Islington Integration and Better Care Fund 2017-2019

Contents

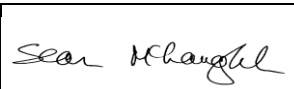
1. General

Local Authority	**Islington**
Clinical Commissioning Groups	**Islington CCG**
Boundary Differences	**Co-terminus**
Date agreed at Health and Well-Being Board:	7th September 2017
Date submitted:	8th September 2017
Minimum required value	
2017/18	**£ 26,189,352.00**
Total agreed value of pooled budget:	
2017/18	**£ 26,189,352.00**

2. Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	

By	Tony Hoolaghan
Position	Chief Operating Officer
Date	7th September 2017

Signed on behalf of the Council	
By	Sean Mclaughlin
Position	Corporate Director Housing and Adult Social Services
Date	7th September 2017

Signed on behalf of the Health and Wellbeing Board	
By	Richard Watts
By Chair of Health and Wellbeing Board	Council Leader
Date	7th September 2017

3. Introduction

The Islington Better Care Fund for 2017-2019 will further the work that has already happened in Islington and Haringey to establish a fully integrated health and social care system.

As in previous years the Better Care Fund will be an integral part of the longstanding joint commissioning and integrated commissioning and delivery plans. Over £50 million of joint health and social care resource will be invested in integrated services, in 2017-2018, for Islington's residents.

The Better Care Fund Plan 2017-19 has been set out following a review of the progress of the Islington Better Care Fund in 16/17. This year the review included:

- A system-wide look at the potential opportunities for scaling up successful activity through the delivery of the North Central London Sustainability and Transformation Plan;
- Identifying the opportunities for joint working through the Islington and Haringey Wellbeing Partnership;
- An assessment of the impact of 2016-2017 Better Care Fund investments; and
- An assessment against the High Impact Change Model for Transfers of Care.

From these a revised programme of activity has been established covering the following:

- Expansion of Care Closer to Home through the implementation of two GP led Care Closer to Home integrated networks (CHINs) one with a focus on frail and elderly and one with a focus on long-term conditions;
- Taking forward a new discharge to assess model (D2A) with a clear focus on integrated community based discharge pathways;
- Implementing the High Impact Change Model for Transfer of Care;
- Continue to focus on provider quality and implementation of high impact evidence based activities – for example care home dementia standards;
- Maintaining and improving the services developed as part of the Better Care Fund programme since 2013-14 for example Care My Way.

4. Commissioning Context

The commissioning framework for the 2017-2019 BCF programme includes the following:

- Islington Joint Strategic Needs Assessment sets out the needs of the local population.

- Islington Joint Health and Wellbeing Strategy – the joint strategy to improve health and wellbeing outcomes for our local population.

- North London Partners in Health and Care Working together for better health and care: our sustainability and transformation plan. This is the North Central London Sustainability and Transformation Plan. It sets out a radical plan to redesign the health and social care system.

- The 2015-2016 and 2016-2017 Better Care Fund plans. These set out the vision for health and social care integration in the borough and the actions we will take to reduce the number of people entering the health and social care system through admissions and through accident and emergency departments; and to ensure that people can get back home following a hospital admission as soon as they are ready to do so.

- Islington Primary Care Strategy - Islington's Primary Care Strategy focuses on driving up 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.

- 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.

- 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.

- High Impact Change Model for Transfers of Care: a review of the high impact interventions has been undertaken and where required the redesign of services has been completed.

5. Islington Vision for Health and Care

Islington has a strong history of partnership working, commitment and energy to implement whole *systems of integrated care*, for the benefits of the local community. The 2015/16 Better Care Fund plan was shaped by system leaders and set out a clear vision for health and social care for the local community. This vision remains relevant and appropriate for the 2017-2019 plan.

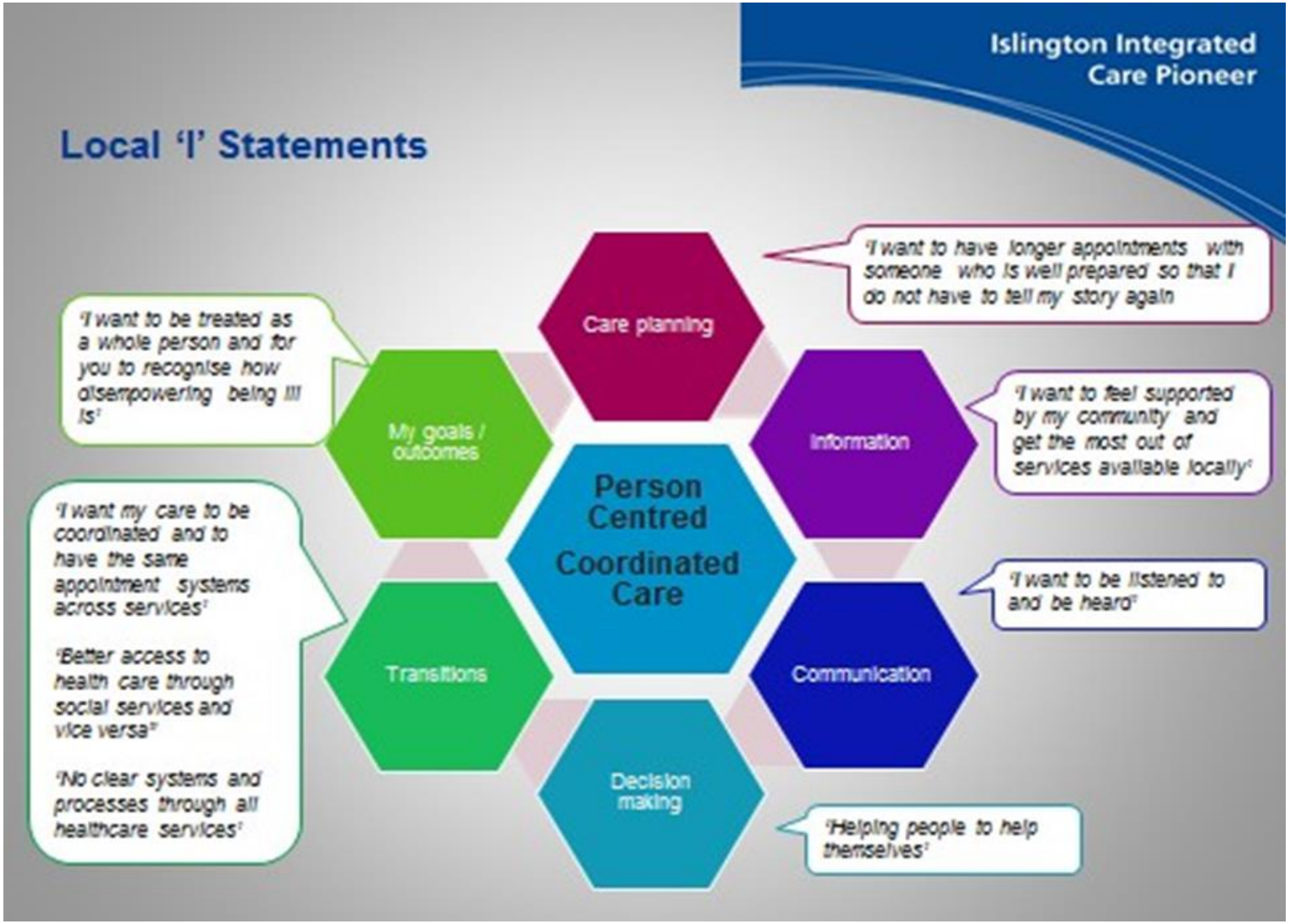
The vision that underpinned the Better Care Fund was built on the work that Islington had developed as an Integrated Care Pioneer. That is:

"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."

The full initial vision for change over five years is available for reference in the 2015/16 submission of the Better Care Fund pages 9-13.

6. Local Voices

The vision for integration in Islington grew from the voices of local people in the community as shown by our seven local 'I' statements. The views of our local population continue to shape all that we do in our local integration.



7. Population Approach

Islington's vision for health and care is also shaped by the needs of our local population to prioritise resource to make greatest impact. Islington is the fifth most deprived borough in London and the most densely populated borough in England. There is an unusual spatial distribution of affluence and poverty across the borough. The high level of deprivation is reflected in substantial

inequalities in health and outcomes. Our Health and Wellbeing Board has identified four key priorities designed to drive system wide improvement.

These are:

- 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

8. Islington's 2020 Vision for Integration

Islington CCG, Islington LA, Haringey CCG, Haringey Council, Whittington Health and Camden and Islington Foundation Trust have agreed to pursue service delivery improvements achievable through integration:

"We are aiming for a population based model that links Whittington Health, our ICO, with our patients, voluntary and community organisations, mental health services, social care and primary care services, in one seamless system. The model will be driven by our local communities and primary care, with a strong focus on prevention aligned to population based outcomes." (Vanguard proposal Feb 2015)

We have:

- A shared commitment to improve outcomes of care and maximise the efficiency of services, both individually and together.
- Experience to date that has already demonstrated the benefit of delivering more holistic and integrated care centred on the individual.
- Our service users frequently say they want better coordinated care and for professionals to support them as a whole person.
- A clear understanding that this commitment does not preclude the continuation of our positive relationships and working arrangements with other boroughs or further development of these now and in the future.

Islington recognises that integration is not an objective or end point in itself, but a tool or model that we can utilise and develop locally when and where this will be of benefit to the health and wellbeing of our population. Any models of integration need to improve the quality, capacity and sustainability of the services we provide and engage and empower people in Islington in managing their own health.

9. Enablers of Integration

The diagram below illustrates how national policy drivers and local enablers, including the Better Care Fund are being used as to achieve integration and deliver a sustainable health and social care system.

10. Islington Health and Social Care Integrated Care Programme

In Islington, the Better Care Fund has been an extension of the integrated working which is already established in the borough. In addition to the Better Care Fund, Islington has over £50 million in pooled budgets across health and social care for adults and children.

Islington has utilised the Better Care Fund to further enable and support the joint work in progress through the Integrated Care Programme. The Better Care Fund priorities locally are:

- Locality Offer across community, social care and mental health services to support primary care capacity;
- Enhancing primary care capacity;
- IT and inter-operability to ensure patient information can be shared across integrated services and along care pathways;
- To meet demographic pressures in social care, and across health and care services for older people and people with learning disabilities;
- To maintain social care eligibility;
- To incentivise providers to support integrated care

The progress of the Better Care Fund has been managed through the Islington Integrated Care Programme. The Islington Integrated care programme board over the past three years (of the five-year national programme) has strengthened partnership working; identified opportunities for integrated care and has overseen whole systems integration initiatives, particularly in bringing of care closer to the individual at home.

In 2015-2016 the approach taken to Better Care Fund was reviewed. The review highlighted the need to maintain focus on outcomes and to increase the scale and pace of improvement by concentrating on a smaller number of activities. As a consequence of these findings the 2016-17 Better Care Fund plan provided renewed outcomes and put shared investments into a smaller number of large schemes. In 2017-2019 our intention is to continue to keep our focus on larger evidence-based schemes but to expand activities to support the provision of out of hospital and community care through the Islington Care Closer to Home programme and by changing practice to deliver the high impact change model for transfers of care.

11. National and Local Policy Drivers

11.1 North Central London Sustainability and Transformation Plan

Health and care partners across North Central London (NCL) have been working together to develop an NCL-wide Sustainability and Transformation Plan (STP). This plan sets out how local health and care services will transform and become sustainable over the next five years, building and strengthening local relationships and ultimately delivering the Five Year Forward View vision.

For the NHS and social care in NCL to meet the needs of future patients in a sustainable way, health and social care partners need to close the gaps in health outcomes, finance and quality of care between the present position and where we need to be in 2020/21. This will include making changes to how local people live, access care, and how this care is delivered. This doesn't mean doing less for patients or reducing the quality of care provided. It means more preventative care, finding new ways to meet people's needs and identifying ways to do things more efficiently.

The Islington Better Care Fund supports the delivery of the NCL STP, in the following area:

- **Care Closer to Home** – this includes improved access to community services and the reduction of unwarranted variation in the delivery of primary care through QISTs (Quality Improvement Support Teams); and CHINs (Care Closer to Home Integrated Networks).

- **Urgent and Emergency Care** - delivering urgent and emergency care (UEC) services that are reliable, work well together and are easily understood. This includes enhanced community based admission avoidance (which includes rapid response) and ambulatory care.

11.2 Transforming Care Programme

Islington continues to participate fully in NCL Transforming Care Partnership (TCP), which overall is within our planned trajectory for reducing inpatient numbers by March 2019. Islington takes a person centred integrated approach to each individual in the TCP cohort with health, housing, social care and families working together to secure a sustainable discharge and reduce the risk of readmission. The approach includes:

- **Care & Treatment Reviews**: CTRs follow a prescribed format to ensure care and treatment is appropriate, safe, least restrictive and is working always to prevent admission or facilitate timely discharge. CTRs are chaired by the responsible commissioner at the CCG or NHSE and attended by the relevant professionals, patient and family members and / or advocates, plus an independent expert by experience and independent clinical expert who are allocated by NHSE. Islington CCG patients all have benefitted from CTRs and we have completed a number of successful community CTRs to avoid admission.

- **At Risk of Admission Registers**: holding a register of 'at risk' individuals in the community is a requirement of the Transforming Care Programme. There is a fully operational 'At Risk of Admission Register' for all people known to the adult community LD team who may be at risk of admission. This has clear criteria, regular review and actions to prevent admissions, including the use of Community Care & Treatment Reviews. Children's Services also hold a separate 'At Risk of Admission Register', with appropriate criteria and monitoring.

- **NCL Funding & Financial Impact**: following the successful submission of the NCL TCP Plan, NHSE have agreed a one-off funding package of £300,000 for 2017-18 across NCL to support the development of crisis intervention and early intervention services. A proposal for using this funding, including required match-funding arrangements, has been agreed by the NCL TCP Board and each CCG and is being implemented to improve support to this client group and reduce inpatient numbers.

  Work is ongoing to determine the financial impact of the TCP programme on CCGs and local authorities as people transfer from NHSE or CCG funded hospital placements and into the community. The financial implications are complex as patients have lengths of stay varying from weeks to years. Some will have had funded packages in the community prior to admission and all those in hospital will be undergoing programs of treatment that will affect their costs on discharge. The biggest impact will be very small numbers of individuals with exceptionally high costs. One discharge in April 2017 has created a £350k cost pressure to the Learning Disabilities budget and a planned discharge later in 2017 is expected to add a further £400k pressure.

11.3 Haringey and Islington Wellbeing Partnership

Islington and Haringey CCGs and councils have established a wellbeing partnership to secure changes to the way we work with our local communities, to reduce future needs and ensure there is the right quality and capacity in local care services to meet the current and future needs of our population. The first two joint programmes include looking at creative ways to increase capacity in the intermediate care offer and a programme focussing on the management of the frail elderly in the community. Both of these will contribute to establishing a new service offer that will help reduced delayed discharges of care and A&E admissions.

11.4 Improved Better Care Fund

In the 2017 spring budget the government announced an additional grant, the Improved Better Care Fund, to enable local authorities to quickly provide stability and extra capacity in local care systems.

Islington Council, like all other councils, is being impacted by increases in the number and acuity of need of residents requiring Adult Social Care services. For the purposes of this, demography is defined as the net movement in placements in Adult Social Care services and increases in eligibility for services. In 2017-18 the demographic pressure in Islington for Older People, Learning Disability, Physical Disability and Mental Health services is estimated to exceed the amount raised by the social care precept. It is therefore intended to use Improved Better Care Fund to:

- Address pressures across local services: in particular services, that are hospital aligned and the multi-disciplinary team working to support vulnerable or frail older people with complex needs to remain living at home in their own communities;
- Protect services: to ensure support for services where otherwise would be considered for budget reductions in 17/18
- Develop sustainable community capacity: including working closely with the voluntary sector which supports people's independence, enabling them to be cared for closer to home;
- Progress at pace service transformation across all client groups: including in-house provision, with a focus on interventions and support which help to address the underlying causes of demand and supporting people in ways which maximises their independence and ability to enjoy an "ordinary life".

12. Progress to date

12.1 2016-2017 Achievements

Key achievements in 2016/17 that were enabled by the Better Care Fund include:

- **Universal coverage for people with complex needs through locality Integrated Health and Social Care Networks**. Islington now has a full programme of 12 Integrated Networks which cover 94% of GP practices across the borough. The aim of the Networks is to identify, and put in wrap around care plans/packages, for the most complex and

vulnerable people in the community. The Networks are community based multi-disciplinary team meetings of key health and care professionals wrapped around small clusters of two to four GP practices.

Each Network consists of a GP from each member practice, a community matron, a senior practitioner social worker, an AGE UK health navigator and a mental health nurse. Evaluation of service user experience completed by HealthWatch through interviews indicated that service users experienced coordinated care.

- **Risk Pool:** Enabling IT solution: Islington has progressed with BT the development of an Integrated Digital Care Record and a Person Held Record called Care My Way (Personal and Professional). Care My Way Professional provides a joined up health and care record and this is in pilot phase in the borough.

- **Workforce to join up health and social care**: The Islington Community Education Provider Network was established and developed an integrated care training programme to enable a skilled workforce that delivers care with dignity and compassion, is motivated to make a difference and is rewarded for its efforts.

- **Development of improved models of community based rapid response services**: Islington health and care is working with Haringey health and care to further develop and align models of care for community based rapid response services. The ambition is to offer an urgent response to people in the community within two hours in a consistent way for people who are at risk of attending hospital and do not require an ambulance. This development forms part of wider programme of work to improve intermediate care services.

- **National status as an Integrated Personalised Commissioning site and Extension of Personal Health Budgets**: Islington in November 2016 was awarded national status as a leading site to bring together health and social care for complex individuals (adults and children) as a site for integrated personalised commissioning. This programme includes developing innovative approaches to deliver care planning and personal budgets as required. A key enabler of this work has been Islington's progression in personal health budgets which is now available to people with multiple sclerosis.

- **Protection of Adult Social Care**: The Better Care Fund, alongside existing pooled budgets between health and social care, has supported investment into frontline services such as social care services that benefit health (core social care offer of assessment, care management and reablement); Carers funding (Carers funding, assessment and carers breaks) and disabled facilities grant (home adaptations for independent living).

  The fund has also been used to support demographic pressures and substantial growth in NHS funded Continuing Healthcare for people with Learning Disabilities and older people. This resourcing has enabled local people to live more independently and return to the community in a timely way when accessing hospital services.

12.2 Performance Overview

The table below provides a summary of performance against the Better Care Fund metrics for 2016-2017.

As part of Islington's annual planning for the Better Care Fund we have considered Islington's performance against the four national Better Care Fund metrics; comparing our performance against the targets set for Islington in 2016/17 and how Islington compares to England, London and the Comparator group over time.

12.3 Performance against Target Activity

Indicator	2016-2017 performance	Target 2016-17	2015-2016 Performance	Better than last year?
Delayed transfers of care (delayed days population aged 18+	783.2	700.2	540.8	No
Percentage of people who have been discharged from hospital into enablement services that are at home or in a community setting 91 days after their discharge to these services	91.4%	92%	97.9%	No
Number of new permanent admissions to residential and nursing care	139	105	133	No
Carer Reported Quality of Life	7.3	7.8	7.3	Same
Non-Elective Admissions	19230	19633	The target is higher than the 2015-2016 performance to account for demographic and non-demographic pressures.	

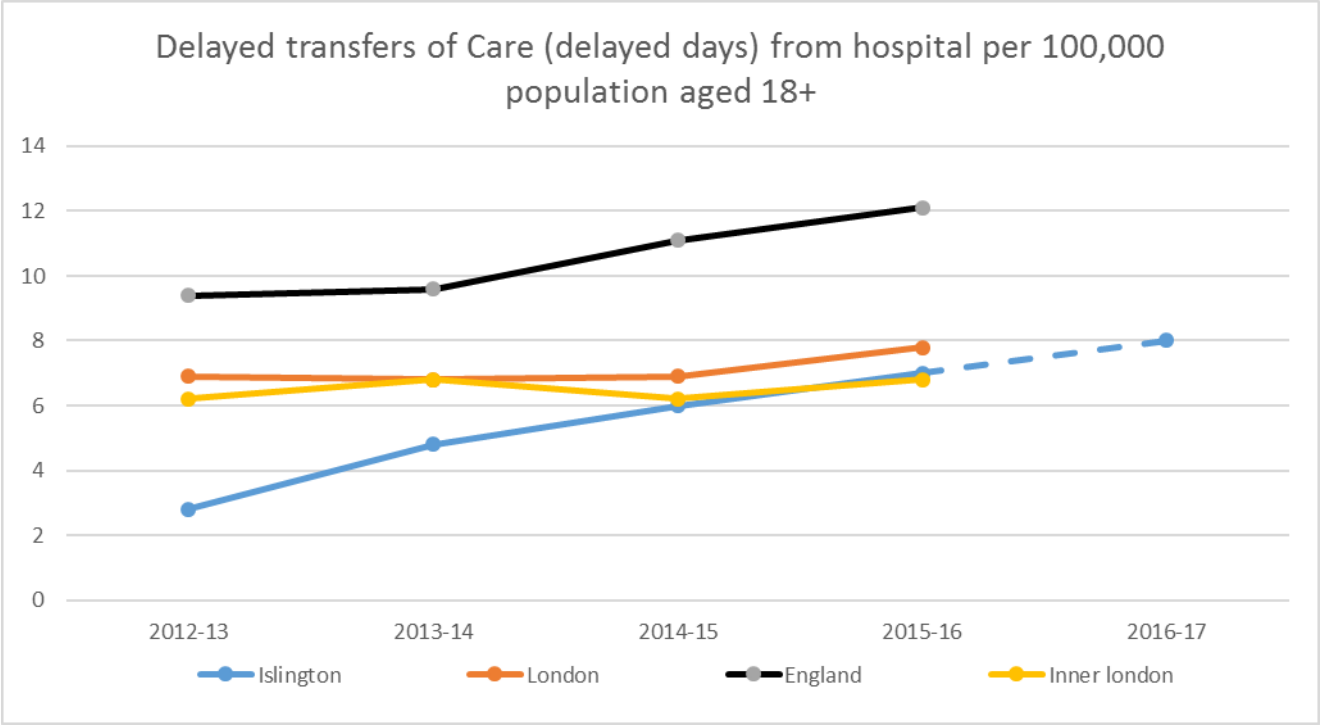
12.4 Overview of 2016-2017 ASCOF Data for Islington

Islington

	2012-13	2013-14	2014-15	2015-16	2016-17
Delayed transfers of Care (delayed days) from hospital per 100,000 population aged 18+	2.8	4.8	6	7	8
Percentage of people (65+) who have been discharged from hospital into enablement services that are at home or in a community setting 91 days after their discharge to these services	96.7%	91.2%	93.3%	97.9%	91.4%
Number of new permanent admissions (65+) to residential and nursing care per 100,000	606.9	678.4	749.0	819.6	695

12.5 Delayed Transfers of Care

Islington's target for Delayed Transfers of Care for Q4 of 2016/17 was 700.2 days per 100,000 population aged 18+, however, performance was 776.8 days.

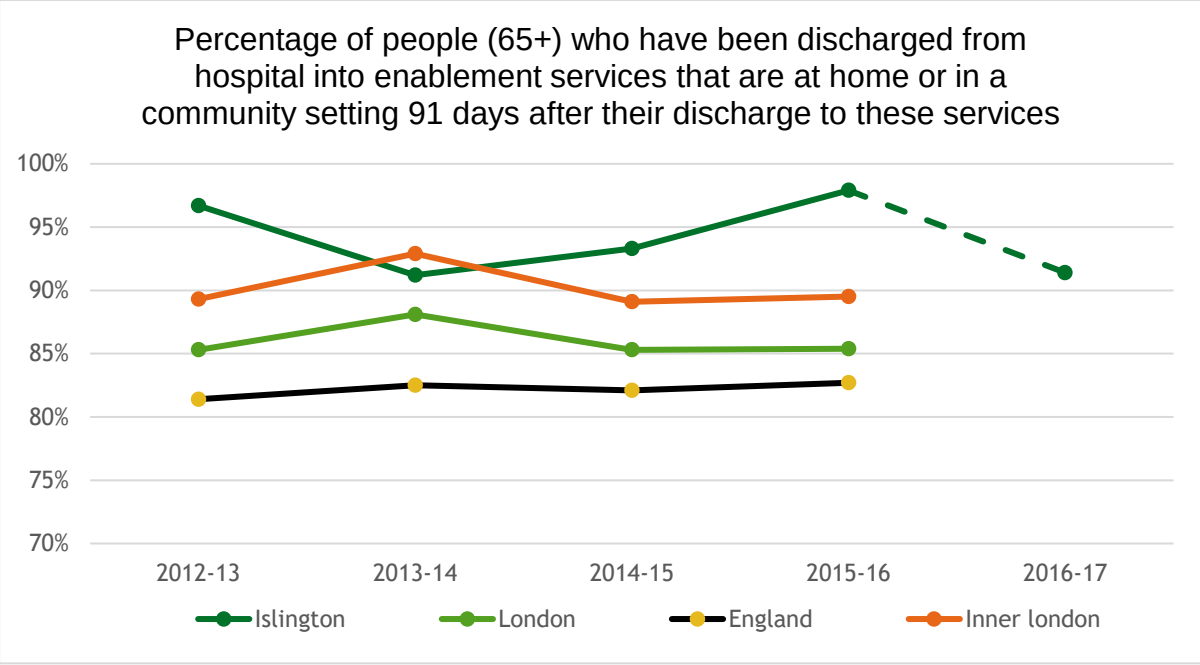


Looking at snapshot data for the number of patients delayed, the total number of people delayed on the 12 snapshot days in 2016/17 was 168 patients; an average of 14 patients per snapshot day. The most frequent reasons for NHS delays was access to further non-acute services and for social care delays. Access to nursing/residential care was the main cause. The adult social care delays mirror the national picture of diminishing capacity in some parts, (domiciliary care and residential care) of the care market. In 2017-2018 there will be further investment from IBCF, in providers to stabilise provision. As part of the D2A pathway the London Borough of Islington is currently working with an external partner to build a predictive model of discharge into social care services, again, to inform practice.

12.6 Clients at home 91 days following discharge from hospital into reablement

Performance exceeded the 92% target for this indicator with 95.7% of patients discharged from hospital into reablement living at home 91 days later. ASCOF measure The Outcome of Short Term Services: Sequel to Support also shows that 96% of clients leaving reablement achieve independence. Performance has remained above London and England performance since 2013-2014. Work to further develop reablement services, including additional telecare support, will be undertaken in 2017-2019.

12.7 Reablement

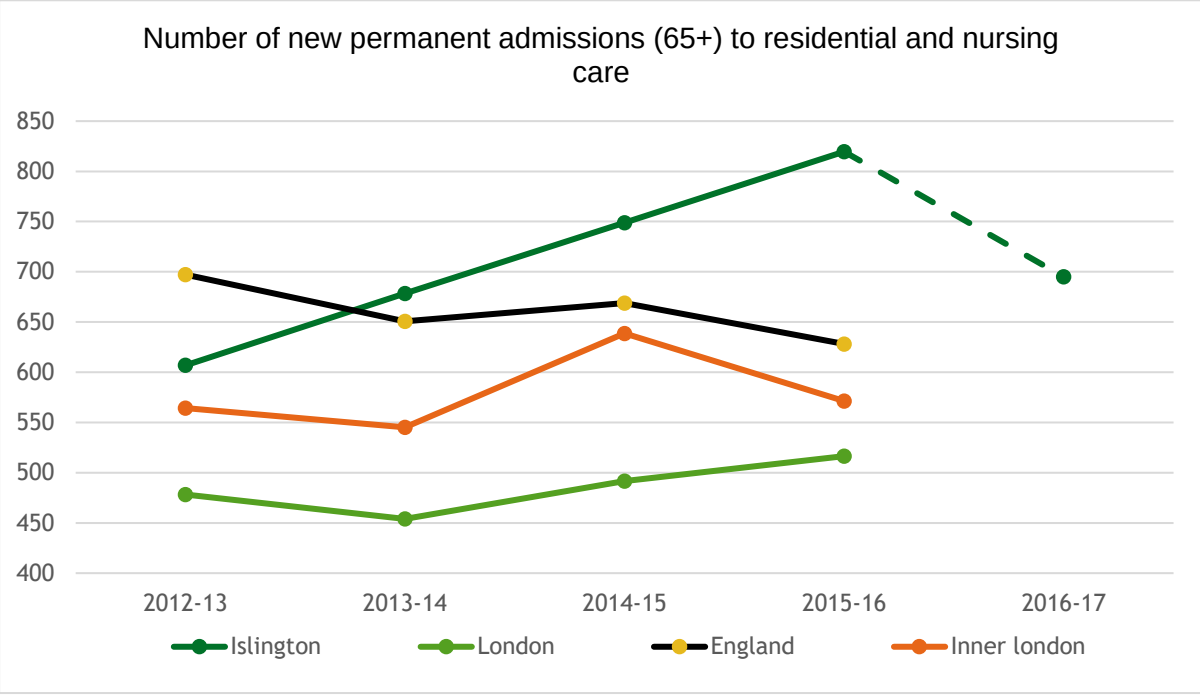


12.8 Number of New Admissions to Residential and Nursing Homes

Initiatives are in place to prevent admission to nursing or residential care through the availability of person-centred services. Joint work is ongoing at the health and social care interface to ensure that patients are discharged back to their own home. These measures include working with Haringey to extend access to intermediate care beds and implementation of an enhanced D2A (Discharge to Assess) pathway.

In Islington, the trend toward older and more complex cases being discharged into the community means that around 50% of older adults admitted to permanent nursing and residential care are aged 85 and over with complex needs, frequently including dementia.

Nursing and residential care admissions will continue to be monitored in 2017/18 to check progress with the implementation of the High Impact Change Model, which is anticipated to improve outcomes, not only for delayed transfers of care but also for permanent admissions to nursing and residential care.

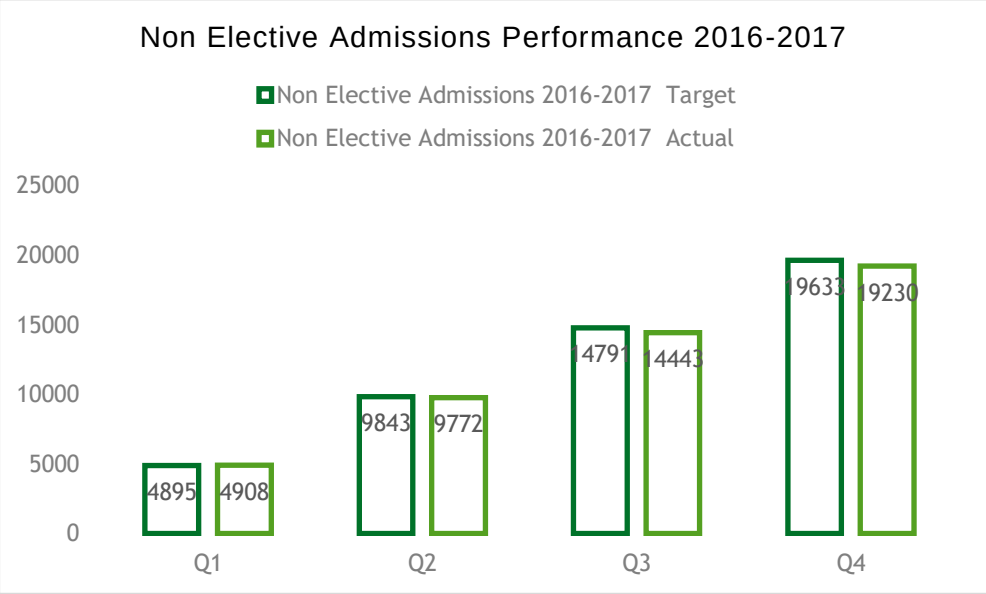


12.9 Carer Reported Quality of Life

The target of 7.8 was not achieved, but performance remained stable at 7.3 in 2016/17. The results of the Survey of Adult Carers have been analysed and used to inform work to enhance carer services and social isolation was identified as an area for improvement. In 2017-2018 further work to assess the current carer offer against the evidence base with a focus on the support required to reduce avoidable admissions and to support carers whilst the person they care for is being discharged.

12.10 Non-Elective Admissions

Islington achieved the target level of non-elective admissions in 2016-2017. Targets were set to mitigate the demographic and non-demographic pressures in the Islington Health and Social Care system. Work to target reductions in non-elective admissions for those with long-term conditions, the frail and elderly, admissions from care homes and children will continue to form part of the Better Care Fund going forward. These are described in more detail in the section below.



13. Priorities for 2017-2019

This section describes the actions that will happen in 2017-2019 to further the impact of Better Care Fund funded services and other pooled budgets to achieve the Better Care Fund performance requirements. This section should read alongside the improvement plan developed following a joint review with NHS providers and adult social care delivery teams of the High Impact Transfers of Care Model (Condition 4)

13.1 Admissions Avoidance

- **Hospital at Home Service:** in 16/17 246 children and young people were treated by the Children's Hospital @ Home service, resulting in the avoidance of 66 non elective admissions and a reduced length of stay for 178 acutely unwell children and young people. The numbers treated by the service has seen a gradual increase since the service was

initiated in 2014. In 16/17 there was a 16% increase in the number of children and young people treated by the service compared to the previous year. It is predicted that this trajectory will continue to rise in 17/18 as the service continues to widen its scope. In 17/18 the service is broadening its scope to include infants with feeding difficulties, jaundice and acute infection; and children and young people with complex needs with a care plan known to community services. The aim with a number of the infants with feeding difficulties, jaundice and children with complex needs is to avoid all secondary care contact through referral from the community.

- **Hospital admissions from Care Homes**: the incidence of hospital admissions from care homes remained comparable to previous years. The majority of these were reported as unavoidable by the care homes, due to significant changes in the resident's condition; e.g. the resident became unwell during an outpatient appointment or the outcome of the clinical assessment indicated a need for hospital. Where hospital admissions were deemed to be avoidable, treatment escalation plans were not in place or it had been advised by the GP. Work is underway to ensure that homes are supported by the GP and the specialist palliative care nurse to ensure that comprehensive Advance Care Plans and Treatment Escalation Plans are in place.

- **Dysphagia Pilot Project** which included the training of over 500 care staff across the care homes in competency based training and education programmes in preventing aspiration pneumonia and has resulted with positive impact on hospital avoidance.

- **Integrated Community Response**: based on the high presence of people with multi-co-morbidities, Islington has developed Locality based MDTs – Integrated Networks for people with complex needs. Islington's MDT processes have been in place for over two years and are an established mechanism to jointly assess and plan care for patients. The purpose of the MDT is to carry out these core activities for appropriate people in the top 5% of the population:

    - Each GP practice holds a patient register for those patients with long-term conditions
    - 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 which is documented
    - 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 commissioned from Age UK
    - Case conferences are used to review care weekly/fortnightly

  GPs are supported through additional investment in community, social care and voluntary sector services to be accountable for the coordination of services for people with complex needs. Any barriers to joined up health and social care planning is discussed at the operational meeting for integrated working and escalated to the overarching integrated care board as needed. The system has been to design to ensure that professionals can take on broader roles within the

care planning process. In 2017-2019 there will be further development of this approach as the Care Closer to Home Integrated Networks are implemented in the two initial areas.

- **Seven Day Services**
  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. In 2016/17 this has included:

  - Launching Extended Access services across the borough, providing 100% of residents with access to Primary Care, 8am-8pm, seven days a week
  - Launching Integrated Urgent Care, our combined 111/OOH service. Provided by LCW, this was one of the first IUC services to go live nationally
  - Provision of rapid response services across Islington and Haringey working to seven days
  - Core community services available seven days, including community nursing and social care
  - We are committed to working across all aspects of seven day working throughout the system, this includes for example further planned work on therapy availability 7/7 and community pharmacy opening hours.

- **Integrated Digital Care Records**
  Care My Way is Islington's integrated digital care record. It has three core components:
  - Care My Way Personal. This gives patient's information and control over their health and care data
  - Care My Way Professional. This brings the various IT systems together in one place, allowing professionals a holistic picture of Islington residents
  - Care My Way Analytics. This provides a cross organisational analytical platform

Care My Way Professional is now live and being rolled out across the borough. Care My Way Personal is scheduled to go live in Q3-Q4 2017/18, as is Care My Way Analytics. These three products underpin our approach to integrating digital systems in Islington, joining up patients, clinicians and commissioners across the borough.

13.2 Self-Care

- **Personal Health Budgets:** in 16/17 there were 10 children in receipt of a personal health budget (PHB), five of which were notional budgets whilst the remaining were direct payments. These children and young people were all from the continuing care cohort and some also cross into the SEND cohort. The majority of these children and young people were also in receipt of a social care personal budget and a couple were also in receipt of a direct payment from education. In these cases, the budgets were combined into one integrated personal budget. The 16/17 spend for these packages was £750,000. The forecast costs for 17/18 are in the region of £900,000, of which £400,000 spend is for

direct payment PHBs. The number of families choosing direct payments rather than a notional budget is slowly rising, from 50% in 16/17 to 70% in 17/18. Personal health budgets are also available to children and young people with palliative care needs, but to date the families have all chosen to use the local palliative care provider. As mentioned above, Islington's status as a national demonstrator site for Personal Health Budgets, will support development of this work.

- Islington has a well-developed Patient Activation Measures process in place, with over 15,000 PAM scores for people with Long Term Conditions. This insight has been used to understand levels of patient engagement and self-care for their health conditions, informing commissioning and clinical decisions.

- Through a Locally Commissioned Service within Primary Care, Islington has invested in supporting a Year of Care approach between GP's and Patients, enabling a longer, more holistic conversation about all health and care needs between people and their clinicians. We are extending this approach to our Integrated Networks, building on the existing training and support framework already in place

- Diabetes Prevention Programme, providing 13 weeks of tailored support for people who are identified as having a high risk of developing diabetes. The service launched with early implementer sites (11 GP practices) in Q2 16/17 and had exceeded its initial NHSE targets for take-up by Q4 2016/17. We are continuing this approach through 2017/18

13.3 Quality and Capacity in the Social Care Market

Lack of capacity in the social care market within Islington has put additional pressures on the health and social care system throughout 2016-2017.A programme of work has been established to improve quality in the care market and so maintain supply of services. In recognition of the risk of failure in the provider market, as a consequence of increasing costs, uplifts in the prices paid for care have been put in place.

As with other inner London health economies Islington has a limited supply of residential and nursing homes in borough and there is limited access to bespoke older people's intermediate care housing – such as extra care or sheltered plus. Therefore, a joint review with Haringey has been undertaken to identify land for additional intermediate care schemes to fill the gap in the market.

All care homes in Islington equating to a total of 437 beds are registered to deliver nursing care. The threshold for nursing care continues to shift with nursing homes delivering care to residents with increasingly complex conditions and a greater range of co-morbidities. The contribution the homes make with support from wider multi-disciplinary teams to reduce hospital admissions and avoidance is well acknowledged.

For 2017-2018 work with Care Homes will include:

- Reducing the number of care home beds under embargo because of quality concerns by proactively working with homes. Islington's model of care and support to care homes compares well with care homes in the national Vanguard sites in that each care home has:

    - A named GP and receives on-going and regular input from a specialist multi-disciplinary team
    - A Lead Nurse is located within the joint commissioning team and supports partnership working into and across all care homes by co-ordinating support from Social Care, Continuing Healthcare, GP's, the Integrated Care Ageing Team (ICAT) and MDT's.

- **Pressure ulcers:** the incidents of acquired pressure ulcer in care homes are mainly low-grade pressure damage. Where there has been tissue damage the care homes continue to work closely with the Tissue Viability Service (TVN) to ensure that tissue viability is optimised. Work is underway to improve analysis of grade classification, individual residents, and whether incidents were avoidable or unavoidable.

- **Falls within homes:** with input from the REACH team, there is an ongoing emphasis on assessing and preventing falls in care homes. The proportion of falls that resulted in hospital attendances or admissions remained low over the period. Safeguarding alerts (which have reported falls as the key reason or contributing factor) and subsequent learning from investigations have highlighted a gap in knowledge that would enable a more proactive approach in the management of falls. The Lead Nurse will continue to work closely with the care homes to improve their approach to preventing falls.

- **Dementia support:** dementia remains a priority area for Islington Council and the CCG. Whilst diagnosis rates remain high when compared to national rates, we want to ensure that people with dementia access support services as early as possible post diagnosis rather than when they are in crisis and reduce avoidable admissions for these individuals. Whittington Health recently has funding agreed for a Dementia Nurse Specialist. It is envisaged that the Specialist Nurse will work closely with the Lead Nurse to ensure that commissioned care homes are fully engaged in the ongoing development and improvements into dementia care.

13.4 Intermediate Care and Rehabilitation

The pooled budget invests in a range of integrated services to help people avoid going into hospital unnecessarily, help people to be as independent as possible after a stay in hospital, and to prevent people from having to move into a residential home until they really need to. Throughout 2016-17, Islington Council and Islington Clinical Commissioning Group jointly funded a variety of 'at home' and 'bed based' clinical rehabilitation services as well as reablement services including:

Service category	Service	Provider	Description & Skill set
Crisis response (Rapid Response)	Rapid Home Care	LB Islington	Domiciliary Care service that can be "turned on" by the acute. For a max of 3 days.
Home based Intermediate Care	REACH home based	Whittington Health	home based multi-disciplinary therapy including physiotherapy and occupational therapy, and nursing
Bed based Intermediate Care	REACH bed based Therapy Team	Whittington Health	Bed based multi-disciplinary therapy including physiotherapy and occupational therapy, and nursing located at Mildmay and St Anne's
	St Pancras Rehab Unit	CNWL	21 Rehab beds
	St Anne's	Forest Healthcare	10 Rehab beds set in a nursing care home
	Mildmay	Notting Hill House Trust	12 Rehab beds in an extra care sheltered setting
Reablement	Community Enablement	Age UK	Short term intervention to increase independence and wellbeing for Islington residents 55 years and older
	In-house Reablement service	LB Islington	Reablement care to people in their own homes for a period of up to 6 weeks
	Mental Health Reablement	C&I NHSFT	Short term intervention to avoid hospital admission and facilitate safe and timely discharge from inpatient services.

Commissioners have recently undertaken a review of the intermediate care provision and have found that services across the system can find it difficult to navigate to appropriate service for complex patients. This can leave referrers with limited options, typically delaying discharge from hospital.

In 2017-2019 work will be undertaken in partnership with Haringey to secure a significant improvement in community-based intermediate care provision and reduce the need for bed based services, with many more patients being managed effectively at home. Summary of work streams:

- **Rapid Home Care**
  Incremental development will help the teams learn from each other and build on good practice. A number of other system changes (such as the STP Urgent Care Programme and Assess at Home) are taking place over the next few years. A test and learn approach will help enable the service to develop in a way that will support the objectives of multiple interdependent system changes.

- **Home-based**
  Our delivery of home based intermediate care involves a complex provider landscape (e.g. respective in-house Reablement services), commissioned therapy teams and hospital discharge teams) and has multiple interdependencies (e.g. CHINS, Assess at Home and schemes and work to improve operational processes within each service). A test and learn approach will enable us build on the work that is already underway and continue to respond to the needs and changes to the system whilst working towards the overall medium/long term vision.

- **Bed-based**
  Unlike home based and rapid home care, where the composition of teams and ways of working can be adapted on an agile basis, the bed based intermediate care provision is discreet, with fewer interdependencies, and its scope is determined by the availability of suitable beds. Joint bed based intermediate care provision will require a business case. Capital investment in beds may be required, along with long term contracts with providers; and will require pooling of budgets. This includes a clinical review of the bed base case that is currently underway.

14. Better Care Fund Plan

The previous section has provided details of our planned activities for 2017-2019. The table below provides a high level summary of the better care fund programme for 2017-2019. Appendix A provides details of each of the key schemes.

Scheme	Activity	Intended Impact	Timescales
Protection of Adult Social Care Services	Social market capacity Care home quality D2A Demographic pressures: - Assessments - Care packages - Integrated CHC Transforming Care Cohort	Capacity to respond to discharge requirements Minimise risk of provider failure Secure safe and sustainable discharge of TCP Clients Reduce avoidable A&E admissions from Care Homes	April 2017 Review April 2018 Reprioritise/ adjustments from April 2018
Carers	Mental Health Carers Support Young Carers Support Carers Services – breaks and respite	Reduce carer breakdowns leading to hospital or residential care admissions	Ongoing
Reablement	Community Reablement D2A	Reduce delays in discharge Reduce delays in readmission following discharge	April 2017 Review April 2018 Reprioritise/ adjustments from April 2018
Care Act	Meeting social care needs for eligible clients Investing in Prevention	Reduce avoidable admissions to residential care	Ongoing

Scheme	Activity	Intended Impact	Timescales
		Keep residents independent in their own homes	Early Support and Prevent Review – as part of the council's SPARKs programme from April 2017. Recommissioning from October 2017.
IT	CareMyWay	Reduce avoidable admissions Speed up transfers of care	Care My Way Professional live and being rolled out. Further development of Care My Way Analytics and Personal in Q3 2017/18.
Out of Hospital – Social Care	Welfare Support First 21 months Supporting out of borough LD residents	Keep residents independent and well in their own homes Avoid hospital admissions for LD clients Reduce avoidable admissions for infants	Ongoing
Out of Hospital Services NHS	Hospital at Home Intermediate Care Provision Falls Prevention Primary Care Self-management	Reduce avoidable hospital admissions Reduce delays in transfer of care Keep residents independent and well in their own homes	Hospital at Home –Expand scope of conditions seen and increase utilisation by Q3 Intermediate Care provision: redesign to incorporate D2A and admission avoidance Q4. Falls prevention: pilot falls service Q4 2017
Out of Hospital Care Closer to Home	CHINS – Frail and Elderly and Long-term Conditions	Reduce avoidable admissions – improved management of LTCs and support to frail and elderly people Increase systemic opportunities to remodel services and pathways through clinically led approaches	Two CHIN networks are in place, covering half the borough. Full coverage will be complete by Q4 2017/18.
Disabled Facilities Grant	Adaptions for clients to aid return home or divert need for ASC/ health services	Keep residents independent and well in their own homes Reduce delays in transfers of care/ discharge Reduce avoidable admissions to care homes – working age and older people Reduce falls related admissions to hospital	Ongoing

Scheme	Activity	Intended Impact	Timescales
IBCF	Stabilising and sustaining adult social care services including the adult social care market	Capacity to respond to discharge requirements. Minimise risk of provider failure. Secure safe and sustainable discharge of TCP clients. Reduce avoidable A&E admissions from Care Homes	April 2017 Review April 2018 Reprioritise/ adjustments from April 2018

15. Risk Assessments

15.1 Programme Risks

The programme risk framework is provided below.

Likelihood			**Impact**
Remote	1	1	Low
Unlikely/chance it could happen	2	2	Medium
Likely to happen	3	3	High
Very likely	4	4	Extreme

There is a risk that:	Likelihood	Impact	Overall risk factor (likelihood* potential impact)	Mitigating Actions
1. Islington residents do not experience services that are designed around their needs and the outcomes they wish for themselves	2	2	4	We have a comprehensive and wide ranging approach to patient leadership, at all levels across local partners. This includes patient participation across key decision making bodies. We are a national demonstrator site for Integrated Personal Commissioning, supporting health care empowerment and the better integration of services. We will use this programme to challenge and strengthen our ambitions in this area.
2. We fail to meet the activity reductions identified	2	4	8	We have a robust programme approach to monitoring delivery to enable us to understand progress and manage schemes as required. We have strong local relationships and governance arrangements to drive change as required. We have focussed on reducing unnecessary hospital activity by key offers in discharge to assess, admission avoidance and ambulatory care.

There is a risk that:	Likelihood	Impact	Overall risk factor (likelihood* potential impact)	Mitigating Actions
3. Implementation of Care My Way fails to deliver planned impact, affecting BCF delivery	1	3	3	Governance structure including service steering group established to ensure delivery and functionality as per Output Based Specification and progress is monitored and managed effectively. We have established a benefits realisation framework. Robust project risk register in place with project risks reviewed by the Governing Body IT Assurance group, Informatics steering group and reported to the Strategy and Finance committee.
4. Key STP programmes fail to deliver planned impact, affecting BCF delivery	2	3	6	The BCF deliverables are closely linked to key STP programmes, particularly 'Care Closer to Home' and 'Urgent and Emergency Care'. We have clear programme governance enabling us to link these areas and closely monitor delivery. Local delivery of key initiatives including Care Closer to Home Integrated Networks and Quality Improvement Support Teams is well under way.
5. Demographic pressures on social care are not managed, affecting BCF delivery	1	3	3	Joint commissioning of services through pooled budget arrangements ensures oversight of commissioning, ability to risk share across organisations and flexibility to invest where it can make the most impact. Very strong relationship with Public Health, to ensure that commissioning developments are rooted in local requirements as well as being evidence based.
6. Social care eligibility is not maintained	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 and we have a shared approach to delivering preventative interventions.

Social Care Market Risk Assessment and Mitigation 2017-2018

In 2016-2017 health and social care partners have worked together to identify the main risks in the current health and social care market.

Likelihood			**Impact**
Remote	1	1	Low
Unlikely/chance it could happen	2	2	Medium
Likely to happen	3	3	High
Very likely	4	4	Extreme

Risk	**Likelihood**	**Impact**	**Overall risk factor (likelihood* potential impact)**	**Mitigating Actions**
Individual provider failure reducing capacity in the market	2	3	6	Audit undertaken and actions in place to address/ manage potential market failure. Use of mixed economy of block contracts (lower financial risk for the provider), in house provision (minimising cash-flow risks) and spot purchasing (reducing risk by not concentrating high need clients with one provider) to maintain capacity.
Lack of specialist skills in learning Disability Market to provide appropriate services to TCP cohort	3	3	9	As part of the North Central London TCP we have reviewed provider capacity and put in place new commissioning plans to increase capacity. This includes: • Increasing capacity in specialist care co-ordination across NCL to support the local provider market • Proposals to develop a competency framework for Positive Behaviour Support (PBS) across NCL to drive up provider quality for this

Risk	Likelihood	Impact	Overall risk factor (likelihood* potential impact)	Mitigating Actions
				• Islington are joining a PBS Framework led by Haringey to attract new specialist providers to the market
Capacity does meet demand for older people residential and nursing care placements	3	3	9	Review of intermediate care completed. Work with NCL boroughs to manage market capacity within NCL in place. Plans for additional intermediate capacity being developed with Haringey
Pressure on registered provider housing stock limits availability of accommodation and support services	2	3	6	LD accommodation plan includes assessment of supply and demand and has recommendations to address gaps in capacity. We are developing new accommodation to meet demographic growth pressures
Providers unable to recruit or retain appropriately skilled workforce numbers	4	4	16	Provider uplifts agreed. Additional cost pressures arising from sleep in rates and LLW increases included in uplift process. NCL workforce development work looking at capacity / skills in the social care market
Providers are no-longer financially viable and exit the market	3	4	12	We will be assessing financial sustainability with local providers through contract monitoring. All residential spot placements for LD, MH & PD have had a care fund calculator (CFC) applied which tells us if they are adequately resourced
Quality is not maintained and homes are subject to new placement suspensions	3	4	12	Regular contract and performance monitoring of care home providers in Islington in addition to the quality assurance work led by the Lead Nurse. Risks at a number of care homes have been identified and addressed via these mechanisms. Monthly RADAR (multi-agency, collaborative information sharing group) meetings to highlight thematic safeguarding concerns.

Risk	Likelihood	Impact	Overall risk factor (likelihood* potential impact)	Mitigating Actions
				Regular strategic meetings with the CQC, joint sharing on intelligence on the state of the market. Joint meetings with providers to discuss best practice replicate approaches where appropriate and understand challenges faced by providers. Managing the market for nursing home placements and domiciliary care through the Any Qualified Provider (AQP) framework agreement for Continuing Healthcare patients. If possible the intention would be to ensure an aligned position between respective CCGs and Councils. Fortnightly sharing of quality and risk information about specific issues with NCL partners about providers including who: • May have handed back contracts or merged with larger organisations, • Are being dealt with via a Provider Concerns Process

16. National Conditions

16.1 National condition one: jointly agreed plan

The Health and Wellbeing Board have been engaged in the development of the Better Care Fund since it was introduced. The board received and discussed regular briefings in 2016/17. Pending the provision of detailed guidance, the board received a briefing on the 28h April 2017, outlining key achievements and actions for the 2017-2019 plan.

The Islington Integration and Better Care Fund plan has been developed, and is owned by, key stakeholders including patients, providers, frontline staff and health & social care commissioners. The Better Care Fund plan has been developed jointly across health and social care with agreement across the senior leaders in the local health and social care economy. This has included detailed local work to understand the content of the requirements of the Better Care Fund strategically, financially and from a risk management perspective.

The key providers that contribute to and are affected on a system level by the plan have been engaged throughout the development of the plan in 14/15 and revisions for 15/16, 16/17 and 17/19. This has included the Whittington Integrated care organisation as the key provider of acute and community services in Islington. The forum for the discussions with providers has been positioned strategically through the integrated care programme, the A&E delivery board and contractually through the contracting rounds for 2017/18.

The additional of IBCF funding has been considered in light of the other whole system investments: Better Care Fund, STP transformation, resilience programme and investments in CHINs. The CCG and local authority are in agreement on the use of this funding to increase capacity in adult social care services.

16.2 National Condition two: Social Care Maintenance

The funding proposals for 2017-2019 are above the RNF minimum amounts in both year and this mirrors the approach taken to investment in adult social care services since the establishment of the Better Care Fund.

Adult Social Care funding is used to invest in core adult social care services and integrated community teams. We have seen demand rising at a time of budget pressure and have been keen to maintain an emphasis on personalisation, prevention and early intervention. This is backed up by a strong public health offer and investment in universal services which are delivered through a rich diversity of voluntary sector provision. For those who need care we have built on the legacy of joint working to make sure that we optimise effort and spend through collaboration with partners. Our focus of this joint work has been to deliver more pro-active interventions using a recovery model so that we can intervene early and maximise independence. Our integrated care programme supports this vision for social care with an emphasis on better information and advice at a population level and co-ordinated care delivered for those who need it, with a focus on reablement and recovery.

Our approach to creating resilience, prevention and early intervention will be reviewed across 2017-2018 as part of a wider council review of how public sector investments are used to reduce the risk of individuals needing high cost intensive services and keeping people independent and at home. This will build on the work already undertaken as part of Better Care Fund to identify key triggers for entry to the health and social care system and ensuring that evidence based interventions are in place to minimise these triggers.

Funding Contributions	2017-18 Allocation RNF £000s	2018-19 Allocation RNF £000s	Islington BCF 2017-2018 £000s	Islington BCF 2018-2019 £000s
Social Care Investment from CCG minimum contribution	£6,103	£6,219	£7,862	£7,862

The investment into social care is within the context of a broader integrated health and social care system supporting out of hospital care.

16.3 National condition three: NHS commissioned out-of-hospital services

Islington has an intermediate care pooled budget and a wide portfolio of out of hospital commissioned services including commissioning services from social care, voluntary sector, primary care and community provision. The planned investment in community services exceeds the minimum investment expected by NHSE.

In 2017/18 we intend to continue to support those services previously commissioned from the Better Care Fund, including:

- Integrated Community Ageing Team. This service brings together geriatrician input from two local acute trusts with a GPwSI from Primary Care, providing clinical leadership to a multi-disciplinary team of nurses, pharmacists, occupational therapists and physiotherapists. The team works across care homes, hospitals and community providing specialist clinical support for older adults
- Integrated Networks. This structures join up all key health and care providers at a patient level, providing structure and capacity to deliver integrated care to those residents most at risk.

In addition, we will provide new investment to support key developments in this area linked to our STP plan, including:

- Care Closer to Home Integrated Networks (CHINS). These structures build on our Integrated Networks, bringing organisations together at strategic and planning level, enabling services to be more closely designed around local populations.

- Quality Improvement Support Teams (QISTS). Provided by our GP Federation, these clinically led services comprising GP's, nurses, analysts and project management skills will address unwarranted variation in primary care services.

Funding Contributions	2017-18 Allocation NHS Out of Hospital £000s	2018-19 NHS Out of Hospital £000s	Islington BCF 2017-2018 £000s	Islington BCF 2018-2019 £000s – excluding risk pool
NHS Commissioned Out of Hospital Services from CCG minimum contribution	£4,944	£5,038	£6,828	£7,159

16.4 National Condition four: High Impact Transfers of Care Model

Islington's self-assessment against the High Impacts Transfers of Care Model and improvement plan is provided below.

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
1. Early Discharge Planning In elective care, planning should begin before admission. In unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set with 48 hours.	**Plans in place** 1. UCLH ensures all patients are seen prior to surgery where discharge planning is discussed. A Ward Exemplar programme is operational at UCLH and all patients should have their discharge date set within 24 hours of admission	1. Identify cohorts of community patients who would benefit most from preadmission discharge planning. 2. Review existing mechanisms and services that deliver pre-admission discharge planning. Gap Analysis. 3. Pilot or transform services to enable pre-elective discharge planning on identified cohort of patients with highest needs.	1. January 2018 2. January 2018 3. March 2018	1. Reduced length of stay 2. Outcome 3. Outcome

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
	Emergency admissions have a provisional discharge date set within 48 hours and services exist **Established** 2. Virtual ward nursing, and integrated social care and rapid response, hospital facing. 3. Integrated service facilitates discharges from A&E at both UCLH and WH 4. Ambulatory care centres available at Whittington 5. UCLH has the Exemplar Ward programme – patients are set a discharge date within 24 hours	**Established** *Emergency admissions have same day/next day discharge dates set which whole hospital are committed to delivering* 4. Operational service providing community facing nursing and therapy prevention of admissions with access to social care packages 5. Improve information sharing between hospital, community and primary care through roll-out of IDCR 6. To clarify and/or expand the role of pharmacists and medicines optimisation advice into virtual wards 7. Develop central CHIN coordinator role to receive info on / notification of pts being discharged. Can then notify GP or arrange any discharge services	4. October 2017, evaluation in April 2018 5. Roll out of IDCR across all providers April 2018 6. Time frame 7. Q3 18/19 if CHIN priority	4. Reduction in avoidable admissions at UCLH and Whittington Hospital. 5. Roll out and utilisation of IDCR 6. Outcome of pharmacy 7. Outcome of CHIN

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
		8 A) Within NCL STP to introduce additional support to care homes in managing care for residents in the last phase of life. This will be a new nursing team. B) Within NCL STP to introduce a single point of access for specialist palliative care advice.	8 A) January 2018 B) April 2018	8. A) reduction in ambulance conveyances and emergency admissions from care homes B) reduction in ambulance conveyances and emergency admissions of people in last phase of life

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
		9 The aim of the mental health Length of Stay Project is to promote recovery by caring for service users in the least restrictive setting. a. Bed occupancy levels will be 95% b. To establish the Accommodation Pathway Project to ensure early identification of patients with housing needs. c. Establish agreed Median LoS for each of the three Divisions that provide inpatient care and reduce the number of patients staying beyond the median by 50% d. Reduce SAMH Acute LoS for new patients from 90 to 65 days.	a. March 2018 b. c. October 2017 d. January 18 e. March 2018	**9.** a. Daily bed occupancy of 95% b. -Early identification of patients with housing needs within the Acute Division. -Reduction in LoS -Reduction in delayed transfers of care caused by lack of suitable accommodation. c. Number of LoS outliers will reduce by 50%. d. LoS is SAMH Acute will be 65 days.

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
2. Systems to Monitor Patient Flow Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan service around the individuals.	**Plans in place** 1. Systems are established to measure patient flow and are actively monitored by multi-agency delayed transfers of care meetings. However, the two main hospitals covering Islington have different systems and different ways of working. 2. To manage the flow of patients UCLH is launching a Tele tracking IT solution which will provide real-time data on bed capacity and patient demand. First phase commences in November 2016. In addition, the CUR (Clinical Utilisation review) IT system commences in October 2017. This will by January 2018 provide data on the patients who do not require an acute bed and will be linked to the current D2A work across Islington and Camden.	**Established** 1. Collate existing processes and systems in place, look to best practice examples elsewhere and determine gap. 2. Determine resource to develop a demand and capacity plan 3. Undertake a demand and capacity plan 4. Align current health and social care services to demand and capacity plan 5. Full demand and capacity plan developed for Out of Hospital services 6. To explore opportunities to risk assessment patient for medicines related problems, in order to prioritise patient for medication review, whilst in the hospital and on discharge into the community	1. October 2017 2. November 2017 3. November 2017 4. March 2018 5. April 2018 6. Time frame	Resource approved to develop demand and capacity plan Demand and capacity plan developed Health and social care services align to demand and capacity plan Reduction in barriers and issues regarding discharges Outcome of pharmacy

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
3. Multi-disciplinary/multi- agency discharge teams, including the voluntary and community sector Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients.	**Plans in place / Established** *Joint NHS and ASC discharge team in place* *Discharge to assess arrangements in place with care sector and community health providers* 1. Multi-Disciplinary Teams are established and due to be evaluated by PIRU so that we can take on board any improvements and continue to promote good practice where this is found 2. Discharge to Assess pathway 1 pilot underway and CHC discharge assessment options being developed.	**Mature** 1. Develop a single assessment and discharge plan 2. Develop Pathway 3 Pilot of Discharge to Assess 3. Develop Proposal for the scaling up of Pathway 3 CHC and 'complex' case management 4. Transform existing joint NHS and ASC discharge offer to scale up discharge to assess scheme 5. Scale up Pathways 0-3 for Discharge to assess, including pathway 3 CHC and complex assessments undertaken out of hospital 6. To clarify and/or expand the role of pharmacists and medicines optimisation advice into MDTs	1. September 2017 2. September 2017 3. February 2018 4. March 2018 5. March 2018 6. Time frame	Reduced number of assessment and discharge plan templates Increased pathways 0 -3 discharges into people's usual place or residence. Reduced DTOCs, Medically Optimised and excess bed days Increased saved bed days Outcomes for pharmacy. CHINs

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
		7. Develop central CHIN coordinator role to receive info on / notification of pts being discharged. Can then notify GP or arrange any discharge services. 8. To identify patients within the R&R Division with planned discharges over the next six months 9. To clinically review and plan actions for current service users who exceed ALOS 10. To identify current service user cohort who are suitable to be cared for in Burghley Road residential care.	7. Q3 18/19 if CHIN priority 8. August 2017 9. September 2017 10. September 2017	7. Discharge numbers from R&R Division will be established 8. ALOS outliers will be reviewed. 9. 6 services users will be identified for transfer.

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
4. Home first/discharge to assess Providing short-term care and Reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home mean that people no longer wait unnecessarily for assessment in hospital. In turn, this reduces delayed discharges and improves patient flow	**Plans in place** 1. Reablement service and pathways established to facilitate home first. 2. Simplified model for Discharge to Assess agreed – home first where possible 3. Pathway 1 Discharge to Assess pilot underway at UCLH and Whittington Hospital. 4. Pathways 0, 2 and 3 being explored to develop pilots. 5. Winter Funding bids underway to continue pilot and scale up capacity of Discharge to Assess. 6. Winter Funding bid to implement single point of access.	**Established (See System change 3)** 1. Pathway 1 scaled up across UCLH and Whittington Hospital. 2. Develop Pathway 3 Pilot of Discharge to Assess 3. SPA operational for discharge to assess 4. Develop Proposal for the scaling up of Pathway 3 CHC and 'complex' case management 5. Transform existing joint NHS and ASC discharge offer to scale up discharge to assess scheme 6. Scale up Pathways 0-3 for Discharge to assess, including pathway 3 CHC and complex assessments undertaken out of hospital	1. September 2017 2. September 2017 3. October 2017 4. February 2018 5. March 2018 6. March 2018	Increased Pathway 1 and 2 Discharges Additional capacity available within all health and social care services Increased pathways 0 -3 discharges into people's usual place or residence. Reduced DTOCs, Medically Optimised and excess bed days Increased saved bed days

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
	7. Reablement pharmacist already in place	7. Proposal for pharmacy technicians to support reablement service 8. Possibly use CHINs to deliver mobile MDT that could visit pts once discharged. This may transform the existing D2A to align it within CHINs 9. Integrated Network Opportunities	7. Time frame 8. Q3 18/19 if CHIN priority 9. Timeframe	Outcomes for pharmacy. CHINs and networks if different

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
5. Seven-day service Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.	**Plans in place** 1. Community nursing and social care available 7 days a week. 2. Rapid Response nursing available 7 days a week and provides a discharge function from hospital and A&E. 3. Seven-day working is available in hospitals with two social workers on duty at weekends. 4. Reablement work seven days a week providing new packages of care. 5. Care homes do accept hospital discharge of known residents from hospital at the w/e.	**Established** 1. Determine demand for 7 day working relating to discharges from discharge to assess pathway work 2. Determine capacity needed to support 7 day discharges 3. Review current 7 day working across health and social care and outline gaps 4. Develop proposal for delivering 7 day discharges 5. Develop plans for comprehensive 7 day working in acute health, community health and social care, including trusted assessors for care homes	1. January 2018 2. February 2018 3. March 2018 4. March 2018 5. April 2018	Clear picture of demand and capacity for 7-day working Proposal for 7 day working

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
	6. Extended Access (GP) 7. UCLH has a 7 day Discharge and therapy Service working on the wards and A&E to support early discharge and prevent admission/readmission	6. Community services and projects that are 7 day	6. Timeframe	

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
6. Trusted assessors Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timey way.	**Not yet established** 1. No single assessment form and referral form 2. Currently care providers assess patients in hospital 3. No data sharing agreements with care homes 4. Discussions have occurred with care homes to test the concept of health and social care staff assessing on behalf of care-homes. 5. UCLH Trusted Assessor working with all patients in UCLH who have been referred to bed based rehabilitation. The post works in the acute and has built strong relationships with staff at the Rehabilitation units.	**Plans in place** 1. Develop single assessment form for care home placements 2. Pilot trusted assessors with health or ASC undertaking assessment on behalf of care-homes when this is their usual place of residence. 3. Incorporate this role into Discharge to assess including pathway 3 complex assessments. 4. Incorporate pharmacy trigger questions into the single assessment: this will enable referrals for medicines optimisation support from community pharmacists and practice based pharmacists.	1. October 2017 2. November 2017 3. March 2018 4. Time frame	Fewer assessments for permanent care home placements undertaken in hospital

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
7. Focus on choice Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options; the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.	**Plans in place** 1. Choice is part of ASC ethos. 2. Patient choice documents and policy will be reviewed and updated 3. Implement integrated personal commissioning.	**Established** 1. Review choice documents and policy with patient and public engagement. 2. Finalise Choice policy and documentation 3. Develop communication plan for patients and carers 4. Integrate voluntary sector within Discharge to Assess pathways (mainly pathway 0)	1. February 2018 2. April 2018 3. April 2018 4. April 2018	Staff and patients/carers have knowledge of and understand the Choice Policy Voluntary sector support discharges homes

System Change	Where are you now? (2016-17 Assessment)	What do you need to do? (Where we want to be in 2017-18)	When will it be done by? (2017-18 Actions)	How will you know it has been successful?
. Enhancing health in care homes Offering people joined- up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care home, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.	**Established** 1. Integrated Community Aging Team provides specialist geriatrician and MDT intervention and care planning. 2. Locality networks and GPs provide integrated multiagency intervention via primary care. 3. Comprehensive community health services provide intervention to care homes. 4. Pilot of Integrated Urgent Care (IUC) professional's advice line for care homes to access to help prevent unnecessary admissions. 5. Care home Lead nurse employed by Health and Care providing care homes with expert support, advice, training and development. 6. LCS (Locally Commissioned Services) already in place for GP medical support	**Mature** 1. Care homes managing increased clinical acuity in care homes with IUC support and LCS updated offer in April 2018. 2. NHS England funding will be announced in Sept 2017, to expand the roles of community pharmacists in supporting Care home nationally.	1. May 2018 2. Time frame	1. Reductions in numbers of acute admissions from Care homes.

17. Overview of funding contributions

17.1 Financial Overview

The 2017-2018 budget plan and the indicative budget for 2018-2019 includes all contributions as set out by the BCF guidance in a pooled budget between health and social care. The minimum investment in Adult Social Care Services and Community Services are above the minimum levels set out in the guidance.

These plans have been agreed by all parties and are included in a section 75 arrangement.

The table below sets out a full overview of funding contributions for 2017-18, indicative funding for 2018-2019 and sets out changes from funding levels in 2016-17. The changes in the funding amounts from 2016/17 to 2017/18 are based on the following rationale:

- Review of the high impact change model and adjusts to reflect the recommended models of care
- Additional investment in primary care led community services through the Community Health Integrated Networks.
- The use of the additional IBCF funding allocated to Islington Council
- Changes to the national requirements such as increase in the DFG allocation

The changes to the funding amounts have been fully agreed across health and social care and represent an overall increase in the value of the fund from 16/17

	Scheme	2016/17 Total	2017/18 Proposed Total	2018/19 Proposed Total
LA	**1 - Protection of adult social services**	**7,802**	**7,861**	**7,861**
LA	**2 - Reablement**	**1,200**	**1,200**	**1,200**
LA	**3 - Carers**	**95**	**246**	**246**
LA	**4 - Care Act**	**663**	**663**	**663**

	Scheme	2016/17 Total	2017/18 Proposed Total	2018/19 Proposed Total
LA	**5 - DFG**	**1,318**	**1,452**	**1,584**
CCG	**6 - IT**	**600**	**600**	**600**
CCG	**7 - Out of Hospital Services**	**5,382**	**6,828**	**7,159**
	Sub-Total	**18,411**	**18,850**	**19,313**

LA	**8- Improved BCF**	**0**	**1,269**	**6,456**
LA	**9 - Improved BCF**	**0**	**6,070**	**3,700**
	Total	**18,411**	**26,190**	**29,466**

17.2 Use of IBCF: Stabilising and Sustaining the Social Care System

The section below sets out how Islington Council will utilise the Better Care Fund funding to meet the national priorities and to secure greater sustainability (quality and financial) across the Islington health and social care economy.

In 2017-18 the demographic pressure in Islington for Older People, Learning Disability, Physical Disability and Mental Health services is estimated to exceed the amount raised by the social care precept. It is there intended to use IBCF to:

- Address local pressures across local services: in particular services, that are hospital aligned and the multi-disciplinary team working to support vulnerable or frail older people with complex needs to remain living at home in their own communities;
- Protect services: to ensure support for services where otherwise would be considered for budget reductions in 17/18.
- Develop sustainable community capacity: including working closely with the voluntary sector which supports people's independence, enabling them to be cared for closer to home;

- Progress at pace service transformation across all client groups: including in-house provision, with a focus on interventions and support which help to address the underlying causes of demand and supporting people in ways which maximises their independence and ability to enjoy an “ordinary life”.

The section below provides further detail on these areas of expenditure under the three prescribed headings and the system benefits from these.

1. **Meeting Adult Social Care needs:** in 2017-2018 the council will further develop and implement new models of care, including its early intervention and prevention services, to put in place a range of services that will further a strengths based approach to social work. This will include:

   - Increasing capacity for responding to initial contacts, through the Discharge to Assess (D2A).
   - Commissioning and purchasing of additional packages of home care, telecare and improving the responsiveness of reablement
   - Sustaining investment in early help and prevention services and working with primary care to increase the use of community provision to meet initial health & social care needs.

   This is expected to:

   - Reduce pressure on limited residential care places through the provision of alternative support models
   - Reduce the number of delayed discharges because of a lack of available care home beds
   - Manage demand for adult social care by addressing some of the triggers that lead to increased demand for care services (for example repeat falls in those over 65 years)
   - Reduce the flow of individuals from early support / reablement services into formal care or hospital.
   - It will also provide an opportunity to shape the social care market and secure the development of local services to better address current and future needs.

2. **Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready:** a proportion of the IBCF funding will be used to maintain and sustain investment in adult social care services to reduce the risk of delayed transfers of care. This will include:

- Investing in additional capacity around the D2A pathway to support the transition of individuals back to their own home. The council will work with NHS partners to embed the service purpose and criteria; and support further development of the hospital discharge model and pathways
- Increase social care capacity working within the Integrated Networks.
- Continue to enable individuals within the transforming care cohort to move back to their local communities.
- Strengthen social work links to acute providers, in addition to the existing integrated services for mental health and learning disabilities, to facilitate a sustainable discharge.
- Jointly re-commission mental health day services to enable individuals to remain within services as their care needs change and reduce the risk of hospital readmission.

This is expected to:

- Secure a reduction in delayed transfers of care attributable to adult social care,
- Helping the NHS manage the cost of A&E and hospital admissions through greater provision of primary and community care
- Improve the experience of service users, promoting independence and enabling self-care.

3. **Local social care provider market is supported:** further work will be undertaken with the social care provider market increase capacity to meet the needs of D2A pathway and facilitate timely discharges into adult social care services. This will include:

- Working across the North Central London to Increase the range and supply of accommodation and support services available.
- Providing inflationary uplifts to providers in the residential and nursing care and domiciliary markets and fund inflationary pressure for existing capacity to stabilise the health and social care market.
- Increasing capacity in the social care market to respond to complex care needs – for example dementia or individuals with behaviours that could challenge – through the commissioning of specialist provision.

This will reduce the risk of financial failure amongst providers and subsequent reduction in the support of care provision and increase the availability of specialist community provision for complex clients.

17.3 Inflationary Uplift Adult Social Care

The CCG and the council have agreed that there will be no inflationary uplift to the Adult Social Care allocation, because further investment in the Care Closer to Home programme will secure benefits to the whole health and social system through early appropriate interventions with those with long-term conditions and the frail and elderly cohorts. Further investment in primary care led integrated community services with a focus on these two cohorts will be an additional element of the plan this year.

17.4 Disabled Facilities Grant

The council has an agreed plan for the use of the Disabled Facilities Grant (DFG) monies that meets the requirements of the BCF plan and statutory duties. The aim is to provide an integrated home adaption, telecare and equipment service that can support people to be discharged quickly into their own home and to reduce the number of individuals whose accommodation needs cannot be meet in their own home as they become older or whose health declines. This includes allocations for the provision of adaptations to disabled people's homes and for Adult Social Services aids, adaptations and assistive technology to help people to live independently for longer.

17.5 Care Act

The allocation of funds for the Care Act are in line with the circulated ready reckoner provided by the Local Government Association (LGA). This funding will continue to be used to embed the Care Act into social care practice and operations. In 2017-2018 there will be further work to commission services that will build individual resilience, help individuals avoid unnecessary entry to the health and social care system and ensure that, wherever possible, individuals are supported in way that helps them to stay at home and to participate in their local community.

17.6 Carers Support – Breaks

There is agreement on the use of carers funding within the Better Care Fund. Carers in Islington have access to direct payments, respite and short breaks services.

17.7 Reablement

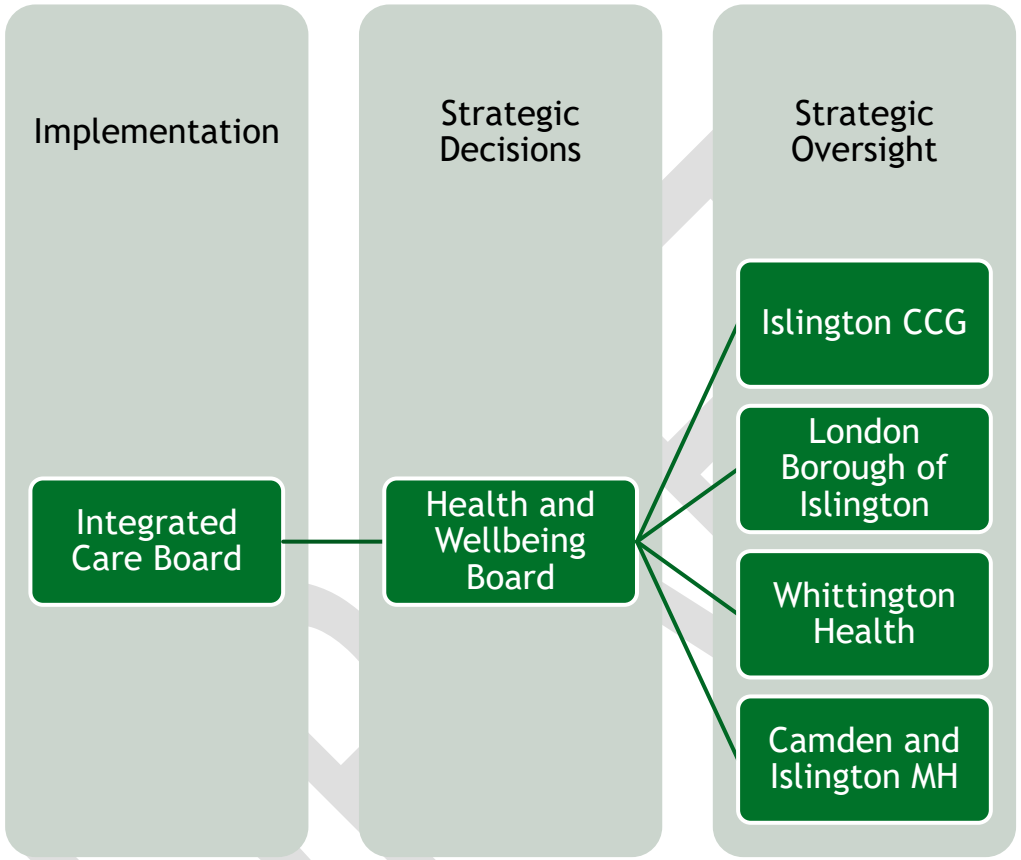
A pooled reablement budget is in place and, as previously detailed, the range and scale of intervention has been agreed by Better Care Fund partners.

18. Programme Governance

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 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. The emphasis of this group is on the transformational change required across health and social care underpinned by national evidence and best practice.

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 required for the BCF. 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; however, these are currently being reviewed for effectiveness and fit with key developments including the Wellbeing Partnership with Haringey and the wider STP work which is supportive of more collaborative working arrangements



The Integrated Care Board oversees various project groups delivering individual pieces of work, and is also reported to by a section 75 Group overseeing the pooled budget arrangements.

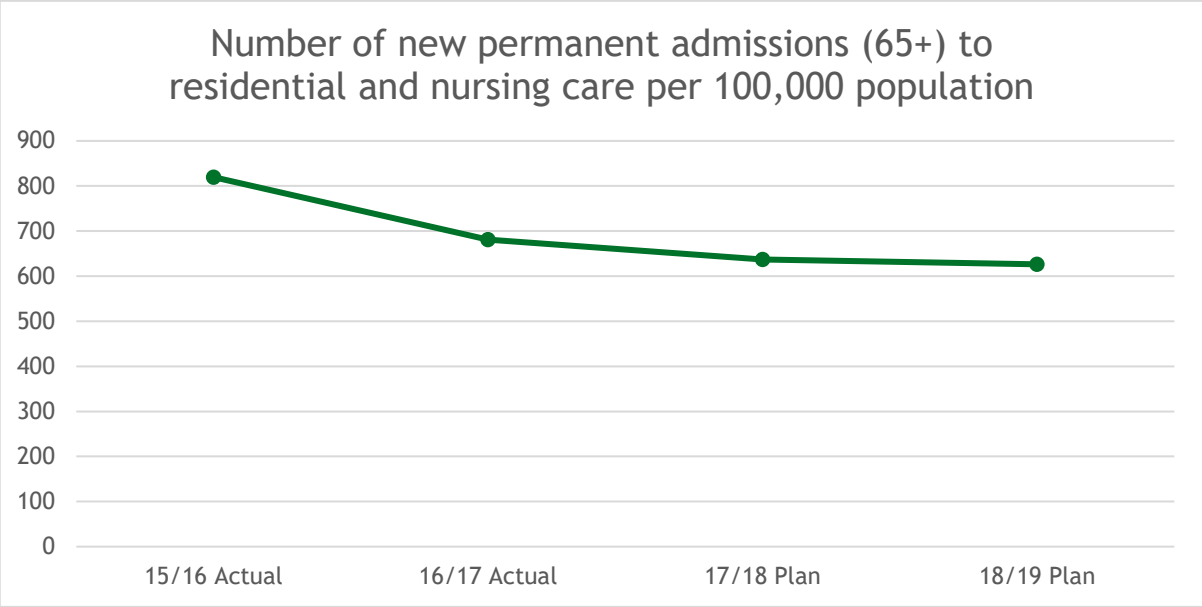
19. Performance Trajectories for 2017-2019

Trajectories for the four BCF metrics are provided in the table below.

BCF Metric	Islington 2017-2019	Islington 2018-2019
Non-Elective Admissions (NEAs)	2.2% Increase This due to expected demographic and non-demographic changes, and reduced activity in line with QIPP schemes	9% reduction
Delayed Transfers of Care (DTOC) - ALL	1.7% reduction This is the 2016/17 whole year actual compared with the 2017/18 whole year target.	TBC
Residential/ Nursing Care Home Admissions	5% reduction	0% reduction due to demographic pressures and D2A requirements
Reablement effectiveness – 91 days still home	0% change due to high performance	0% change due to high performance

19.1 Rationale for Targets

19.1.1 Residential Admissions

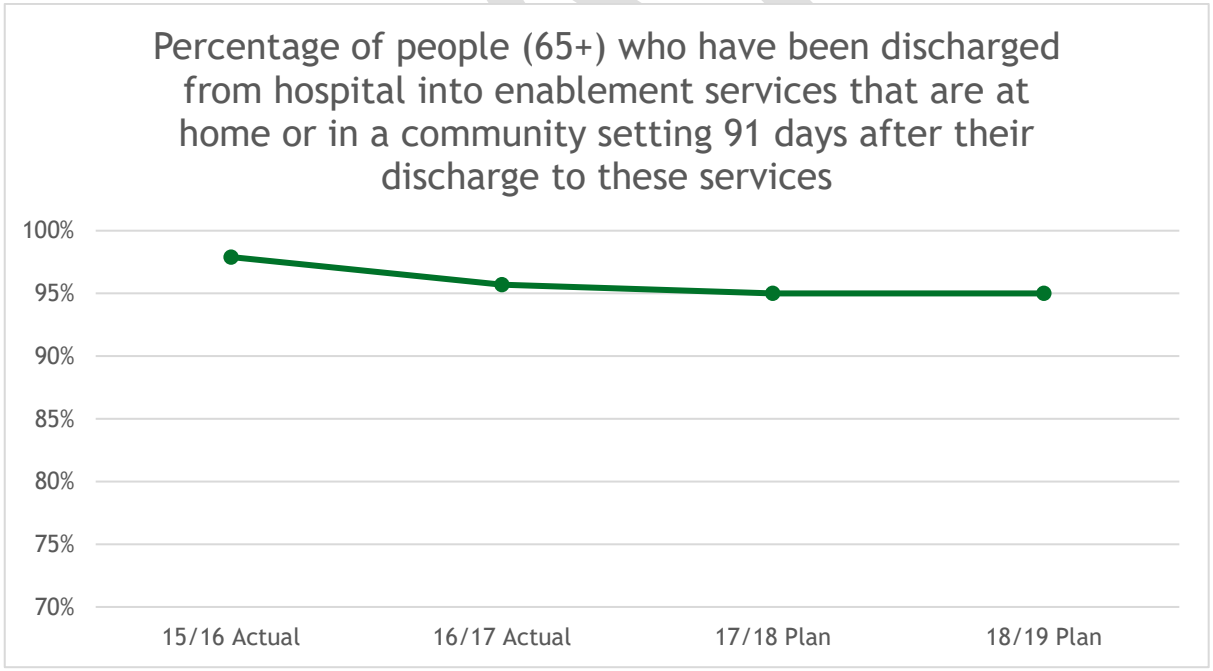


In 2016/17, the actual number of permanent admissions to nursing/residential care was 137 clients. For 2017/18, there is a planned reduction of 5% to 130 clients admitted. The plan is for this number of admissions to be maintained at 130, although the rate of admissions will be reduced to 626.3 by the end of 2018/19. This is deemed to be realistic as the High Impact Change Model for Managing Transfers of Care (HICM) is implemented. By establishing early discharge planning, by moving to a mature model of multi-disciplinary teams and by establishing discharge to assess, it should be possible to avoid using temporary placements. A temporary placement may be used while a complex package of community based care is put in place. By the time this complex package is in place, the client is often settled in the care home and this becomes a permanent placement. The implementation of the HICM is expected to have a beneficial impact on reducing the number of permanent admissions to nursing/residential care.

The rationale for not reducing the number of clients admitted in 2018/19 is that there is evidence of increasing frailty among the older adult population. In Islington, the older adult population, including those aged 85+, is shoring an increase and, as the average age on admission to permanent nursing/residential care is 85, this demographic change is anticipated to place pressures on the need for nursing/residential care. An analysis by Public Health of the Frailty Index (an index based on a range of 35 deficits including disease states, signs and symptoms and disabilities) shows that about a third of older adults registered with GP practices have mild frailty and high percentages of fall-related hospital admissions are found in older people with a mild or moderate frailty, which creates a risk of admission to nursing/residential care.

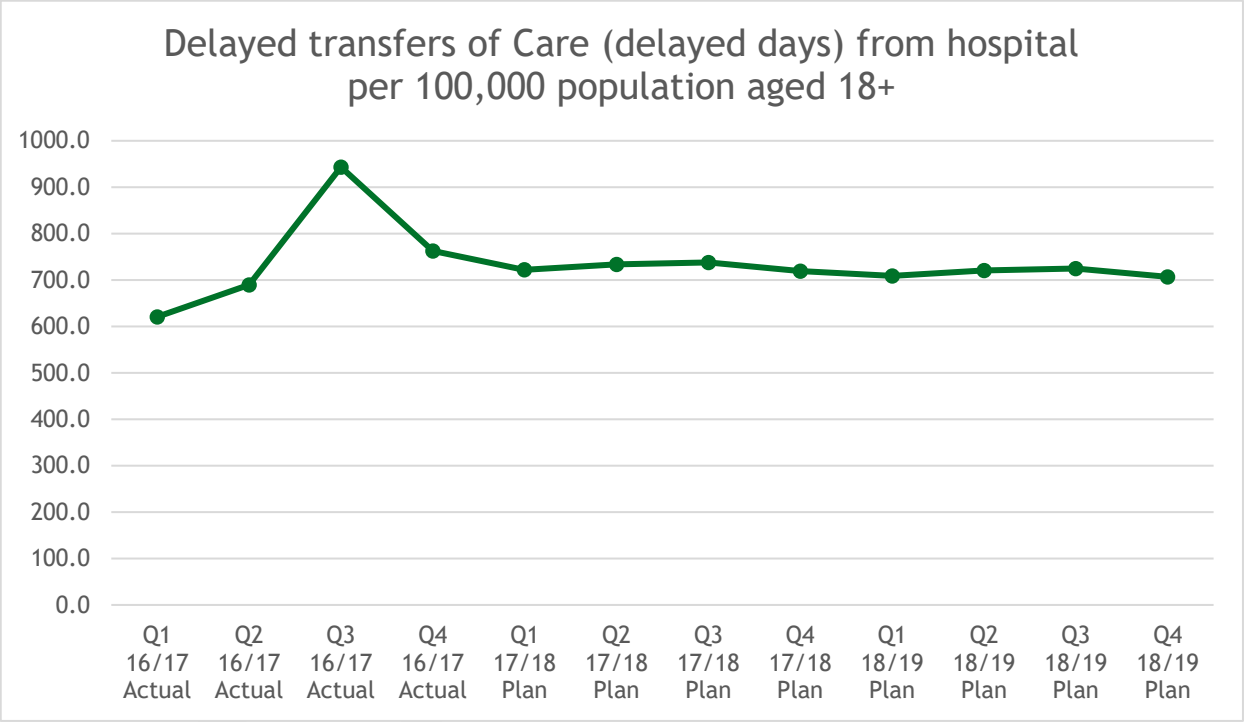
Therefore, the target for 2018/19 is realistic to take into account the increased demographic pressures, which prevent an actual decrease in numbers of clients admitted but results in a reduction in the rate of admissions to 626.3.

19.1.2 Reablement



Performance is high for this indicator, therefore, the target of 95% is designed to maintain performance at this high level.

19.1.3 Delayed Transfers of Care

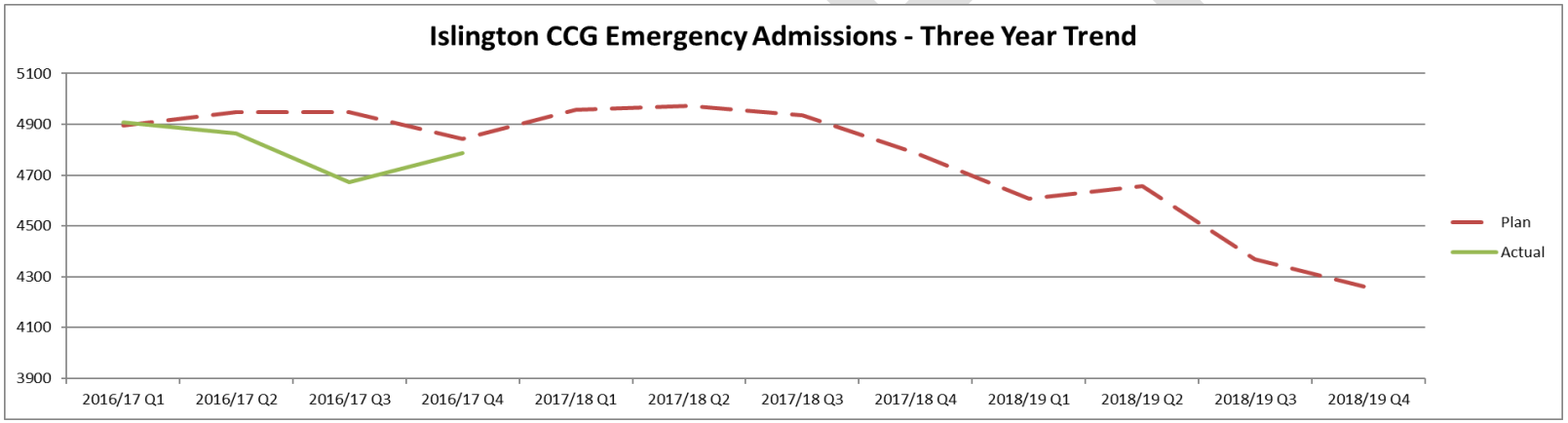


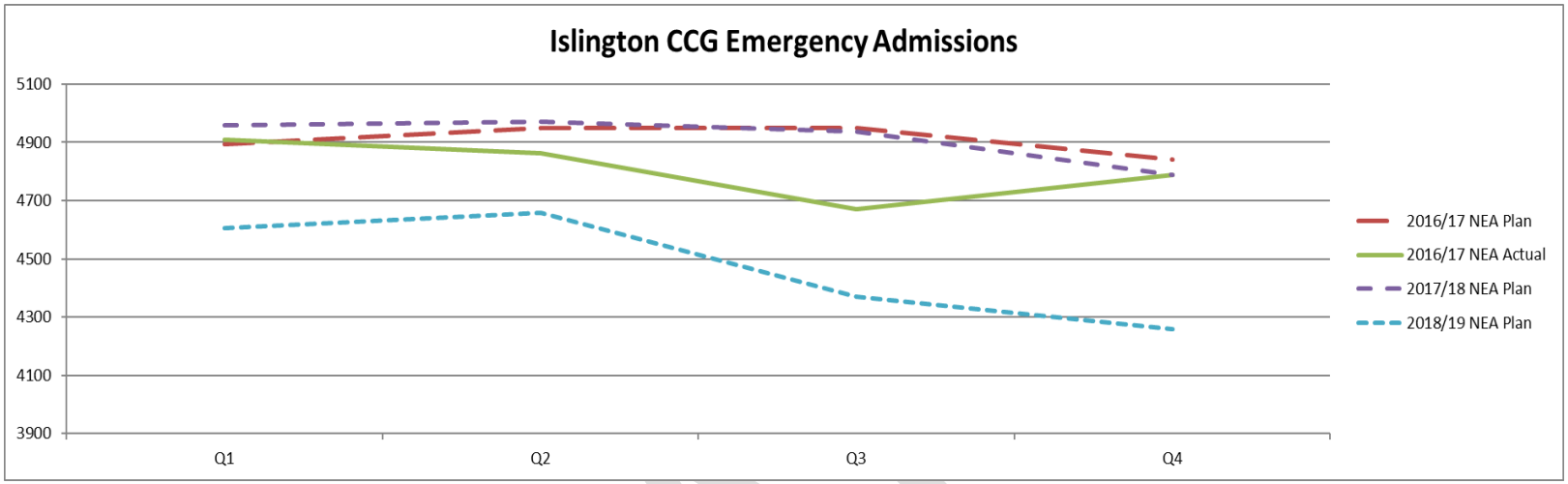
The targets for Delayed Transfers of Care have been developed using the targets specified by DCLG and NHS England, while aiming for a further reduction of 1.8% for 2018/19. The HICM is expected to enable DToCs to be reduced through the use, for example, of discharge to assess, early discharge planning and trusted assessors. Looking at discharge to assess in particular, in Islington, we are currently conducting two test and learn pilots for

discharge to assess with each of the two main hospitals that serve Islington (the Whittington and University College London Hospital). This is based on Medway Model Pathway 1. This is allowing current discharge pathways to be tested to make immediate improvements and to generate additional learning. Best practice around Pathway 3 procedures are also being explored along with an intermediate care bed ward audit to allow resources to be used more efficiently.

Progress with the HICM and performance against targets will be closely monitored by the multi-disciplinary Delayed Transfers of Care Operational Group to ensure compliance with targets.

19.2 Non-Elective Admissions





20. Delayed Transfers of Care (DTOC) plan

Islington has a developed structure around managing DTOC's, with established escalation resolution processes and a standing oversight group involving all key providers. This group has been instrumental in managing DTOC issues and seeking to continue to address these.

Our core plan for DTOC development and improvement is expressed above in the self-assessment table for the eight High Impact Changes, setting out how we will invest and develop our services to deliver increased hospital efficiency and flow. These eight High Impact Changes are overseen at a STP level by our Urgent and Emergency Care Board, with clear reporting links from local A&E delivery board enabling a system wide approach to be taken to managing DTOC's and all hospital flow issues.

APPENDIX A - SCHEME LEVEL SPENDING

Scheme Name: 1. Protection of Adult Social Services **Health Lead Commissioner/Joint SRO: NHS Islington CCG** **Council Lead Commissioner/Joint SRO: London Borough of Islington** **Date/version: 1/05/2017**	ISLINGTON NHS Islington Clinical Commissioning Group	
What is the problem this scheme is trying to solve? Protect the provision of adult social care services for national minimum eligibility and protect social care services that benefit health Protection of Adult Social Care in the context of increased demographic pressure and additional assessment demands for people and carers as part of the care act		
What is the proposed solution to this problem? (description of the 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 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.		
What are the expected impacts of this solution? (outcomes and benefits) Access to services where needed for people who meet eligibility Adherence with the wellbeing principle and emphasis on prevention agenda Allocation of resources for equitable provision		
What contracts are likely in scope? In house provision and various spot arrangements	**Current Providers** London Borough of Islington Spot purchase packages as required	**17/18 value (£)** 7,861,000

What resources are likely required to develop and implement the solution? 1. Robust performance management framework to analyse demand and costs to allocate resources where appropriate 2. Strategic market shaping strategy and implementation 3. Dynamic social care workforce to complete assessments	**Estimated Cost** 1. Resource costs to be contained in house to ensure frontline provision
What are the likely timescales and key milestones to; a) develop b) implement and c) realise the benefits of the proposed solution? Ongoing scheme from 16/17 Benefit realisation in year	
What are the key risks associated with this scheme? Demand and costs unable to be contained within budgets	
What are the likely implications for commissioners? for providers? Better value for money and visibility of demands and costs are likely outputs for commissioners Providers will need to demonstrate quality and value as part of delivering provision within a tighter economic context	

Scheme Name: 2. Reablement **Health Lead Commissioner/Joint SRO: NHS Islington CCG** **Council Lead Commissioner/Joint SRO: London Borough of Islington** **Date/version: 1/05/2017.0**	ISLINGTON NHS Islington Clinical Commissioning Group
What is the problem this scheme is trying to solve? 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.	

What is the proposed solution to this problem? (description of the scheme)
Islington has blended intermediate care and reablement pathways across health and social care. Recent reviews demonstrated that on the whole these pathways are effective at delivering outcomes. There is further scope for innovation and pathway efficiency through process improvement methodologies.
This scheme relates to maintaining existing provision as well as implementing the recommendations of the intermediate care and reablement review
.

What are the expected impacts of this solution? (outcomes and benefits)
Increased access to reablement and rehabilitation services
Reduced waiting times
Reduced future demand on services through emphasis on early intervention and independence

What contracts are likely in scope?	**Current Providers**	**17/18 value (£)**
Whittington In house LBI	London Borough of Islington Whittington	1,200,000

What resources are likely required to develop and implement the solution?	**Estimated Cost**
1. Programme and project management to oversee and implement changes 2. Commissioning and contracting expertise to align existing arrangements with stretch KPIs	1. Resource costs to be contained in house to ensure frontline provision

What are the likely timescales and key milestones to; a) develop b) implement and c) realise the benefits of the proposed solution?
Ongoing scheme from 2016-17

What are the key risks associated with this scheme?
Achieving provider collaboration for effective pathway and partnership working
Aligning KPIS to reduce perverse incentives in the system

What are the likely implications for commissioners? for providers?
Improved quality and visibility of performance are likely outputs for commissioners
Providers will need to work effectively across the rehabilitation and reablement pathways with increasing complexity of service users

Scheme Name: 3. Carers
Health Lead Commissioner/Joint SRO: NHS Islington CCG
Council Lead Commissioner/Joint SRO: London Borough of Islington
Date/version: 01/05/2017 v1.0

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What is the problem this scheme is trying to solve?
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.

What is the proposed solution to this problem? (description of the scheme)
The Carers Hub has been commissioned to act as the first point of contact for carers to access a range of advice, information, support and signposting. The service supports carers to have a life of their own alongside their caring role and ensures that they are supported to stay healthy, mentally and physically well, are safeguarded and treated with dignity. This includes for example access to a drop in centre, a carers network, a carers corner at four Islington libraries, free training, Carers Emergency Carers Card and a flexible breaks fund of up to £600. Carers are also able to access a heavily subsidised council handyperson service to make improvements and adjustments to their homes. Carers are generally found to be time poor and financially worse off as a result of their caring role. This Handyperson service aims to support carers to improve and maintain their living environment and improve their wellbeing

The Care Act 2014 has given carers recognition in their own right and is based on the wellbeing principle. As a result of this new legislation the Hub service has been extended to include completion of carers assessments on behalf of the Council and to support young carers transitioning into adult services; giving carers the choice and control over who supports them in completing their assessments. The assessments identify improvements carers would like to achieve based on the 9 wellbeing principles detailed in the Care Act. Support is provided to achieve these outcomes which are detailed in the support plan and includes access to the full

carers offer provided via the Hub service and for those eligible for support, it will extend to a personal budget of up to £1600 per annum, depending on their level of need. Some carers are also offered an independent advocate to support them through this process.

Carers are better supported through the range of services offered and are able to achieve improved outcomes from this support. These outcomes are now documented by the Hub through the new carers assessment process and can be reviewed annually.

What are the expected impacts of this solution? (outcomes and benefits)
This scheme is a continuation of 15/16 work and is an established service in Islington

What contracts are likely in scope?	**Current Providers**	**17/18 value (£)**
No change to existing contracts	Charity/Voluntary Sector	246,000

What resources are likely required to develop and implement the solution?	**Estimated Cost**
1. Resources already in place to commission and manage the Carers Hub	n/a

What are the likely timescales and key milestones to; a) develop b) implement and c) realise the benefits of the proposed solution?
The Carers Hub service was re-commissioned in 2015 and awarded to Age UK by a panel made up of staff and carers; it has a maximum extension date to 30 September 2020. The service has been designed with a focus on the continual improvement of the carers offer to reflect the changing needs and range of needs of carers. This will be achieved through encouraging greater involvement of carers in developing services through co-production and improved identification of hidden carers in the community. Delegating authority to the Hub to complete Carers Assessment also gives carers greater choice and control over who supports them and for the first time we will be able to measure whether carers outcomes have improved against a set of wellbeing principles.

What are the key risks associated with this scheme?
Identifying hidden carers for equitable access
Enabling a range of voluntary sector organisations to work in collaboration

What are the likely implications for commissioners? for providers?
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 Name: 4. Care Act
Health Lead Commissioner/Joint SRO: NHS Islington CCG
Council Lead Commissioner/Joint SRO: London Borough of Islington
Date/version: 01/05/2017 v1.0

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What is the problem this scheme is trying to solve?

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.

The allocation of funds for the Care Act are marginally different from the circulated ready reckoner by the LGA. In recognition that other funding streams also contribute to the Care Act requirements, the funding arrangements from the initial March submission continue.

What is the proposed solution to this problem? (description of the scheme) Maintain commitment to personalisation and personal budgets where possible Allocate sufficient resources for emerging carer assessments and new packages of care Embed the wellbeing principle into practice with an emphasis on prevention Enable a robust social care workforce to manage new assessments and packages Innovate for access to social care for service user led assessment where appropriate		
What are the expected impacts of this solution? (outcomes and benefits) Provision of assessment and care where required to meet the changing requirements of the Care Act Equitable provision and access Focus on prevention and self-management where possible		
What contracts are likely in scope? London Borough of Islington (in house) Spot arrangements	**Current Providers** London Borough of Islington Spot arrangements	**18/19 value (£)** 663,000
What resources are likely required to develop and implement the solution? Resources already in place		**Estimated Cost**
What are the likely timescales and key milestones to; a) develop b) implement and c) realise the benefits of the proposed solution? This scheme is a continuation of 15/16 work		

What are the key risks associated with this scheme?
New carer assessments and new service user demands are more than the resource allocation
Difficulties developing workforce and service user expectation to meet the new requirements of the care act

What are the likely implications for commissioners? for providers?

- Able to manage and maintain assessment, services and emphasis on wellbeing and prevention for commissioners
- Potential new opportunities for providers depending on requirements of users

Scheme Name: 6. IT
Health Lead Commissioner/Joint SRO: NHS Islington CCG
Council Lead Commissioner/Joint SRO: London Borough of Islington
Date/version: 01/05/2017 v1.0

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What is the problem this scheme is trying to solve?
Islington CCG and London Borough of Islington (LBI) Council are working together to deliver:

- Interoperability and information exchange between GP's, providers and people
- Having a digital person held health and social care record (PHR) for the people of Islington

What is the proposed solution to this problem? (description of the scheme)

- Islington have commissioned BT to develop an integrated care digital record and person held record

What are the expected impacts of this solution? (outcomes and benefits)

• Safer care – patient background, context and medications • Saves time – reduces time trying to find out information • Reduces risks – where patients unable to inform clinicians about relevant information / fax errors etc. • Reduction in duplication of activities • Allow empowerment of patients/citizens. • Patients/citizens at the centre of their care		
What contracts are likely in scope? 1. IT procurement completed	**Current Providers** BT	**17/18 value (£)** 600,000
What resources are likely required to develop and implement the solution? 1 Programme and project management to oversee and implement changes 2. Commissioning and contracting expertise to align existing arrangements with stretch KPIs		**Estimated Cost** 1.Already in place
What are the likely timescales and key milestones to; a) develop b) implement and c) realise the benefits of the proposed solution? • Please see attached slide deck		
What are the key risks associated with this scheme? • For a large scale IT programme – there are numerous risks and these are managed through a risk management approach. • Key risks include: delivery on timescales, provider management, correct data feeds, development of required user functionality		

What are the likely implications for commissioners? for providers?

- Commissioners able to understand whole pathway impact through Care My Way analytics module
- Providers able to work across organisations much more coherently

Scheme Name: 7. Out of Hospital Services
Health Lead Commissioner/Joint SRO: NHS Islington CCG
Council Lead Commissioner/Joint SRO: London Borough of Islington
Date/version: 01/05/2017 v1.0

ISLINGTON
NHS Islington Clinical Commissioning Group

What is the problem this scheme is trying to solve?

- Islington's integrated care strategy aligns with the BCF ambition that commissioning of out of hospital services supports the wider health and social care system deliver quality care. This scheme relates to rolling out planned initiatives as well as maintaining existing services, and closely aligns to the 8 high impact change models.

What is the proposed solution to this problem? (description of the scheme)

- Full coverage locality networks with wrap around care and support teams
- Aligned primary care mental health teams
- Age UK navigators
- Integrated out of hospital services
- Integrated Care and Assessment team
- Rapid Response functions
- Supported discharge functions
- Specific disease specific pathways

What are the expected impacts of this solution? (outcomes and benefits)

- Reduced delay transfer of care for health and social care
- Support for people in the community where appropriate and possible
- Increased quality of care
- Support to reduce non elective emergency admissions

What contracts are likely in scope? 2. ULCH 3. Whittington 4. Primary care 5. VCS	**Current Providers** • ULCH • Whittington • Primary care • VCS	**17/18 value (£)** 6,828,000
What resources are likely required to develop and implement the solution? 1. Programme and project management to oversee and implement changes 2. Commissioning and contracting expertise to align existing arrangements with stretch KPIs		**Estimated Cost** Already in place
What are the likely timescales and key milestones to; a) develop b) implement and c) realise the benefits of the proposed solution? • Various dependent on scheme. Projects overseen at Integrated Care Board and A&E delivery board, with increasing input from STP workstreams		
What are the key risks associated with this scheme? • DTOC and NEA rates may still rise despite the commitment to out of hospital services resulting in cost pressures in the system		
What are the likely implications for commissioners? for providers? • If schemes are effective, there is a net beneficial effect for both providers, commissioners and patients through the mechanisms developed in Islington		