



Report of: **Director of Commissioning, Islington CCG**

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	20 April 2016	B1	All

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SUBJECT: Islington CCG Commissioning Intentions for 2016/17

1. Synopsis

The National Planning Guidance 2016/17 – 2020/21 for the NHS published on 22 December 2015 confirms that two plans are required to be delivered for 2016/17 onwards:

- A five year Sustainability and Transformation Plan (STP), driving delivery of the Five Year Forward View based on a Strategic Planning Group footprint (North Central London), for final submission late June 2016;
- A one year Operational Plan for 2016/17 for the CCG, as a milestone for delivering the STP, for final submission 11 April 2016.

This paper provides an overview of development of the Sustainability and Transformation Plan (STP) for North Central London and the Islington CCG Operating Plan for 2016/17.

2. Recommendations

To note and comment on the development of the Sustainability and Transformation Plan (STP) for North Central London and the Islington CCG Operating Plan for 2016/17.

3. Introduction

The National Planning Guidance 2016/17 – 2020/21 for the NHS published on 22 December 2015 confirms that we will be required to deliver two plans for 2016/17 onwards:

- A five year Sustainability and Transformation Plan (STP), driving delivery of the Five Year Forward View based on a Strategic Planning Group footprint (North Central London), for final submission late June 2016;
- A one year Operational Plan for 2016/17 for the CCG, as a milestone for delivering the STP, for final submission 11 April 2016.

These plans focus on delivery of the Five Year Forward View (FYFV) and an accelerated rate of service transformation as well as a shared approach to planning through system wide Strategic Planning Groups (SPG) including specialist commissioning, providers and local government. Therefore we must ensure our plans deliver:

- A radical upgrade in prevention and public health;
- A concerted effort to improve the quality of care, aligned to the introduction of new models of care;
- A focus on getting finances back in balance; and
- A place based system wide vision for transformational change to address local and national challenges and priorities.

The timetable for submission of Plans is summarised below:

	Operational Delivery Plan (ODP)	Sustainability and Transformation Plan (STP)
First cut	11 February 2016	31 March 2016
Second cut	2 March 2016	6 May 2016 (unconfirmed)
Final Version	11 April 2016	30 June 2016

4. The Sustainability and Transformation Plan (STP) 2016/17 – 2020/21

This plan will be developed collaboratively across our North Central London (NCL) Strategic Planning Group (SPG) for a five year period. This plan must address the priorities for change in a robust transformation plan that includes a clear vision, robust leadership and governance arrangements, milestones for delivery and agreed actions to achieve our vision. These plans need to be developed in collaboration with our whole health and care system (including local authorities and the third sector) with providers, commissioners and our population for a five year period.

The North Central London Strategic Planning Group in London) is to produce a multi-year Sustainability and Transformation Plan (STP) for the local healthcare system, outlining how local services will get from where it is now to where the Five Year Forward View requires them to be by 2020. STPs will therefore set out the strategic vision accounting for national and regional priorities which will be enabled through operating plans.

Guidance clearly highlights five elements that must be included in the STP:

- Local leaders working together as a team;
- Development of a shared vision with the local community and local government;
- Programming a clear plan of actions to deliver to the vision;
- Execution against this plan;
- An ability to learn and adapt to overcome challenges and meet our objectives.

In addition the STP must be developed openly and engage patients, carers, clinicians, citizens and local partners such as independent and voluntary sectors and Health and Wellbeing Boards. It will include activity for specialised services, primary medical care, prevention, social care and integration locally with local authority services.

The STP will need to demonstrate a system wide local sustainability plan for the local NHS system to balance its books across all organisations. The 'National Challenges' set out in three main questions to be answered by this plan are a core element but must not be considered as the only necessary answers to be provided by the plan:

1. How will you close the health and wellbeing gap?
2. How will you drive transformation to close the care and quality gap?
3. How will you close the finance and efficiency gap?

4.1 Sustainability and Transformation Plan Content

Each healthcare system will need to produce a Sustainability and Transformation Plan for the local healthcare system outlining how local services will get from where they are now to where the Five Year Forward View requires them to be by 2020. Plans should include:

4.1.1 Vision and strategic goals

- A multi-year, place based vision for the local population for each SPG;
- Alignment and consistency with organisational plans, outlining proposed changes to services and implications for each organisation;
- Vision that should be developed and tested with local stakeholders;
- Assurance that the SPG is financially sustainable post-implementation;
- A centralised financial, activity and capacity model that demonstrates triangulation of assumptions across all stakeholders;
- A demonstration of value for money using both financial and economic appraisal techniques.

4.1.2 Case for change

An overview of health needs of local population, areas for quality improvement, and local financial challenges facing the local health economy.

4.1.3 Priorities

A set of measurable (SMART) priorities for the next five years which build on plans submitted last year.

4.1.4 Enablers

An outline of the key enablers required to deliver the vision and priorities, including IT, workforce requirements, estates changes or utilisation.

4.1.5 Implementation plan

Detailed milestones, clear ownership, resourcing and risks for each priority area for action. A summary of progress to date in developing the Sustainability and Transformation Plan is appended for information.

4.2 Funding

The planning guidance confirms that financial resource will be provided for as follows:

- A new Transformation Fund held centrally by NHS England and awarded to systems and organisations who can demonstrate robust collaborative leadership supported by Sustainability and Transformation Plans with clear visions and plans;
- A Sustainability Fund of £1.8 billion from the Transformation fund distributed directly to provider trust organisations based on calculations trust by trust to return the NHS provider sector to financial balance. Recovery milestones will need to be met (deficit reductions, access standards and progress on transformation) as well as embedding a culture of 'relentless cost containment' in order for trusts to continue to receive funding.

5. Islington CCG Operating Plan for 2016/17

Commissioner and provider plans for 2016/17 will be submitted in April and need to be agreed by NHS England and NHS Improvement (who oversee NHS provider plans). Planning Guidance places great emphasis on the triangulation of plans across commissioners and providers in operating plans for 2016/17.

The plan must also deliver to year one milestones for seven day service priorities and a clear list of nine 'must dos' for 2016/17, set out in the guidance for all local systems.

5.1 Seven-day services

The priorities set out for 2016/17 reflect the NHS Mandate and Five year Forward View (FYFV) implementation. These priorities include partial roll out of seven day services delivering:

- **Access to acute services** complying with four of the ten **clinical standards** for seven-day services for 25% of the population (we already support Whittington Health to deliver seven day services through our current contract);
- **Enhanced access to primary care** for 20% of the population (we are already delivery enhanced access through primary care through the i:Hub service funded through the Prime Minister's Challenge Fund and locally commissioned services);
- **Consultant cover and diagnostic services** at weekends to reduce increased deaths compared to weekdays, as part of the seven-day service offer;
- **Better integration of 111, minor injuries, Urgent Care Centres, GP out of hours** to improve alternative out of hours service offers to patients (the new integrated 111 and out of hours service across North Central London (NCL) will commence in October 2016).

5.2 The nine 'must dos' for 2016/17:

1. **Develop our North Central London (NCL) Sustainability and Transformation Plan (STP)**, determining and delivering against our local critical milestones towards the triple aim within the Five Year Forward View. The triple aim relates to:
 - A radical upgrade in prevention and public health;
 - A concerted effort to improve the quality of care, aligned to the introduction of new models of care;
 - A focus on getting finances back in balance.
2. Deliver **system wide aggregate financial balance**, including productivity and workforce improvement programmes within providers and **Right-Care programmes** by commissioners, such as value based commissioning and population based outcomes;

3. Implement local plans to address **sustainability and quality of general practice**, including workforce and workload issues;
4. Achieve **access standards for A&E and ambulance waits** (category A 8 minute calls) including implementation of the Urgent and Emergency Care review through new networks;
5. Delivery of **18 week referral to treatment** standard, including offering patient choice;
6. Delivery of the 62 day, 2 week and 31 day **cancer standards** as well as ensuring **earlier diagnosis** to improve one year survival rates and reducing diagnosis on emergency admissions;
7. Achieve two **new mental health access standards**, for commencement of NICE approved care packages within 2 weeks (for 50%) of referrals for **First Episode Psychosis** and treatment within 6 weeks (for 75%) and 18 weeks (for 95%) of referrals for **IAPT**. This also includes maintaining diagnosis rate of at least two thirds for **dementia**. The CCG is achieving these standards in 2015/16;
8. Delivering **transformation of care for people with learning disabilities** including implementation of all elements of new published policy;
9. Implement plans for **affordable improvements in quality**, including provider publication of annual avoidable mortality rates.

These are not new to Islington CCG and we have already got clear programmes in place or in development for these priorities. Our plan will need to bring these priority programmes of work together, incorporate how they will link to the NCL Sustainability and Transformation Plan, ensure implementation delivers benefits across health and care in line with the ambitions of our local authority and ensure we have stretch milestones throughout the year that we can achieve and are agreed within our contracts with providers.

5.3 Islington CCG Plan

This section of the paper provides an overview of the first draft of the Islington CCG Operating Plan submitted to NHS England on 8 February 2016. On 8 February 2016 the CCG submitted:

- A summary financial plan for 2016/17;
- A summary activity plan for 2016/17 to deliver the NHS Constitution waiting time standards for A&E, cancer, and referral-to-treatment times.

A balanced budget has been produced for 2016/17, however risks around the values and assumptions with acute contracts along with the deliverability of savings plans need to be considered before a robust final position is presented.

The position within this report will form the basis of this submission with further reviews and submissions over the course of the next two months as contract negotiations with providers' progress.

5.3.1 Allocations

Islington CCG's programme allocation for 2016/17 has been confirmed as £326,996k. **This represents an increase of £6,947k or 2.17% to manage planning assumptions and commissioning pressures.** The £326,996k programme allocation includes section 256 funds (£5,894k), which are pooled into the Better Care Fund and £1,679k for winter pressures (the 2015/16 value rolled forward).

It should also be noted that of the 2.17% allocation growth, three specific items must be funded as a minimum. These are:

- i). CAMHs transformational funding from 2015/16 - £450k;
- ii). The provider cost increase of CNST and National Insurance contribution increases – no exact figure but assumed in the tariff changes, i.e. the net inflator (see section three) that will be applied to provider contracts to cover these costs;
- iii). GP IT, which in the past has been funded separately. The core service cost was £599k in 2015/16. The assumption is that the transitional element (£180k) is discretionary and does not have to be funded by the CCG.

In summary, the CCG’s core allocation before running costs for the next five years is set out in the table below. Details of the primary care and specialist commissioning allocations are also set at Appendix B.

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Allocation £k	320,049	326,996	335,737	344,901	354,268	367,234
Allocation per capita £		1,371	1,385	1,402	1,421	1,455
Growth		2.2%	2.7%	2.7%	2.7%	3.7%
per capita growth		0.4%	1.1%	1.2%	1.4%	2.4%
Target £k		308,479	317,818	326,987	336,383	351,381
Target per capita £		1,293	1,311	1,329	1,349	1,392
Opening Distance from target (DfT)		9.6%	6.7%	6.4%	6.2%	6.0%
Closing (DfT)	8.8%	6.0%	5.6%	5.5%	5.3%	4.5%

Note: DfT denotes distance from target.

5.3.2 Planning Assumptions for CCGs

The following planning assumptions have so far been confirmed and been applied to the initial operating plan for the CCG:

- A net uplift to provider contracts encompassing inflation, tariff changes, and efficiency requirements
- Demographic growth - 1.8% in line with population growth estimates used in the CCG allocation;
- Prescribing inflation assumed to be 4.9%, i.e. inflation plus demographic growth;
- Non-demographic – 1% at this stage on acute contracts only to allow for operating plan priorities including early detection of cancer;
- Unavoidable national cost pressures within the allocation uplift represent 1.4% of the 2.17%. CAMHs (£450k), GP IT (assumed core only £599k) and provider Trusts national insurance and CNST increases (assumed to in the net tariff inflator), have all been planned for.

The plans also include the assumptions that:

- Contributions to the national continuing care pool are not required in 2016/17 (£500k) so have been removed from plans. It is unclear whether the pool will be required in 2017/18;
- A 1% non-recurrent fund has been set aside to support provider deficits; as required;
- The CCG needs to find funds to meet planning requirements including support for the Healthy London Partnership (£490k) and the NCL transformation programme contributions previously funded

from the 1% fund now being held in case the local health economy needs it to balance the overall position. As a result, no funds are currently available for the NCL transformation fund;

- Mental Health expenditure and 'parity of esteem' requires the CCG to increase mental health commissioned service costs by a minimum uplift of 2.17%, i.e. the CCG's allocation growth.

5.3.3 Cost of Planning Assumptions

The values within the following table are only from applying business rules to NHS providers and the prescribing budget.

In summary, £12.6m is required to meet planning assumptions from a growth figure of £6.9m – a **pressure of £5.7m**.

	Demographic growth @ 1.8%	Non-Demographic growth @ 1%	Inflation 3.1%	Tariff efficiency @ 2%	ETO/DTR tariff impact	CQUINS @2.5% - net impact	Total
Acute	3,622,000	1,723,000	6,246,000	(4,028,000)	149,000	1,960,816	9,672,816
Non-Acute	1,432,000	0	2,463,000	(1,121,000)	0	157,995	2,931,995
TOTAL	5,054,000	1,723,000	8,709,000	(5,149,000)	149,000	2,118,811	12,604,811

NB: ETO tariff impact 0.7%, DTR (0.9)%

After reversing all non-recurrent items including metrics, challenges, readmissions and those agreed Whittington schemes and assuming an element of drawdown from the 2015/16 surplus (£2.95m from the £7.95m), a savings target of 3% is required.

This allows demand reserves of £3.7m to be established and meet the cost pressures associated with the Integrated Digital Care Record (IDCR) project (£583k) and the final quarter funding of i:Hub primary care service when funds from the Prime Minister's Challenge Fund end.

Although the planned surplus decreases to £5m, or 1.5% of resource allocation, this is still within the planning guidelines.

QIPP schemes of £5.7m (see table below) have been identified and the plan assumes the balance (£3.3m) will be identified before final submission. This will meet the 3% target and allow demand reserves of £3.7m to be set aside. If the QIPP balance is not found, demand reserves will fall - potentially as low as £0.4m.

Current QIPP scheme	Value (£'000)
Non-Elective admissions	800
Productivity metrics	1,650
Price changes (i.e. critical care)	670
Primary care (Gastroenterology & Anti-Coagulation)	175
Elective admissions (Kidney)	140
Other acute (IDCR, Meds & Challenges)	422
Continuing Care	250
Welfare Rights Service	30
Prescribing	600
Better Care Fund (duplication with primary care budgets)	750
Programme costs (administration & Interim)	50
Running Costs (reserve)	200
TOTAL	5,737

5.3.4 Activity planning assumptions

On 8 February the CCG submitted high-level activity plans for 2016/17. The table below provides a summary of the plans for 2016/17 submitted compared to forecast activity levels in 2015/16:

	Outpatient referrals	Outpatient First Attendances	Outpatient Follow-ups	Electives Daycase & Inpatient	Non-elective Admissions	A&E attendances
2015/16 outturn	96,778	90,588	215,688	23,400	24,555	99,193
Demographic growth	1,742	1,631	3,883	421	441	1,786
Non-demographic growth	2,517	2,354	5,608	187	196	1,489
National schemes	327	327				
QIPP	-79	-79	-265			
Better Care Fund					-679	-679
2016/17 baseline	101,285	94,821	224,914	24,008	24,482	101,789
Growth %	+4.7%	+4.7%	+4.3%	+2.6%	-0.3%	+2.6%

In summary our activity planning assumptions for 2016/17 are:

- Based on a start-point of forecast outturn for 2015/16 that is in line with our year-end financial forecasts;
- Uplifted for demographic growth by 1.8% across all activity categories, with this being consistent with population assumptions underpinning the CCG's allocation;
- Uplifted for non-demographic growth in line with the financial assumptions in our plans for 1% to be applied to acute provider baselines. Uplifts vary by activity category but equate overall to the 1% financial uplift in the plans above:
 - 2.6% uplift for outpatient referrals and attendances;
 - 0.8% increase in elective procedures;

- 1.5% increase in A&E attendances;
- 0.8% increase in non-elective admissions.
- Increased for additional cancer outpatient activity, 5% over and above demographic and non-demographic uplifts, accruing from earlier detection initiatives. This is shown under “national schemes”;
- Reduced for the impact of QIPP initiatives and admission avoidance schemes funded through the Better Care Fund. These deductions will increase as further QIPP schemes are identified for next year;
- The final row in the table above shows the net impact of applying growth (demographic, non-demographic, and for cancer) and deductions for the impact of QIPP initiatives and admission avoidance schemes funded through the Better Care Fund. The net impact by activity category are:
 - 4.7% increase in outpatient referrals and first attendances, with the increase designed to ensure delivery of waiting time standards for cancer and referral-to-treatment times;
 - 4.3% increase in outpatient follow-up attendances, with the uplift being 0.4% less than that for first attendances for the impact of productivity metrics (reduction in follow-up ratios and consultant-consultant referrals);
 - 2.6% increase in elective procedures, with the increase designed to ensure delivery of waiting time standards for cancer and referral-to-treatment times;
 - 2.6% increase in A&E attendances to reflect demand trends in 2015/16;
 - 0.3% decrease in non-elective admissions with growth being offset by the impact of admission avoidance schemes funded through the Better Care Fund including integrated networks (extended health and care teams aligned to practice networks), the integrated community ageing team, and work on supporting people with long-term conditions.

NHSE assurance that the CCG is commissioning sufficient activity to meet NHS Constitution targets in 2016/17 is to compare activity trends experienced in 2015/16 to those forecast for next year. The table below summarises those trends:

Net activity trends – including growth and QIPP	Outpatient referrals	Outpatient First Attendances	Outpatient Follow-ups	Electives Daycase & Inpatient	Non-elective Admissions	A&E attendances
Growth % 2015/16 to 2016/17	-0.1%	+3.2%	+1.9%	+2.4%	-0.9%	+2.6%
Growth % 2015/16 to 2016/17	+4.7%	+4.7%	+4.3%	+2.6%	-0.3%	+2.6%
Trend Comparison	+4.8%	+1.5%	+2.4%	+0.2%	+0.6%	0

In all activity categories, after applying growth (demographic and non-demographic) and QIPP offsets, net trends for 2016/17 match or exceed the trends experienced in 2016/17.

5.3.5 Delivery of NHS Constitution Targets

In the plan for 2016/17 submitted on 8 February 2016 the CCG declared compliance with NHS Constitution standards for next year. The table below, provided by NHS England summarises expected compliance in 2016/17 compared to performance in 2015/16. The Integrated Quality, Finance and Performance Report sets out a more detailed analysis of current performance:

Indicator Type	Current standards met (Y/N)	Plan standards met (Y/N)
Referral-to-Treatment – 92% open pathways less than 18 weeks from GP referral	Y	Y
Diagnostics – 99% tests completed within 6 weeks of GP referral	N	Y
Cancer 62 day – 85% receive first treatment within 62 days of referral from GP or screening	N	Y
Cancer 2 Week Wait – 93% seen within 14 days of GP referral	N	Y
Dementia Diagnosis – 66.7% of expected dementia prevalence diagnosed	Y	Y
IAPT Access – 15% of people diagnosed with depression or anxiety have access to service	Y	Y
IAPT Recovery – 50% of people referred complete treatment and moving to recovery	N	Y
IAPT 6 Week Wait – 75% receive first treatment within 6 weeks of referral	N	Y
IAPT 18 Week Wait – 95% receive first treatment within 18 weeks of referral	N	Y
Urgent Care - A&E – 95% seen within 4 hours	N	Y

Performance against the NHS Constitution standards in 2016/17 is summarised below:

- 92% of people on incomplete referral-to-treatment pathways have been waiting for 18 weeks or less in line with performance in 2015/16. Waiting list backlogs and Whittington Health and Moorfields were removed in 2014/15 and at UCLH in the first quarter of 2015/16, and all three Trusts are currently meeting the standard as at December 2015;
- 99% of people will receive their diagnostic test within six weeks of GP referral from quarter two 2016/17 once the backlog of people waiting over six weeks at UCLH is removed by July 2016. Currently Whittington Health achieves the 99% standard for tests being carried out within six weeks of GP referral;
- Cancer 62-day waits will comply with the 85% standard from June 2016, in line with the recovery plan from UCLH. Performance from June onwards will ensure the standard is met for the year as a whole;
- Cancer two-week waits from GP referral to first attendance are expected to be met in 2016/17, with both Whittington Health and UCLH expecting to regain compliance in January 2016 and March 2106 respectively;
- Dementia diagnosis rates in Islington are the highest in England and at 83% in 2016/17 exceed the national standard of 66.7% diagnosis rate;
- In 2016/17 the CCG expects to meet the standards for access to psychological therapies (IAPT), with forecast based on:
 - More than 15% of people diagnosed as having depression with access to psychological therapy services;
 - The recovery rate for IAPT, 50% of people complete their treatment and are moving to recovery, is expected to be achieved in 2016/17, with the standard expected to be achieved for the first time in the final quarter of 2015/16;
 - The waiting time standard for IAPT (75% seen within six weeks and 95% seen within 18 weeks) with current performance, supported by an incentive scheme in the Camden and

Islington Foundation Trust contract, being 75% seen within six weeks and 95% seen within 18 weeks;

- The CCG is forecasting to meet the 95% standard for people being seen in A&E within four hours, with CCG performance measured through the emergency departments at Whittington Health and Moorfields Eye Hospital. Moorfields meet the A&E standard in 2015/16 whereas the Whittington Health and care economy does not. A recovery plan has been agreed with the Trust to deliver the 95% standard by July 2016.

6. Implications

6.1 Legal Implications

The CCG's commissioning intentions for 2016/17 in response to planning guidance are consistent with the operations of existing Section 75 Agreements between the CCG and Islington Council.

6.2 Financial Implications

As set out in the report.

6.3 Resident Impact Assessment .

The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding. No specific resident impact assessment is required in regards to this report.

6.4 Environmental Implications

The environmental implications of the Sustainability and Transformation plan will be assessed when the final draft is available.

As it stands, the Islington CCG Plan has some minor environmental implications, as the extended weekend hours will result in impacts associated with building usage, including energy and water use and waste generation. However, the better integration of 111, minor injuries, Urgent Care Centres, GP out of hours services may result in efficiencies that reduce the impacts of those services.

7. Conclusion and reasons for recommendations

The Health and Wellbeing Board is asked to note and comment on the development of the Sustainability and Transformation Plan (STP) for North Central London and the Islington CCG Operating Plan for 2016/17.

Background papers:

- None

Attachments:

- Appendix A: North Central London Sustainability and Transformation plan progress update March 2016
- Appendix B: Islington Allocation Summary

Final Report Clearance

Signed by



31 March 2016

Director of Commissioning, Islington CCG

Date

Received by

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Head of Democratic Services

8 April 2016

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Date

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