. The top 3 primary reasons for emergency admissions are external causes, respiratory disease and diseases of the digestive system

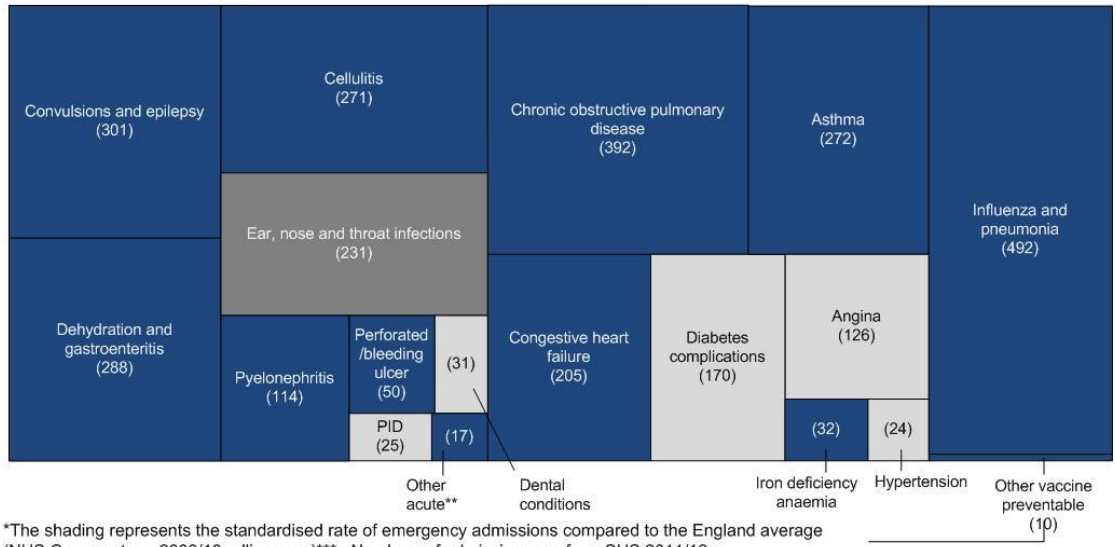
Of the total emergency admissions in 2011/12 approximately 36% were for ambulatory care sensitive conditions or potentially ambulatory admissions.



Ambulatory conditions are those conditions for which emergency hospital admissions in adults may be avoidable by effective management in primary care. In Islington respiratory diseases account for the largest proportion of ACS conditions.

The following chart shows the relative amounts of ACS admissions. The larger the box, the more admissions. Dark blue boxes indicate a higher rate of admissions against the England average.

ACS emergency admissions by primary diagnosis, Islington responsible population*



*The shading represents the standardised rate of emergency admissions compared to the England average (NHS Comparators, 2009/10 rolling year)***. Numbers of admissions are from SUS 2011/12

Lower No different Higher

**Gangrene and nutritional deficiencies

***National ACS admission rates currently unavailable from NHS Comparators

Source: Islington Emergency Admissions profiles
Source: http://evidencehub.islington.gov.uk/wellbeing/Healthsettings/HO/EA/Pages/default.aspx

Developments already underway to reduce hospital admission include the Ambulatory Care Service at the Whittington and RAID. However, an integrated approach developed within the locality (BCF01 and BCF02) as well as work with

primary care and others to improve access (**BCF5)** and delivering more specialist services in the community eg IV at home (**BCF4**) will support our approach.

4. People are living with multiple long term conditions

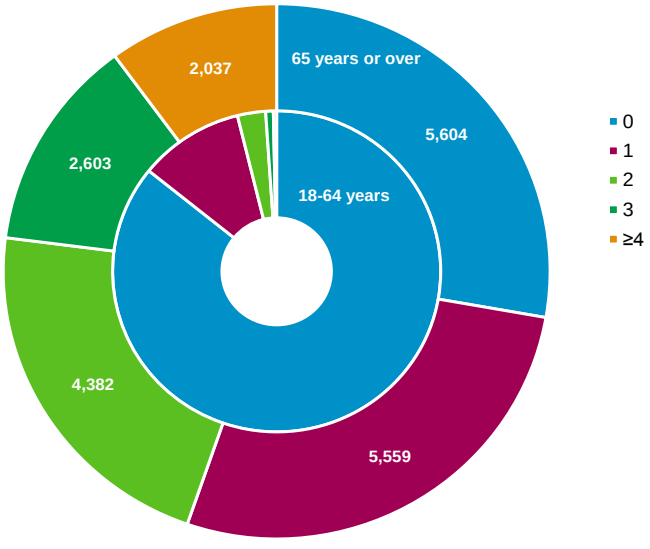
Around one in six adults in Islington has at least one diagnosed **long-term condition.**
Overall, a third of adults with long-term conditions in Islington are living with multiple conditions and at relatively young ages. This highlights the need for planned and integrated care for people with multiple conditions to achieve optimal health outcomes.

However, it should also be noted that a large proportion of the illness associated with long-term conditions occurs in older people (those aged 75 and over). The most prevalent condition is high blood pressure followed by type 2 diabetes, chronic depression, psychotic disorders, cancer, coronary heart disease and chronic obstructive pulmonary disease.

People with mental health problems or learning disabilities have a higher prevalence of long-term conditions which highlights the need to ensure equitable access to services according to need, right across the patient pathway, from prevention through to end of life care.

It can also be expected that there will be an increase in the number of people living with multiple long term conditions including dementia and mental health. The number of conditions a patient has can be a greater determinant of a patient's use of health services than the actual condition**.**

Number of diagnosed long term conditions in people aged 65 and over, Islington's registered population, September 2012



Source: Islington's GP PH dataset, 2012

Pathway review for long term conditions has already reaped benefits in areas such as COPD where Islington has seen a reduction in acute admissions. The intention to commission the diabetes pathway differently and based on outcomes is designed to support care delivery that is bespoke to the individual rather than "one size fits all".

As it is an innovative solution to pathway redesign we are keen to support acute hospitals to work differently on this **(BCF10).**

5. **Mental health and dementia are prevalent amongst the local population**

In 2011 there were over 3,000 people diagnosed with serious mental illness in Islington. People diagnosed with a serious mental illness have a significantly higher prevalence of all long term conditions.

There are more than 28,000 people living in Islington with depression, anxiety or both and 1 in 3 people with depression have another long term (physical) condition, compared to 1 in 10 of the general population.

There are significant variations in diagnosed prevalence between practices in Islington as well as in referrals to IAPT services and recording of key risk factors. This is a focus for primary care development and improvement in the borough.

Depression-related admissions

- There were 81 admissions for depression in 2011/12 among Islington's responsible population. In addition, there were another 1,186 admissions where depression was one of the secondary reasons for admission
- Hospital admissions for depression-related reasons include over 40 patients with multiple (3 or more) admissions in a year. The largest reason for admission is due to poisoning and other external causes: these patients are likely to be at significantly increased risk of suicide, which remains an important cause of premature deaths in the borough, and require close and timely follow-up and support to help reduce risk

Source: Islington Depression and anxiety profile, 2012

Dementia diagnosis rates are high compared to London averages but the impact of dementia is high

- In 2011, there were approximately 750 people recorded with a diagnosis of dementia amongst Islington practices
- Islington's crude diagnosed prevalence (0.37%) is significantly lower than the London average (0.32%)
- Statistical modelling of the expected number of dementia cases indicates that over 70% of the expected numbers of cases of dementia have been diagnosed in Islington; above the London and England averages (44%).
- People with dementia have a higher proportion of comorbidities compared to Islington's general population over the age of 65. Of those with dementia, 84% have more than one long term condition compared to 60% of the total population aged 65 and over, while 14% have five or more long term conditions compared to 4% in the older population.

Source: Islington Dementia Profile, June 2012

The mental health offer within the Locality model **(BCF1**) is designed to provide much more support to primary care to build capacity, provide swift access to

specialist advice and to case management at a local level with MDT input.

Finally, because of our poor health outcomes and high health inequalities preventing problems from occurring in the first place and then ensuring early intervention when they do, is important in not only managing and reducing the rates of A&E attendances and emergency admissions, but for promoting and maintaining good health and wellbeing and a sense of self-empowerment and independence. Ensuring prevention occurs, according to need and throughout a person's life course, will also help reduce health inequalities in Islington. **(BCF9**)

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

As an Integrated Care Pioneer, much of the work set out within the Better Care Fund is under way, and builds on a well-established history of integration in Islington. Integration efforts in Islington are spread throughout providers and commissioners.

Detail around milestones are set out in the individual scheme descriptors, but April 2015 sees delivery of several key parts of the plan;

- Implementation of Integrated Health and Care Teams
- Implementation of Integrated Rapid Response Teams
- Transformation of Adult Social Care
- Improving Access to Primary Care

Projects are developed using a local project management structure with clinical leadership. Key milestones include:

2014/15

- Cohort for co-ordinated care agreed
- Test and learn integrated health and care teams
- Evaluation of MDT teleconferences
- Project teams developing commissioning options for rapid response and supported discharge
- Sign off IT strategy by Governing Body
- Development of business case and specification for IT inter-operability
- Consultation for new social care configuration
- Launch of workforce plan and listening events to develop new ways of working
- Development of new initiatives with primary care to support access
- Roll out of Patient Activation Measures, building on House of Care model of practice

2015/16

- Stage two of locality development – roll out of integrated health and care

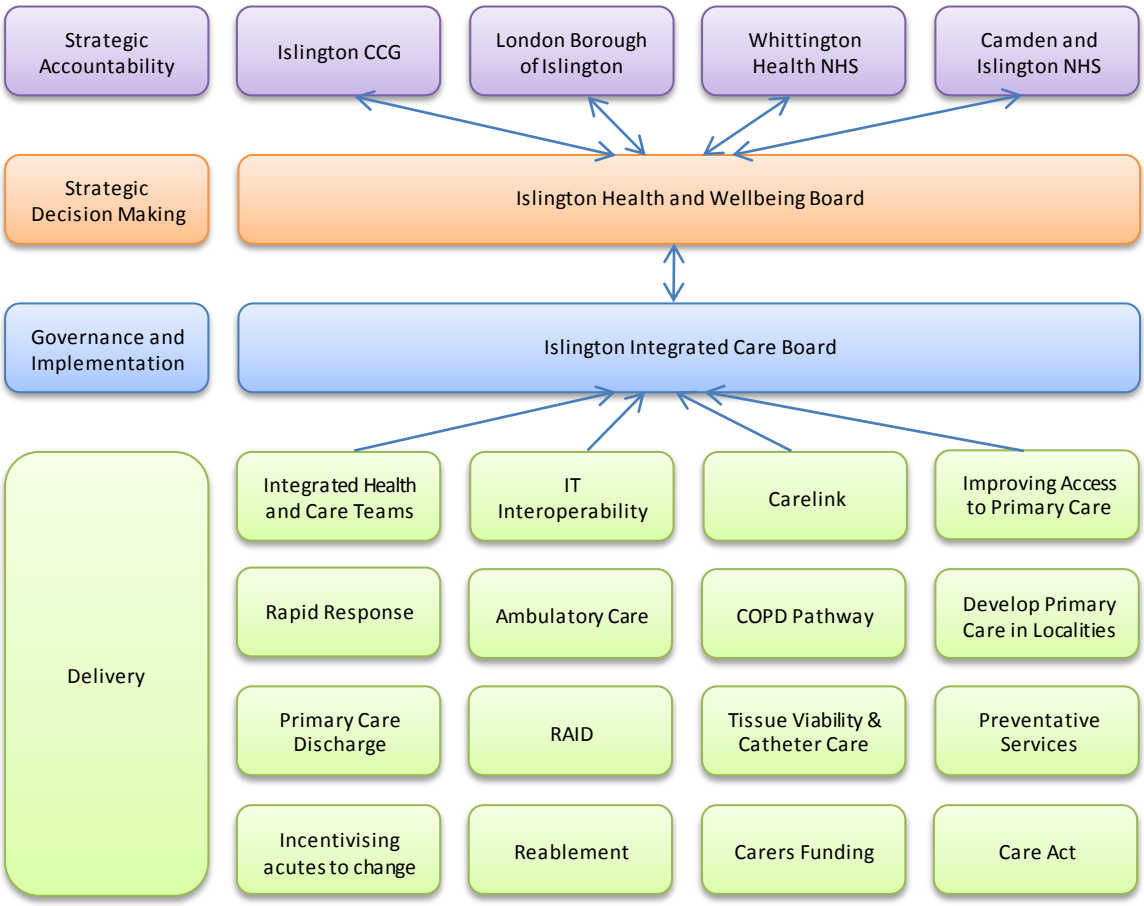
teams
- New adult social care model implemented
- New information and advice offer across care and health
- Mobilise IT
- Rapid response function streamlined
- Move towards greater collaboration in primary care
- Value based commissioning running in shadow form for diabetes and mental health pathways

b) Please articulate the overarching governance arrangements for integrated care locally

Islington's integrated care programme is supported by a Board that is made up of representatives from the Council, the CCG, provider organisations, patients/users and the voluntary sector, including Healthwatch. The Board is chaired by a GP and Vice Chair of the CCG. This Board oversees the programmes of work within the Integrated Care Pioneer and holds work stream leads to account through that.

A Programme Director for Integrated Care, a joint appointment between the Council and the CCG leads on the programme management function across a range of local integration schemes. Operational Groups for individual Integration/BCF schemes report to the Integrated Care Board providing a level for resolving operational issues and a clear escalation route. Plans developed as part of the Better Care Fund will fall under this Board.

The Health and Wellbeing Board is the strategic decision maker for the local health and care economy and as such receives annual reports on the programme. Annual reports on the Section 75 arrangements go to the CCG Governing Body and the Council's Executive. The diagram below illustrates local arrangements;



c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The CCG and Council already have joint commissioning arrangements and these will support the operational delivery of the BCF plan.

The Integrated Care Board has representation from the CCG and the Council and this will drive the projects through:

- Assessing project performance through highlight and exception reports
- managing delivery by exception
- Producing a report for Health and Wellbeing Board Programme on status, immediate challenges and accountable actions.

Each project team will report against project impact and elements that are off track via the bi-monthly Highlight Report.

A standardised bi-monthly highlight report will be developed for each project team to track delivery:

Activity: Outturns to underlying Direction of Travel and patient impact for all key metrics
Quality: Resident feedback included PROMS, user and carer QOL measures, feedback from Making it Real Board
Finance: In addition, finance is tracked through the QIPP programme with monthly reporting arrangements before bi- monthly Board
Risk: Risk review to Board

In addition workstream leads attend a bi-monthly meeting with the Programme Director to go through the detail of progress within projects.

d) List of planned BCF schemes

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the Detailed Scheme Description template (Annex 1) for each of these schemes.

Ref no.	**Scheme**
BCF1	Locality development - Integrated Health and Care Teams
BCF2	Locality development - rapid response
BCF3	Locality development - primary care discharge
BCF4	IT interoperability
BCF5	Social care investment to benefit health
BCF6	Developing the Locality Offer
BCF6 (a)	Ambulatory Care
BCF6 (b)	RAID
BCF6 (c)	Carelink
BCF6 (d)	COPD Pathway
BCF6 (e)	Tissue Viability and Catheter Care
BCF7	Improving Access to Primary Care
BCF8	Develop primary care capacity to support localities
BCF9	Develop Preventative Services
BCF10	Incentivising Acutes to Deliver Change
BCF11	Reablement
BCF12	Carers Funding
BCF13	Support mitigating pressures in health care for people with Learning disabilities and older people
BCF14	Protection of Adult Social Services - moderate needs
BCF15	Protection of Adult Social Services - demographic pressure
BCF16	Community Capacity Capital Grant
BCF17	Disabled Facilities Grant
BCF18	Support Implementation of Care Act

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

e details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	How likely is the risk to materialise? Please rate on a scale	Potential impact Please rate on a scale of	**Overall risk factor** (likelihood	Mitigating Actions

	of 1-5 with 1 being very unlikely and 5 being very likely	1-5 with 1 being a relatively small impact and 5 being a major impact And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	*potential impact)	
We have modelled our risks on the basis of the changes that we expect to see in the pattern and configuration of services over the next five years, as explained in 2) c)				
1. We fail to meet the activity reductions identified	2	4	8	The CCG has a contingency plan that would: extend QIPP and reprioritise schemes for investment. Regular review of performance targets to ensure we understand progress and active management of schemes to make sure we can reprioritise if required. Strong local relationships at Board level to drive change.
2. Islington has identified too broad a programme of work to ensure focus and delivery	2	4	8	High ambition in Islington to deliver transformational change and challenging Integrated Care programme. Board meets bi-monthly with monthly workstream leads meeting and regular reporting through to structures within the CCG

				and Council. Strong alignment with the Council's Moving Forward programme. Team in place to support the programme and as a Pioneer we are getting support from external agencies to lead the way in transforming the way we deliver services. This includes systems leadership support, support to develop the Community Education Provider Network and support to share some of our best practice and learn from others. Focus is maintained through regular themed events that look in detail at scheme areas.
3. The development of a locality offer across community , social care and mental health services to support primary care fails to deliver the changes planned	2	4	8	*The BCF plan has a number of key interdependencies with other CCG/Social Care programmes. The service/cultural change required is being managed through these key programmes/approaches:* The Integrated Care Programme Board is developing a multi-agency joint Workforce Development Strategy to ensure clear leadership and ownership within stakeholder organisations. The development of a locality offer, based on the concept of multi-disciplinary teams in four geographical areas of the borough, is being developed with local providers so that there is a tangible 'service' offer for each population, that is focused on the prevention and management of long

				term conditions. Islington CCG has expressed an interest in the new system of 'co-commissioning' primary care services with NHSE, thereby developing purchasing power over local services in line with our HWB objectives. The locality offer is heavily interdependent on enhancing primary care capacity. Transforming primary care is one of the CCGs four key strategic programmes and is well supported both in terms of management and investment. Islington is now part of a Community Education Provider Network (CEPN) and as such has started a series of 'listening' events with staff to engage them with our proposals and new ways of working. The NCL CCG Collaborative Work Programme on Value Based Commissioning, that addresses directly Diabetes, Mental Health and Frail elderly services, have involved commissioners, providers and service users to design new pathways. Islington CCG/London Borough of Islington have a wide range of patient/public engagement programmes to enable local users and carers to drive and participate change in the configuration of services, including the 'Making It Real' Board that has a clear role in service

				design/redesign. The CCG has focused on reducing the over reliance on traditional hospital services by investing in new services, such as ambulatory care, hospital at home, enhanced recovery programmes, and there is planning in place for an integrated rapid response service. The development of these services demonstrates capacity and capability in the local health economy to 'do things differently' and these services and care principles will be solid foundations on which to build a new locality services offer.
4. Enhancing Primary Care Capacity fails to deliver the capacity to support more complex patients in the community	2	4	8	*The development of additional capacity, and high quality services in primary care is promoted on the basis of the four locality structure in Islington. We are managing the risks to delivery in these ways:* The CCG is engaged in a positive dialogue with local general practice to develop new ways of working across the locality networks. These discussions are underway. The CCG is interested in commissioning salaried GPs and practice nurses in addition to the current workforce to extend capacity. There are also several work streams that will ensure easier management of patients in primary care: The Interoperability (IT) work stream will enable GPs to manage patients

				more effectively by being able to access medical care data immediately and interface with secondary care easily. Islington CCG, alongside Camden CCG, has recently concluded an extensive review of Urgent Care. Amongst the key recommendations are changes to the service models for Out-of-Hours care and Urgent Care Centres, both of which will alleviate pressure in primary care. The CCG is supporting primary care with improvements in referrals through retrospective review and the Map of Medicine tool. There are also a number of new care pathways for children in development, again extending the scope of conditions that can be managed in primary care settings
5. IT and inter-operability to ensure that patient information can be shared across integrated services and along care pathways fails to be delivered	1	1	1	Islington CCG Governing Body approved the business case for 'Development and Implementation of Person Held Record and Interoperability'. This was a joint enterprise between the CCG and London borough of Islington. The programme is due to deliver a service via procurement commencing April 2015. Within the business case approach, the CCG has approved the risks and mitigations of non-delivery of the project and the ensuing inter-operability.

6. The additional investment and service change fails to meet demographic pressures in social care, and across health and care services for older people and people with learning disabilities	1	3	3	*The NHS in Islington has a strong history of successful joint working with the local authority at commissioner level and in service delivery for these client groups. The development of the Better Care Fund builds on this.* Joint commissioning of services through pooled budget arrangements ensures oversight of health and care commissioning, ability to risk share across organisation and flexibility to invest where can make most impact. Very strong relationship with Public Health, to ensure that commissioning developments are rooted in local requirements in an environment of often transient and acute needs, as well as being evidence based. The Islington Disability Strategy Group run jointly between local authority and NHS commissioners oversees the 'total offer' for those with learning disabilities. Rigorous commissioning of acute, community and continuing health care is embedded in the commissioning portfolio of the CCG.
7. We fail to maintain social care eligibility	1	3	3	The Council is committed to providing a range of preventative functions to support residents to maintain independence. The CCG supports this aim. The development of the service offer envisaged within the Better Care Fund approach has been agreed

				at CEO level on the understanding that provision may be affected by changes in the eligibility criteria.
8. Incentives to providers to support integrated care fails to deliver transformation	2	4	8	Financial and service development incentives are fundamental to our strategy for supporting change. Using the discipline of the NHS contract, we have already supported the development of the Ambulatory Care Unit by reinvesting emergency readmissions funding, for example, and through investment streams, have developed new services. We have also used the NHS Quality Premium in 2013/14 to incentivise key metrics associated with the Better Care Fund, for example, patients at home 91 days after discharge or rehabilitation and CQUINs regarding support to the Value Based Commissioning programme. We are now looking into new ways of incentivising developments as well as key performance metrics and these are being considered across all our key programmes as we prepare for the commissioning round 15/16. Strategically, the early successes of the Pioneer demonstrate the clear, unified local vision for integrated care in the borough, and the level of responsibility that each stakeholder has in achieving that vision. All stakeholders are clear about the expectation for their workforce to operate differently and are engaged

				to co-create the locality offer that will support service integration. Additionally, Islington is fortunate to have an already established Integrated Care Organisation in the form of the Whittington Health NHS Trust. The development of the provider model is being given extensive support by a dedicated Transformation Board which aims to maximise the opportunities for our joint priorities and minimise discord and risk in the local health system by removing perverse incentives and achieving tangible service changes that produce higher quality care and not just financial savings.
9. Patients, service users and carers continue to experience poorly co-ordinated services that are not designed around their needs and the outcomes they want to achieve for themselves	2	2	4	We have set up the Making it Real Board which is contributing to the design of new ways of working. Are developing with patients and users a "narrative" about how they can expect services to look in future Strong focus on personalisation and supported self management building on work already in place using the house of care model.

*Financial impacts are detailed within financial modelling

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

In 2014/15 we have a QIPP programme of £15m and a BCF additional funding requirement of £1m above current S256 investment.

In 2015/16 we have a QIPP programme of £12m and BCF of £10m above current investment. Over the two years the BCF equates to c40% of QIPP.

We are confident in finding this additional investment and will prioritise within commissioning intentions as the CCG focuses on integrated care, urgent and primary care.

Contingency plan:

The CCG has made a commitment to release funds for BCF regardless of the non-elective reduction as integrated working is our direction of travel and already within our commissioning intentions as a CCG. We have an agreement with the Council to fund the full amount of BCF in 2015/16. If the target fails to be met the CCG will look at its programme of QIPP from which to fund any shortfall. The CCG is confident that this will be effective with its track record of delivery and its relatively stable financial position.

We have a range of investments and if required would look to reprioritise to re-profile spend. This is already considered through regular review with colleagues in finance teams.

Commissioners have been working with acute trusts to reduce hospital admissions, particularly readmissions, and A&E attendances. We want to see a continuation of this work as well as a focus on acute productivity to bring efficiencies within the local health economy.

The impact of the Better Care Fund will be;

- A locality offer that supports integrated discharge and rapid response to avoid unplanned hospital admission or readmission
- Secondary care colleagues gain confidence that complex patients can be discharged into the locality
- Intermediate care services that support early discharge and therefore reduce length of stay
- Alignment of community services and social care functions, like re-ablement, to support independence in the community
- IT infrastructure that supports shared care and less duplication
- An expectation that specialists working in acute hospitals will be outward facing and able to support community colleagues
- Acute trusts that focus on reducing unplanned admissions through ambulatory care, early supported discharge and services like RAID to support adults with mental health needs

In terms of savings:

- Acute productivity will lead to realised contract efficiency
- Development of a community offer will reduce unplanned admissions
- Ambulatory care services are being expanded at the Whittington and can already demonstrate reduced admissions and readmissions
- UCH are developing ambulatory care and we want to see this scaled up so that it provides a proactive triage
- RAID is delivering reduced admissions for adults with mental health needs at the Whittington and is within Islington's QIPP programme
- Through the skilling up of community colleagues in the management of long term conditions we expect fewer exacerbations leading to A&E attendance and fewer outpatient admissions
- Oversight of data at system wide level will enable clear oversight of spend
- New models of working will also be supported by the Urgent Care Review that seeks to streamline the urgent care offer

Failure to deliver will lead to:

- Pressure on local budgets
- Continued risk to acute partner's ability to manage peaks in emergency attendances and admissions
- Continued pressure to meet NHS constitution targets
- Opportunities to invest in community and primary care will be compromised
- Opportunities for enhanced recovery are lost leading to more placements into long term care

Where we are now:

- We have agreed the 2014/15 and 2015/16 baseline with Camden and Islington Foundation Trust (CIFT) – 2014/15 contract signed
- Whittington – 2014/15 contract signed
- UCH baseline agreed for 2014/15, contract yet to be signed
- Whittington ICO is a net beneficiary of BCF through development of the localities and seven day working
- Working with the Whittington to develop their 5 year plans (they have brought in the Kings Fund to support this work)
- Urgent Care Review finalised
- Systems Resilience Group formed and meeting monthly. Aligned with integrated care programme.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

North Central London CCG's have together agreed a vision for the BCF which is for

people to live longer, healthier and happier lives by focusing on their abilities and potential with and without support. Safe and effective support will come from integrated multi-agency health and social care providers working with local people, and their carers, to deliver the best outcomes for individuals and their communities. The aims of the overall NCL BCF are consistent with the Islington BCF plan that focuses on delivery of the Pioneer Programme. Islington works closely with neighbouring boroughs, particularly Camden and Haringey to ensure that when commissioning integrated care programmes we have alignment. However, availability of resource varies between boroughs which means we may develop different solutions.

The Council has a programme of transformation work underway within adult social care services, the Moving Forward programme. This programme will ensure the requirements of the Care Act 2014 will be met, and that there is a sustainable social care offer in Islington. This programme is aligned to the BCF and Integrated Care Pioneer through joint oversight arrangements within the Housing and Social Care Management Structure (Service Director for Social Care is SRO for Moving Forward as well as member of Integrated Care Programme Board). Some areas of work sit across both programmes; for example the Locality development, supported by the BCF will be delivered jointly through Moving Forward and the Integrated Care Pioneer. Similarly, the development of personal health budgets is being delivered jointly with the Council using the same brokerage systems for both. This means that we can start to develop joint plans within an efficient and less bureaucratic system.

Islington CCG has representation on the UCH Clinical Integration Programme Board that seeks to align the integration initiatives across the organisation with stakeholder commissioners (UCH also have a seat on Islington's Integrated Care Programme Board). Examples of work that have been developed include the UCH at Home service that seeks to support early discharge. Further work includes improving rapid response to reduce admissions and reviewing the delayed transfers to ensure Islington residents are discharged in a timely way. The challenge for UCH as a local provider is the number of commissioners with whom it works and therefore different pathways in place. Support around IT inter-operability, being funded through the BCF should mitigate some of this.

The Mental Health Advisory Group brings together key stakeholders to oversee the development and commissioning of services and supports for adults with mental health needs. Camden and Islington Foundation Trust is a member of this and also a member of the Integrated Care Board. This group has aligned work with the integrated care programme including providing nurse input into supported housing schemes; developing a mental health offer into the four localities and investing in supporting adults with mental health needs back into employment.

The Whittington Transformation Board, a partnership across Whittington Health, Islington and Haringey CCG's and local authorities that aims to provide strategic oversight of major change projects. Integrated care is one of the trust's five strategic goals and there is representation at a senior level on Islington's Integrated Care Programme Board. As Whittington Health is an integrated care organisation it is anticipated that they will benefit from the developments of the BCF particularly around supporting the shift of provision into the community.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

As part of developing the Islington Operating Plan for 2014/2016 we have aligned our plans at borough level.

Work is underway at an NCL wide level to define the interventions that will be required on a collaborative level to support achievements identified under the local Better Care Fund initiatives. This will be important in maximising the commissioning effort across acute and community services where they serve more than one borough, and for Islington will be particularly significant in regards to its local Trusts; Whittington ICO, UCLH and CIFT.

The planning principles are shared here to demonstrate absolute alignment between the aims and objectives of the Better Care Fund and the overall approach to commissioning that the CCG has adopted for the following few years.

All identified BCF schemes are reflected in the Operating Plan submission for 2014-16 that was made in April and will be refreshed for the advent of 2015-16. We have recently assessed the source and application of funding over the 2 year period and provide the detail here.(see C)

The financial model is predicated on a -1.55% reduction from 2014-15 through to 2018/19. Built into this reduction are work programmes around Ambulatory Care Services (ACS), Improved access to Primary and Urgent care and several other integrated care related QIPP projects. The BCF is very much linked to the financial modelling as it is utilising all these elements and including newly defined projects such as Children's services - Hospital at Home, Integrated Liaison & Assessment Team (ILAT) and a scaling up of the existing ACS project to deliver a higher level of Non-Elective reduction.

The 2% difference between the 5 year plan and BCF plan are bridged by the above schemes in particular the ramp up of ACS. Integrated care and in particular the reduction of NEL admissions has and will be an ongoing priority, with particular focus around the joint working between the Local Authority, CCG and our main Provider The Whittington.

1. 2 – 5 Year Planning Principles

At borough level in Islington, we have identified the key ingredients of our transformed service offer. We want to see:

- An offer of early intervention and prevention for the whole population
- Health and care systems and pathways that are co-produced with patients and users
- Strong clinical leadership shaping and supporting change
- Hospitals that plan and support discharge from the first day of admission
- Better access to voluntary and community based services through better information and advice

- Joined up care delivered through four localities based around GP practices
- Better identification and co-ordination of patients/users at high risk of hospital admission
- A programme of supported self-management for children and adults with long term conditions
- More personalised service offers through the roll out of personal health budgets and increasing numbers of those who opt for a personal budget
- Services that are more easily understood and accessed through single point of access, single assessment processes and 7 day working
- Better alignment of physical and mental health services, thereby promoting parity of esteem across the health continuum
- A skilled workforce that delivers care with dignity and compassion, is motivated to make a difference and is rewarded for its efforts
- IT systems that support joined up care by becoming interoperable

2. New ways of working in Islington

In developing our Five Year Plan, we want to renew those commitments but also recognise the challenges of the future. The following challenges exist for the NHS in Islington:

New Ways of Working

- We want services taken to people in their local communities or homes
- We want appropriate services in hospital
- We recognise there are different ways of delivering services, using smart phones, emails, the web and want our local hospitals and community services to take advantage of technology in this way
- In return, we want patients to become more self-reliant, taking more responsibility for their own care. We will invest in ways of helping them to do that

Value for Money

- We want services that add value; we will have to consider stopping services that do not or add limited value
- There can be no true value without high quality; Islington has some of safest and highest quality health services nationally and we want to preserve that legacy and improve in areas that need it
- Despite the lack of growth in budgets, we would never consider charging our patients for services that they do not already pay for (e.g. prescriptions, dentistry)

Nurturing Partnerships

- We want to work more closely with our fellow commissioners at borough level, whether that be through our excellent links with the local authority, public health and with our community partners and/or the voluntary sector
- We want to work very closely with the Whittington as our main provider of services in the community and at the hospital, as well as other hospitals such as University College Hospital and the Royal Free
- We have to develop more cohesive links with primary care and specialised

commissioning teams at NHS England

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

NCL CCGs have submitted a joint application to adopt responsibility from NHS England for a range of additional primary care commissioning activities aimed at delivering our 5 Year Strategic Plan and supporting primary care transformation. Adoption of these responsibilities will allow us to:

- Ensure that local factors, (high premises and workforce costs, extreme health inequalities, the London acute landscape) are recognized within our commissioning intentions and resources; and
- Develop an integrated capitation funding model for patient pathways, particularly in relation to urgent care and personalized care for people with complex long-term conditions.

There is significant overlap in what all the CCGs are doing, and this will help our co-commissioning work. In addition this work will support our local Pioneer programme and the work being supported through the BCF:

- Extending access to appointments; including 8am-8pm opening;
- Ensuring GP provider collaboration and development of GP networks to integrate with other services (pharmacy, CHS, Specialist) to deliver personalized care for patients with complex long term conditions;
- Reducing variability and increasing quality;
- Improving patient experience and feedback ;
- Closing the gap on expected and observed prevalence for LTCs, and more proactive care;
- Promoting self-care;
- Integrating care better and ensuring that primary care plays a key part in successful delivery of integrated;
- Taking a strategic approach to primary care premises; and
- Supporting the primary care work force.

Working in the Locality integrated health and care teams GP practices will be further supported to deliver the proactive patient care set out in Transforming Primary Care; personalised care plans, named and accountable GP's , a care co-ordinator and better access to primary care.

We believe that co-commissioning will reduce some of the current risks in the system by bringing commissioning back to a local footing.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Islington is proud of its history in protecting social care for those who need it and maintaining eligibility levels to ensure those with moderate needs and above are supported to live independently in the community.

Demand is rising at a time of unprecedented budget pressure, and work is being undertaken in partnership with the CCG, local NHS Trusts, and the voluntary sector to ensure that adult social care services can be successfully sustained in Islington.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Islington has developed Section 75 pooled budgets as well as used Section 256 transfers to support the development of a strong social care offer. We plan to continue this way of working with the added requirement of supporting the new social care reforms including the development of a seven day offer.

We are using the Better Care Fund to support demographic pressure, to maintain eligibility and to support the additional demand for information and advice that we expect to see as a result of the new Care Bill.

We also want to invest in our locality offer which is likely to see an increase in demand for domiciliary support for those who are cared for at home as we reduce the numbers of those in hospital or in long term care institutions. This is a significant challenge at a time of budget reduction in local authorities, and the Better Care Fund will partially ameliorate this pressure, and provide some time and focus for the remodelling of adult social care. It is recognised that adult social care will need to be remodelled by March 2015 to both support the implementation of the Care Act, and the roll-out of a joined-up locality offer. Options are currently being considered by the Moving Forward Programme, in partnership with the Integrated Care Board.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£4.822m is provided for in the BCF for 2014/15 to protect adult social care (scheme BCF5). This will partially mitigate the anticipated significant budget reduction to adult social care in 2014/15 and 2015/16.

£6.598m is provided for in the BCF for 2015/16 to protect adult social care (Schemes BCF5,BCF14 and BCF15). Again, this will partially offset the significant budget reduction to adult social care in 2015/16, and enable social care to absorb demographic growth (Scheme BCF14 and BCF15). Islington aims to continue to provide social care services to those with a level equivalent to the current FACS Moderate. This supports the prevention of more acute needs developing, and therefore ameliorates pressure on health services. This figure (£6,598k) is shown in tab "2.Summary" in the part two submission. The discrepancy between cells G18 and D18 is due to not all local authority funding is for the protection of adult social care – identified schemes for this purpose is above.

£1.2m is allocated to Scheme BCF11 to support integrated reablement and rehabilitation in Islington. Reablement is provided by Islington Council.

£1.4m is allocated to Scheme BCF13 to mitigate demographic pressure on continuing healthcare budgets.

Islington has a high and increasing number of people living with learning disabilities. The needs of this group are planned for and funded via a S75 pooled budget between Islington CCG and the Council. There has been an increase in the numbers of people with a learning disability who meet NHS Continuing Healthcare criteria, with a £1m pressure on the pooled budget. The increased demands on the pooled budget will be met through Scheme BCF13.

There is also a lesser, but still substantial, demographic demand for the care and support of older people. Again, this has also led to an increased pressure on continuing health care budgets. These increased demands are also accounted for in Scheme BCF13.

£663K is allocated through Scheme BCF18 to support the implementation of the Care Act 2014. This is the exact proportion for Islington of the £135m allocated nationally for this.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Islington is well-placed to implement the requirements of the Care Act, having established a number of key requirements, such as a deferred payments scheme, a joint transition team, a comprehensive offer for carers, and a strong track record of personalisation. However, there will be an expected increase in demand due to self-funders and more family carers coming forward for assessment. We are currently quantifying this demand using local market intelligence and the tools shared by the

national joint programme team. As reflected in the London Councils and ADASS response to the draft guidance and regulations, there remains a risk that any calculation of additional demand can be an approximation only, and more demand than expected might be experienced.

In addition, there are two prisons in Islington, and there could be significant additional demand on the Council depending on the requirements of the final guidance and regulations expected in October 2014.

It is recognised that the final guidance and regulations of the Care Act 2014 will not be published in time for the submission of the Better Care Fund templates. Therefore, there might be additional demands in the final guidance that have not been accounted for in this plan.

A sub-group of the Moving Forward Programme Board, the Care Act Implementation group, is overseeing this work, and is chaired by the Service Director for Adult Social Care.

v) Please specify the level of resource that will be dedicated to carer-specific support

£415k is allocated to support carers through Scheme BCF12.

Islington Council and Islington CCG have worked in partnership to develop a strong carers' offer through a pooled budget arrangement. Our approach is to identify and support carers in the right way at the right time to prevent the breakdown of caring situations. We have commissioned a Carers' Hub, which supports over 1,000 family carers and administers a short-breaks scheme.

As well as more traditional services such as respite and sitting services, Islington offers weekly direct payments for carers to spend flexibly in the way that most benefits them. Additional demand from carers is anticipated as a result of the Care Act, and we are planning to develop and extend our Carers' Hub model through the Better Care Fund. This will both protect the current offer for carers, and enable more carers to benefit from these services.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Local authority budgets have not been materially affected.

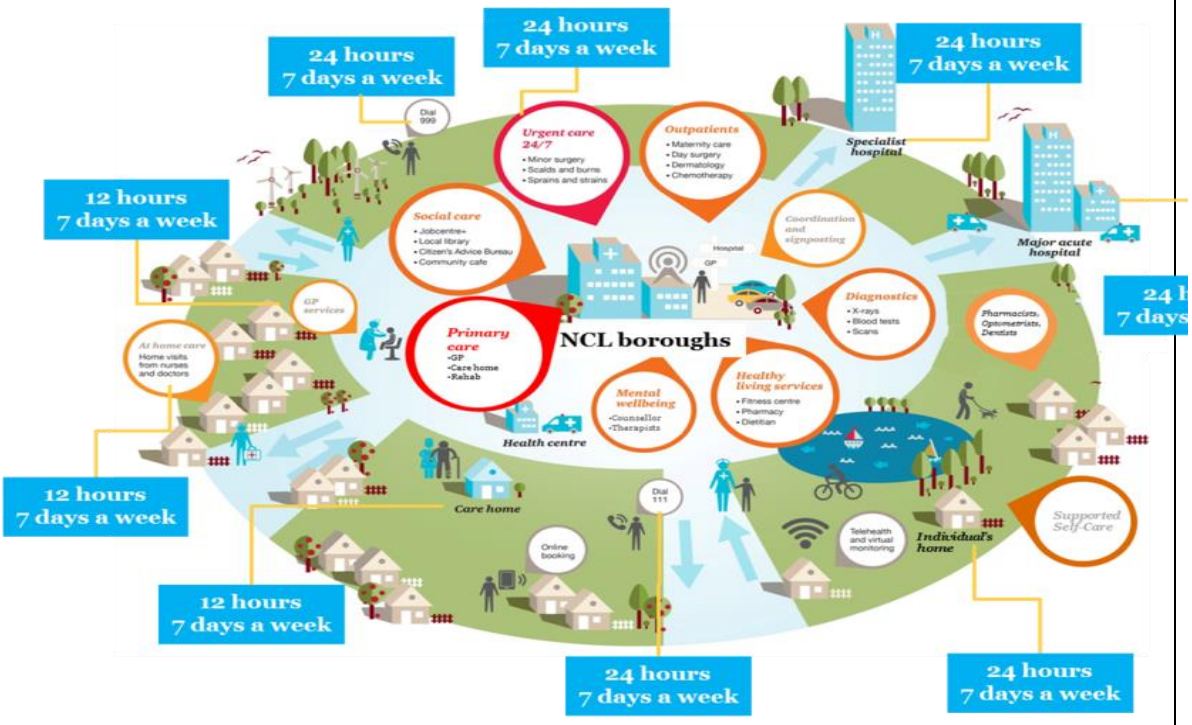
b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Compliance with Seven Day Service Clinical Standards will be delivered through:

- All local Urgent Care Working Groups have prioritised 7 day working in their Improvement Plans. This includes access to consultants, therapies, diagnostic and mental health services;
- Greater collaboration between providers to ensure "network working" to cover current gaps;
- The London Quality Standards have been included in the proposed KPIs for acute providers. Requirement for Remedial Action Plans in the case of non-compliance;

The diagram below summarises plans for 7-day working locally.



Islington has a strong commitment to providing seven day health and social care services across the local health economy, evidenced by our work to date to extend a seven day offering across key services.

<u>London Borough of Islington Adult Social Care Seven Day Offer</u>
Islington Adult Social Care has several elements to their seven day offer being expanded from April 2015 with the support of the BCF: EDT, Reablement &

Brokerage service.

Emergency Duty Team (EDT)
The EDT offer is an extended social work service that will respond during the weekend. Social Workers will be trained to become advanced social work practitioners. They will work on a rota basis with the permanent EDT staff at the weekend. The EDT senior will be in charge of weekend shifts and will liaise with the advance Adult SW to allocate specific pieces of work as received, (e.g. Supporting discharges from hospital/ avoiding unnecessary admissions, Adult Safeguarding/Vulnerable adult Interventions that cannot safely wait for the next working day / setting up protection plan, assessing and putting in place emergency care packages/reablement packages, Mental health act assessments, and responding to 'No responses)'.

Enablement and Home Support Service
We already have seven day working and response from reablement, with in-reach to acute hospitals, and strong links to the FEDS therapies team to identify people who could go home with reablement support. This seven day working has supported our excellent track record on delayed transfers of care and our improved length of stay as we are able to mobilise professionals to support discharge outside of the traditional Monday-Thursday window.

This service will continue to offer a seven days service and will take referral up to 12pm at weekends. The team will have the capacity to respond to new referrals within 24 hours and will be able to agree the start date of the service within 24 hours. Request for restart to facilitate a hospital discharge will be implemented within 24 hours of receipt.

Brokerage Home Care
All brokerage services will be able to take referrals seven days a week via EDT Practitioners. In the event of an emergency, providers will have the capacity to undertake an assessment and commence service on the day of referral every day of the year.

<u>The Whittington community offer</u>

The Whittington has developed a checklist against progress and is on track with plans to deliver a seven day offer from April 2015.

We also want to quantify more clearly what the additional funding requirement is, although we plan to use the Better Care Fund to pump prime the offer. From experience at the Whittington where acute therapists were moved to seven day working it did require additional resource, partly because we still needed the same level of staffing during the week (more or less) to respond to demand, mobilise patients etc. and partly because of the enhanced payments for unsocial hours. The change there also included extended hours for the FEDS (Rapid response in ED) team, so that there is an 8.00 - 8.00 service. This expansion to seven day working did produce benefits such continuity of therapy input, support for the enablers e.g. so that people don't 'seize up' if discharged prior to weekend

and not moving about or get reassurance if they are struggling. Also there was more interaction with families who may work during the week.

Primary care offer

Primary care colleagues have already started to consider how they may collaborate to provide extended hours services and this is supported by an improving access locally commissioned service that will see an additional 144 hours a month available across practices. This is being rolled out from October 2014.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

All health and care systems will use the NHS number as an identifier from 2014/15. The London Borough of Islington has already uploaded NHS numbers for current adult social care clients, and has systems in place to accurately record the NHS numbers of new clients.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Our ICT strategy and work programme requires our existing software suppliers to deliver open APIs and confirm that they meet current ITK standards. It is also a requirement for all future contracts including our bid for the development and implementation of a Person Held Record and interoperable platform recently submitted for integrated digital care funding.

We already have security systems in place including the use of GCSX email.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Safe and secure sharing of information between and within health partners and Islington Council is paramount and the Council is interested in being a pilot site to adopt the new secure email service under ISB 1596 Secure email standard. Likewise the Council is level 2 compliant with the IG toolkit and had a full suite of IG policies. Housing and Adult Social Services is developing an action plan to meet all of the Caldicott 2 recommendations.

The CCG achieved Accredited safe Haven status in March 2014, in part by achieving

100% against level 2 of the IG Toolkit. It has a comprehensive suite of information governance policies and guidance in place. The CCG has developed good working relationships with key stakeholders across the health and social care economy, particularly with Public Health and patient representatives, and is currently compliant with all information governance requirements.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

The CSU is not using the CCG's locally developed risk stratification tool because of its interpretation of restrictions imposed by the Confidentiality Advisory Group, when it agreed a section 251 exemption for risk stratification.

Therefore up to date information is 'risk stratified' using the CSU's preferred tool, the Combined Predictive Model. Monthly SUS and EMIS data flows are made available to inform health and social care responses.

The Integrated Care Board has agreed that the Integrated Health and Care teams will initially **work with the top 2% at risk of admission together with any person that the team feels would benefit from the integrated approach**. We understand this population across a variety of measures which will inform our approach to shaping the teams as well as monitoring the impact of this development.

- Personal (age, long terms conditions, gender, risk score)
- Activity (across primary and secondary health care, mental health and social care provision)

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Islington's MDT processes have been in place for the last 18 months and are used as a platform to jointly assess and plan care for patients. The purpose of the MDT is to carry out these core activities:

- Each GP practice holds a patient register for those patients with LTC's
- Patients at risk of hospital admission are identified using the risk stratification tool
- An integrated care plan is used as a basis of care planning with the patient
- Cases are discussed at the MDT planning meetings
- A lead professional is identified to co-ordinate and follow up care
- The Voluntary Sector Navigator supports the patient to follow up goals
- Case conferences are used to review care

In order to inform the scaling up of the locality offer we have undertaken an evaluation of the MDT process in the early months of 2014/15. To date nearly 500

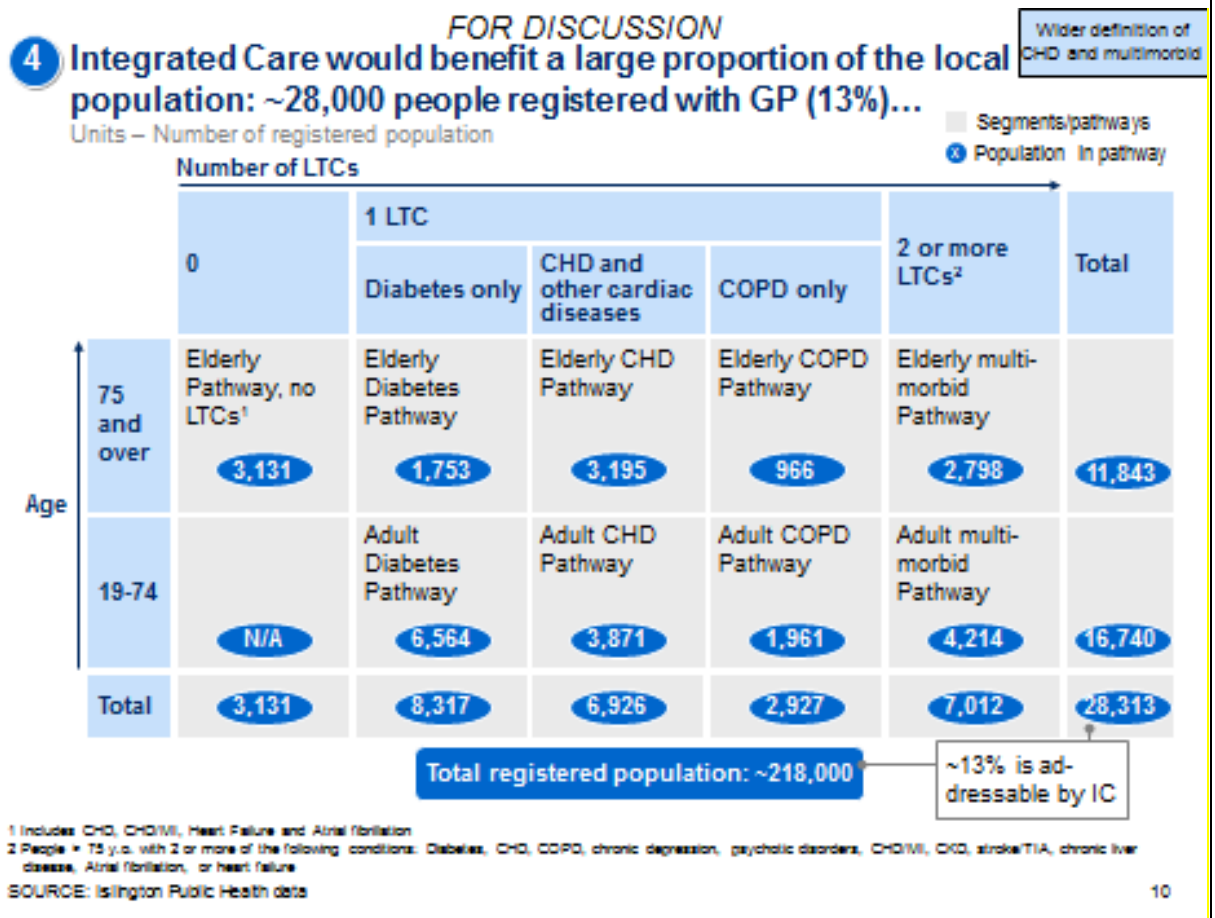
patients have been discussed and reviewed through the MDT.

Findings from the evaluation include a consistent reduction in A&E inpatient and outpatient activity after an MDT. Overall the report found a 27% reduction in A&E attendances from the group of patients discussed. Further findings support the scaling up of the process with the new locality offer.

Islington has just been successful in a bid to become a Community Education Provider Network and we see workforce development as a key enabler in supporting new ways of working in localities. This includes developing a different skills mix so that professionals can take on broader roles within the care planning process. It is within this programme of work that we will be working, across providers, with frontline staff to develop new ways of working and support culture change.

Joint assessments and care planning will also be supported by the work we are doing on IT interoperability as we know that with the current limitations staff are having to enter information on different systems

Islington has developed its own risk stratification tool that was launched in September 2012 although this is currently under review. Early work looked to identify segments of the population that could benefit from integrated care.



It is expected that one of the areas of most benefit from use of risk stratification will be the tier 2/3 patients who are currently low/moderate users of health and social care. Identifying them at a lower level risk allows the opportunity to provide greater

input within the community to prevent them from becoming more unwell and being admitted to secondary care.

Using risk stratification is a key element of the development of the locality service redesign as it will provide the opportunity to analyse need at a locality level (and at individual level within the locality) so that services can be designed accordingly.

As part of the Integrated Health and Care teams, we are commissioning new resource from Camden and Islington NHS Foundation trust to bring mental health services closer to Primary Care. This will provide psychiatry, psychology, mental health nursing and social work as a core part of the Integrated teams.

For people with dementia, we have Dementia Navigators, providing individual case management approach for people with Dementia and their carers to support them through the systems and ensure best use of resources.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Approximately 13% of the at risk population already have a joint care plan in place as a result of the MDT approach.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

From the outset we have been keen to engage with patients and service users and worked with them to develop a set of “I” statements along the lines of those developed by Making it Real. These were crucial in helping us shape our vision and prioritise what was important to the people who receive services.

We have launched a Making it Real Board where we are working with users to develop plans to improve the delivery of care and identify areas of co-production. This Board has been successful in attracting a range of users and carers who can provide different insights from their experience of the health and care system which will be an invaluable resource. The Making it Real Board is co-chaired by the Service Director for Social Care and a service user. Both sit on the Integrated Care Board. In addition to these, a member of Healthwatch sits on the Board as well as two lay representatives from the community.

The Making it Real Board has developed its own action plan identifying areas of work that are a priority to users and their carers. In addition, the members of the group are supported to become leaders for other “experts by experience” through attending training and conferences, for example a cohort attended the TLAP conference in Birmingham.

During our work we have involved users and patients to co-produce service design and improvement. Examples include:

- Work with over 250 patients to develop our local “I statements”
- a report highlighting the experience of those who have one or more long term condition to inform how we co-ordinate care better
- working with women who have used mental health services to identify areas of work – this has informed the Integrated Care plans for Camden and Islington FT
- working with local community organisations to identify issues of access to services that has led to us working with GP front of house staff and community pharmacies
- commissioning St Joseph’s hospice to work with patients, family members and carers who have experience of the last years of life care services to provide feedback on those services as well as using them to develop an improved offer through district nursing
- using patients and users to undertake peer to peer research into the N19 pilot which is a short term project to test a model for integrated health and care teams
- working with patients and users to inform our model of multi-disciplinary working
- the development of peer researchers to support the development of a patient narrative for integrated care
- working with harder to engage groups through local community organisations

We have confidence that this approach has given us a good understanding of local views and comments of integrated care and is being developed as we move forward in our plans.

Finally, we have started to develop a communications strategy so that we can have a more streamlined approach to communication with all stakeholders.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

We have been working with partners over the last eighteen months to develop our plans for integrated care upon which we have based our Better Care Fund submission. We have harnessed the excellent leadership that exists in our local health and care economy so that we remain sighted on the challenges within the sector and develop change through a whole system model. We believe that this commitment to working in partnership both with service providers but also service users and patients has helped us to secure Pioneer Status for our integrated care programme.

Work to date has included workshops with health and social care providers from the statutory and voluntary sector as well as having provider representation on our Integrated Care Board and on work-stream project teams. We hold an annual conference for social care and housing support providers where we have consulted on our plans for integrated care as well as regular meetings through the CCG with health providers, for example, monthly GP forums and the Whittington Transformation Board.

The Council and Whittington Health have Section 75 arrangements and integrated management structures to better co-ordinate and deliver community health care and social services. They have used these relationships to start piloting new ways of working so that we can test and evaluate models as we develop our thinking.

Similarly our mental health services are delivered through pooled budget arrangements with another key provider, Camden and Islington Mental Health Foundation Trust who have been at the forefront of our work to shift care out of secondary health services. They are also supporting us to improve health inequalities by providing more proactive support for physical as well as mental health.

UCH is also a key player who has not only been represented at the Integrated Care Board but has jointly employed a Divisional Clinical Director - Integration with the Whittington to improve links between their acute provision and the local community offer.

All providers have been engaged with the North Central London CCG's to develop a new approach to commissioning for outcomes; value based commissioning. This has focused on three pathways, frail elderly, diabetes and mental health. Working across providers, commissioners and users/patients we have been able to develop our thinking about how to contract differently and incentivise the system to work more closely together. This work dovetails with the development of our plans around the BCF where we want to understand the segments of our population in order to develop different contracting models.

ii) primary care providers

Islington supports a GP forum that meets bi-monthly and we have strong clinical support for integrated care initiatives. As well as two Clinical Leads from the Governing Body Islington also has four Locality Clinical Leads who chair the MDT's and have also been instrumental in supporting the development of the risk stratification tool.

The development of the rapid response and primary care discharge schemes outlined in this BCF come directly from engagement with GP's at the forum. As such the operational groups have a GP chair, able to provide the clinical leadership that will support wider change.

iii) social care and providers from the voluntary and community sector

As set out above we have held workshops with health and social care providers from the statutory and voluntary sector as well as having provider representation on our Integrated Care Board and on work-stream project teams. We hold an annual conference for social care and housing support providers where we have consulted on our plans for integrated care.

Furthermore the CCG has a quarterly voluntary and community sector forum where we have presented and discussed plans to deliver integrated care.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Our vision for acute providers is that they will provide care for those who need it; plan for discharge from day one and have active services at the front door to avoid admission.

Islington CCG is the lead commissioner for Whittington Health Integrated Care Organisation. The majority of acute services are provided by Whittington Health and University College Hospital.

Since 2012 there has been a Transformation Board for the Whittington across the partnership of Islington and Haringey that seeks to support the development of the hospital into securing Foundation Trust status. As the Whittington also provides community services across the two boroughs it is in an excellent position to work with commissioners to support the delivery of our vision for integrated care.

Commissioners have been working with acute trusts to reduce hospital admissions, particularly readmissions, and A&E attendances. We want to see a continuation of this work as well as a focus on acute productivity to bring efficiencies within the local health economy.

The impact of the Better Care Fund will be;

- A locality offer that supports integrated discharge and rapid response to avoid unplanned hospital admission or readmission
- Secondary care colleagues gain confidence that complex patients can be discharged into the locality
- Intermediate care services that support early discharge and therefore reduce length of stay
- Alignment of community services and social care functions, like reablement,

to support independence in the community
- IT infrastructure that supports shared care and less duplication
- An expectation that specialists working in acute hospitals will be outward facing and able to support community colleagues
- Acute trusts that focus on reducing unplanned admissions through ambulatory care, early supported discharge and services like RAID to support adults with mental health needs

In terms of savings:

- Acute productivity will lead to realised contract efficiency
- Development of a community offer will reduce unplanned admissions
- Ambulatory care services are being expanded at the Whittington and can already demonstrate reduced admissions and readmissions
- UCH are developing ambulatory care and we want to see this scaled up so that it provides a proactive triage
- RAID is delivering reduced admissions for adults with mental health needs at the Whittington and is within Islington's QIPP programme
- Through the skilling up of community colleagues in the management of long term conditions we expect fewer exacerbations leading to A&E attendance and fewer outpatient admissions
- Oversight of data at system wide level will enable clear oversight of spend
- New models of working will also be supported by the Urgent Care Review that seeks to streamline the urgent care offer

Failure to deliver will lead to:

- Continued pressure on CCG and Council budgets
- Continued risk to acute's ability to manage peaks in emergency attendances and admissions
- Continued pressure to meet NHS constitution targets
- Opportunities to invest in community and primary care will be compromised
- Opportunities for enhanced recovery are lost leading to more placements into long term care

Where we are now:

- We have agreed the 2014/15 and 2015/16 baseline with Camden and Islington Foundation Trust (CIFT) – 2014/15 contract signed
- Whittington – 2014/15 contract signed
- UCH baseline agreed for 2014/15, contract yet to be signed
- Whittington ICO is a net beneficiary of BCF through development of the localities and seven day working
- Urgent Care Review finalised

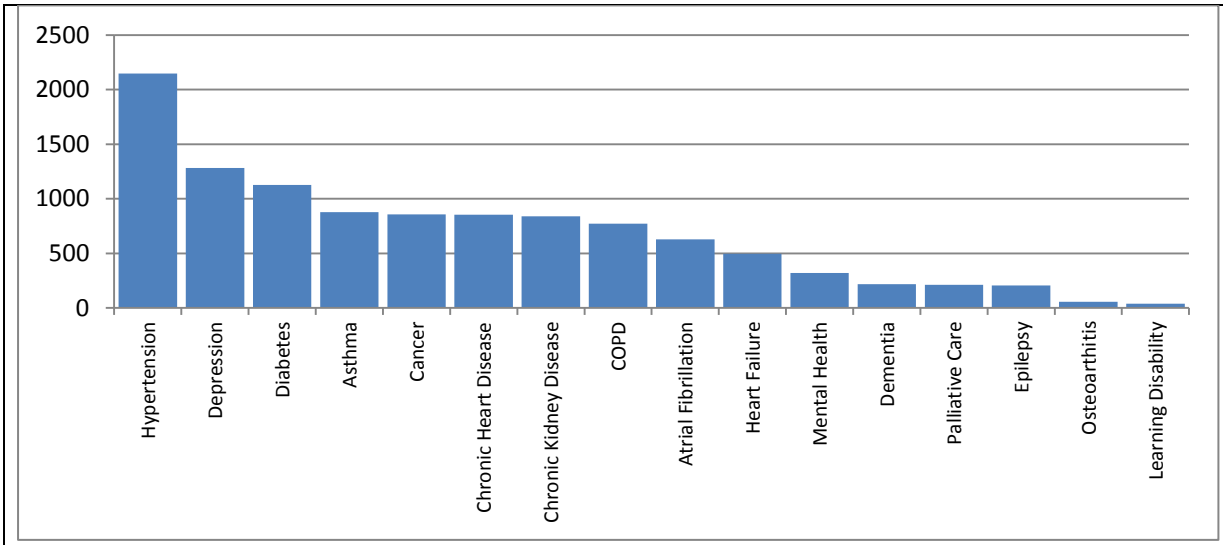
Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute

providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

9) ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
BCF1
Scheme name:
Locality Development – Integrated Health and Care Teams
What is the strategic objective of this scheme?
To provide integrated care within a community setting; focussing on those people most at risk of admission and those people who would most benefit from an integrated approach. This scheme aims to improve system capacity to deliver Care Closer to Home by bringing existing skills and expertise together with new investment in a co-ordinated approach.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This service will create integrated health and care teams wrapped around primary care. This multi-provider development brings together Primary Care, Social Care, District Nursing, Community Matrons, Allied Health Professionals and Mental Health Professionals, with support from Secondary Care colleagues as required. The service will be structured and led around primary care, alongside staff from Camden and Islington NHS Foundation Trust, London Borough of Islington, UCLH NHS Foundation Trust and Whittington Health NHS Trust together with voluntary sector providers. This work builds on our existing multi-disciplinary initiatives to developing and scale up the concept across Islington. These teams will work together on a regular (weekly/fortnightly) basis to share skills and expertise, and ensure a more joined-up approach for the patient. We have defined the target audience for this service as the top 2% of people at risk of admission, together with any person who the members of the team feel would benefit from an integrated approach. In Islington, the top 2% represents • 4,650 people across 36 practices • 63% are over 60 • 44% have 3 or more long term conditions Diagnosed Long Term Conditions within top 2% risk stratified population:



We have mapped this population to our social care, mental health and community health populations. Bringing these data sources together provides a significant step forward in terms of understanding need and highlight opportunities for better co-ordinated activity. It will also provide a robust baseline in order to monitor impact of the scheme in terms of affecting risk scores.

We are keen that this model, while grounded in a risk stratified approach, places equal weight to professional opinion to ensure engagement and maximise benefits. We are piloting this service in 2014 and this will enable a better understanding of the cohort of 'people who will benefit from an integrated approach'.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Providers are detailed above. Islington CCG is the lead commissioner for Whittington Health NHS Trust and Camden and Islington NHS Foundation Trust. Camden CCG is the lead commissioner for UCLH NHS Foundation Trust. The London Borough of Islington and Islington CCG have a long history of joint working with a well-established joint commissioning team.

We anticipate expenditure during 14/15 on enabling participation in the pilots; this will fund staff time from primary care, community health and social care teams.

The lead commissioner for this work is the Integrated Care Programme Director at Islington CCG/Islington Council. The Operational Group comprises senior management from across Primary Care and key provider organisations.

We have identified 9 practices to engage in phase 1 (test and learn) of the development. This will launch in October 2014. We intend to roll out the model across the borough from April 2015.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Published evidence for these schemes is limited, but includes key sites such as Torbay[2]

Other evidence provided by the King's Fund[3] shows that

- care co-ordination can have a significant effect on quality of life
- integrated primary care systems are associated with better patient experience
- models of chronic care management is associated with lower costs and better outcomes

Our own local evaluation includes an evaluation of the N19 pilot (a year long pilot in the north of the borough to test integrated team working) (June 2014)
Evaluation of Islington's approach to multi-disciplinary teleconferencing (August 2014)

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Moderate
2	Residential Admissions	Moderate
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	High
6 (local)	Carer Reported Quality of Life	Moderate

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Led by patients, Islington has developed a local version of the National Voices 'I Statements'.

Patient Perspective	How this project will support this
I want to be listened to and heard	• Patients will have to repeat their story less as information will be shared across the Integrated Team • Care plans will be structured around patient outcomes, identified and articulated by the patient with support from the integrated team

[2] http://www.kingsfund.org.uk/publications/integrating-health-and-social-care-torbay
[3] http://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/care-coordination

	• We will measure success of the project by measuring how much we support patients to reach their outcomes
I want to be treated as a whole person and for you to recognise how disempowering being ill is	• The most vulnerable people in Islington will be identified and have their care joined up; they will experience fewer hand-offs and reduced risk of 'falling in between the gaps' • Staff will hold a holistic understanding of patient's need, working across boundaries to provide a response to the whole person's needs
I want my care to be co-ordinated and to have the same appointment system across services	• Patients will have a named care co-ordinator who has meaningful oversight of interventions across primary care, social care, mental health and the voluntary sector • Staff will understand each other's skills and roles, trust each other's assessments and act on them • Referrals will be verbal and instant
I want to have longer appointments with someone who is well prepared so that I do not have to tell my story again	• The integrated team will share records and information within the service and with the wider locality teams • We will move from multiple interventions from multiple professionals, to more intensive interventions from one care co-ordinator
I want to feel supported by my community and get the most out of services available locally	• The rotational staff model will support learning throughout the system, particularly regarding the 'whole population offer' and self-care developments • The team will work closely with the single point of access and the voluntary sector to identify more local opportunities for support
I want you to put a greater focus on my mental well being	• Mental Health services will be closely integrated into the model through a new model sitting between Primary Care and C&I services • Increasing numbers of staff will have confidence in responding to mental health issues through training and peer support
I want to feel respected and to feel safe	• When patients need ongoing care, they will be discharged effectively from the multi-disciplinary teams • Safeguarding functions within Islington Council will be integrated into this team, sharing skills and capacity

External evaluation of our multi-disciplinary work (teleconferences) to date has demonstrated impact in reducing A&E attendance, reducing admissions and reducing GP appointments. As well as these activity measures, we want to monitor impact of the scheme by understanding

- Patient stories and feedback
- Staff feedback
- Risk scores for the relevant population
- Peer (i.e. patient) review of the process

What are the key success factors for implementation of this scheme?

This scheme will be piloted through 2014/15. This pilot will provide considerable information towards a successful full borough implementation in 2015/16.

While we need to create robust structures to enable these teams to function, detailing operational policies, creating effective information sharing arrangements and refining the patient cohort through risk stratification and professional opinion, our key focus for successfully implementing this scheme will be creating effective working relationships within the team.

Scheme ref no.
BCF2
Scheme name:
Locality Development – Rapid Response
What is the strategic objective of this scheme?
To shift health and social care interventions away from hospital and closer to home, and build capacity in primary care, by providing a rapid (2 hours) response from an integrated health and care team.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Current provision involves a range of services delivering varied rapid response functions (across social care, district nursing, mental health, etc.) to different standards and models. This scheme will integrate these existing services with a newly commissioned clinical capacity, providing a multi-organisational response from Camden and Islington NHS Foundation Trust, London Ambulance Service, London Borough of Islington, UCLH NHS Foundation Trust and Whittington Health NHS Trust. The service will be a multi-disciplinary, 7 day service, comprising General Practitioners, Social Workers, Nurses, Mental Health professionals and Allied Health Professionals. The service will have access to rapid response Reablement services and Intermediate Care beds. We have identified the following activity as potentially appropriate for this service • People approaching existing services for rapid support (awaiting data) • Presentations at A&E with no investigation/no treatment or Category 1 investigation/Category 1 treatment (c1100/month at Whittington and UCLH)* • LAS conveyances resulting in 0 or 1 day admissions (c240/month at Whittington and UCLH)* • Requests for home visits from Primary Care (c585/month) * Evidence from the NHS Alliance suggests that around 10-30% of this work may be classified as appropriate for primary care.[4] We are explicitly not defining eligibility for this service based on conditions. Eligibility will be a matter of timely, co-ordinated professional assessment. However, we expect the following conditions to be potentially appropriate for this service. • Exacerbation of long term condition, e.g. diabetes, COPD, Parkinson's, heart failure, etc. • Falls (without head injuries) • Infections, e.g. urinary/catheter issues, chest infections • Diarrhoea and vomiting • Minor injuries • Functional deterioration

[4] http://www.nhsalliance.org/publication/breaking-the-mould-without-breaking-the-system-3/

- Acute episodes of chronic pain
- Breakdown in care and support networks, including safeguarding alerts requiring a rapid response
- Urgent breakdowns in equipment
- Urgent crisis relating to housing resulting in risk of admission
- Cognitive deterioration, e.g. dementia, delirium
- All lower limb cellulitis unless patient presents as systematically unwell with pyrexia or confusion.
- Lower respiratory tract infection in an individual without a previous diagnosis of a Long term condition

These conditions, together with the locations for the service, will be developed through the cross-organisational Operational Group. We are expecting to pilot this work in early 2015, going fully live by April 2015.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Providers are detailed above. Islington CCG is the lead commissioner for Whittington Health NHS Trust and Camden and Islington NHS Foundation Trust. Camden CCG is the lead commissioner for UCLH NHS Foundation Trust. The London Borough of Islington and Islington CCG have a long history of joint working with a well established joint commissioning team.

The lead commissioner for this work is the Integrated Care Commissioning Manager at Islington CCG. The Operational Group comprises senior management from across key provider organisations, and the group is chaired by a Primary Care clinician.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Published evidence for these schemes is limited, but includes

- Commissioning a new delivery model for unscheduled care in London, London Health Programmes 2012[5]
- Rapid Response Services, NHS Evidence, 2011[6]
- Emergency Care and Emergency Services, Foundation Trust Network, 2013[7]

To draw on best practice, we have worked with other local authorities who have developed similar schemes. Clinical opinion has led assumptions about impact.

[5] http://www.londonhp.nhs.uk/publications/unscheduled-care/
[6] http://www.evidence.nhs.uk/aboutus/Pages/AboutQIPP
[7] http://www.foundationtrustnetwork.org/resource-library/emergency-care-and-emergency-services-2013/

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	High
2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Led by patients, Islington has developed a local version of the National Voices 'I Statements'. Rapid Response has been matched to these 'I Statements' as follows

Patient Perspective	How this will be recognised
I want to be listened to and heard	• Care and support will be provided as close to home as possible, as quickly as possible • Access hours will be extended and arrangements will be simplified
I want to be treated as a whole person and for you to recognise how disempowering being ill is	• The team will work in a multi-disciplinary way, enabling a holistic and timely response to emergencies • The structure will be simplified for patients facing a crisis
I want my care to be co-ordinated and to have the same appointment system across services	• The team will understand and work closely with the variety of services supporting an individual, in particular the Integrated and Long Term care teams
I want to have longer appointments with someone who is well prepared so that I do not have to tell my story again	• The integrated team will share records and information within the service and with the wider locality teams • A common assessment and care plan will be shared within the team
I want to feel supported by my community and get the most out of services available locally	• The rotational model will support learning throughout the system
I want you to put a greater focus on my mental well being	• The team will incorporate elements of Enhanced Reablement, able to respond to cognitive decline • The team will build links with key Mental

	Health services within C&I NHS trust
I want to feel respected and to feel safe	• The team will have effective discharge arrangements to ongoing care and support • Safeguarding functions within Islington Council will be integrated into this team where a rapid response is required, sharing skills and capacity

Key feedback loops will include confidence in the Rapid Response system by Primary and Secondary Care providers, decreased activity in secondary care and increased activity in community settings such as Reablement and Intermediate Care.

As well as evaluating against these criteria, we will measure the shift in activity against the following

- People approaching existing services for rapid support (awaiting data)
- Presentations at A&E with no investigation/no treatment or Category 1 investigation/Category 1 treatment (c1100/month at Whittington and UCLH)*
- LAS conveyances resulting in 0 or 1 day admissions (c240/month at Whittington and UCLH)*
- Requests for home visits from Primary Care (c585/month)

What are the key success factors for implementation of this scheme?

- Integration of existing services across social care, primary and secondary (acute and mental health) health services
- Commissioning additional clinical resource
- Confidence in Rapid Response factors across the system
- Admissions avoidance

Scheme ref no.
BCF3
Scheme name:
Locality Development – Primary care discharge
What is the strategic objective of this scheme?
To strengthen discharge arrangements following hospital admission, focussing on ensuring more effective transfers of clinical care between secondary care providers and primary care. The strategic aim of this scheme is to reduce readmissions, build capacity in primary care to support people immediately post discharge and improve discharge processes to improve joint working between secondary and primary care. The scheme is being worked up in response to gaps being identified by GP practices in Islington through the GP Forum.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
We want to improve local discharge arrangements from Whittington and UCLH Hospitals. Discharge from hospital is a key point in a person's care arrangements; as well as the stress of a hospital admission, it involves a transfer of care and clinical responsibility together with a possible change in health and care needs. We want to better support clinicians and patients with this process, and mitigate unwanted outcomes. The patient cohort will initially be those people managed by the Integrated Health and Care Teams (scheme 14.04). This is defined as the top 2% at risk of admission and anyone who the team feels would benefit from an integrated approach. As part of the IHCT pilot running from October 2014 we will review discharge arrangements for this patient cohort. This will better identify needs and help shape the scheme in greater detail, including provider details.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
This scheme will be worked up in partnership with providers across the acutes, community and primary care settings. The lead commissioner will sit within the Integrated Care Team within the CCG. As the scheme is developed an appropriate procurement route will be identified. Timescales for implementation are still beind developed.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Further work is required to identify best practice and evidence to support the development of a scheme. To date there is anecdotal evidence that discharge from acute hospital settings could be managed more successfully in primary care if:

- information was provided in a more timely manner
- discharge notes were fully completed with clear information on, for example, updated medicines management
- primary care colleagues were provided with sufficient notice to be able to schedule visits to the patient within three days of arriving home

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low
2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Moderate
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Led by patients, Islington has developed a local version of the National Voices 'I Statements'.

Patient Perspective	How this project will support this
I want to be listened to and heard	Patients will have to repeat their story less as information will be shared across the Integrated Team Care plans will be structured around patient outcomes, identified and articulated by the patient with support from the integrated team We will measure success of the project by measuring how much we support patients to reach their outcomes
I want to be treated as a whole person and for you to recognise how disempowering being ill is	The most vulnerable people in Islington will be identified and have their care joined up; they will experience fewer hand-offs and reduced risk of 'falling in between the gaps' Staff will hold a holistic understanding of patient's need, working across boundaries to provide a response to the whole person's needs
I want my care to be co-ordinated and to have the same appointment system across services	Patients will have a named care co-ordinator who has meaningful oversight of interventions across primary care, social care, mental health and the voluntary sector Staff will understand each other's skills and roles, trust each other's assessments and act on them

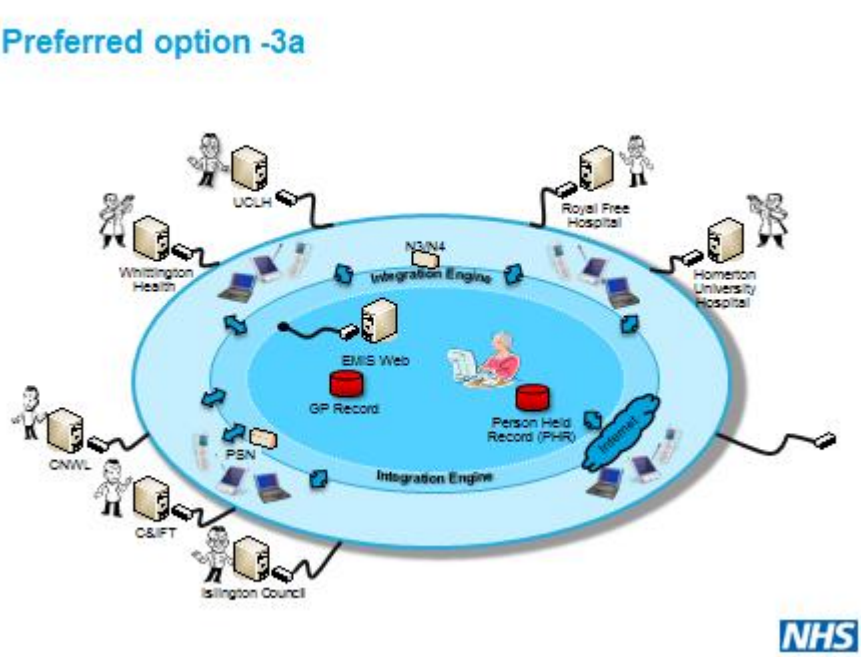
	Referrals will be verbal and instant
I want to have longer appointments with someone who is well prepared so that I do not have to tell my story again	The integrated team will share records and information within the service and with the wider locality teams We will move from multiple interventions from multiple professionals, to more intensive interventions from one care co-ordinator
I want to feel supported by my community and get the most out of services available locally	The rotational staff model will support learning throughout the system, particularly regarding the 'whole population offer' and self care developments The team will work closely with the single point of access and the voluntary sector to identify more local opportunities for support
I want you to put a greater focus on my mental well being	Mental Health services will be closely integrated into the model through a new model sitting between Primary Care and C&I services Increasing numbers of staff will have confidence in responding to mental health issues through training and peer support
I want to feel respected and to feel safe	When patients need ongoing care, they will be discharged effectively from the multi disciplinary teams Safeguarding functions within Islington Council will be integrated into this team, sharing skills and capacity

We will also work with clinicians to develop feedback mechanisms through the MDT approach to care planning.

What are the key success factors for implementation of this scheme?

- Successful and safe hospital discharge
- Timely information flowing through to primary care
- Reduction in readmission within 30 days

Scheme ref no.
BCF4
Scheme name:
IT interoperability
What is the strategic objective of this scheme?
We are working jointly with Islington Council to jointly procure an Integration engine to allow the sharing of agreed data across health and social care through the development of an integrated digital care record. We aim to procure an IT solution that will allow clear data linkages between primary, secondary and community providers allowing cross clinician view of a patients record. This will give a seamless view of a patient journey across providers via the provision of an integration engine. This data will then feed into the patients PHR (Person Held Record), where the citizen holds and gives consent to sharing their record. It will allow the patient a clear view of their record along with the ability to input into certain areas. As this is a person held record it will travel with the patient across health and social care providers and across geographical boundaries.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Working with our partners across pathways to provide information in real time that supports and aids clinical decision making in the following programme areas: • Urgent care • Integrated care • Primary care • Planned care The solution will initially focus on people in crisis and then those with Long term conditions, rolling out to all people who wish to access their records in Islington.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Islington CCG working in partnership with London borough of Islington will work together with our providers to deliver the programme. The diagram below shows the providers we work with and how the system will connect together.



The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There are many advantages to investing in this joint project between Islington CCG and Islington Council to deliver inter-operability and a person-held record amongst health and care providers in Islington:

- PIONEER SITE – Islington is a pioneer site making it both an exemplar to other CCGs and also a test-bed for collaborative solutions to drive transformation and integration;
- MOBILE POPULATION – Islington has a transient population with the highest rate of people under the age of 45 moving in and out of the borough in London, driving the need for common information standards across CCGs;
- CO-TERMINUS WITH LOCAL AUTHORITY – Islington CCG and Islington Council have a well-established and long history of joint commissioning across health and social care that has delivered integrated services, giving better outcomes for people in Islington. Both organisations have a track record in delivering efficient and effective services through joint working. Integrated management information will transform the whole system, enabling us to take further steps forward in delivering personal health budgets for people with mental health, continuing health care and value based commissioning.
- DIVERSE POPULATION – Around 35% of Islington's population were born outside the UK whilst 20% do not speak English as a first language. Providing online functionality and person-held information helps to increase access to services;
- INTEGRATED CARE – This provides the capability to make Integrated Care viable amongst all health care and social care providers.
- EMPOWERMENT OF PATIENTS AND CITIZENS – The outcomes of this

project will be to patients and citizens at the centre, enabling them to have control of their record, give consent to share information and to manage their care
- EFFICIENCIES – In times of needing to do more with less, these digital improvements will help integrate health and social care and provide system wide efficiencies and savings.

We have worked together to identify the needs, market test what is possible, benchmark ourselves against neighbouring CCG's and are confident the solution we have specified will deliver the intended objectives.

Failure to act will result in the continuation of the current, inconsistent and manual/ paper-based processes and a missed opportunity to realise the benefits of more efficient working, whilst both organisations will be unsupported to achieve their strategies.

To do nothing would not support the integrated care agenda, release savings and in particular, this would be contrary to Islington's status as a Pioneer site, with the related expectations that it is able to test radical options and can overcome the barriers to delivering co-ordinated care and support.

Furthermore, doing nothing will not support the urgent care agenda by providing the ability to link up across London in the future. Islington CCG and Islington Council will be unable to deliver their work programmes, the outcomes required by the Better Care Fund and aspirations as a Pioneer organisation.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Benefits to Patients at the centre of care:
- Patients empowered to manage their own care and be part of decision-making Improved patient experience;
- Less repetition of health history every time treatment is accessed in different organisations, as up to date information will be available through the data sharing agreements once consent is given;
- Care is co-ordinated between providers giving patients greater reassurance, confidence and trust in the clinicians treating them;
- Greater access to health information, data and knowledge, helping to maintain health and wellness, not just treat illness;
- Improvements in the patient experience due to a reduction in unnecessary admissions and treatment in more appropriate care settings.

Benefits to Clinicians:
- Effective Information Governance ensured;
- Between different provider organisations;
- Between providers and citizens;

- To inform strategic health priorities;
- Better and faster / real time clinical decisions based on richer and more timely information;
- Improved continuity of care across provider organisations.

Improved outcomes

- Reduced prescribing errors;
- Increase safety and reduced risk in relation to vulnerable individuals and children;
- Reduced length of stay due to accurate, up to date information to aid clinical decision making;
- Improved patient outcomes due to improved self-management of post-operative care;

For Islington Integrated Care Pioneer, undertaking this change programme also means being able to deliver the expected benefits from the Work Programmes. For example:

- Urgent Care - Joined up services aiding clinical decision making; reduced errors
- Planned Care - Self-management of health; reduction in tests; reduction in missed appointments (DNAs)
- Integrated Care - improved Care Planning (Health and Social Care); joining-up care outside the borough
- Primary Care - linking across GP systems; reduction in missed GP appointments

We have attempted to quantify financial benefits for implementing a Person Held Record and interoperability in terms of cost efficiency and productivity savings. This high-level analysis is based on published evidence and statistical information for the potential benefits that such functionality can bring and provides a top-down view of the magnitude of benefits that could be achievable.

The indicative high-level financial benefits have been estimated at £14.0m across a 10 year period. These benefits will be realised across a wide number of organisations in the Islington Integrated Care Pioneer, including, General Practitioners and health and social care providers, such as Islington Council.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A Programme Steering Committee will be formed to oversee the programme, supported by a project team. We will also have a challenge and confirm team made up of independent people from our governing body to provide additional governance.

Benefits realisation plans and risk register will be developed as part of the next phase of the project.

We have patients and clinicians at the centre of our planning, specifying, implementation and evaluation plans who will ensure that what is procured will meet the objectives.

The programme will be independently evaluated after implementation.
What are the key success factors for implementation of this scheme?
• Data moves across health and social care providers automatically to provide information and aid clinical decision making • Information is provided in real time • Patients and citizens have control of and access to their record

Scheme ref no.

BCF5

Scheme name:

Social care to benefit health

What is the strategic objective of this scheme?

This is the £4.822m transfer to adult social care in 2014/15, and £4.822m in 2015/16. This will directly ameliorate the budget reductions to adult social care in 2014/15 and 2015/16 as a result of the reduction in the revenue support grant.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This partially supports the core adult social care offer of assessment and care management. This has enabled LB Islington to maintain low levels of delayed transfers of care, and maintain high performance in terms of the number of people still at home 91 days after discharge.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

These are services already commissioned by the London Borough of Islington. This includes domiciliary and residential care, provided through both block and spot contracts. No milestones are associated with this scheme.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

NA

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low
2	Residential Admissions	High
3	Reablement	Low
4	Delayed Transfers of Care	Moderate
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

NA

What are the key success factors for implementation of this scheme?

Protection of core social care offer.

Scheme ref no.
BCF6
Scheme name:
Developing the Locality Offer
What is the strategic objective of this scheme?
This scheme will facilitate the shift of activity from hospitals to community by creating additional capacity within the Integrated Health and Care Teams and wider community based services. The focus on the investment is: • Scaling up what works o building on our success with Ambulatory Care o RAID and Carelink o Long term conditions pathways, in particular COPD • Supporting innovation across community provision; o expanding services for children's community nurses o extending scope of community provision eg tissue viability o developing initiatives in Primary Care and the Voluntary Sector
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
We are currently working with providers to scale up existing initiatives which will be detailed in the six month letters. Further scoping is required to sign off the investment plans but work underway now includes: • Piloting integrated health and care teams • Expanding ambulatory care to include IV at home • Review of RAID and Carelink • Community geriatricians developing evaluation and new model • Hospital at home service for children • Review of care homes support from primary care to ensure it utilises support from community geriatrician • Expanding initiatives in the community This ICHT pilot will give us a more detailed, local picture of the existing gaps in provision which, if met, would enable us to support more people in the community.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
These services will be commissioned by Islington CCG and by Islington Council. The lead for commissioning these services will be the Integrated Care team at Islington CCG. Providers will include Primary Care, Islington Council (Social Care), Whittington NHS Trust, Camden and Islington NHS Foundation Trust and the voluntary sector and

private sector.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Detail in attachments: BCF6 (a) – ambulatory care BCF6 (b) – RAID BCF6 (c) – Carelink BCF6 (d) – COPD BCF6 (e) – Tissue viability
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
See attached
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
All projects are developed with evaluation methods embedded within, the Community geriatrician service is due to be evaluated, from a patient perspective, by Healthwatch in early 2015 for example.
What are the key success factors for implementation of this scheme?
These schemes are designed to: • Ensure that people receive care in appropriate settings • Reduce attendance at A&E • Reduce unplanned admissions • Reduce length of stay • Deliver joined up care for individuals • Focus all parts of system together on admission avoidance to hospital and or residential care, early supported discharge and care outside of hospital All these schemes are operational now, so no milestones are included in the descriptors.

Scheme ref no.
BCF6 (a)
Scheme name:
Ambulatory care
What is the strategic objective of this scheme?
Whittington Health is scheduled to open a new ACS centre from start 2014/15, with the aim of reducing length of stay and avoiding A&E attendances and unnecessary admissions by delivering care in a more pro-active and transformational way. The trust is proposing a tariff structure which reflects the pathways that will operate in the new service and valued to share the financial benefits of the new model between the trust and commissioners.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Excerpt from Whittington Health Business Case The key features of the new adult ambulatory care service are as follows: The service will operate out of a dedicated facility with dedicated staff. The new unit will form a key part of and optimise the 'hot floor' alongside the Emergency Department, Acute Assessment Units and 'hot seat imaging.' The new facility has been designed with the help of patients and staff to provide a treatment space which is practical, appeals to patients and is pleasant for staff; The service is clinically led by Dr Clarissa Murdoch, a geriatrician by background as well as an acute physician; championing the benefits of caring for our complex elderly patients in an ambulatory way. Dr Murdoch is supported by, Dr Nathalie Richard Consultant in Emergency Medicine and GP by background. Such diversity in the clinical leadership of the service ensures that patients across the acute care pathway, regardless of age or presenting condition or complexity can be considered as a suitable candidate for the service. The service is staffed by a senior and experienced team comprising of consultants, medical, surgical and ED registrars, community matrons, senior nurses and HCA's; The service will provide a point of direct telephone contact which the consultant will provide real time management advice to GPs; The service will include supported discharge to the hospital at home service, with direct integrated support from the community nursing teams (Managerially, AEC sits with the Integrated Care and Acute Medicine (ICAM) division within Acute Services). Crucially as an Integrated Care Organisation, this means that Ambulatory Care is managed alongside our Emergency and Community Services by the Head of Acute Services; By diverting activity away from ED, the new service will help us with the achievement of the ED target which in turn will help commissioners achieve their quality bonus; • The aim of the new service is to reduce adult emergency admissions trust wide by 11% on a like for like basis, plus potentially a reduction in surgical readmissions, and a further reduction in paediatric admissions.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Excerpt from Whittington Health Business Case

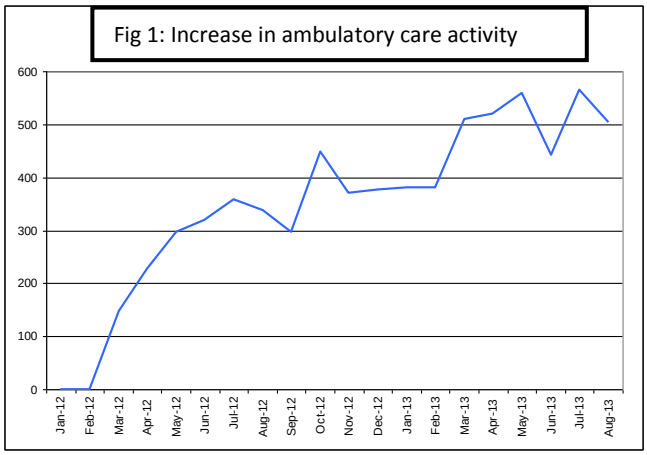
"Being part of an Integrated Care Organisation is at heart of this service already, with community matrons already being a vital part of our core multi-disciplinary tem we aim to best serve the resident population of Islington and Haringey. Full expansion of this service will further demonstrate Whittington Health's commitment to truly integrated acute, community and primary care and collaborative service delivery through providing the physical environment, staffing mix and technology to aid this. We aim to bridge the gap between primary and secondary care".

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Excerpt from Whittington Health business case

Overview

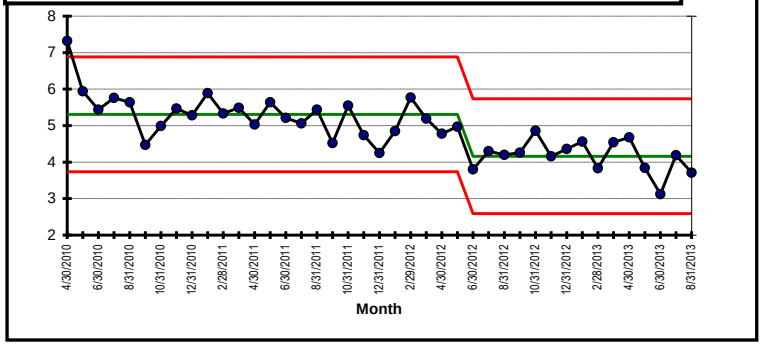
Unlike other AEC services, Whittington Health's model of care is unique because it is not based on set clinical conditions, but instead is focused on what care is right for the patient and where this care can be delivered. It is a partnership between acute and emergency medicine and will facilitate earlier discharge from the wards as well as relieving pressure from ED by diverting flow away; and has integrated community services in the footprint - community matrons and hospital at home case finders. A service which everyday proves integration of services both throughout the hospital and into the community.



Current model

The current service that runs from three clinical rooms at the front of the Emergency Department has been operational since February 2012. The Monday-Friday service is staffed by 2 doctors and 2 nurses, overseen by the consultant of the day. There is a nurse led service providing treatment continuation at the weekends. The service has a distinctive model of care and is unique in its integrated approach to delivering care. It is a joint initiative between the acute medical and emergency medicine teams. Such diversity in the clinical leadership of the service ensures that patients across the acute care pathway, regardless of age or presenting condition or complexity can be considered as a suitable candidate for the service. There has been a steady increase in ambulatory care attendances since the service launch.

Fig 2: Reduction in length of stay for admissions with ambulatory care sensitive conditions



There has also been a coincident reduction in the average length of stay for non-elective admissions - the reduction in length of stay for ambulatory care sensitive conditions is even more significant.

This fall is in part due to the ambulatory care centre providing a role in supported discharge including providing the medical cover necessary for community IV anti-biotics. The fall is also due to the application of enhanced recovery principles to emergency medicine, and the trust's ability to link directly with community staff to discharge the patient earlier using district nurses to support patients in their own homes.

And whilst trusts across London have seen an increase in their conversion rate from ED to admissions, the Whittington's conversion rate has fallen from 21% to 19% over the last two years.

The role of the community matron as part of the ambulatory care team is key to ensuring a smooth transition for patients from hospital back to the community. The in-reach model sees senior community matrons facilitate early discharge of patients safely back to their homes from ED, ISIS, AAU and other inpatient wards. Adult patients under the care of the AEC will receive on-going assessment, delivery of direct clinical care and evaluation delivered by the community teams, coordinated and led by the AEC community matrons.

This model of care will build on Whittington Health's existing good practice by providing a credible, safe whole systems approach that supports clinical teams to continue to develop new integrated pathways, and ways of working that meets the needs of the patient, commissioners, the wider health and social care system.

The service has recently extended its opening hours, allowing the service to increase capacity to support winter pressures. The service now runs from 9am-8pm on weekdays, and also provides medical capacity at the weekend.

Future model

To establish whether more could be done with ambulatory care, an audit was undertaken of all admissions from ED over a period of a week in March 2013. The audit looked at the patient journeys of 262 patients to ascertain whether patients could have been diverted into AEC with more staffing and physical resources. The results demonstrated that 33% (85 out of 262) of patients would be appropriate for AEC, and of these 93% (78 out of 85) would attend on the same day as their ED attendance and 7% (7 out of 85) would be booked to return the next day. The number of patients identified as high risk of admission equated to 27%.

The audit concluded that scope exists for the service to treat more patients across a wider range of conditions and hence save more admissions, but capability is currently limited by the lack of available space in the area around the Emergency

Department.

The future model will enable the service to meet what is currently unmet demand from existing referral sources including directly from GP's and ED; many of whom will be identified via a new triage system at the 'front of house' in ED. With increased capacity and a more appropriate physical environment, we would look to increase the number of virtual ward patients we look after supported by our community matrons. The consolidation of resources will also allow us to increase our work with surgery, other medical specialities and care of the elderly.

A new triage facility will be implemented at the front of the Emergency Department to stream suitable patients to ambulatory care as swiftly as possible. In additional the MALS front entrance from Magdala Avenue will provide a community facing, direct access point for patients to the unit diverting unnecessary flow from ED.

Services across the acute care pathway will very much work in parallel in the first year because the increase in activity will not achieved instantaneously. However it is crucial that from quarter two, the pathways across ED, ISIS, ambulatory care and AAU are monitored; with a view to changing the profile of ISIS and the distribution of staff from ED if the anticipated shift in activity is realised.

The relocation and integration of the Dorothy Warren Day Hospital (DWDH) services into the new AEC will not only centralise a lot of similar work, but also will provide the expertise to care for complex elderly patients. As part of the new service, AEC will be the hub of communication and resource for the integrated frailty service. Elderly patients make up the largest group of unplanned admissions, have significant longer lengths of stay, significantly more adverse events in hospital and there is also evidence of de-compensation associated with hospitalisation.

The DWDH activity is charged as outpatient activity currently and will continue to be charged on the same basis under the new model. The activity reporting and recording will identify DWDH activity separately using a separate clinic code. The volumes associated with DWDH in the new model are shown on page 8.

Therefore, as part of the large-scale AEC service this integrated frailty service will identify patients in ED, from the community via GP, community matrons, teleconferences and JKU wards to provide multi-disciplinary reviews and high risk assessments including therapy input to avoid admissions for complex elderly patients with comprehensive geriatric assessments. The input of the consultant geriatricians will enable the service to work with GP's to flag those patients who are a risk and ensure that they receive the care and treatment that they require as soon as possible.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	High

2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	High
6 (local)	Carer Reported Quality of Life	Low

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monthly monitoring of activity and regular meeting with the Trust to evaluate the efficacy of the new service.

What are the key success factors for implementation of this scheme?

Excerpt from Business Case

1. Ensure no decision about me without me

Providing a patient-centered service in the right place, at the right time with the right person is what ambulatory care does – making sure that the patient and their regular support network receive the right amount of information and support around their care and treatment. Also working in partnership with colleagues across health and social care to promote independence and self-management where possible.

2. Deliver efficient, effective services that improve outcomes

Nationally, 49 ambulatory care sensitive conditions have been published and used to demonstrate that there are a significant number of patients who can have their care delivered in an ambulatory way which ultimately enables trusts to manage the rise in emergency admissions. Inpatient admission, especially for complex elderly patients, can prove detrimental to health, so providing a solution closer to home has much broader benefits to their health. Providing a 'hot floor' service for patients on the acute care pathway provides better experience and outcomes for patients and staff alike.

3. Improve the health of local people

The ambulatory care service will house both adult and paediatric services, providing the best care for all different age groups from young babies to our frail elderly patients. All cohorts of patients may be considered suitable for the services being provided in ambulatory care.

4. Change the way we work by building a culture of innovation and continuous improvement

Already our ambulatory care service is being held up as an exemplar of good practice, and being able to consolidate our resources into a dedicated area will ensure we can continue to develop an excellent service which has already received praise nationally. A service which is transformational in the way that we want to care for our patients and fits perfectly with being part of the integrated pioneer status that Islington CCG is already striving towards.

Scheme ref no.
BCF6 (b)
Scheme name:
RAID (Rapid Assessment Interface and Discharge)
What is the strategic objective of this scheme?
The RAID model of care provides integrated mental health input into the care of patients at the Whittington Hospital, particularly focusing on improving input to the needs of elderly people. The RAID model is an evaluated model of care (LSE 2011) that is demonstrated to both improve quality of multi-disciplinary care and to deliver cost savings. The aim is to implement this service model in order to replicate the impact of RAID in Islington. The project aims to ensure fast access to appropriate assessment, integrated care, and effective discharge based on an effective multi-disciplinary package of care. Specific areas for improvement will be in case finding, reduction in length of stay; avoidance of admission and reduction of readmission to inpatient care.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The service will ensure: • One point of contact and access for the acute hospital, covering all liaison activity (including substance misuse activity) within the acute Trust. This will ensure consistency of response, as well as opportunities to ensure that a suitably skilled team is available, and for up-skilling in relation to self-harm and overdoses. All cases referred to the service will be assessed. This will include people living outside Islington. • Case finding, linking to existing dementia and alcohol posts. The enhanced resource will enable more assertive case finding as a result of the increased capacity available to enable this to take place. • Every referral in A&E to be seen within one hour and all other referrals seen within 24 hours, with appropriate and timely review, • Advice on alcohol problems, including detoxification and referral to our 'morning after clinic' or other community agencies, • Advice on substance misuse treatment, including methadone maintenance. • Assessment of care needs of older people with mental health problems, • Early detection of mental health problems to enable rapid and appropriate intervention, • Training and support to acute hospital staff on recognition and management of mental health problems • Continuity of care for people already known to mental health services, • Input to discharge planning, and general advice and support • Integrated communication to primary care, using general hospital discharge information (this could be participating as a when appropriate to MDT teleconference in Islington re ongoing management plan.) Specifically, the project offers a comprehensive range of mental health specialities within one multi-disciplinary team, so that all patients over the age of 16 can be assessed, treated, signposted or referred appropriately regardless of age, address, presenting complaint, time of presentation or severity. The service operates 7 days

week. The service will emphasise rapid response, with a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on the wards. The service will meet the mental health needs of all adult patients in the hospital, including those who self-harm, have substance misuse issues or have mental health difficulties commonly associated with old age, including dementia. It will provide formal teaching and informal training on mental health difficulties to acute staff throughout the hospital. It will also put an emphasis on diversion and discharge from A&E and on the facilitation of early but effective discharge from general admission wards.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The plans have been discussed with the CCG, local GPs and clinicians at Camden &Islington Foundation Trust and Whittington Health.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

RAID evidence demonstrates a benefit:cost ratio of 4:1. This level of benefit will be achieved over a multi-year timescale – and may require risk adjustment as the LSE evaluated RAID model may have started from a lower baseline of integration than is the case in Islington.

The projections of 2014/15 activity are based on data contained in the Whittington Health RAID Project Baseline Data Analysis.
Savings are expected in three areas:

1. Reduction in Average Length of Stay
2. Reduction in Emergency Re-admissions
3. Reduction in Admissions from A&E

The modelling assumptions for the first two are set out below.
Where appropriate an average tariff has been applied to the activity to estimate the financial impact of the proposals. The average tariff is £1980 per spell. Given the short timescale for producing this analysis it was decided that an average tariff should be applied, however, if time permits then the analysis may be revised to a more granular level and the HRG tariff applied.

1. Reduction in Average Length of Stay.

- The analysis is based on the actual activity for April to October 2014, which was then extrapolated to a full year forecast based on monthly straight line projection (the activity was divided by 7 and multiplied by 12).
- Only non-elective activity was included in the analysis as the trust has not shared the elective data.
- The activity and average length of stay were projected for each category of patient, and a 0.5 day reduction in average length of stay applied.
- From this a bed day reduction was calculated along with a bed reduction based on 365 days of the year and 85% occupancy.
- Based on the analysis the trust would be able to reduce its bed capacity by over 7.6 beds if the 0.5 reduction in average length of stay was achieved.

- Baseline data at HRG level is needed to enable these savings to be split between Trust and commissioner, with respect to impact on excess bed days / trim point.

Islington

April to October 2013

Category	Activity	Bed Days	Avg LoS
Dementia	318	2626	8.26
Substance Misuse	418	1797	4.30
Psychosis	155	793	5.12
Non-psychosis and Other	502	2191	4.36
Total	**1393**	**7407**	**5.32**

2013/14 Forecast

Category	Activity	Bed Days	Avg LoS	Bed Days Based on 0.5 days Reduction	Bed Day Reduction	Bed Reduction Based on 85% Occupancy
Dementia	545	4502	8.26	4229	272.71	
Substance Misuse	717	3081	4.30	2722	358.57	
Psychosis	266	1359	5.12	1226	133.43	
Non-psychosis and Other	861	3756	4.36	3325	431.00	
Total	**2388**	**12698**	**5.32**	**11502**	**1195.71**	**3.85**

Haringey

April to October 2013

Category	Activity	Bed Days	Avg LoS
Dementia	185	1606	8.68
Substance Misuse	180	688	3.82
Psychosis	72	280	3.89
Non-psychosis and Other	319	1598	5.01
Total	**756**	**4172**	**5.52**

2013/14 Forecast

Category	Activity	Bed Days	Avg LoS	Bed Days Based on 0.5 days Reduction	Bed Day Reduction	Bed Reduction Based on 85% Occupancy
Dementia	317	2753	8.68	2594	159.14	
Substance Misuse	309	1179	3.82	1025	154.43	
Psychosis	123	480	3.89	418	62.00	
Non-psychosis and Other	547	2739	5.01	2466	273.43	
Total	**1296**	**7152**	**5.52**	**6503**	**649.00**	**2.09**

Trust Total

April to October 2013

Category	Activity	Bed Days	Avg LoS
Dementia	576	4864	8.44
Substance Misuse	851	3369	3.96
Psychosis	299	1311	4.38
Non-psychosis and Other	1054	4989	4.73
Total	**2780**	**14533**	**5.23**

2013/14 Forecast

Category	Activity	Bed Days	Avg LoS	Bed Days Based on 0.5 days Reduction	Bed Day Reduction	Bed Reduction Based on 85% Occupancy
Dementia	987	8338	8.44	7844	494.29	
Substance Misuse	1459	5775	3.96	5046	729.43	
Psychosis	513	2247	4.38	1991	256.43	
Non-psychosis and Other	1807	8553	4.73	7649	903.57	
Total	**4766**	**24914**	**5.23**	**22530**	**2383.71**	**7.68**

Reduction in Emergency Re-admissions.

- The analysis is based on the actual activity for April to October 2014, which was then extrapolated to a full year forecast based on monthly straight line projection (the activity was divided by 7 and multiplied by 12).
- A 10% reduction in emergency re-admissions was modelled and this equated to 97 fewer admissions and a reduction of 520 occupied bed days.
- The analysis shows that the trust could reduce its bed base by over 1.6 beds if the 10% reduction was achieved.
- The estimated cost saving of the 10% reduction in re-admissions is c£191k, of which £104k for Islington and £51k for Haringey.

Islington

April to October 2013

Category	Activity	Bed Days	Avg LoS	Emergency Re-admissions	Re-admission Bed Days
Dementia	318	2626	8.26	95	582
Substance Misuse	418	1797	4.30	75	298
Psychosis	155	793	5.12	40	206
Non-psychosis and Other	502	2191	4.36	95	554
Total	**1393**	**7407**	**5.32**	**305**	**1640**

2013/14 Forecast

Category	Activity	Bed Days	Avg LoS	Emergency Re-admissions	Re-admission Bed Days	10% Reduction in Emergency Re-admissions	Reduced Re-admission Bed Days	Bed Reduction Based on 85% Occupancy	Cost Saving
Dementia	545	4502	8.26	163	998	16	100		
Substance Misuse	717	3081	4.30	129	511	13	51		
Psychosis	266	1359	5.12	69	353	7	35		
Non-psychosis and Other	861	3756	4.36	163	950	16	95		
Total	**2388**	**12698**	**5.32**	**523**	**2811**	**52**	**281**	**0.91**	**£103,526**

Haringey

April to October 2013

Category	Activity	Bed Days	Avg LoS	Emergency Re-admissions	Re-admission Bed Days
Dementia	185	1606	8.68	46	492
Substance Misuse	180	688	3.82	29	100
Psychosis	72	280	3.89	17	36
Non-psychosis and Other	319	1598	5.01	59	288
Total	**756**	**4172**	**5.52**	**151**	**916**

2013/14 Forecast

Category	Activity	Bed Days	Avg LoS	Emergency Re-admissions	Re-admission Bed Days	10% Reduction in Emergency Re-admissions	Reduced Re-admission Bed Days	Bed Reduction Based on 85% Occupancy	Cost Saving
Dementia	317	2753	8.68	79	843	8	84		
Substance Misuse	309	1179	3.82	50	171	5	17		
Psychosis	123	480	3.89	29	62	3	6		
Non-psychosis and Other	547	2739	5.01	101	494	10	49		
Total	**1296**	**7152**	**5.52**	**259**	**1570**	**26**	**157**	**0.51**	**£ 51,254**

Trust Total

April to October 2013

Category	Activity	Bed Days	Avg LoS	Emergency Re-admissions	Re-admission Bed Days
Dementia	576	4864	8.44	157	1192
Substance Misuse	851	3369	3.96	128	460
Psychosis	299	1311	4.38	74	272
Non-psychosis and Other	1054	4989	4.73	205	1112
Total	**2780**	**14533**	**5.23**	**564**	**3036**

2013/14 Forecast

Category	Activity	Bed Days	Avg LoS	Emergency Re-admissions	Re-admission Bed Days	10% Reduction in Emergency Re-admissions	Reduced Re-admission Bed Days	Bed Reduction Based on 85% Occupancy	Cost Saving
Dementia	987	8338	8.44	269	2043	27	204		
Substance Misuse	1459	5775	3.96	219	789	22	79		
Psychosis	513	2247	4.38	127	466	13	47		
Non-psychosis and Other	1807	8553	4.73	351	1906	35	191		
Total	**4766**	**24914**	**5.23**	**967**	**5205**	**97**	**520**	**1.68**	**£191,438**

Reduction in Admissions from A&E

- The Birmingham model (where RAID staff intervened with patients at the MAU before being admitted to the wards) showed a 3% reduction in admissions.
- Islington RAID staff intervenes at A&E rather than MAU. Further baseline data is needed to model the relevant patient cohort through A&E, MAU and admissions to define the expected reduction and quantify savings.

Islington has applied a robust risk adjustment to the modelled savings . Collaborative work is needed in 2014/15 to establish quality benefits and savings for both Trust and commissioners.

Impact on WH Contract value in 14/15: £75k in-year, with a view to the service being self-funding (£250k pa) by year end.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Moderate
2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Islington has applied a robust risk adjustment to the modelled savings . Collaborative work is needed in 2014/15 to establish quality benefits and savings for both Trust and commissioners.

What are the key success factors for implementation of this scheme?

Reduction in admissions and better patient and professional experience are the two key outcomes

Scheme ref no.
BCF6 (c)
Scheme name:
Carelink
What is the strategic objective of this scheme?
Carelink will provide a rapid response, quick access, extended hours Reablement type service for Islington residents or camden residents with an Islington G.P.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Patients over the age of 18 who either live in Islington, or who have an Islington GP and live in Camden. Referrals are accepted from Whittington and UCL Hospital Emergency Departments only. Acceptance criteria • Population covered is as above • Patients will have capacity to accept and engage with the service, and have active goals appropriate for a Reablement type service • Patient is assessed by hospital staff as safe for discharge home with provision of any appropriate equipment from hospital, support from Carelink and any other services arranged by the hospital (e.g. District Nursing) • Patient is able to manage toileting needs at night with the support of appropriate equipment • Patient is able to transfer with equipment and with the assistance of maximum 1 person • Patient is able to manage nutritional requirements safely as assessed by appropriate hospital staff (assessed by SLT/Dietician for swallowing difficulties or OT/Nurse for nutritional needs Exclusion criteria • Patients under 18 • Patients lacking capacity to accept and engage with the service • Patients not living in Islington or registered with an Islington GP • Patients requiring medical treatment that would require an admission • Patients requiring double-handed visits, or assistance from more than one person to transfer • Patients with mental health or dementia needs that prevent their engagement with Carelink Carelink will provide patients with a structured reablement programme to improve independence, well-being and choice for those referred from Emergency Departments at Whittington and UCL Hospitals. The intervention will be a Reablement type care package for up to 10 days. The intervention will consist of up to four visits per day from Carelink staff supporting people with regaining independence in daily tasks like personal care, managing medication, supporting therapy exercises and interventions, cooking, dressing, shopping and housework.

Service Description
Carelink is a Reablement type service. This involves interventions in the patients home to include

- Help with washing and dressing
- Help with medication
- Help with meal preparation
- Help with cleaning, shopping and laundry

The intention is for Carelink to work with patients to improve their confidence and independence in these areas.

Carelink can provide up to four calls per day. These calls will normally be for one hour from one care worker at a time. As much as possible, Carelink will try to provide calls at the time requested by the patient, and will aim to provide consistency in carers

Pathway
Carelink will accept referrals from Whittington and UCL Hospital Emergency Departments. Referrals will be accepted on paper and then acceptance will be confirmed by Carelink telephoning the ward to agree a start time.

Carelink will accept referrals from **Monday – Friday, 9am-8pm** and **Saturday-Sunday 9am-3pm**. Carelink will respond to faxed or email referrals within 30 minutes by calling the ward to agree the referral, reject the referral or request further information.

A copy of the referral form is included as appendix 1. The referral form is intended to be brief to facilitate rapid referrals. The referral form is to be given to the patient to act as an initial care plan. The referral form contains a timetable for visits and the outcomes expected from the Carelink intervention.

If accepted onto the service, Carelink will be able to start the first care visit within two hours from accepting the referral.

Once accepted onto Carelink, Carelink will provide full care co-ordination and case management for the patient. This will provide the patient with a single point of contact to resolve issues relating to health and social care. This will include, as a minimum,

- Telephoning Islington's Reablement service on the first working day following the start of the Carelink intervention to get any relevant history
- Regularly reviewing the patient's needs and adapting the care plan as appropriate. The intention is that for many patients, the involvement of Carelink will be reduced over the 10 days. This regular review process will involve feedback from Carelink workers and telephone calls or home visits with the patient and their carers.
- Working with the patients and carers to make changes to the schedule as required
- Responding to emergencies, such as 'no replies'

- Supporting the patient with interactions with other services, such as district nursing, by chasing up referrals, sharing information and co-ordinating care
- Identifying additional needs as required and referring on to other services
- Planning with the patient for their discharge from Carelink.
    - For patients where their needs can be resolved in 10 days or less, Carelink will work with the patient to identify when the service is no longer required and provide appropriate signposting to support in Islington, such as Age UK Enablement services.
    - For patients who are going to need support for longer than ten days, Carelink will, at an early stage, identify those patients and start discussion with Islington's Reablement service. Carelink will agree an appropriate transfer date with Reablement and provide a comprehensive handover to the Reablement team.

Where patients have an Islington GP but live in Camden, Carelink will arrange handover to the appropriate local authority support. This will need to be identified early during the Carelink intervention.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Carelink will need to develop effective working relationships with a variety of services and providers in Islington. This includes referrers at UCL and Whittington Hospitals, community providers including Whittington Health (District Nurses, REACH teams, specialist nursing teams) and Primary Care, London Borough of Islington's Reablement service as the main contact for onward social care / Reablement referrals, and the voluntary sector, primarily Age UK's Community Enablement service.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- Relevant local strategies include Islington Joint Health and Wellbeing Strategy (2013), Islington CCG Care Closer to Home Strategy (2012), Islington CCG Urgent Care Strategy (2011) and the Joint Adult Commissioning Strategy (2012)
- National Service Framework for Older People 2001
- Community Care (Delayed Discharges etc) Act 2003
- Our Health, Our Care, Our Say (White Paper 2006)
- Maximising the Potential of Reablement, SCIE (2013)
- National Audit of Intermediate Care, NHS Benchmarking (2013)
- Intermediate Care: Halfway Home, DoH, 2009
- Ready to Go? Planning the discharge and transfer of patients from hospital and intermediate care, DoH 2010
- The Short Term Outcomes and Costs of Home Care Reablement Services, University of York, 2009

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Moderate
2	Residential Admissions	Low
3	Reablement	moderate
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	High
6 (local)	Carer Reported Quality of Life	Low

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Carelink will report on the following activity and quality indicators. Due to the pilot nature of this service, reports will be provided monthly direct to Islington Commissioners and no performance targets are being set beyond the process detailed in the specification as above.

At the end of the pilot period, Carelink and Islington Commissioners will meet to review the work.

What are the key success factors for implementation of this scheme?

- To reduce hospital usage for appropriate patients at Emergency Departments at Whittington and UCL Hospitals.
- To increase independence by providing short term Reablement services (up to 10 days) for people at home following an attendance at the Emergency Department
- To identify, refer and work with appropriate health and social care interventions during the Reablement period and to discharge to appropriate required interventions
- To improve the patient and carer experience within the target group during the hospital admission and after
- To improve identification of appropriate patients at the Whittington and UCL Hospitals Emergency Departments

Scheme ref no.
BCF6 (d)
Scheme name:
COPD Pathway
What is the strategic objective of this scheme?
An admission avoidance scheme based on the whole COPD pathway which focuses on improving the care given in primary care and community, including the delivery of the Acute Exacerbation COPD pathway
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Various elements of the whole pathway should impact upon reduction of emergency admissions including: • COPD Locally Commissioned Service for GP practices • Education for primary care clinicians to improve skills • Community nurse clinics • Regular home oxygen reviews • Pulmonary rehabilitation for patients to improve self-management • Acute exacerbation pathway which helps to support patients at home when they are experiencing an exacerbation rather than be admitted to hospital (target time for first contact = 4 hours, up to 6 visits at home). The above initiatives are well established and continuing into 2014-15. CCG implementation of Map of Medicine should see greater use of community pathways including COPD in 2014-15 and support this reduction in emergency admissions.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Discussions have taken place between CCG and GPs, Community Respiratory Team and Whittington Health
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Excerpt from: http://www.londonhp.nhs.uk/wp-content/uploads/2011/06/COPD-profile-Islington.pdf Emergency admission rates are significantly higher than the national average. Residents in Islington are more than three times as likely to be admitted for COPD as residents in the local authority with the lowest admission rate. The proportion of registered COPD patients admitted to hospital is also significantly above average. • Once admitted for COPD, patients from Islington spend significantly longer in hospital than other patients in England; over four days more than the local authority with the shortest length of stay. • Readmission rates within 90 days of an emergency admission for COPD are statistically similar to the national average. However, almost 40 percent of

Islington patients admitted to hospital for COPD return within 90 days.

- The high emergency admission rates are coupled with significantly high mortality rates; Islington residents are over five times as likely to die

Expected impact on providers

COPD Summary (5% reduction)			
	NEL	Short Stay	Total
Barts	£1,037	£0	£1,037
Homerton	£3,183	£726	£4,230
Other	£308	£0	£308
Royal Free	£572	£0	£588
UCLH	£31,858	£1,391	£34,528
Whittington	£27,770	£0	£29,423
North Mid	£40	£0	£40
BCF	£214	£0	£214
Grand Total	£64,982	£2,117	£67,099

The following HRG codes are expected to be impacted – worked example based on Whittington Health:

NEL

HRG Code	Reduction in activity	Savings
DZ21A	10.08	£6,139.9
DZ21J	4.08	£10,792.2
DZ37A	0.48	£301.1
DZ21H	2.64	£8,895.6
DZ21E	0.12	£463.0
DZ21K	0.60	£1,177.9
Grand Total	**18.00**	**£27,769.70**

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Moderate
2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Low

5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Islington has applied a robust risk adjustment to the modelled savings . Collaborative work is needed in 2014/15 to establish quality benefits and savings for both Trust and commissioners.

What are the key success factors for implementation of this scheme?

Patient Safety	Improves patient safety by ensuring appropriate clinical reviews and follow ups, support at home to manage conditions and avoid admissions
Clinical Effectiveness	Care given in accordance with NICE guidance, reviews to ensure clinical effectiveness of care
Patient experience	Improving patient experience by providing care closer to home and avoiding admissions, teaching self-care
Workforce	Support to community and primary care from secondary care consultants improves skills and supports better community and primary care workforce.

Scheme ref no.
BCF6 (e)
Scheme name:
Tissue Viability & Catheter Care
What is the strategic objective of this scheme?
This pilot aims to test a service model for the management of leg ulcers, urethral catheters and central venous catheters by the Tissue Viability (TV) and District Nursing Service (DNS) in Islington
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Previously, the remit of the DNS covered housebound patients only; ambulant patients were expected to be seen in general practice by practice nurses. Wounds such as leg ulcers are however difficult to manage in general practice because of the level of knowledge and expertise required, and the majority of practice nurses do not have the skills to undertake urethral or supra pubic catheterisation or the management of central venous catheters. This project transferred ambulant patient caseload activity to the TV and DNS. The aim was for the service to cover a caseload of approximately 90 patients in the first instance moving to cover an additional 200-300 in forecast unmet need following a survey conducted by primary care. The project has piloted a roll out of additional skills to the DN team to enable 24/7 care of patients with catheter issues (urinary and central venous line), and to support care of ambulatory leg ulcer patients. The expanded skill set enables rapid healing and faster discharge.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Discussions have taken place between CCG and GPs, Community Respiratory Team and Whittington Health
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Expected outcomes are: • Reduced attendances at A&E for catheter related problems • Reduced emergency admissions for catheter, leg ulcer and cellulitis problems • Improved patient experience • Accelerated healing of ulcers The expected level of reduction is 30% reduction for catheter related admissions. *15% reduction for Cellulitis related admissions *15% reduction for Leg Ulcer related admissions. *The Whittington has had its figures risk adjusted to 8.5%

Admission Avoidance (Leg Ulcers, Cellulitis, Catheters)

Projected 2014-15
Costs (Pre QIPP)

	Catheter		Cellulitis		Leg Ulcers		All	
Provider	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
RAL	1	1274	11	47285	5	43655	17	£92,214
RKE	19	17758	115	239950	12	35038	146	£292,747
RRV	8	9369	59	137154	6	22935	73	£169,458
Grand Total	**31**	**£30,915**	**213**	**£472,084**	**29**	**£122,229**	**273**	**£625,229**

Projected 2014-15
Savings

	30% Catheter		15% Cellulitis (Whittington 8.5%)		15% Leg Ulcers (Whittington 8.5%)		All	
Provider	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
Royal Free	0	382	2	7093	1	6548	3	£14,023
The Whittington	6	5327	10	20396	1	2978	16	£28,701
UCLH	2	2811	9	21945	1	3670	13	£28,425
Grand Total	**8**	**£8,520**	**21**	**£49,433**	**3**	**£13,196**	**32**	**£71,150**

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Moderate
2	Residential Admissions	Low
3	Reablement	moderate
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	High
6 (local)	Carer Reported Quality of Life	Low

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Islington CCG is awaiting data from Whittington Health to demonstrate quality and financial returns on investment. It is intended to renew the pilot for an additional year, following which a full evaluation will be conducted at end 2014/15. The intention is that the project should become self-funding at end of 2014/15 from savings.
What are the key success factors for implementation of this scheme?
Please refer to section on ‘evidence base’

Scheme ref no.
BCF7
Scheme name:
Improving Access to Primary Care
What is the strategic objective of this scheme?
To build on the first year of the access scheme which supported practices to develop their systems of work to improve patient access and experience, and reduce use of alternate sources of primary care urgent care (A&E, Urgent care Centres, Walk In Centres), for conditions suitable for primary care response. To provide additional capacity for booked appointments for Islington registered patients outside core hours To help practices respond to pressures and demands with additional capacity **Medium Term:** To support practices to prepare to respond to expected demands such as the developing London Wide Standards for Primary Care To enable a more localised system of primary care urgent care
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Practices will be incentivised to provide additional working hours outside contracted opening, offering booked appointments to their registered patients. The number of hours will be proportional to their list size. These hours will be in addition to any currently offered by the Extended Hours DES. If all practices take up the scheme, an additional 120+ hours will be available. Appointments will be made available with registered primary care health professionals. Practices will be required to demonstrate that the offered hours have taken into account patients views.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The service will be commissioned by Islington CCG using established governance processes for approval, and performance and payment routes in use with the remaining LCS programme. The service will be provided by Islington GP Practices. There are no alternative providers for this service as it requires access to both patient medical histories, and the registered patient list. The service is also a direct extension of the GMS core functions, although contractually outside this arrangement
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
• The need for additional primary care capacity is well evidenced as a means to reduce reliance on secondary care or other sources of urgent care. • The methodology is established within the Extended Hours DES which has

been established for over 5 years and demonstrated to work well
- The practicality and deliverability is supported by the Local Medical Committee
- The need for additional capacity in primary care was supported by all practices as part of the July Pan Islington Forum

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Moderate
2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The outcome measures are an extension of the Year 1 Improved Access LCS
- Reduced attendance at A&E for 'minor' issues during GP practice opening hours
- Increased satisfaction shown in the IPSOS Mori bi-annual patient survey
- Measured opening hours from participating practices
- Number of used appointments from participating practices

What are the key success factors for implementation of this scheme?
- Increased opening / availability of primary care in Islington
- Reduced attendance at A&E for 'minor' issues during GP practice opening hours
- Increased satisfaction shown in the Ipsos Mori bi-annual patient survey
- Development of a locality based service for urgent primary care from October 2016

Scheme ref no.
BCF8
Scheme name:
Develop primary care capacity to support localities
What is the strategic objective of this scheme?
The strategic objective is to support the development of capacity within primary care that will be able to manage more patients in the community.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
We want to support primary care to develop a locality based collaborative model, creating benefits across the system for patients, providers and commissioners. This key structural work will support improvements for all patients registered with Islington CCG.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The Islington CCG commissioners will continue to support Primary Care across Islington.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The King's Fund[8] have set out expected benefits from federated models as • strengthen clinical governance and improve the quality and safety of services • develop training and education capacity • strengthen capacity of practices to develop new services out of hospital • make efficiencies and economies of scale • improve local service integration
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Moderate
2	Residential Admissions	Moderate
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

[8] http://www.kingsfund.org.uk/topics/commissioning/primary-care-toolkit

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Patient surveys and complaints are the key means by which we have a feedback loop on success
What are the key success factors for implementation of this scheme?
Success factors include: • more efficient mechanism for commissioning with a range of practices • working collectively to agreed standards will lead to improved patient outcomes and experience • creating a more sustainable model of primary care at a time of increased pressure and expectation

Scheme ref no.
BCF9
Scheme name:
Develop Preventative Services
What is the strategic objective of this scheme?
To reduce the number of preventable emergency A&E admissions in Islington's older population (over 65) through the delivery of a range of public health/social care services that address the main causes/risk factors of emergency A&E admissions.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There are a number of preventative services in Islington that contribute towards managing the main risk factors that are responsible for a large proportion of A&E admissions, including: excess cold (including fuel poverty and poor insulation), respiratory illness (including flu and pneumonia) and falls in the home. The scheme intends to improve the links between these services, offering greater integration of care for residents/service users and the ability to manage multiple risk factors simultaneously. The prevention offer will also include an additional scheme which intends to improve the proportion of people with learning disabilities that complete a health check. This will directly contribute to reducing emergency A&E admissions through the development of individual health action plans that address the main causes of admissions in this population group. As well as immediate prevention for A&E admissions, the aim is to build capacity within the community which, over a longer period of time, would support communities to manage and maintain their health and wellbeing. This would create a strong network that local people, particularly those who are from traditionally deprived communities in the borough, can access, thus offering a life course approach to support. The scheme comprises: • SHINE – a single point of referral into a wide range of interventions (including those that address excess cold, fuel poverty, fire safety, falls assessment, enablement and befriending services) • Residential environmental health – targets the vulnerable residents in the private rental sector working with tenants and landlords to improve safety in the home and address insulation and excess cold issues • COPD housebound stop smoking service – offers a home based smoking cessation service for people with COPD • Winter well campaign – pro-active contract service that targets vulnerable residents over 75. The project acts as an extension to SHINE to residents that may not be aware of the existing referral systems. The programme will also promote flu and pneumococcal vaccination uptake among the eligible population. • Enablement service – an enablement and befriending service that forms part of the reablement pathway

- Community wellbeing project – this project is in partnership with Islington Giving and is being delivered by Help on Your Doorstep in the New River Green estate. The project has four key elements:
    - Research and insight with local community into their needs and skills
    - Design with local community
    - Delivery by local community
    - Evaluation with local community
- Community co-ordination – to provide a way that the wellbeing work with the local community is supported, does not take place in silos and can be measured. Through the integrated care programme we are currently developing an approach which will commission, co-ordinate, monitor and evaluate the community wellbeing projects and programmes through a third sector organisation.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners sit across Public Health and Social Care. Providers include:

- SHINE –delivered by Islington Council
- Residential environmental health –delivered by Islington Council
- COPD –delivered by Whittington Health
- Winter well Campaign –previously provided by Age UK Islington
- Enablement - delivered by Age UK Islington
- Community wellbeing project – delivered by Help on Your Doorstep
- Community co-ordination – provider to be identified

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Local hospital and A&E data indicates that 15% of emergency admissions are linked to accidents and 12% are related to respiratory illnesses. Residents aged 85+ have the highest admission rate and almost 70% result in a hospital admission. A&E admission data indicates a seasonal trend, with increased rates during winter.

The second highest rate of ambulatory care sensitive emergency hospital admissions in Islington are as a result of COPD (after admissions for influenza and pneumonia). These are admissions that could be avoided by better identification and management of COPD in primary care, including stop smoking services.

Pressures in secondary services are expected to increase rapidly due to an aging population, people living longer and in some cases, living longer with long term conditions. Although Islington has a relatively young population compared to the England average, evidence suggests that the use of emergency services and secondary care services by this population group will continue to grow.

The University of Birmingham published a policy paper highlighting the “10 high impact” changes related to prevention that should be embedded in older people’s services to reduce demand for secondary services (Allen and Glasby 2010). The majority of the ten high impact recommendations target the main causes of

emergency admissions in Islington and include: promoting healthy lifestyles, vaccination programmes, falls prevention, housing adaptations, reablement services and partnership working.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low*
2	Residential Admissions	Low*
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Moderate

* We are expecting this work to take some time demonstrate impact, but will expect Moderate impact in the longer term

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The existing schemes have established evaluation pathways and the scheme would seek to use the information collected via these evaluations. This would include:

- Uptake and quit rate of COPD home based stop smoking service
- Referrals managed by SHINE service and what intervention(s)those referrals received
- Uptake of flu and pneumococcal vaccination programmes
- Process evaluation information from residential environmental health

Service user experience surveys are included in the evaluation of the COPD services
Community wellbeing project will create a full report of the qualitative data from research phase of the project and final evaluation

What are the key success factors for implementation of this scheme?

- Reduction in A&E admissions linked to respiratory illness and external causes in people aged 85+
- Increased cross referral between the projects
- Increased uptake of flu and pneumococcal vaccination programme
- Improvement of wellbeing score
- Attendance at-number of people at engagement events, community support or community projects
- Patient experience feedback on community projects

Scheme ref no:
BCF10
Scheme name:
Incentivising acutes to deliver change
What is the strategic objective of this scheme?
We aim to commission services across the care pathway to deliver value and improve outcomes for our patients. Commissioning in this way will realign services to provide a more holistic journey for patients built around their needs rather than those of the service providers. It will transfer expertise out of the acute setting and into community based integrated practice units where other diabetes related services are co-located thereby reducing secondary acute activity. This project aims to develop and implement a new contract & funding model of diabetes and also mental health service provision specifically aligned to the achievement of both clinical and patient related outcomes. The VBC integrated practice unit model will be contracted through a different contracting model e.g lead provider with a payments being made based on the achievement of outcomes, in addition to activity and processes. This is one of a range of projects which will contribute to and support the overall BCF target of reducing secondary care admissions and attendances by 3.5%.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Diabetes Current provision of diabetes services is delivered by a myriad range of providers with differing agendas - it is fragmented and does not directly address the needs of patients with diabetes. Value-based health care is about developing a shared common purpose to achieve the best possible outcomes for patients per pound spent. Developing a shared common goal unites the interests of all - patients, commissioners, providers - in support of a sustainable and high quality health care system. Value is defined from the perspective of the patient, and depends on results or outcomes that matter to patients, rather than inputs or volume of services delivered. Historically, care has been organised and paid for around volume of services delivered, rather than value. The new model of service provision will take the form of an integrated practice unit which brings together all aspects of diabetes care to be provided under a new contracting model which co-locating services in hubs which will provide a better, more integrated service for patients offering rapid access to specialist care, ease of referral through a single point of access and extended hours (8am – 8pm). The scope of the service includes all areas of care for patients with type 1 and type 2 diabetes in Islington and Haringey, providing care is specifically related to diabetes. Outcomes are condition-specific around groups of patients with similar needs, multidimensional, and include results which matter to patients. Existing approaches to health outcomes measurement have been limited mainly to things within one

dominant provider's control. This has tended to reinforce existing 'silos' of care. The expected benefits of a value-based approach are improvements in outcomes that matter to groups of patients with similar needs, for no greater cost to deliver. In addition, this approach drives different providers to work together to better coordinate care for patients, improving their experience and outcomes. Where such an approach has been implemented, as in stroke care across London, measurable improvements in outcomes have been achieved.

Mental health

People who live with psychosis (clusters 10-17) experience inequitable access to physical health services and massive health inequality, dying up to 25 years younger than fellow citizens. The comorbid physical and mental health needs of this cohort are not given equal importance and attention by all health care providers. There are significant whole system costs to not treating comorbid severe and enduring mental illness and long term conditions, that could be ameliorated by reducing unplanned care and increasing preventative interventions e.g. earlier diagnosis and self-management. The scope will cover people with Psychosis in HONOS-Pbr clusters 10-17, provides an opportunity to

- Improve the experience of service users as described by the outcomes produced by the ERG
- to improve physical health outcomes for people in the clusters with comorbid Long Term Conditions (LTC)
- Increase life expectancy for those with a SMI
- to provide a mechanism for acute, community, primary care and mental health providers to work together to improve outcomes for people with psychosis
- to provide a large enough cohort (approx. 3,400 in Islington and 3,100 in Camden) in order to change the way service are commissioned through a new IPU.
- to provide truly integrated care

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Diabetes IPU will be commissioned jointly by Haringey and Islington CCGs. We have been working with University College Hospital London, Whittington Health and North Middlesex Hospital, along with our GP providers, public health, patients and carers and council.

The mental health IPU is being developed jointly by Camden and Islington CCGs. We are working with Camden and Islington Mental Health Foundation Trust, University College Hospital London, Whittington Health and Royal Free and Central North West London Trust, along with our GP providers, public health, patients and carers and council.

The following are key milestones

- Outline business case approved by October 2014
- Full business case approved by January 2014
- Implementation by April 2015

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Published evidence for value based commissioning schemes is in its infancy however the acknowledged guru is Professor Michael Porter some of whose work is outlined below:

- A review of value–based commissioning in mental health – NHS Midlands and East – 2013 Emma Perry, Jo Barber and Elizabeth England
- Value-Based Health Care – HBC October 2012 Michael Porter
- The Strategy That Will Fix Healthcare – HBC October 2013
- What is Value in Healthcare? – New England Journal of Medicine
- Great Western Hospital: High risk Pregnancy Care – HBC January 2013 (revised) Michael Porter

Through the developmental work that Islington and Haringey CCGs are undertaking with this project we expect to become pioneers for future value based commissioning service models and to be the source of evidence based best practice. We are supported by Outcomes based Healthcare and Cap Gemini who provide expertise on the principles and model of value based commissioning.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

We will be expecting providers to work together in a different way to provide joined up, integrated and seamless care for patients and that the health and well-being of our local population will improve as a result of commissioning in this way.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We worked with patients, carers and clinicians across the pathways to identify the outcomes that are important to them. The achievement of the agreed patient centred outcomes is key to the success of the service and will be strictly measured. The provider will be paid on achievement of the outcomes. The financial model is currently in development. The approach we have taken has been to:

- Identify and agree scope and cohort of patients within the project
- Identify and agree outcomes
- Review and agree measures
- Identify and agree measurement tools to be used to measure the outcomes

The table below lists the outcomes expected for the diabetes pathway

1. **Mortality**	**5. Outcomes related to Clinical Outcomes/Complications:**

1a. A measure of mortality rate	5a. Lower limb amputation/PVD A measure of lower limb amputation /PVD rate
1b. A measure of premature mortality rate: years of life lost	5b. Preventable blindness A measure of preventable blindness / retinopathy
2.Health related Quality of Life	5c. Renal Disease A measure of renal disease
2a. A measure of quality of life	5d. Stroke (CVA) A measure of stroke
3. Outcomes related to Symptom Control (e.g. hypoglycaemia, lethargy):	5e. Heart attack (MI) A measure of MI
3a. Symptom-free A measure of symptom control	5f. Erectile Dysfunction A measure of erectile dysfunction
3b. Symptom recognition A measure of the recognition of high/low blood sugar	**6. Amount of time out of normal routine**
4. Patient Identified Outcomes	6a. Disruption A measure of disruption by care to life
4a. Control A measure of feeling in control of diabetes	6b. Impact on people around me A measure of whether family/carers are supported
4b. Confidence A measure of feeling confident in managing diabetes	**7. Experience of Care/Treatment Process**:
4d. Support A measure of feeling supported in managing health	7a. Care Coordination A measure of feeling that care is more coordinated
4e. Fear/anxiety A measure of feeling free from fear/anxiety	7b. Access A measure of timely and organised access to services
4f. Happiness/Mood A measure of mood	7c. Right person, right time A measure of feeling that I can access the right person/service at the right time
4g. Self-management: Monitoring A measure of being able to monitor diabetes	7d. Planned Care A measure of feeling involved in care planning
4i. Self-management: Understanding A measure of being able to understand how to manage diabetes	**8. Clinical Outcomes/Complications over time (i.e. delayed onset)**
4j. Self-management: Managing A measure of how to feel more able to self-manage diabetic care	8a. Amputation/PVD A measure of the onset of amputation/PVD
	8b. Preventable blindness A measure of the onset of preventable blindness
	8c. Renal Failure A measure of the onset of renal failure

	8d. Stroke (CVA) A measure of the onset of stroke
	8e. MI A measure of the onset of MI

What are the key success factors for implementation of this scheme?

- Integration and fluid movement across a whole system pathway
- Patients reporting satisfaction with a more integrated service which is flexible and attuned to their needs.
- Fewer attendances and admissions to A&E
- Patients reporting better ability to self-manage their condition
- More patients being managed in primary care
- Higher numbers of patients undertaking self-management programmes
- Staff reporting improvement in ways of cross agency working
- Shorter waiting times for support services
- Providers working collaboratively
- Ability to measure outcomes as well as current processes and activities

Scheme ref no.
BCF11
Scheme name:
Reablement
What is the strategic objective of this scheme?
To provide supported discharge from acute and institutional settings, and to prevent admission to acute and institutional settings, through the timely provision of reablement and rehabilitation support.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Reablement; intermediate care beds; specialist rehabilitation. Reablement is an established intervention. We have some innovative aspects to our reablement service, including pharmacy input to support optimal medication concordance and mental health nursing to lead on reablement for people with dementia. Reablement is open to all adults who would benefit, though the service is largely delivered to older adults.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
These services are currently commissioned through a pooled budget managed under the S75 between Islington CCG and the Council. The reablement and rehabilitation services are provided by Whittington Health and the Council via a provider S75 agreement. Bed-based intermediate care services are provided by a number of external providers.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The current reablement and rehabilitation services support low rates of delayed transfers of care, and high performance in relation to numbers of people still at home 91 days after discharge. Reablement is recognised as an effective intervention by SPRU/PSSRU research as outlined by SCIE.[9] It is recognised that the services need to increase productivity in order to meet increased demand within the current cost envelope, and better support the 3.5% admissions avoidance target. Analysis and modelling of the services is currently underway. This is a partnership approach between commissioners and providers.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

[9] http://www.scie.org.uk/publications/briefings/files/briefing36.pdf

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low
2	Residential Admissions	Moderate
3	Reablement	High
4	Delayed Transfers of Care	Moderate
5	Patient / Service User experience	Low
6 (local)	Carer Reported Quality of Life	Low

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Reablement currently monitor outcomes in terms of patient experience and satisfaction through exit surveys. Quantifiable data is gathered by discharge destination and reductions in support required. We participate in the National Audit for Intermediate Care which allows benchmarking against other Reablement organisations.

What are the key success factors for implementation of this scheme?

Not applicable - reablement is an established intervention in Islington, which has been operating for several years. There are no milestones associated with this scheme.

Scheme ref no.
BCF12
Scheme name:
Carers Funding
What is the strategic objective of this scheme?
To better support carers in Islington by identifying, valuing and supporting their key role across the whole system.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
We know that carers are under-identified, and are also less likely to make effective use of health and social care support. This project seeks to both increase formal identification of people who are carers, and once identified, to support them through the health and care system to ensure their needs are best met. We have a strong offer for carers, but too often these services are not accessed at the right time. A key metric for Islington's BCF is 'Carer Reported Quality of Life' – ASCOF 1D. This service will directly seek to improve that metric. Islington Carers Hub service will continue to support carers to maintain and improve their health and wellbeing through the range of services offered by the Hub and through their partners. The Hub model is based on a single point of access which means that carers know where to go and will get accurate and timely information and advice. Carers will also be signposted accordingly for more specialised advice, information, support and other universal services through the work developed and pathways established with partners, including partners in the primary and secondary care setting. Identification of hidden carers is key to supporting carers to maintain and improve their health and wellbeing and thereby sustain their caring role. The Census tells us there are over 16,000 carers in the borough, the hub currently has a membership of over 1000 carers. The outreach and engagement role of the Hub will support organisations to develop innovative ways to identify carers and establish good practice. There is a target of identifying 150 hidden carers in 2015/16. This number is planned to grow year on year through embedding good policies and practices across partners and within the Hub service itself.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Islington has a long standing pooled budget for carers services, held between Islington CCG and Islington Council, and funding a variety of services for carers, including the local Carers Hub and Carers Breaks. Carers UK are the provider of the Carers Hub which will be used as the main vehicle for increasing carer support
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
National Carers Strategy 2011

Islington Joint Commissioning Strategy 2012-17

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low
2	Residential Admissions	Moderate
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Low
6 (local)	Carer Reported Quality of Life	High

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We already have a carers pathway group, made up by carers. This group feeds into project design, development and feedback

What are the key success factors for implementation of this scheme?

Islington Carers Hub service will contribute to the following outcomes measured as part of the carers offer:

- Carers are supported to maintain or improve their health and wellbeing
- carers will be able to access a range of services through the hub
- carers know where to go for information and advice
- carers are supported in their caring role
- carers can take up opportunities that they may have been excluded from because of their caring responsibilities
- carers can participate in their local communities including social and leisure opportunities

The Carers Hub is an established intervention in Islington. There are no milestones associated with this scheme.

Scheme ref no.

BCF13

Scheme name:

Support mitigating pressures in health care for both people with learning disabilities and older people

What is the strategic objective of this scheme?

To mitigate the increase in NHS Funded Continuing Health Care pressures.

This will ensure that the S75 pooled learning disability budget, which is hosted by the local authority, does not lead to additional pressures on local authority budgets. It will enable the successful completion of the Winterbourne View action plan in Islington, which has already been successful in moving the majority of people in assessment and treatment centres into less restrictive and more appropriate settings.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

£1m will be used to offset increases in demographic demand in the Learning Disabilities S75 pooled budget (where an increase in numbers of people eligible for continuing healthcare has increased significantly). £400k will be used to offset the increased demand for continuing healthcare support for older people.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Continuing healthcare services are delivered via the Continuing Healthcare framework contract.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- Numbers of people eligible for continuing healthcare in Islington
- Pressures identified on existing budgets.
- The drive to support increased numbers of people with more complex needs at home as a result of the Winterbourne View action plan

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low
2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Low

6 (local)	Carer Reported Quality of Life	Low

Whilst this scheme will have considerable impact for the patients and carers it works with, the overall impact will be low due to the numbers of people involved.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- S75 governance meetings
- Winterbourne View action plan (reported to CCG Governing Body, and HWBB)

What are the key success factors for implementation of this scheme?

- Continued effective oversight of CHC pooled budgets through existing arrangements

The CHC pooled budget is an established intervention in Islington. There are no milestones associated with this scheme.

Scheme ref no.

BCF14 and 15

Scheme name:

Protection of Adult Social Care:

- Protect the provision of adult social care services for those with moderate needs
- Protection of Adult Social Care in the context of increased demographic pressure

What is the strategic objective of this scheme?

- Continuation of meeting people's needs before they become critical, therefore reducing pressure on more intensive services
- Mitigating the demographic increase in the demand on social care services, which is above and beyond the increase in demand due to the Care Act, and which needs to be met within the context of a reduced budget**.**

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Islington aims to continue to provide social care services to those with a level equivalent to the current FACS Moderate. This supports the prevention of more acute needs developing, and therefore ameliorates pressure on health services.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

These are services commissioned by the London Borough of Islington. This includes domiciliary and residential care, provide through both block and spot contracts.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The demographic investment required to enable the sustainable provision of adult social care is based on modelling by LB Islington, and takes into account the need to efficiencies.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low
2	Residential Admissions	Moderate
3	Reablement	Low
4	Delayed Transfers of Care	Moderate
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Making it Real Board
What are the key success factors for implementation of this scheme?
That eligibility is maintained and that Islington residents who need support can access it in a timely way. This is an established intervention, with funding to protect existing services. There are no milestones associated with this scheme.

Scheme ref no.

BCF16

Scheme name:

Community Capacity Capital Grant

What is the strategic objective of this scheme?

The Local Authority has received the ring fenced capital programme funding from the Department of Health's Community Capacity Grant fund to support the development of specific adult social care initiatives.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The funding will be used to provide further investment in IT systems development to support the implementation of the Care Act changes, for the refurbishment and development of in-house daycare services.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

These are services delivered directly by the London Borough of Islington.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Draft guidance and regulations for the Care Act 2014

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low
2	Residential Admissions	Moderate
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Moderate

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

NA

What are the key success factors for implementation of this scheme?

NA

Scheme ref no.
BCF17
Scheme name:
Disabled Facilities Grant
What is the strategic objective of this scheme?
Existing capital transfer to the local authority. The Disabled Facilities Grant has conditions set elsewhere which will form the basis for this scheme.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
N/A
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
N/A
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
N/A
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	
2	Residential Admissions	
3	Reablement	
4	Delayed Transfers of Care	
5	Patient / Service User experience	
6 (local)	Carer Reported Quality of Life	

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
N/A
What are the key success factors for implementation of this scheme?
N/A

Scheme ref no.
BCF18
Scheme name:
Support Implementation of the Care Act
What is the strategic objective of this scheme?
Support the Implementation of the Care Act
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Islington is well-placed to implement the requirements of the Care Act, having established a number of key requirements, such as a deferred payments scheme, a joint transition team, a comprehensive offer for carers, and a strong track record of personalisation. However, there will be an expected increase in demand due to self-funders and more family carers coming forward for assessment. We are currently quantifying this demand using local market intelligence and the tools shared by the national joint programme team. As reflected in the London Councils and ADASS response to the draft guidance and regulations, there remains a risk that any calculation of additional demand can be an approximation only, and more demand than expected might be experienced. In addition, there are two prisons in Islington, and there could be significant additional demand on the Council depending on the final requirements of the final guidance and regulations expected in October 2014. It is recognised that the final guidance and regulations of the Care Act 2014 will not be published in time for the submission of the Better Care Fund templates. Therefore, there might be additional demands in the final guidance that have not been accounted for in this plan.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
A sub-group of the Moving Forward Programme Board, the Care Act Implementation group, is overseeing this work, and is chaired by the Service Director for Adult Social Care.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Draft guidance and regulations for the Care Act 2014
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

BCF Metric	Description	Impact
1 (P4P)	Reducing non-elective admissions	Low
2	Residential Admissions	Low
3	Reablement	Low
4	Delayed Transfers of Care	Low
5	Patient / Service User experience	Moderate
6 (local)	Carer Reported Quality of Life	Low

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A sub-group of the Moving Forward Programme Board, the Care Act Implementation group, is overseeing this work, and is chaired by the Service Director for Adult Social Care.

What are the key success factors for implementation of this scheme?

A clear programme approach, with identified legal, finance and communications support.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Islington
Name of Provider organisation	The Whittington Hospital NHS Trust
Name of Provider CEO	Simon Pleydell
Signed on his behalf by	Siobhan Harrington, Deputy Chief Executive
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	9697
	2014/15 Plan	9547
	2015/16 Plan	9399
	14/15 Change compared to 13/14 outturn	-1.51%
	15/16 Change compared to planned 14/15 outturn	-4.63%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	146
	How many non-elective admissions is the BCF planned to prevent in 15-16?	438

Table 1: Schemes aligned to deliver BCF Non-Elective reductions

Scheme	**14/15 (1 Quarter)**		**15/16 (3 Quarters)**	
	ACT	**COST**	**ACT**	**COST**
Children's services - Hospital at Home	12	£34,456	37	£103,368
COPD	5	£6,942	14	£20,827
District nursing and leg ulcers	4	£7,175	13	£21,526
*Ambulatory Care Service	116	£137,271	349	£411,812
Carelink	9	£16,615	26	£49,845
	146	**£202,459**	**438**	**£607,378**

Outturn figures are taken from MAR returns which were submitted as part of the CCG operating plan; they have then been aligned with additional BCF requirements.

BCF scaled from 14/15 QIPP to project 15/16 position.
QIPP schemes and BCF are built in to 14/15 contract baselines

*The Ambulatory Care Service business case supplied by the Whittington had a 958 Non-Elective admission target. This has been risk adjusted.

For Provider to populate:

	Question	Response
1.	Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?	We agree that the data in terms of a reduction in non-elective admissions is in line with commissioners' assumptions.
2.	If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?	
3.	Can you confirm that you have considered the resultant implications on services provided by your organisation?	We continue to work through and consider the implications on services provided by our organisation. As an integrated care organisation we are identifying the benefits on community service provision of the local BCF plans.

Name of Health & Wellbeing Board	Islington
Name of Provider organisation	University College Hospital NHS Trust
Name of Provider CEO	Sir Robert Naylor
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	7431
	2014/15 Plan	7316
	2015/16 Plan	7202
	14/15 Change compared to 13/14 outturn	-1.55%
	15/16 Change compared to planned 14/15 outturn	-1.55%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	37
	How many non-elective admissions is the BCF planned to prevent in 15-16?	11

Table 1: Schemes aligned to deliver BCF Non-Elective reductions

Scheme	**14/15 (1 Quarter)**		**15/16 (3 Quarters)**	
	ACT	**COST**	**ACT**	**COST**
Children's services - Hospital at Home	9	£27,927	28	£83,781
COPD	4	£8,312	12	£24,937
District nursing and leg ulcers	3	£7,106	10	£21,319
Ambulatory Care Service	16	£24,634	49	£73,901
Carelink	4	£7,666	12	£22,997
	37	**£75,645**	**111**	**£226,934**

Outturn figures are taken from MAR returns which were submitted as part of the CCG operating plan

BCF scaled from 14/15 QIPP to project 15/16 position.
QIPP schemes and BCF are built in to 14/15 contract baselines

For Provider to populate:

	Question	Response
1.	Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?	We support the BCF schemes as ones that will support reductions in emergency admissions. We feel the proposed reductions are highly ambitious and will require successful implementation of significant service redesign to enable the health economy to deliver them. We are committed to working closely with Whittington Health as the provider for community services in enabling these plans to be successful. UCLH have undertaken extensive work assessing re-admissions in the past and this has historically shown that over 80% of 30 day re admissions were in fact clinically appropriate. We are currently undertaking a programme of work to re-evaluate this over the next few months. Investment in COPD, Heart failure and Frailty with a view to radically changing current pathways is critical and UCLH are currently working collaboratively with Islington and Whittington Health to make this possible.
2.	If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?	
3.	Can you confirm that you have considered the resultant implications on services provided by your organisation?	We are fully supportive of the target reduction levels. While this represents lost activity and income, we incur income penalties in relation to much of the targeted activity, either through the emergency marginal rate or through readmissions penalties. Reductions in targeted emergency admissions will also support us in our search for additional capacity due to rising demand in other parts of our clinical workload.