ISLINGTON

NHS
Islington Clinical Commissioning Group

Joint Commissioning
222 Upper Street
London
N1 1XR

APPENDIX 1

Annual Report on the Partnership between Islington Council and Islington NHS Clinical Commissioning Group, 2016-17

1. Synopsis

1.1 Islington Council and the NHS in Islington have a long and successful history of working in partnership. The rationale for the joint commissioning of health and social care services is to produce better outcomes for vulnerable Islington residents than could be achieved by the Council and the Clinical Commissioning Group (CCG) alone.

This report refers to the partnership agreement between Islington Council and Islington CCG via a Section 75 agreement (National Health Service Act 2006).

Islington Council is signed up to other Section 75 Agreements with Whittington Health and Camden & Islington Foundation Trust. This report does not cover those, but rather the agreement to jointly commission services with Islington CCG.

1.2 Children and Adults Joint Commissioning supports the delivery of the Health and wellbeing priorities:

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

There are three key drivers:

1. *Effective* care and support for vulnerable people, who often need support from more than one service, is integrated and well-co-ordinated

2. *Value* (outcome over cost), can be produced, for the Council and the CCG, by pooling investment in 'pooled' budgets, managed by a joint commissioning management structure. Gaps or weaknesses in one part of the system of services, often affects services in another part.

3. *Sustainable* services are more likely when services work well together. The NHS and Islington Council face rising demand, growing expectations and increasing financial constraint. By developing and using joint commissioning levers, more sustainable delivery models can be developed.

1.3 This report will describe the main service developments for Children's and Adult's Services, as well as the Better Care Fund and provide assurance on the value produced by the pooled budgets and the joint commissioning arrangements in 2016-17.

2. Recommendations

2.1 This report is primarily for assurance.
It is recommended that Islington Council and Islington Clinical Commissioning Group note this report.

3. Adult Services

3.1 Pooled Budgets

Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Regulations 2000 provide the legislative framework for partnership working and allow for the establishment of a 'pooled' fund.

During the financial year ending 31 March 2017, six adult pooled budgets were in operation between Islington Council and Islington CCG, and hosted by the Council: Learning Disability, Intermediate Care, Mental Health Commissioning, Carers Services, Mental Health Care of Older People and the Better Care Fund. The breakdown of contributions is in appendix 1.

The summary revenue position for 2016-17 is shown below.

Table 1: 2016-17 Islington Council and Islington CCG Pooled budget summary table

Section 75 agreement	2016/17 Gross Budget (£)	2016/17 Outturn (£)	2016/17 Actual Variance (£)	LBI (£)	NHS (£)
Intermediate Care (Delayed Transfer of Care)	6,795,100	6,702,582	(92,518)	(49,960)	(42,588)
Learning Disabilities	29,279,000	31,171,624	1,379,624	1,209,930	169,694
Mental Health Commissioning	4,634,000	4,634,000	0	0	0
Carers Pooled Fund	1,055,300	960,889	(94,411)	(85,914)	(8,497)
Mental Health Care of Older People (MHCOP)	5,655,960	5,655,960	0	0	0
Better Care Fund*	17,096,000	15,896,000	(1,200,000)	0	0
Gross Expenditure	**65,690,700**	**65,624,885**	**(7,305)**	**1,074,057**	**118,638**

*Total BCF fund is £18.411m. Funding streams of £1.2m, £95k and £1.020m are included directly in Intermediate Care, Carers and Learning Disabilities respectively.

3.2 Adult Joint Commissioning

In addition to the pooled budgets integrated workforce arrangements, through the Adult Strategy & Commissioning department, ensure that there is a joined up approach to health and care across all commissioned services, including those not funded through pooled budgets.

London Borough of Islington made changes to the Adult Commissioning structure at a senior level with the recruitment of a Service Director, Adult Social Care Strategy & Commissioning, providing leadership for Joint Commissioning at the Council.

During 2016 arrangements for the Haringey and Islington Well Being Partnership were developed with the signing of the partnership agreement in early 2017. This arrangement will facilitate closer working arrangements between Haringey and Islington Local Authorities, Clinical Commissioning Groups and Whittington Health Foundation Trust, with a view to establishing an Accountable Care System. Work continues in the Well Being Partnership, which now has a designated Director in the CCG to develop that partnership and the infrastructure needed to bring system wide integration.

The Sustainability and Transformation Plan for North Central London was published and a central CCG Executive Team created for the five CCGs (Islington, Camden, Barnet, Enfield and Haringey). This development of a joint Executives Team for Islington and Haringey with one Chief Operating Officer and joint structure at Director level. These initiatives will help Islington and Haringey, and other partners in North London to transform services for local residents focusing on integration, care closer to home and reducing inefficient use of hospital based services.

Nevertheless it is recognised that all things cannot be done at a North London (STP) level, or even Haringey and Islington level. As such local joint commissioning structures and initiatives for Islington are a valued demonstration of efficient seamless working; one which is regarded as a model to emulate among other partners.

Islington CCG and the Council remain committed to the Islington Joint Commissioning function and team. There are no plans to bring this function closer together with Haringey Council and CCG at present, although parties remain committed to the Haringey and Islington Well Being Partnership and continue to work together to achieve the aims of the Partnership.

4. Review of Adult Service Developments

4.1 Older People and Mental Health Care of Older People

This pool provides a funding contribution to two care homes with nursing: Highbury New Park and Muriel Street which specialise in the provision of nursing care for older people with dementia and mental health ill health. Both homes are provided by Care UK. They work to:

- support local hospitals avoid and delay hospital admissions
- avoid delayed transfers of care, and
- provide good quality care in the community following discharge from hospital.

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 (MDT's) to reduce hospital admissions and avoidance is well acknowledged.

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.

The homes, with support from the Lead Nurse and input from the wider MDT's have been working towards improvements into the identified areas. The embedding and sustainment of improvement has been particularly challenging at the Muriel Street home due to the absence of clinical leadership and appropriate internal infrastructure.

Both Muriel Street and Highbury New Park have had been subject to Care Quality Commission (CQC) inspections over this period. The CQC also conducted a focussed inspection on Muriel Street in September and October 2016. These inspections noted significant shortfalls in the care provision and

identified a number of breaches related to the following:

- infection control;
- monitoring of staff to ensure they remained fit to carry out their roles;
- staffing and person centred care.

Following the recruitment of a new home manager in November 2016, there has been rapid progress made with respect to addressing concerns raised by the CQC, Council and CCG. A full CQC inspection was conducted in March 2017 and though the overall outcome states that the home continues to require improvements, the findings demonstrated improvement in all five inspection domains. Critically, all previous breaches had been addressed appropriately. Commissioners are more confident that the homes' current leadership (Home Manager and the Clinical Lead) will be able to sustain the improvements made.

Highbury New Park was inspected by the CQC in May 2017 and assessed to be fully compliant in all the inspection areas, receiving an overall rating of "Good". Positively, the home has been successful in retaining its Good rating for the last two years.

As a result of the quality monitoring, a number of quality improvement initiatives were implemented over 2016-17. These initiatives were developed in part to address gaps in the delivery of effective and safe care, but primarily to continue to improve the experience of residents in the homes.

During 2016-17 our focus has been on developing:

- A more skilled qualified and unqualified workforce in care homes. The Community Education Provider Network (CEPN) has a particular focus on care homes and a number of staff within the homes are engaged in cross sector training, particular with respect to the Health Education England Funded Care Certificate. There are continued efforts to engage the care homes and social care providers in integrating the workforce within the local health and social care system.
- The utilisation of secondary sector training to deliver extended clinical skills in support of Advance Care Planning and Treatment Escalation Plans.
- A more robust activities coordinator forum to progress new and innovative ideas around activities in care home environments.

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.

As noted in the previous annual report, recruitment and retention remains an area of concern across all health and care sectors. This has impacted to a higher degree on the Islington care homes. The disparity in pay structures has meant that the homes have struggled to compete for high calibre staff and are therefore heavily reliant on agency nursing staff.

In their efforts to address this, care homes have introduced a number of actions, including structured induction to minimise the risks associated with temporary nursing and the use of the same bank staff to ensure a degree of care continuity. This is in addition to the ongoing support from the wider multidisciplinary teams, including the Integrated Care Ageing Team. The additional support has been essential to sustain improvements particularly around clinical care and hospital avoidance.

Additionally, the 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 has resulted in reduced hospital admissions.
Currently, these care homes have permanent home managers in post and clinical leads. This has enabled the development of positive working relationships with the GP and the wider MDT to manage the increasingly frail and complex residents and support the sustainability of the training and input being provided to the homes.

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. Care home providers are making continuous progress with the management of residents with dementia. The care home organisations have internal strategies, with specific dementia leads in post who lead on training and developing care delivery and implementing best practice.

Notably, Highbury New Park has been involved in the University College London Partnership (UCLP) dementia training and this has had a positive impact on the quality of care delivered by the home. As some parts of the dementia service pathway may be more effective than others, we will continue to review the efficacy of dementia services

Whittington Health recently had 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 improvement of dementia care.

Commissioned care homes continue to receive support to work towards the vision outlined in the NHS 5 Year Forward Plan with particular emphasis on treating people in a safe environment, protecting them from avoidable harm and helping people to recover from episodes of ill health or following injury.

Areas of further development
A number of actions will be progressed over 2017/18 including:

- bespoke staff training for areas identified in action plans, for example: on site falls training, pressure ulcer prevention and grading classification training, and continence management training. This includes access to training provided by the secondary care sector;
- implementation of NICE guidance NG27 (2015) and piloting an integrated Care pathway to establish a Hospital Transfer Pathway 'Red bag' initiative between acute and care homes setting;
- roll out of student nurse placements following evaluation of current placements and the development of a learning environment for other learners;
- increased uptake of facilitated clinical supervision with all homes participating by the late 2017;
- establishment of Clinical Incidents Learning workshops across all care homes to facilitate shared learning and continuous improvement;
- review of the falls pathway, including falls prevention, across Islington led by the CCG and LBI Commissioners with support from Public Health and providers;
- as part of the winter planning supported by the NHS England guidance, initial discussions have commenced on mechanisms required to implement the 'Trusted Assessor model' aimed to improve hospital discharge into the care sector;
- an emphasis on forward planning and linking 7 day discharges with the Trusted Assessor model to support more effective discharges to the care homes on weekends
- use of 111/Ambulance Call out being progressed through the Home Manager Clinical Care Improvement Group (HMCCIG) forum;
- ensuring the 'Are You Concerned About a Resident' guidance is introduced fully and applied consistently across care homes;
- homes refer to and follow directives in the Anticipatory Care Plan/Treatment Escalation Plan and/or Advance Care Plan in place and take the required actions prior to ambulance call outs;
- exploring the feasibility of reviewing care home contract key performance indicators to ensure they reflect health and social care priorities, can be more accurately measured and to enable better national benchmarking.

4.2 Intermediate Care and Rehabilitation

Intermediate care is a priority area for the CCG and the Council. 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 hospital and delivered for a maximum of 3 days.
Home based Intermediate Care	REACH home based	Whittington Health	Home based multi-disciplinary therapy including physiotherapy, occupational therapy, and nursing
Bed based Intermediate Care	REACH bed based Therapy Team	Whittington Health	Bed based multi-disciplinary therapy including physiotherapy, occupational therapy and nursing supporting Mildmay and St Anne’s
	St Pancras Rehab Unit	CNWL NHS Trust	21 inpatient rehabilitation beds
	St Anne’s Nursing Home	Forest Healthcare	10 rehabilitation beds in a nursing home setting
	Mildmay	Notting Hill House Trust	12 rehabilitation beds in an extra care sheltered setting
Reablement	Community Enablement	Age UK	Short term interventions 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	Camden & Islington NHS Foundation Trust	Short term interventions to prevent hospital admissions and facilitate safe and timely discharge from inpatient services.

Home Based Intermediate Care
REACH provide home based multi-disciplinary therapy including physiotherapy, occupational therapy and nursing. They also support the bed based providers, screening referrals from both acute and community settings. There have been significant improvements in the last financial year. During the year they managed to reduce their length of stay from 61 days (Last FY) to an average of 47 days which helps with the flow of patients through the unit. In addition they are exceeding their waiting time target of six weeks; currently achieving seeing patients within 23 days.

Intermediate Bed Based Care
Intermediate bed based care is provided at three sites, and has continued to play a key role throughout the year in supporting those with the most complex physical rehabilitation needs; also supporting hospital discharges from the Whittington and UCLH. The units have historically managed their own triages and admissions but it has become clear that this has meant that the available beds have not always been utilised most effectively. To that end, a single point of access was setup to manage referrals into the Intermediate care beds and went live in November 2016.

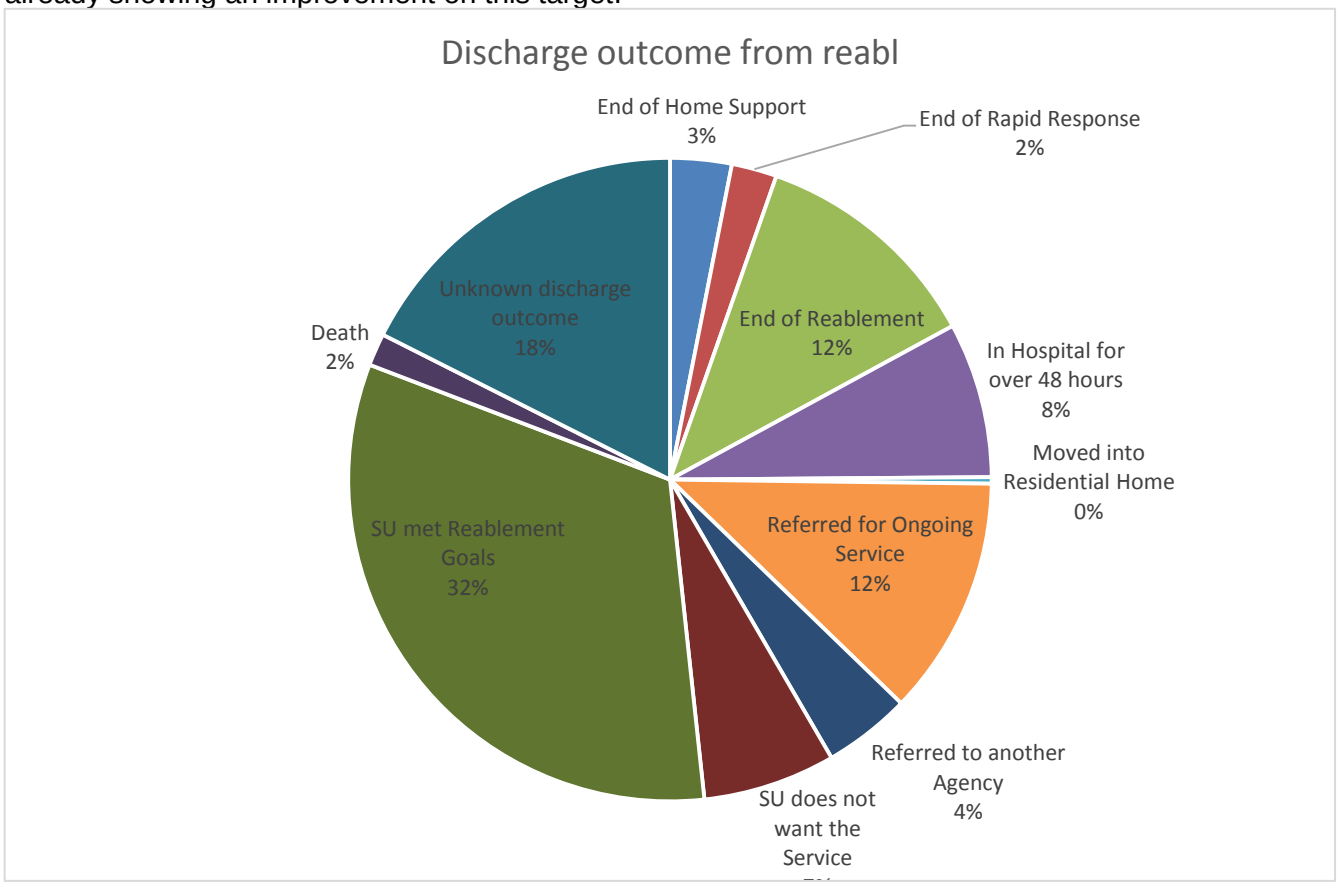
This led to the following benefits:

- patients are more likely to be placed in the most appropriate bed to meet their needs
- bed capacity has been maximised with greater utilisation of the community beds and fewer waits for the inpatient beds
- health related delayed transfers of care have reduced

Reablement
Islington Council provides a Reablement service to people in their own homes for a period of up to 6 weeks, usually following a period of illness or injury. The majority of people receiving these services are older adults but the service is offered to all Islington residents 18 years and over who meet the eligibility criteria. The length of time service users spend with the service is dependent on their rehabilitation goals and progress against these, which is regularly monitored. Referrals into the service are considered for all people leaving hospital or entering social care via Islington's Access Service.

All residents in receipt of adult social care services are also considered for referral to reablement during the review of their care packages. Social workers assess whether they would benefit from reablement interventions in order to increase their independence.

The Reablement service received an average of 48 referrals a month in 16/17. Data compliance was an issue at the start of the year which lead to a large percentage of unknown discharge outcomes. Of those where outcome was recorded 32% met there reablement goals. 2017/18 data and data quality is already showing an improvement on this target.



The vision for intermediate care going forwards
Commissioners have recently undertaken a review of the intermediate care provision and have found that the existing commissioning models for intermediate care are unnecessarily complex, with a range of providers (as set out in the table above) offering different services, which are not joined up.

Services across the system can find it difficult to navigate complex patients to the appropriate service. This can leave referrers with limited options, typically delaying discharge from hospital. It is clear that there is a need for simpler intermediate care pathways and more effective management of provision. Given the similarities in population demographics and existing intermediate care models, joint working

could realise benefits for both Islington and Haringey. Aligning intermediate care jointly creates an opportunity to develop a simpler, more comprehensive pathway that has sufficient scale and flexibility to meet a broad spectrum of patient need. At a wider system level, however, we need to continue to work jointly with Camden where we have traditionally had joint contracting relationships at the St Pancras site as well as the need for joined up discharge arrangements from UCH.

Providing community teams, such as home-based therapy and Reablement, across both boroughs is also likely to simplify processes and create better use of resource, particularly in areas such as workforce skill mix, capacity and IT/data sharing. Significant improvement in community-based intermediate care provision is likely to have a positive impact, reducing the need for bed based services, with many more patients being managed effectively at home.

There is also a need to future proof the service so that in 5 years plus the whole system will be resilient and meet the demands of an aging population with increased health and social care needs.

The key to the success of intermediate care is to ensure that people are facilitated through the system to enable them to return, or remain home and live as independently as possible. It is proposed that the current intermediate care system should be redesigned through a collaborative and outcome focused approach. This approach will ensure that patient, clinical and financial incentives are aligned under a single framework to promote cohesiveness, value for money and better outcomes for service users.

Given this work is now underway to develop local models as part of the Well Being Partnership.

The programme of work has been split into the following themes:

Project	**Proposed approach**	**Why?**
1. Rapid Home Care	Test and learn (agile)	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.
2. Home-based	Test and learn (agile)	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.
3. Bed-based	Business case (transformative)	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 discrete, 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.

4. Mental Health	Business case (transformative)	Discussions are underway with providers to join up intensive therapy with social care elements of reablement to help prevent hospital admission and support hospital discharge. This is part of the intermediate care review of mental health services.

Vision

- A simpler system with a single point of access for both hospital and community referrals
- Combined with changes to the discharge pathways the model will work on a 'home first' basis and have an emphasis on admission avoidance and increasing independence
- Community urgent response and intermediate care teams will support other out of hospital services to quickly increase or reduce the level of support, in response to changing level of need.

Benefits

- Reduces Hospital Admissions
- Reduces Length of Stay in Hospital
- Helping people to live as independent as possible after a stay in hospital and therefore reduces the need on domiciliary care and wider social care support
- Delays how early people move into a residential or nursing home care
- Helping residents to live healthy and independent lives
- To help support elderly and disabled people to live independently, and provide good quality care for those no longer able to do so
- Ensure residents have a good quality of life
- Ensure that residents have improved outcomes for themselves and their families specifically around long term conditions.

4.3 Mental Health

Mental Health and wellbeing are priority areas for both the Council and the CCG, and are one of the four priorities of the Health and Wellbeing Board.

Services commissioned through the pooled budget can be categorised as follows:

- Accommodation
- Prevention
- Intermediate care

Commissioned accommodation services provide support to service users to enable men and women with severe mental health to lead fulfilling lives in the community, maximising life opportunities and independence.

For the majority of accommodation services, placements are being fully utilised, with voids filled within a reasonable timeframe after a service user has moved on. Hilldrop Road residential care home supports older men with alcoholism and Korsakoff's syndrome, and is delivered by St Mungo's Broadway. The care home has a total of 29 beds; Islington has a block contract for 12 beds. A CQC inspection in December 2016 delivered an overall rating of 'inadequate'. As a result, the Provider Concerns process was implemented by the Council to address the issues identified, and support the provider to make the necessary improvements. This improvement work continues, however a follow-up inspection by CQC in July 2017 has resulted in a revised rating of 'Requires Improvement.' The CCG and the Council continue to work with the provider to ensure improvements are fully embedded. Highbury Grove Crisis House provides short-term accommodation (up to 14 days) for up to 12 adults who are experiencing a mental health crisis and who need 24-hour support or support at night. This is considered a prevention service as its primary remit is to prevent admissions into acute inpatient services, and to support people to manage their mental health within a community setting.

During 2016-17 efficiencies were delivered to the pooled budget. Some of this was as a result of

renegotiating terms and conditions with providers to deliver more cost effective services, the rest as part of re-commissioning accommodation based services. These efficiencies will come into effect December 2017. All changes to service delivery have been subject to consultation with service users prior to implementation.

Housing Related Support
Housing Related Support services for homeless adults with a mental health need were re-commissioned. This provides three levels of support to 199 individuals, as they develop the skills to live independently. Contracts are due to commence late 2017.

Hornsey Lane Residential Care Home
A business case for additional investment into this residential service for older people with a mental health problem has resulted in increased staffing levels, ensuring a higher quality of support is provided to residents.

Priorities for 17-18 include:

Intermediate Crisis Care Pathway
Work to develop an intermediate pathway (for people at risk of crisis, or who have experienced a mental health crisis, and require support to recover in the community) has continued. Extensive consultation has taken place with service users at Isledon Road Resource Centre on future plans for the service, the results of which will be used to re-shape the existing specification. Additional day provision currently delivered by Islington Mind will also be included in this work, along with Highbury Grove Crisis House (short-term accommodation for people experiencing a mental health crisis) and the Reablement service, which provides a time-limited package of care in people's homes following a mental health crisis, or to prevent a crisis. The intention is for all services to work in partnership to provide a community-based pathway which will reduce hospital admissions, and support people to remain well.

4.4 Learning Disability and Autism

The learning disability 'pooled budget' commissions the Islington Learning Disabilities Partnership (ILDP) which is an integrated health and social care team that provides for the holistic needs of young people and adults with a diagnosis of global learning disabilities, provided by London Borough of Islington, Camden & Islington NHS Foundation Trust (C&IFT) and Whittington Health NHS Trust.

Learning disabilities is undergoing a programme of developments to improve the quality of services while meeting demographic pressures and savings requirements. ILDP is experiencing demographic pressures, estimated to be £1.8m in 2016/17. A significant part of this is an increase in complexity of need and an increase in the number of people with learning disabilities in need of continuing health care.

Services for adults with learning disabilities are experiencing significant changes to the context in which support is provided. The Care Act introduced new requirements for prevention/early intervention, supporting well-being, market shaping, Safeguarding and support to family carers. Specific to this client group the Transforming Care programme (following the exposure of abuse at Winterbourne View in 2011), the Confidential Inquiry into Premature Deaths of People with LD (CIPOLD) and the failings exposed at Southern Health and published in the Mazars Report, showed that despite decades of progress people with learning disabilities still experience health inequalities, poor access to care and poor care, with serious consequences.

In addition to this the population is changing & growing as more people with learning disabilities live longer and more young people with very complex needs reach adulthood. Alongside this there is an increasing recognition of the multiple and additional needs which people with learning disabilities frequently experience, such as Autism, mental health needs, forensic behaviours, challenging behaviours, substance misuse issues, ADHD, health conditions, physical & sensory impairments, risk-taking behaviours and as victims of abuse and/or traumatic life experiences. There are significant health conditions such as epilepsy which are more prevalent in people with learning disabilities.

532 young people and adults with learning disabilities are receiving a formal support package and / or professional support from ILDP, 321 are in full-time accommodation services, as follows:

Adults with learning disabilities in full-time accommodation		
Service Type (NB includes independent sector and 'in-house' services)	Numbers (all ages) (In borough, Out of Borough)	% of total
Residential Care	110 20 In borough, 90 Out of Borough	34%
Nursing Care	8 3 In borough, 5 Out of Borough	2%
Hospital Care	2 2 Out of Borough	1%
Supported Living	189 160 In borough, 29 Out of Borough	58%
Shared Lives	12 5 In borough, 7 Out of Borough	4%
Total in accommodation services	321	100%

The pooled budget supports the commissioning of a range of accommodation based services. In 2017-18 there is an intention to bring spot purchased packages under a more robust contractual framework to enable performance monitoring and quality assurance, and we are working with ILDP to ensure all individually funded arrangements are subject to appropriate and proportionate monitoring.

As well as spot purchasing and commissioned accommodation, in-house services are increasingly being monitored by commissioners in partnership with the service managers to ensure that services are good quality, effective, efficient and sustainable. Part of this work is to establish a more formal relationship between commissioning and in-house services so that these services are subject to the same level of expectations and scrutiny as our local independent sector. Following intensive reviews recommendations have been made for improving service delivery and reducing costs.

Commissioners continue to explore options around how services are procured, to ensure that people can access a range of high quality options using personal budgets. A Dynamic Purchasing System (DPS) for Supported Living is currently being developed, and we are exploring joining Haringey's new Positive Behaviour Support (PBS) Framework. These would supplement or gradually replace current block contracts and spot purchasing arrangements & may deliver efficiencies to existing contracts.

New accommodation services are being developed across several sites in order to meet the growing need for good quality supported accommodation for people with learning disabilities and reduce reliance on expensive out of borough placements.

There is an active 'move-on' project which is assessing people who are in inappropriate accommodation and/or out of borough residential care services, with the aim of supporting those people to move to more suitable, more local and more independent living options. This project has a £200,000 savings target for 2017-18.
The ILDP is also undergoing an intensive review in order to improve efficiency, effectiveness and support the controlling of costs through better demand management and robust reassessment and

review processes.

Autism
Autism continues to be an area facing significant demographic pressure. We know that the needs of people with autism who also have a learning disability are well catered for by ILDP, however we recognise that the needs of people with autism who do not have a learning disability are less well known and there is risk of people 'falling through the gaps' of service eligibility criteria.

The Islington Autism Project (IAP) was launched in October 2016 - the team, consisting of one senior practitioner and one support worker, have a specific remit around supporting people with autism who don't have a learning disability and reviewing how we can sustainably meet the needs of this cohort going forward. This has contributed to the development of an Islington Partnership Board reviewing and considering how we can better support people with autism.

Transforming Care
Transforming Care is the program of work initiated in the aftermath of the abuse exposed at the Winterbourne View hospital in 2011. It relates to people with learning disabilities and/or autism who also have challenging behaviours and/or a mental health condition, focussing on ensuring they are not inappropriately admitted to specialist hospital care and are supported in our communities wherever possible. The Transforming Care programme remains one of NHS England's key priorities.

The term "challenging behaviour" describes behaviour of such intensity, frequency, or duration, as to threaten the quality of life and/or the physical safety of the individual or others. 10 to 15% of people with learning disabilities nationally express challenging behaviour.

The vision for people with learning disabilities or autism was set out by the national Winterbourne View Joint Improvement Programme, and remains relevant:

"Everyone, with no exception, deserves a place to call home. Person by person, area by area, the number of people with learning disabilities and autism in secure hospitals or assessment and treatment settings will permanently reduce. At the same time local community based support and early intervention will improve to the point it will become extremely rare for a person to be excluded from the right to live their life outside of a hospital setting."

Our strategic actions focus on ensuring that we support this population with effective community services that promote their independence and well-being and reduce the risk of hospital admission. Much of this work is being planned at a North London Partners (NLP) level which is our Transforming Care Partnership (TCP). There is an Implementation Group driving this work with a Programme Board which started in July 2016 to oversee progress.

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.

There has been a successful bid to a Housing Capital and Technology Grant from the Department of Health and NCL has been awarded £704,000. Islington can draw down on this fund in order to support the development of bespoke housing solutions for a small number of individuals with the most complex needs who need a specialist housing solution.

Work is ongoing to determine the financial impact of the Transforming Care 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 LD budget and a planned discharge later in 2017

is expected to add a further £400k pressure.

4.5 Carers

Islington Carers' Hub (ICH), provided by Age Concern Islington, is the main commissioned service for carers, and one stop shop for all carers advice, information and support – has continued to identify, support and advise carers in Islington through partnership work with a variety of organisations, from GPs, JCPs and hospitals to other Council-funded services e.g. The Stroke Association, the Dementia Navigator Service. Increasingly, the ICH is working with our VCS sector to improve our understanding of carers provision in the mixed economy, and to improve linkages with these organisations. The ICH continues to identify, register and support new carers. In 2016-17 the total number of new carers referred to the service was 481, bringing the total number of carers registered to ICH up to 2261, from 1700 the year before.

Support features include the provision of advice and information regarding community care enquiries; employment enquiries; and welfare enquiries. In addition, the ICH carries out statutory Carers' Assessments – this delegated authority makes the ICH something of an outlier amongst carer-specific services in the country, though local authorities are increasingly delegating such authority to similar services. The ICH also holds support groups and focus groups to discuss carers' issues, holds outreach sessions in venues such as GP surgeries and local hospitals, distributes informational newsletters (email and paper copies), and awards one-off lump sums of money to carers and families for respite via the Flexible Breaks Fund (FBF). The FBF is available to carers and families who do not qualify for Direct Payments via Carers Assessments, or for whatever reason choose not to have a Carers Assessment.

More recently, the ICH has worked closely with Prevention Commissioning on improving relationships and processes between the ICH, Family Action (Children's Services' Young Carers' service) and the Access team, particularly though not solely related to a carer's transition from Children's Services support to Adult Social Care support, and the difference in service to be expected from both offers. The ICH has also recently been given access to the Council's Adult Social Care information system, LAS. This will allow for more fluid and timely completion of Carers Assessments; assessments currently carried out by ICH have to be manually input into the system by the Access team, risking backlogs and delays.

New KPIs for 2017-18 have been set, which include:

- Expanding on the range of environments in which ICH provide information and advice surgeries, e.g. by utilising the Octopus Community Hubs and similar community-based, grant-funded services.
- Working with community-based organisations to co-ordinate a targeted campaign aimed at carers to increase awareness of the service and their available support functions.
- To work with Family Action and Children's Services to plan and agree improvements to the current transition process for Young Carers and Young Adult Carers.

These new targets also include better understanding and segmenting the needs of those whom carers care for, and to conduct focus groups with carers aimed at better understanding the findings of the Council's recent Annual Carers Survey.

The Flexible Breaks Fund (FBF), which enables carers and families to take a break from their caring role, continues to be awarded to carers and families of carers who do not qualify for formal support from health and/or social care. The FBF is a legacy of pre-Care Act provision and is therefore less necessary as all carers now have access to an assessment and some form of support from the Council, Health or the ICH.

The Council and ICH has therefore reviewed options to re-purpose this funding for more generally and widely beneficial provision. Consultation with carers as to what this funding could be used for has completed. The resulting changes are to be an increase in therapeutic-type activities put on for all carers wishing to access such provision. Additionally, the Activities Service, a service for those 50+ years old that provides activities in the community and also provided by Age UK Islington, has been

opened up to carers. Some FBF monies will be used to fund carer-specific activities via this service.

5. CHILDRENS SERVICES

5.1 Pooled and non- pooled budgets

Whilst there are no pooled budgets in children services, the Section 75 agreement covers one non-pooled budget which funds the staffing and running costs of the Children's Health Commissioning Team.

The Children's Health Commissioning team, located within the local authority, but who also work into the CCG, have developed well established linkages between health and local authority commissioning including Public Health. The direct management of the team is provided by the CCG's Director of Commissioning with a dotted line to LBI's Head of Partnerships and Support Services. The team links into the Children's Services Management Team through a regular health focussed meeting together with Public Health every 6 weeks which is also attended by the CCG Director of Commissioning.

Unlike adults, children's health and social care provision are commissioned separately. However, the S75 agreement enables the Children's Health Commissioning team to commission health services funded by the CCG or the local authority and to do so working closely with Public Health, other local authority partners and schools. This is particularly important in relation to the commissioning of speech and language and other paediatric therapies, services for children with disabilities, child and adolescent mental health services and health services for vulnerable children: including services into the Pupil Referral Units, children looked after, young carers and those known to the Youth Offending Service / Targeted Youth Support.

In 2016/17 the local authority contributed £130,200 towards the cost of this team and the CCG contributed £176,000.

Aligned budget: Within Children's Services there is also an 'aligned' budget which covers the spot purchasing of placements for children with complex emotional, social and behavioural problems and/or disabilities.

Decisions about funding of these placements are made by a Joint Agency Panel (JAP) which is attended by the Head of Children's Health Commissioning and commissioners from Social Care and Education. This low volume, high cost budget is carefully monitored via the JAP Panel which in 16/17 has continued to function effectively. The overall outturn in 16/17 was £2,794,769 with a standard split operating across agencies such that the outturn for each agency was as follows: CCG – £882,592, Education – £585,784, Social Care – £1,062,818 and ILDP £263,575.

5.2 Children's Health Strategy

The Children's Health Commissioning Team has continued to focus on the delivery of the Children's Health Strategy. Developed in 14/15 the strategy guides the work of the team and partners, setting out the direction of travel for Children's Health Services in Islington over the next 5 years; to deliver improved health and well-being outcomes for children and young people and their parents and carers. Regular progress reports are made to the Children's Service Improvement Group and the team are currently developing an annual update on progress against the key objectives.

5.3 Children's Integrated Care

The Children's Health Commissioning Team leads on the Children's Integrated Care Programme and central to this is ensuring that children's health care is managed in the community where it is safe to do so. This has required close collaboration between primary, community and acute (hospital) services as well as linking up with local authority partners as needed.

Key projects that supported this in 16/17 were:

- The asthma friendly school nurse post: The school nurse is delivering an asthma friendly programme to all schools in Islington, which includes implementation of an asthma policy, care plans, training, asthma register and emergency procedures. 40 out of the 64 Islington schools have completed the asthma friendly school programme.

- Children's Nurses in Primary Care: The children's nurses are continuing to deliver clinics in primary care to improve health and wellbeing outcomes for children with certain long term conditions. Over 213 children were seen by the service in 16/17.

- Children's Multidisciplinary Team Teleconference: The Children's MDT Teleconference brings together an extensive core team of professionals once a month to discuss up to 10 children that would benefit from a multidisciplinary team discussion, including those with multiple A&E attendances. The core team includes the child's GP, a paediatrician, community nurse, school nurse, health visitor, pharmacist, Families First and SHINE. The numbers of referrals to this service significantly dropped in 16/17 and will therefore be going through changes in 17/18.

- Hospital @ Home: Hospital @ Home enables acutely unwell children to have their care managed at home who would otherwise be treated in hospital. The project started in August 2014 and in 16/17, 291 children were treated by the Hospital @ Home service.

5.4 Most community health services for children in Islington are provided by Whittington Health and the Children's Health Commissioning team inputs directly into the monitoring of the overall contract with Whittington Health in relation to these services and in particular those that the CCG directly commissions which include the following:

- Services for Children with Additional Health Needs such as Speech and Language Therapy, Occupational Therapy, Physiotherapy; Community Paediatrics, Community Children's Nursing, Continuing Care, Palliative Care, bladder and bowel, Audiology and Continuing Care.
- Services for Disabled Children including the Integrated Disabled Children's Service, Short Breaks Services and Assessment and Diagnostic services delivered from the Northern Health Centre.
- Child and Adolescent Mental Health Services (CAMHS) and
- Integrated Health Teams working within the Targeted Youth Support, Youth Offending Services and Looked After Children's Services

The team also undertakes a series of engagement/monitoring meetings regarding the above and involves the local authority partners in these as needed. Hence the S75 is enabling the local authority to have more direct involvement in the monitoring of the Whittington health contract than would otherwise be the case. The value of the children's element of the contract with Whittington Health for community services is currently being disaggregated.

Some of the achievements in 16/17 are as follows:

- The jointly funded speech and language therapy posts in mainstream schools, funded (between the CCG and schools Forum) continues to have a really positive impact on the delivery of services into mainstream schools. Schools are now in receipt of ongoing provision which enables both direct intervention but also development of whole school approaches to support language and communication skills in schools.

- The Children's Health Commissioning Team has worked closely with Education and Social Care in implementing the Special Educational Needs and Disability (SEND) reforms.

- The Joint Commissioning Sub Group is chaired by The Head of Children's Health Commissioning and significant progress has been made over the past year in the implementation of the Joint Commissioning Action Plan. This integrated approach to SEND across the CCG and LBI will be central to positive outcomes in the forthcoming SEND Joint Inspection. Key focus of the work during 16/17 was the growing incidence of Autism and the subsequent impact on services.
- Islington CCG has also become a second phase early adopter site for integrated personal commissioning (IPC). IPC is the next step along from personal health budgets, enabling greater

choice and control through the joining up of budgets from health, social care and where relevant education. In the first wave of work around IPC the Children's Health Commissioning Team will be rolling out IPC to identified cohorts of looked after children and young people at risk of mental health support needs and also those that already have mental health support needs. This work is being undertaken in partnership with Independent Futures, Children Looked After Health Team and Children's Social Care, CAMHS and SEN.

- The Schools Forum have continued to purchase CAMHS in schools which has meant that a comprehensive service was been provided across all Children's Centres, Primary and Secondary schools as well as special schools. This has enabled the delivery of a seamless service from early identification and intervention through to more specialist interventions when required. Feedback from Children's Centres and schools has been consistently positive.

- The CCG has continued to fund health services into the Youth Offending Service including a nurse (who also works into the Pupil Referral Unit) and a speech and language therapist. These services have been well received and enabled a far more comprehensive delivery of health services to this group of YP. Children's Joint Commissioning are represented on the YOS Improvement Board to ensure that health services are delivering effective assessments and interventions and that the resource is being optimised.

- The Children's Joint Commissioning Team have also led the procurement of a piece of work to develop Trauma Informed Approaches in schools and their local communities, which will be delivered in 17/18.

- The CLA health team continued to perform well in meeting the statutory health targets in relation to health assessments (initials and reviews) and immunisation rates for children looked after.

- The Children's Health Commissioning Team have led on the development of Islington's Local CAMHS Transformation Plan 2015 - 2020, which is currently being refreshed. This has led to a significant increase in funding within local services to develop local service provision and support progress towards national targets in relation to improving access, specialist provision and most recently ensuring robust crisis care pathways are in place. The Team will be working closely with Children's Social Care this year to look at the delivery of CAMHS services to Children Looked After (CLA) to ensure we are maximising the use of the dedicated resource for CLA. The team also initiated a small grants programme within the voluntary sector looking for innovative and creative projects that support children and young people's emotional wellbeing. Six voluntary sector services were successful. These services began in Sept/Oct 2016 with funding agreed for the following year. The Transformation Plan also provided the catalyst to evolve the Youth Health Forum into what is currently called the Children and Young People Emotional Wellbeing Network. This will be a provider led initiative jointly funded by Children's Health and Young People's Services and will be advertised during early 2017/18.

5.5 Children's User and Carer Involvement

The Children's Health Commissioning team leads on ensuring that children and young people and their carers are involved in the design and delivery of health services, linking in with Healthwatch, Public Health and other partners as needed. During 16/17 this has included:

- Over the 2016/17 period, the Children's Health Commissioning Team have directly engaged with 104 young people (aged 13 to 25) and 41 parents / carers throughout a range of stages of commissioning, including development, design, procurement, delivery and monitoring of services. There has been additional engagement with children, young people and parents/carers by commissioned service providers that we have supported. This is more difficult to quantify but is in the region of 135 young people.

- The Parent Champions have renamed themselves to become Islington Parent Consultants. During 2016/17 they carried out an extensive piece of consultation work around the ASD review. This was to gather information on parent carers experience of our current assessment and diagnostic

pathways for children with ASD. They were involved in an initial meeting with the researcher and worked with her to design a survey and a poster advertising 2 focus groups which they facilitated. This information was put into the final review. The second piece of work was to run 2 focus groups looking at gaining information on the local area's effectiveness in identifying and meeting the needs of children and young people who have SEND which supports our inspection planning. The consultants are currently involved in gathering views of parent's experience of using the Bladder and Bowel service which will form part of a wider service review. The Islington Parent Consultants will be presenting their involvement in this project at The Disability Board in July 2017 and it is anticipated that we will extended the role of the parent consultants, to include parents who have English as a second language as well as develop a young person's model to support our involvement and participation of CYP with SEND.

5.6 Vulnerable Children

The team lead on ensuring that vulnerable young people with individual needs, such as mental health, receive appropriate packages of care that meet their specific needs. This includes spot purchasing packages of care for looked after children placed out of borough, as well as monitoring young people who are placed in T4 (adolescent psychiatric beds) to ensure they are discharged back to the community as soon as they are able with the right support in place from health education and social care. Our local Tier 4 panel comes together on a monthly basis with senior colleagues from Education, Health and Care to review all cases and ensure appropriate support is in place to facilitate prompt, safe and effective return home with ongoing support in the community.

The team work closely with Social Care and Education for young people who are part of the Transforming Care Cohort. (Children and Young people with LD / Autism who also have mental health needs or behaviour that challenges). The team attends all Care and Treatment Reviews (CTRs) of young people in hospital beds and they convene and chair all community CTRs for young people who may be at risk of a hospital admission or placement in a residential home / school. The Head of Children's Commissioning is responsible for maintaining the 'At Risk of Admission Register', a register that is based on consent, which enables us to regularly review and maximise community provision to support these YP and their parent's carers to prevent admission where possible.

6 Better Care Fund

The Better Care Fund is a national initiative aimed at supporting health and care transformation and integration. Nationally, the Better Care Fund represents the largest financial incentive for the integration of health and social care. The government requires Clinical Commissioning Groups and local authorities to pool budgets and to agree an integrated spending plan. Nationally the government supported this change through allocating £3.9 billion in 2016/17 and additional two year funding for 2017-2019 set out below:

Better Care Fund funding contribution (£bn)	2017-18	2018-19
Minimum NHS (clinical commissioning groups) contribution	£3.582	£3.65
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431	£0.468
New grant allocation for adult social care (Improved Better Care Fund)*	£1.115	£1.499
Total	£5.128 billion	£5.617 billion

*Combined amounts announced at Spending Review 2015 and Spring Budget 2017

In Islington, the Better Care Fund has been seen as an opportunity to extend the established culture of integrated working. The Better Care fund has played two key roles through enabling integrated care transformation and protecting adult social care provision.

The Better Care Fund enables resources for a range of services and new transformation initiatives. The key areas in 2016/17 were:

Integrated Networks – Islington now has a full programme of 12 Integrated Networks which cover 94% of GP practices across the borough. The Networks are community based multi-disciplinary team meetings of key health and care professionals wrapped around small clusters of 2 to 4 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 – they are supported by a large admin team.

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 provide an early foundation for integrated health and care in the local health and care system and include a mechanism in which to align the following areas into a delivery vehicle:

- Rapid response
- Co-ordinated care for those most in need (through integrated health and care teams)
- Prevention and early intervention
- Proactive, long term care

AGE UK Health Navigator Service - The Health Navigators provide Islington's main link to social prescribing. Referrals are made into the service from all health and social care professionals and the Navigators signpost to the many other voluntary services in the borough as well as to statutory services. The Navigators attend the Integrated Networks as core members of the team and undertake case management in order to support some of the most vulnerable and high risk patient improve their health and wellbeing. They have a strong focus on working with socially isolated individuals.

Managing transfers of care - This is a new national condition under the Better Care Fund and work is underway to implement the eight elements of the High Impact Change model including a discharge to assess pathway within Islington. This will integrate acute and community services across health and care so that people receive a simplified, timely and seamless service.

Protecting Adult Social Care - the Better Care Fund provides additional funding to Adult Social Care. In Islington, this has enable protection of services and provision of care packages to people who meet eligibility criteria. The funding of this area supports the whole health and care system. London Borough Council has maintained access to services through the Better Care Fund and implemented all the requirements of the Care Act including wellbeing principles.

Integrated Personal Commissioning and Personalised Health Budgets – IPC is a national programme which aims to improve quality of life for people with complex care needs by empowering them to have more control over their care. As an IPC 'early adopter', Islington has stretching targets to introduce PHBs, including integrated health and social care budgets, for people with multiple long term conditions and learning disabilities. Money from the BCF will be used for the payment of these PHBs and integrated health and social care budgets. In the long run these will be resourced from existing contract spend, as we develop a commissioning approach to freeing funds from traditional contracts..

Integrated Digital Care Record – 'CareMyWay- Personal and Professional'. The Better Care Fund has supported the development of the integrated digital care record between health partners (hospitals, GPs, mental health, community services) and children's/adults social care. This pilot has developed much learning across the partnership and has helped inform North London Partners of their longer term interoperability.

Implementation of **innovative blended roles** to enable medics and other professionals to work across organisational boundaries. This has included a new blended social care role with expertise in housing, who work within the integrated network.

The impact of these investments and funding allocations are monitored through a range of metrics. The Better Care Fund Metrics are set nationally and are set as system indicators rather than granular indicators of impact of individual initiatives. The Integrated Care Programme has a more in depth dashboard for specific local interventions.

Overall, Islington improved on its target of reducing non-elective admissions and it's Reablement target. There is ongoing work being undertaken around transfers of care to enable to the borough to meet the challenging targets set for DTOCs and residential admissions. Islington is continuing to work together to further improve performance and analyse areas where there has been a year on year increase.

The ambition for 2017/18 and beyond is to continue to embed integrated working using a whole systems approach, and to evaluate the impact of new and existing initiatives.

7. Conclusion

7.1 The partnership between Islington CCG and Islington Council continues to ensure an integrated approach to service commissioning and delivery to meet the needs of vulnerable residents in a co-ordinated and seamless way. This report demonstrates some of the benefits over the last year for both children and adult and highlights some of the priorities for 2016-17.

2016-17 was again a year of achievement. We have continued to use models of care to develop new ways of working and will continue to strengthening the offer around individuals and their families.

Efficiency and effectiveness remains top of the agenda as the Council and CCG mange financial constraints and demand pressures. Planning and delivering services within a strong joint commissioning approach will help mitigate risks and ensure that we continue to deliver quality seamless services to our local residents**.**

Report Author: Jill Britton, Assistant Director Joint Commissioning
Sheron Hosking, Head of Children's Commissioning

Tel: 020 3866 2930
Email: jill.britton2@nhs.net