NHS
Islington
Clinical Commissioning Group

Islington Clinical Commissioning Group Narrative for Operating Plan

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No	Areas	Key features to be demonstrated in plans	Narrative
1	Delivery across the five domains and seven outcome measures	Your understanding of your current position on outcomes as set out in the NHS Outcomes Framework	Islington's Health and Wellbeing Board brings together key partners from local government, the NHS, and HealthWatch Islington, representing the voice of local residents and patients, to work together to understand what local people need to improve their health outcomes. The challenge facing us all as partners in the health and wellbeing system is how to ensure sustainable, high quality, resident-centred, outcome-focused health and care services now and into the future, against a backdrop of ever tighter resources, rising demand and expectations and increasing costs. The scale of this challenge makes it even more crucial that we continue to prioritise on the basis of population health and wellbeing needs, as described in the JSNA, and that the actions we take to address those needs are evidence-based and effective. A particular highlight of this year's JSNA, received at the Health and Well Being Board in October 2014, is the evidence showing the decline in early deaths from heart disease over the last six years. Although Islington's death rate from heart disease in those aged under 75 years remains higher than the England average, it has been falling at a faster rate. This means that the inequalities gap in heart disease deaths between Islington and England has substantially narrowed. The fall in the leading cause of premature mortality in Islington reflects a systematic approach to primary and secondary prevention through a mix of universal and targeted interventions sustained and developed since the middle of the last decade through a partnership between the NHS and the council, reflecting a shared commitment to driving improvements in health inequalities.

Mortality rates in infants and in the major causes of early, preventable deaths are declining; for most conditions, improvements have been occurring at a faster rate than England and London. Cumulatively, these are resulting in a narrowing of the life expectancy gap between Islington and England, but there remain significant inequalities between Islington and the rest of the country and within Islington between different areas and communities.

Prevention and treatment of liver disease is an important local priority. Premature mortality rates from liver disease have fallen faster than England in the most recent period, after being significantly higher over the past 10 years, and are now similar to England.

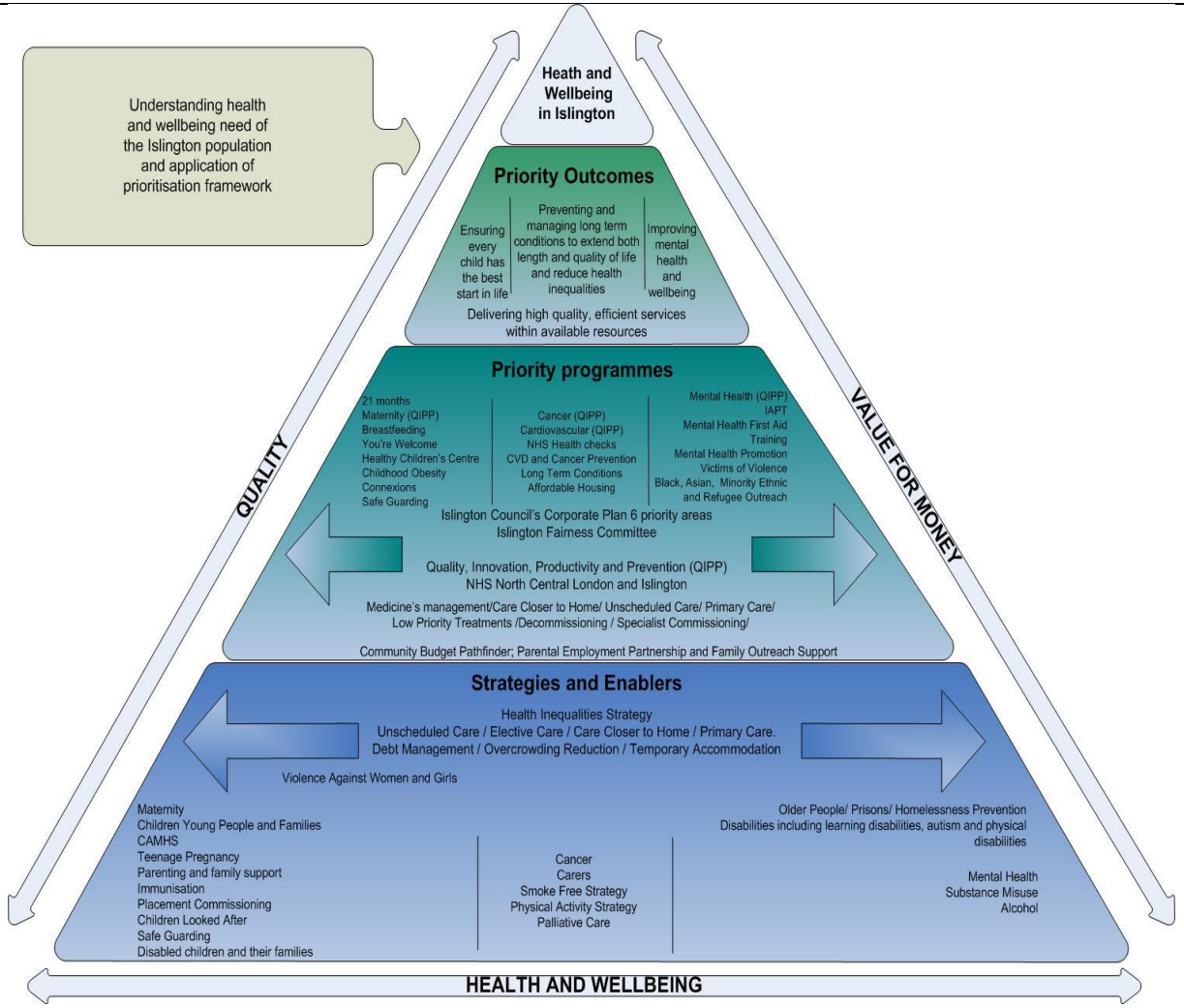
Table 1 NHS outcomes shared with Public Health:

Outcome	Period	Islington	England	London	Commentary
Infant mortality rate, per 1,000 live births	2010/12	2.2	4.1	4.1	**BETTER THAN ENGLAND** Rates of infant mortality are reducing at a faster rate compared to England and London. Giving children the best start in life is a key priority for the health and wellbeing board.
Under 75 mortality rate from all cardiovascular disease, deaths per 100,000 population	2011/13	105.8	78.2	80.1	**WORSE THAN ENGLAND, BUT IMPROVING SIGNIFICANTLY** Although rates remain higher than London and England the rate of reduction has been faster than England and London, particularly since 2007-09.

			Under 75 mortality rate from respiratory disease, deaths per 100,000 population	2011/13	38.3	33.2	31.9	**SIMILAR TO ENGLAND** Mortality rates are similar to England and London. Trends are steady.
			Under 75 mortality rate from liver disease, deaths per 100,000 population	2011/13	18.7	15.7	15.7	**SIMILAR TO ENGLAND** Rates have fallen faster than England and London over the past 5 years and are now not significantly different to the England average.
			Under 75 mortality from cancer, deaths per 100,000 population	2011/13	156.1	144.4	136.5	**SIMILAR TO ENGLAND** Mortality rates are declining and now similar to England.
			Excess under 75 mortality rate in adults with serious mental illness (check with Dalina)	2012/13	364.9	347.2	London data not available	**SIMILAR TO ENGLAND** Adults in Islington with mental illness are just over 3.5 times more likely to die under the age of 75, compared to 3.3 times higher nationally.
			Percentage gap in the employment rate between those with long-term health conditions and the overall employment rate.	2013/14	15.7%	8.7%	10.7%	**WORSE THAN ENGLAND** Islington has a higher proportion of people with long term conditions who are not in employment compared to the overall employment rate. 50%

								of people in Islington who are not in work have mental ill health.
			Emergency readmissions within 30 days of discharge from hospital	2011/12	12.2%	11.8%	12.1%	**SIMILAR TO ENGLAND - BUT OLD DATA** Rates in Islington show an upward trend similar to London and England.
2		The actions you need to take to improve outcomes	Infant mortality has fallen in Islington, and is now significantly below the national and London averages. It remains the case that there are significant levels of risk factors for infant mortality in the borough. The local 'First 21 months' programme includes actions to improve pregnancy outcomes, including encouraging timely antenatal booking, linking parents-to-be into services through Children's Centres, working to implement 'Preparing for Birth and Beyond', perinatal mental health services and the Family Nurse Partnership, among other examples. Long term conditions continue to be a major challenge in Islington. Early deaths amongst people with cardiovascular disease, cancer and respiratory disease are the key drivers of the life expectancy gap between Islington and England. These are addressed through a dual approach based on shared local intelligence and analysis between the CCG and council of (1.) addressing the major lifestyle risk factors (such as smoking, alcohol, obesity, poor diet and physical inactivity); and (2.) 'closing the gap' on long term conditions – promoting earlier identification of risk factors such as hypertension and earlier diagnosis of long term conditions in order to facilitate earlier treatment and lifestyle interventions and hence better outcomes.					

3	Improving health	Working with HWB partners, your planned outcomes from taking the five steps recommended in the "commissioning for prevention" report	Islington's HWBB has agreed a priorities framework that outlines the overarching health and wellbeing priorities for the Borough of Islington, to support and inform the development of commissioning strategies and plans. The overarching Joint Health and Wellbeing Priorities for Islington identified in the framework 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 • Improve mental health and wellbeing. A fourth, cross-cutting priority is the need to deliver high quality, efficient services within available resources. Action to address these priorities (see figure 1.) is central to achieving the vision of improved health and well-being outcomes for the Islington population and a reduction in health inequalities. These health and wellbeing priorities for Islington are explicitly based on Islington's Joint strategic needs assessment which provides an assessment of population health needs. The key underpinning priority programmes, work streams and strategies that will contribute towards delivery of these overarching health and well-being priorities are also captured in the framework. Specifically the pyramid illustrates how each strategic plan or programme area relates to each of the four priorities, or highlights where a strategic plan or programme is a cross cutting 'enabler', contributing towards delivery across the board e.g. high quality primary care or care closer to home. **Figure 1. Islington HWBB priorities**


Understanding health and wellbeing need of the Islington population and application of prioritisation framework
Heath and Wellbeing in Islington
Priority Outcomes
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
Delivering high quality, efficient services within available resources
Priority programmes
21 months
Maternity (QIPP)
Breastfeeding
You're Welcome
Healthy Children's Centre
Childhood Obesity
Connexions
Safe Guarding
Cancer (QIPP)
Cardiovascular (QIPP)
NHS Health checks
CVD and Cancer Prevention
Long Term Conditions
Affordable Housing
Mental Health (QIPP)
IAPT
Mental Health First Aid Training
Mental Health Promotion
Victims of Violence
Black, Asian, Minority Ethnic and Refugee Outreach
Islington Council's Corporate Plan 6 priority areas
Islington Fairness Committee
Quality, Innovation, Productivity and Prevention (QIPP)
NHS North Central London and Islington
Medicine's management/Care Closer to Home/ Unscheduled Care/ Primary Care/
Low Priority Treatments /Decommissioning / Specialist Commissioning/
Community Budget Pathfinder; Parental Employment Partnership and Family Outreach Support
Strategies and Enablers
Health Inequalities Strategy
Unscheduled Care / Elective Care / Care Closer to Home / Primary Care.
Debt Management / Overcrowding Reduction / Temporary Accommodation
Violence Against Women and Girls
Maternity
Children Young People and Families
CAMHS
Teenage Pregnancy
Parenting and family support
Immunisation
Placement Commissioning
Children Looked After
Safe Guarding
Disabled children and their families
Cancer
Carers
Smoke Free Strategy
Physical Activity Strategy
Palliative Care
Older People/ Prisons/ Homelessness Prevention
Disabilities including learning disabilities, autism and physical disabilities
Mental Health
Substance Misuse
Alcohol
QUALITY
VALUE FOR MONEY
HEALTH AND WELLBEING

			The JSNA highlights the most important underlying factor affecting premature mortality is socioeconomic status. Islington is ranked as the **5th most deprived borough in London** and **14th most deprived nationally.** The borough has the second highest level of child poverty in the country. Poor health and risk of poor health is unequally distributed within Islington and remains significantly higher in key population groups including those from lower socio-economic groups, people with physical illness including long term conditions and people living with long term, serious mental ill health. The level of poor health is also particularly high in some ethnic groups including the White Irish and "other" ethnic groups, which in Islington include the Arab, Iranian and Turkish populations. People from Black African and Caribbean populations are also at increased risk from certain conditions such as hypertension. Preventative and treatment services are appropriately targeted for population groups in order to shift population health outcomes positively, and reduce health inequalities within the borough. A major recent focus is on value-based commissioning, which aims to drive improvements in outcomes for people with specific conditions through coordinated, system-wide commissioning and service delivery. Work over the last year has focused on people with diabetes and improving the physical health outcomes of people with serious mental illness.
4	Reducing health inequalities	Identification of the groups of people in your area that have a worse outcomes and experience of care, and your plans to close the gap	Public Health currently commissions a number of evidence-based lifestyle interventions and support services for adults in Islington which aim to tackle the underlying risk factors that are associated with premature death and chronic disability. These include stop smoking services, NHS Health Checks, physical activity interventions and weight management service. Services are for those who are currently in good health but have lifestyle risk factors (primary prevention), as well as and for people who already have a chronic condition and lifestyle risk factors (secondary prevention), while others are about encouraging people to be screened to detect serious conditions earlier. In order to deliver services to support people to adopt healthier lifestyles at sufficient scale and

			particularly those with one or more behavioural risk factors including smoking, physical inactivity and weight a new integrated lifestyle service is being commissioned. The aim of this new integrated lifestyle service is to use motivational behaviour techniques to support people to improve their lifestyle.
5		Implementation of the five most cost-effective high impact interventions recommended by the NAO report on health inequalities	***Answers in relation to smoking, high blood pressure and cholesterol lowering*** Islington has one of the highest rates of smoking quitters per 100,000 adult population in London, however in common with other London and national areas, local stop smoking services are seeing significant reductions in the numbers of smokers making quit attempts. There were 579 quits in the first half of 2014/15 compared to a target for the year of 2000 quitters. Much of this decline coincides with the increasing use of electronic cigarettes which smokers are using to quit unaided or to "vape" as a substitute where smoking is prohibited. Locally, a major boost of stop smoking support is happening through the final quarter of the year, and guidance on e-cigarettes and stop smoking support has been agreed and implemented. Cessation support in primary care, particularly in general practice and through community pharmacies, is a fundamental component of the smoking cessation offer and has accounted for approximately 70% and just under 20% of all four-week quits respectively. There are specific services for people with COPD. Local CQUINs with trusts include providing stop smoking advice and referrals to stop smoking services for all patients. Camden & Islington Foundation Trust will implement its Smoke-free sites policy in March 2015, accompanied by a major training and development programme with staff. In 2015/16 significant changes are planned for the way in which cessation support is delivered in Islington, which seeks to improve the effectiveness of interventions to further address health inequalities and reach the population groups that are still most affected by continuing to smoke e.g. those with mental ill health and pregnant women. Some specific actions include: • The Local Commissioned Service agreements for community pharmacies' and general practice for 2015-16 increase the focus on improved quit outcomes by identifying target communities and disease groups with the highest smoking prevalence.

			• The Hospital, Housebound and COPD service commissioned from Whittington Health will be maintained with referral pathways out to primary care strengthened. • Public Health will support the Camden and Islington Foundation Trust to ensure that on discharge, service users have access to cessation support in community settings as well as smoke-free support for inpatients. • During 2015/16 Islington will work in partnership with other North/North East London boroughs to develop an approach to further tackle illicit sales. Islington will also explore the promotion of community cessation support linked to fixed penalty notices issued for cigarette littering **Health checks** The health checks programme is a key programme to help prevent heart disease, stroke, and diabetes and kidney disease by supporting early identification of disease and identifying those at high risk of these conditions and managing that risk. Between 1 April 2014 and 30th September 2014, Islington was the top performing London Borough for Health Checks delivered, and ranked 2nd out of 152 Local Authorities in England and continues to do well Health Checks delivered in Primary Care have continued to be targeted at high-risk groups, those who have risk-factors for CVD and those on mental health and/or learning disability registers. Public Health have developed a pathway for the identification and annual clinical follow-up of patients at high-risk of cardiovascular disease which has been incorporated into the Islington CCG Locally Commissioned Service for long term conditions, which was launched on the 1st December 2014.
6		Implementing EDS2	Islington Clinical Commissioning Group (Islington CCG) has worked with HealthWatch Islington (formerly Islington LINK) for the last two years and will continue to do so this year to use the Equality Delivery System to assess how we meet the needs of our local population (focusing on the nine protected characteristics and health inclusion groups), identify gaps and set our equality objectives for the year ahead. We work with the local community throughout the year – focusing on the nine protected characteristics

			and health inclusion groups – to understand how local health services meet their needs and the barriers they face in accessing these services. We also work with our local voluntary and community organisations, using the EDS tool, as well as the research we already have (research gathered throughout the year and JSNA) to assess where we are as an organisation. We follow a similar exercise with our Governing Body. Out of this process we create our equality objectives. We review the objectives every year and set new ones. In the last two years this has included reviewing our interpreting services in primary care and delivering customer care training to reception staff in GP practices to be able to effectively communicate with patients that may face particular barriers when accessing care i.e. sensory disability, vulnerable patients, frail and elderly, young people and those with a Long Term Condition.
7		Examination of how the organisation compares against the first NHS Workforce Race Equality Standard	The CCG has been publishing and monitoring its workforce data since April 2013. This concludes race equality information about governing body members, existing workforce, recruitment and leavers. The CCG has already analysed its data as part of the EDS2 self-assessment. In 2015-16 the CCG will: • Update equality information of all staff and governing body members; • Produce staff equality information by using the WRES metrics; • Implement the EDS2 action plan which includes specific actions relating to workforce equality; and • Monitor providers' equality performance against the WRES (and EDS2) through contract monitoring
8	Parity of esteem	The resources you are allocating to mental health to achieve parity	Islington CCG has as one of its four strategic priorities the improvement of mental health and well-being and within each of its associated programmes[1], the promotion of parity of esteem between mental and physical health services is paramount.

[1] Integrated Care; Planned Care; Primary Care; Urgent Care

		of esteem	A recent review of the resource allocation (in the manner of a programme budget analysis) has identified the following specific items: • £48,181,431 (subject to final agreement of contracts) for core Mental Health Services • £756,962 for Continuing Care provision • £2,457,168 for primary care prescribing • £250,00 to contribute to the ILAT model that supports the management of mental health admissions to A&E at the Whittington Health ICO • £84,378 pay costs for Assistant Director of Mental Health Commissioning. *We also have significant commissioning support to the MH programme via other members of the team, the CSU and the Local authority that is not accounted for here* In 2014/15 the CCG used an incentive shame in the contract with CIFT (over and above CQUIN) to target a reduction in the waiting times for both IAPT and the Early Intervention Service for Psychosis, in preparation for the 2015/16 planning guidance. These are estimated costs for 15/16 and are subject to final contractual agreement or in-year spend (in the case of primary care prescribing). The complexity of the answer to this area of questioning is rather poorly accommodated and something we will turn our attention to in 15/16.
9		Identification and support for young people with mental health problems	In 2014/15, the CCG and the London Borough of Islington produced a revised Children's Health Strategy. The strategy has 11 strategic priorities. The promotion of mental health and emotional well-being cuts across many of the themes; in particular however, the following areas have been identified for improvement in 2015/16: • Ensure that the Child and Adolescent Mental Health Service (CAMHS) Strategy and associated action plan is refreshed • Ensure local CAMHS services are delivering timely, responsive and effective services to meet the needs of children in Islington. • Review existing parental mental health offers into Children's Centres, Children in Need

			services and perinatal mental health to identify gaps and ensure best use of resources to promote resilience in users and the wider family. • Ensure that we deliver the Crisis Care Concordat Action plan in relation to Islington CAMHS
10		Plans to reduce the 20 year gap in life expectancy for people with severe mental illness	Plans to reduce the 20 year gap in life expectancy for this cohort of patients cannot be restricted to one intervention or even a series of treatments or care pathways. The management of severe mental illness in Islington relies on a range of holistic, multi-agency care that moves across the continuum of health and illness and health and social care agencies to reduce the overall prevalence, the severity of disease and offer the support to people to recover and/or manage their mental and physical illness. Plans exist for the short and long term and from 2015/16 we continue the journey working towards the following: • Increasing the numbers of those identified with mental health needs in employment, having moved through the treatment and recovery phases of illness • An 'end-to-end' pathway for managing parental mental health, in conjunction with maternity and children's services and embedded in the locality approach supported by primary care • Pathways specific to patients with serious mental illness and long term conditions to reduce the vast gap in life expectancy (for example, up to 20 years between a patient with SMI and a patient without SMI with heart disease) • Development of Value Based Commissioning service models, i.e. 'Integrated Practice Units' for diabetes and psychosis to better align physical and mental health services (see Question 38, point 5, for more detail on the VBC programme in Islington/NCL). • Targeted health checks for people affected by serious mental illness • A pathway for those patients in the local population who are not registered with general practice or mental health services but for whom primary care is an essential requirement. This is to reduce emergency admissions to secondary/specialist care (in 13/14 38% of unplanned admissions were for patients previously unknown to health services) • Full implementation of the Crisis Concordat between participant agencies (active from 2016/17,

			that demonstrably reduces the burden on acute mental health care) • For those with mental illness and alcohol misuse co-morbidities, more targeted services in primary care • Over time, a step wise reduction in those receiving services in the 'upper' tiers of care, i.e. admitted/specialist care, to support greater investment in primary/community provision. Significantly reduced referrals and reliance on the Care Programme Approach will enable increased capacity in locality based mental health support • An 'asset' based approach to developing services where service users are appointed as experts to assist in devising best practice care pathways/programmes
11		The planned level of real terms increase in spending on mental health services	As an opening offer, Islington CCG is proposing an increase in the value of the Camden and Islington Foundation Trust (CIFT) contract for 15/16. Commissioner priorities for enhancing patient and carer well-being and satisfaction, whilst delivering value within any agreement are as follows: • Management of acute bed pressures (and their impact on the mental health system) • Crisis Concordat implementation • Referral to treatment performance • Improving clinical outcomes • Integrated care (including Primary Care Mental Health in Islington) The proposed commissioner financial settlement is to be seen in the round, where value is driven by the effective and efficient leadership and management of the mental health system The key areas of note are: • A non-recurrent investment of £1.5m to address acute bed pressures; • Inflation offered at 1.93%; offset against an efficiency of 3.8%; Additional investment sums subject to C&I FT demonstrating return on existing 2014-15 investments, and CCGs and C&IFT agreeing business cases against commissioner priorities. These are:

			Existing recurrent investment in Islington Mental Health services over and above baseline activity	**£**
			Neuro – Developmental disorders clinic (ADHD/AUTISM)	£117,000
			Nero Development Disorder £9k to make a total investment in service of £126,000 for Islington CCG	£9,000
			Single process for managing out-of-area referrals for Specialist Psychological Therapies	£20,800
			Serious mental illness Rehab and Recovery and Locality MDG Cohorts LTC Matrons	£408,200
			Personality Disorder – Primary Care Crisis Pathway	£159,000
			'Troubled Families' – Mental Health investment in multi-disciplinary team	£80,000
			Family Support	£150,000
			Increase capacity for Islington memory service – service pressure	£297,900
			Improving end of life care planning for people who have dementia	£61,500
			Increase capacity for Islington memory service – carer service enhancement	£41,900
			MH Transition Service	£95,000
			Recovery College	£200,000
			Whole system capability training	£90,000

			Primary Care Psychiatrists in IAPT	£90,000
			New Investments 15/16	
			Reinstatement of incentive scheme	£425,000
			Further investment plans to be identified	£286,983
			Development of existing plans	£120,000
			Investment to Support Access and Crisis Intervention	£280,780
			Early intervention psychosis service for over 35's	£287,500
			Complex Primary Care Mental Health	£312,000
			Risk Share – 2015/16	£750,000

12	Convenient access for everyone	How you will deliver good access to the full range of services, including general practice and community services, especially mental health services in a way which is timely, convenient and specifically tailored to minority groups	**Broadening access in primary care through a Locally Commissioned Service** We recognise that extending access to primary care is an issue for all sectors of the local population and have therefore been working with general practice in Islington to simply offer more. The Islington Primary Care Locally Commissioned Service is designed to provide additional capacity in primary care outside core hours of 8.00 am to 6.30 pm. It is intended to be simple to implement, but to have a real impact on additional options for patients. It will run for 12 months from commencement. During 15/16 year, it is expected that there will be additional information about the London wide standards for primary care, the development of localities in Islington, and future provision of urgent care services (111, OOH and Urgent Care Centres). This will influence future specifications of this LCS which it is anticipated will need to be provided on a collaborative basis to ensure equity and a more comprehensive coverage. The LCS will have two components: • Component 1: Extended Hours for one year commencing October 2014: Practices will be incentivised to provide additional booked appointments during extended opening hours outside core contracted hours. • Component 2: Protected Development Time to develop a locality based approach from October 2015: To prepare for a redesigned LCS from October 2015, the current specification will include a component to provide protected time to practices. This time will be used to reflect collectively on experience and learning from the previous year's improving access LCS, and to prepare for the next years iteration of the LCS. Additionally, a collaboration of Islington member practices, with the support of the CCG, has recently applied for 'PM Challenge Funding'. **Islington's i-HUB** proposal seeks funding to develop a number of measurable trial initiatives, with tangible and sustainable outcomes, that we believe will deliver: • efficient primary care capacity through collaboration, optimisation and smart technology

			• reduced reliance on A+E and acute hospital admissions, providing a coherent building block of the urgent care system • provision of care closer to home • improved urgent and primary care integration • improved patient safety through continuity in patient documentation • a more equitable experience across Islington's patient population • potential savings in prescribing costs • a well-conceived evolution in Islington from ad hoc practice clusters (e.g. SIGPAL and WISH) to a pan Islington federation (PIF) • quantifiable experience of a future model for primary health care, and • a tested operational service model, designed from learnings from the above experience. The **i-HUB** pilot will deliver tangible service benefits to patients from across the whole of Islington, including: • a rota of evening appointments across a locality, meaning that if a patient's own practice does not offer a Monday evening appointment, they can book an appointment in a neighbouring practice in advance, with a practitioner that has full access to their clinical records • patients will be able to see an experienced clinician outside of their busy working schedules • a shared clinical record will help reduce repeat attendances by optimising continuity of care • The clinicians at i-HUB will be able to request specialist investigations whose results will automatically be reported to the patient's GP. No more need for administration staff or clinicians to chase results from the hospital • fully shared access to EMISweb across Islington will provide a layer of contingency such that when a specific site goes down, the interoperability of shared records enables services to continue at a neighbouring venue

			• a single phone access number will take over when individual practices are closed (i.e. the half days and the periods from 0800-0830/0900 before a practice physically opens). It also sets in place the foundation that allows a single phone number to be used to book any appointments and any Islington practice during core hours. Islington CCG has always been proactive in introducing and promoting technology to improve the patient experience. It is funding the purchase of a shared primary care record**.** Islington CCG also intends to link up GP clinical records with community services through the application of EMIS Community. This will augment any changes that we put in place even further. **i-HUB** will build on these ongoing advancements by developing a bespoke training program to make best use of existing technologies and accelerate their adoption across all GP practices. The bid is awaiting approval from the PM Challenge Fund. If it is successful, tailoring access to specific groups will be given due consideration as the service specification is developed. In identifying the geographical location we will be sensitive and flexible to local needs in each of the hubs. ***Inquiry into GP Access by Islington Health and Care Scrutiny Committee*** In October 2014, the London Borough of Islington Health and Care Scrutiny Committee received a report with a number of recommendations to commissioners and providers of primary care in regards to improved access to GP Appointments. This followed two years of inquiry and the gathering of a huge amount of evidence, much of which was facilitated by the CCG. The recommendations will be taken into consideration by the CCG as it moves forward into co-commissioning arrangements. The report can be found here: http://democracy.islington.gov.uk/documents/g2453/Public%20reports%20pack%2021st-Oct-2014%2019.30%20Health%20and%20Care%20Scrutiny%20Committee.pdf?T=10

			2. Access to community services and secondary care Access to community and secondary care services in the local acute sector are subject to agreed local waiting time standards and the national 18 week pathways. We require, for example, a waiting time of no more than 6 weeks for 100% of patients for referral to assessment/initiation of treatment for the community based Musculo-Skeletal Service. Currently we are reviewing the service specifications for MSK as well as District Nursing and Podiatry to reflect many of the changes to access, treatment pathways and discharge processes that have taken place over previous years. This will include consideration of access tailored to specific minority groups. **3. Access to mental health services** Improving access for people requiring mental health support, in a variety of settings and different ways, is a priority for Islington CCG. In 2015/16 we wish to see the following: • People getting access to the right talking therapies that work for them in a reasonable time • People who need it get their first mental health assessment without waiting more than three weeks • People who use more GP appointments than they need due to their mental health problems use less • People living with serious mental illness and long term conditions get the physical health care they need in a planned way We will do this through a QIPP programme focused on improving whole system efficiency by shifting use of services from unplanned to planned activity and through referral management, by building on existing successful services. The joint focus of this strategy is on prevention and value for money using the mental health tariff to drive efficiency and system change.
13		Plans to improve early diagnosis	Improving outcomes and patient experience for cancer patients through early diagnosis is an approach described in the 2010 Model of Care for London and refreshed in the 2014 5 Year Cancer Commissioning

		for cancer and to track one-year cancer survival rates	Strategy for London. The strategic approach taken by the pan-London Transforming Cancer Services Team is to deliver improvements to cancer services through transformational change driven by cancer commissioning intentions. These pan-London commissioning intentions focus on a range of early diagnosis initiatives, including direct access to diagnostics and best practice commissioning pathways. Providers of cancer services in NCL are monitored against the cancer commissioning intentions within the cancer quality assurance framework of Clinical Quality Review meetings in NCL (part of business as usual). The 5 Year Cancer Commissioning Strategy for London recommends that CCG's consider these areas for development in local plans. These plans may tailor an approach for a CCG or within a locality group or SPG with a focus on **early** diagnosis initiatives in both primary and secondary care. A strategic focus on cancer planning is recommended.
14	Meeting the NHS Constitution standards	That your plans include commissioning sufficient services to deliver the NHS Constitution rights and pledges for patients on access to treatment as set out in Annex B and how they will be maintained during busy periods	The CCG receives regular reports and feedback regarding the delivery of the Constitution targets, and has a robust escalation process to address performance concerns. This has included understanding the causes of performance failings and reviewing the recovery plans. The CCG has monthly contract management meetings with main providers which gives a forum for the discussion and resolution of contracting and performance issues. Where there have been performance issues, for example regarding A&E 4 hour waits at The Whittington, the CCG, CSU and Trust have had weekly teleconference calls. These have been helpful in providing current performance analysis and an early warning and opportunity to resolve capacity issues over the forthcoming days. Islington's System Resilience Group includes representation from all main providers, Social Care, LAS and Out of Hours providers, and has been effective in identifying capacity and flow issues throughout the health system and working collaboratively to resolve the issues. For further detail see item 24.
15		How you will prepare for and	***Dementia diagnosis rates***

		implement the new mental health access standards	A large scale pilot has been undertaken across Islington GP practices in 2014 to ensure that coding levels are high. This has been successful, and Islington has one of the highest rates of coding in the country. ***Improving Access to Psychological Therapies*** The CCG is confident that it will achieve the 3.75% IAPT target for Q4 of 2014/15 and will continue to deliver a good service in 2015/16. Our main provider (Camden and Islington FT) has sufficient capacity to deliver the targets – this is evidenced by January's activity being 553 vs the commissioned level of 388. The IAPT service provided by Camden and Islington FT is a consultant-led service, so the casemix of patients is more complex than the national average, and this is reflected in lower recovery rates. The Trust is expected to deliver a recovery rate of 46% in the final quarter of 2014/15 and to continue this performance through the first three quarters of 2015/16. The plan for the final quarter of next year is a recovery rate of 50%. ***Improving Access to Mental Health Services*** The CCG has been performing well against the mental health access targets. In quarter 3 of 2014/15 73% of people waited 6 week or less from referral to entering a course of IAPT treatment, and the CCG is on course to deliver the 75% target from quarter 4 and throughout 2015/16. Similarly, the percentage of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period is expected to be 74% in the final quarter of 2014/15 and the CCG is on course to deliver the 75% target by the end of 2015/16.
16	Response to Francis, Berwick and Winterbourne View	How your plans will reflect the key findings of the Francis, Berwick and Winterbourne View Reports –	**Islington Quality Framework** The Islington CCG Quality Framework was introduced in July 2013 as a direct response to the findings of the Francis Inquiry and Berwick recommendations. It has not been updated since this time; this is something that is currently being considered and an update on the timetable and process will be given in the April 2015 submission.

		including how your plans will make demonstrable progress in reducing the number of inpatients for people with a learning disability and improve the availability of community services for people with a learning disability	There are many ways in which we work with our local Trusts to discharge our responsibilities under the Francis recommendations. Primarily we hold providers to account via the Clinical Quality Review Groups (CQRG) that oversee the quality and performance agenda of each contract. In Islington, the CQRGs for each Trust are chaired by either the Director of Quality and Integrated Governance (Whittington Health ICO and Moorfields Eye Hospital) or the Director of Commissioning (CIFT). The CQRGs mandate attendance from Medical and Nursing Directors and this is often supplemented by other Executive Directors, Chief Operating Officers, Clinical Directors etc. Standing items are as follows: • Serious Incident, Never Event and Duty of Candour reporting • Safer Staffing • Complaints (Following Clwyd Report) • Trust performance against all NHS Constitution targets, i.e. RTT, 4 hour waits, Cancer, Infection Control, MSSA and the wider suite of metrics • Key performance indicators and CQUINs • Other local priority issues. Over 14/15 this included oversight of the RTT backlog recovery plans The performance of each Trust as established in the monthly CQRGs is reported to the Quality and Performance Committee on a monthly basis and from there a summary report is given at the bi-monthly Governing Body meetings. In regards to the development of the annual planning round, business-as-usual in Islington is subject to the committee process and as such the usual risk analysis, equality impact assessments and adherence to the CCG Quality Framework is ratified in the presentation of plans. However, building on Francis's wider recommendations, we do not simply rely on this mechanism to performance manage the local system. Regular 'Board Link' visits with our member practices, patient/carer/public participation events, feedback from Islington Healthwatch and working closely with the regulators, in particular the CQC, as well as other commissioners, helps us develop a more holistic view of quality, patient satisfaction and outcomes. We also have a planned series of visits by Governing Body members and GPs that evaluate patient experience and other aspects of quality. In 2015/16, we plan to extend the range of visits to include major sites of Moorfields operation across the capital and following up

			of patient concerns that have been raised in other forums. We will continue our programme of unannounced visits of residential care homes in the borough and where necessary outside the borough where residents may be placed. **Recommendations of Winterbourne View Report** From a strategic perspective, the Islington CCG/Partnership Disability Commissioning Programme aims to: • Provide a local offer of safe support to disabled people and their family carers • Maximise people's independence and provide an integrated pathway of care to meet people's changing needs • Promote the uptake of personal budgets as a means of supporting personalisation aspirations and building an independent and competitive local market place. • Make brave, evidenced based decisions, which may challenge existing approaches. • Deliver better, efficient services within available resources Islington is a small borough with historically a limited number of local placements for people with learning disabilities requiring residential support. Thus the recommendations of the Winterbourne View Report had a number of implications for the joint commissioning strategy locally in terms of expanding local capacity in both residential and non-residential support and repatriating Islington patients from out of area providers. Specifically, in relation to Islington's Winterbourne View Improvement Plan: • Support people in the least restrictive local care options. • Apply the Positive Behaviour Support Policy to all contracts • Deliver 'Circles of Protection' In practical terms, these aims are being delivered in Islington in the provision of local services, these being: • We have reached our target of halving Islington patients in assessment and treatment centres in April 2014. Every patient in such a setting now has an individual plan for relocation into more local less intensive care settings. This will be monitored on a monthly basis

			• Leigh Road residential unit, opened in July 2014. This is care supported scheme for 19 people with high needs, as well as and Leigh Road 'Move On' flats, i.e. supported semi-independent living • Windsor Road provision, also opened in 2014. This is a care supported scheme for 12 people with high needs 2015 • Building social inclusion and respite services into the local service infrastructure
17	Patient safety	How you will address the need to understand and measure the harm that can occur in healthcare services, to support the development of capacity and capability in patient safety improvement	As stated in the previous answer, the Clinical Quality Review Groups are the forum in which we directly challenge each Trust on the occurrence of Serious Incidents and Never Events. We monitor the timeliness and quality of reporting in these areas as well as seek assurance that learning has been shared following such an event, e.g. the undertaking of themed training Trust wide or a change in clinical practice. From a strategic perspective there is support from an NCL Serious Incident Panel that reviews issues across the patch and makes recommendations for wider improvements across the health economy. Lessons learned, themes and trends are considered on a quarterly basis by the Directors of Quality as part of the NCL SPG and through the local arrangements for assurance to the Islington Governing Body. We are assured that all local providers will meet their responsibilities under Duty of Candour. Regular reports are already being received at Clinical Quality Review Group meetings.
18		How you will increase the reporting of harm to patients, particularly in primary care and focused on learning and improvement	The CCG conducts bi-annual 'Board Link' visits to each member practice where quality and outcomes are discussed, such as improvements recommended by the practice patient participation groups and data regarding how many of their patients attend A&E. There is a very positive relationship with local primary care, with regular engagement forums and clinical training events organised for member practices to participate in. We have expressed an interest in co-commissioning with NHS England to enhance their own responsibilities for commissioning primary care.

19		Your plans for tackling sepsis and acute kidney injury	Both CAS alerts for tackling sepsis and acute kidney injury in a more appropriate, timely manner were received last year. CAS alerts are routinely noted as part of the monthly SI reporting template for each relevant trust at the CQRG meetings. The action plan is then discussed and monitored. The CCG can report that as at February 2015 both CAS alerts have been responded to in each of the host Trusts and that the action plans have been approved and implanted. In the case that these areas are mandated as CQUINS for 2015/16 the CCG will follow national guidance around their implementation.
20		How you will improve antibiotic prescribing in primary and secondary care	Within the Medicines Management function, we are doing the following: 1. Reviewing antimicrobial stewardship arrangements in provider trusts in conjunction with the Infection Control and Quality & Safety teams. 2. Developing plans for achieving the proposed new antimicrobial quality premium. 3. Revising local primary care antimicrobial guidelines (due for ratification at Islington Medicines Optimisation Group on Thursday 12 March 2015). 4. Including an audit of primary care antimicrobial prescribing in line with the local guidelines in the Medicines Optimisation Scheme for 15/16. 5. Maintaining a watching brief on local infection and resistance patterns in conjunction with local microbiologists. This is a developing area and the CCG medicines management team will be attending a major national commissioners' event (http://www.events.england.nhs.uk/all/431) on antimicrobial resistance on 4 March 2015 which may further influence and develop plans.
21	Patient experience	How you will set measureable ambitions to reduce poor	The CCG uses a variety of data already available to aggregate ambition in relation to poor patient experience across all local health services, such as the following:

		experience of inpatient care and poor experience in general practice	• National Patient Survey • FFT Action Plans • Access data (from NHS Constitution standards) • London Quality Standards • CCG Balanced Scorecard (as per Assurance processes) These data are considered through the individual CQRGs for each of the Trusts where assurance around improvement is sought and action plans are monitored. As regards primary care the data is fed back through the 'board link' processes. Regular board seminars each feature a patient story, usually told by the patient themselves, or their carer or advocate about their experiences in the health care system. Over recent years, particular attention to patient experience has been given through local contract Key Performance Indicators and CQUINs. We also regularly audit NICE compliance in local Trusts. As a form of strategic assurance, these activities are overseen through the Quality and Performance Committee and fed back to the Governing Body.
22		How you will assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for those patients	***In regard to children:*** The ICCG designated nurse (child protection) represents the CCG at Islington health providers safeguarding committees to monitor, challenge and seek assurance about their safeguarding children arrangements. The designated nurse and designated doctor also have regular review meetings with Safeguarding leads in provider Trusts to monitor implementation of recommendations from Serious Case Reviews. The ICCG are active members of the Islington Safeguarding Children Board who's key objectives and functions are to ensure the effectiveness of what is done by each partner organisation to monitor and evaluate the effectiveness of practice to safeguard children. ***In regard to adults:*** The ICCG Designated Professional (Adult Safeguarding) represents the CCG at Islington health providers

			Adults at Risk committees to monitor, challenge and seek assurance about their safeguarding adults at risk arrangements. The Designated Professional also has regular meetings with Designated leads across the NCL footprint to ensure the approaches/requirements off providers to evidence their effectiveness are consistent across the patch. This year in the contract there are specific KPIs/standards specific to the adults agenda which will be measured regularly with the services commissioned by the CCG. Within the standards there is one which is specific to training, this will be monitored regularly to evaluate the number of the staff who have had relevant training and how this is being embedded into everyday practice. The CCG are active members of the Safeguarding Adults Board and also chair the Quality Assurance committee.
23		How you will demonstrate improvements from FFT complaints and other feedback	Provider FFT scores for Islington CCG providers form part of the monthly CCG integrated report, these are benchmarked against other London providers and changes in scores are tracked. The results from FFT are discussed at the CQRM, where scores require improvement whether as an overall Trust or in a specific service/ward we will request an action plan and trajectory for improvement from the Trust is provided and this will be discussed at the following CQRM (some of which have patient representatives as part of the meeting). Complaints and PALS reports are reviewed on a quarterly basis at the CQRM. As part of their contractual obligation providers are required to highlight actions and learning from complaints and PALS issues (including social media and NHS Choices). Islington CCG in combination with NEL CSU has developed for 2015/16 a complaints dashboard for providers to complete on a quarterly basis which identifies themes, trends and actions being taken in complaints as well as assurance of the provider complaints management processes, this benchmarks against other providers and will enable the sharing of best practice. Other patient experience indicators such as PREMS and PROMS, patient surveys, Healthwatch feedback and quality assurance visits are analysed and the CSU provide benchmarked reports from any surveys. Assurance is sought through the CQRM with regard to the actions being taken to address any areas of underperformance and the CQRM will continue to monitor these plans to ensure that actions have been put in place, this has included quality assurance visits. As part of the contract round for 2015/16 patient and voluntary sector feedback was sought and

			incorporated into the development of KPI's and CQUINs in order to embed a better patient experience within the providers serving the CCG population. These contractual requirements should drive a measurable improvement in patient experience and quality of care provided.
24		How you will ensure that all the NHS Constitution patient rights and commitments given to patients are met	NHS Constitution targets are reviewed first of all with Trusts as a standing agenda item at the Clinical Quality Review Groups. Where compliance is not indicated, Trusts are required to develop improvement plans which in turn are monitored through the CQRG process. Where the Director of Quality and Integrated Governance feels it is appropriate, issues are escalated outside the group to executive level across the Trust/other commissioning organisations. As standard a performance report is reviewed at the Performance and Quality Committee and the latest dashboard is also shared within the monthly Finance report at the Strategy and Finance Committee. Both committees are attended by the Chief Finance Officer who leads performance management in the CCG and by virtue of their status in the governance structure each committee reports to the Governing Body. In 2014/15 this was most demonstrable in the establishment of the Systems Resilience Group to oversee the maintenance/improvement of performance against Constitution targets, particularly in regards to referral-to-treatment waiting times and the A&E 4 hour wait. In summer of 2014, in anticipation of seasonal pressures, the Islington Systems Resilience Group was formed. This is the forum where all partners across the health and social care system come together to undertake the regular planning of service delivery. The SRG plans for the capacity required to ensure delivery, and oversee the coordination and integration of services to support the delivery of effective, high quality accessible services which are good value for taxpayers. The goals of the SRG are to bring together both urgent and planned care and to enable systems to determine appropriate arrangements to delivering high quality services and improving patient experience. The focus of the SRG is to: • Determine service needs to Islington • Initiate local changes needed • Address issues that have previously hindered whole system improvements

			Whilst decisions on any aspect of funding are made by the relevant statutory body or through shared governance arrangements where pooling is in place, the SRG has a key role in building consensus across members and stakeholders and advising especially on the use of non-recurrent funds and marginal tariff. The Group reports regularly to the CCG's Quality and Governance Committee, through to the Governing Body. The report sets out the main matters discussed and any decisions taken. It also draws the attention of the Governing Body to any matters requiring disclosure to them, or requiring Governing Body approval. The membership comprises: • Joint Vice-Chair (Clinical)/ Chief Officer, CCG (Chair) • Integrated Care Programme Director, CCG • Head of Service Transformation, CCG • Head of Performance and Information, CCG • Representative/s from Whittington Health • Representative from Moorfields Eye Hospital • Representative from London Ambulance Service • Representative from Care UK (GP out of hours) • Representative from NHS111 • Representative from London Borough of Islington • Representative from Commissioning Support Unit • Representative from NHS England • Representative from Public Health • Patient Representative/s The arrangement was initially put in place for Winter 2014/15; the Chief Officer is now in discussion with local partners as to the legacy forum into 15/16/off-winter period. This arrangement should be at least in draft form to discuss in our April final Operating Plan submission.

25		How you will ensure you meet the recommendations of the Caldicott Review that are relevant to the patient experience	The CCG has an appointed Clinical Director who is the nominated and trained Caldicott Guardian. He acts to protect the interests of all residents in issues surrounding personal data and Information Governance. For Islington, in practical terms, this is realised most evidently in the Pioneer collaborative that Islington CCG and its partners are committed to driving transformation and integration. The CCG has been developing its integrated care programme working alongside Pioneer colleagues, partners and providers. In order to make a difference, ensure the CCG delivers the digital vision set out by the Department of Health in 2012 and take forward our Pioneer plans to integrate care across our partners; Islington must transform the use, sharing and publication of information to patients, residents, clinicians and other staff in health and social care. This business case examined two objectives that Islington now need to achieve: • Interoperability and information exchange between organisations. This would allow the flow of data to be sent between two or more organisations for the benefit of co-ordinating service provision across care pathways improving patient care and data analysis. • Having a person held health and social care record for the citizens of Islington (PHR), so that the individual holds control of their record, can manage their care such a long term condition and gives consent to providers of care to view their record. The solution will be used and accessed by Islington health and social care staff as well as other organisations that need to have access to the solution to support patient care. This will include other healthcare organisations, social care partners and independent sector providers. The solution will be capable of supporting the delivery of care across multiple care settings including integration and interoperability with existing and future organisation systems. The change programme requires the CCG and its partners to address considerable changes to how services and patients access and manage health records. This will have to be tested against the Caldicott

			principles in the planning phase. **Person Held Record** Developing and implementing a Person Held Record coupled with interoperability between health providers, will have a number of functions and impacts on the provision of care. It will: • put the patient at the heart of care, empowered them to manage their own care and be part of decision-making • empowering clinicians with real-time, accurate information and improve patient outcomes • make the shared patient data available to authorised clinicians and carers where and when it is needed • support assessment and other data collection forms so that users from different care settings can add data • support workflow so that clinicians and carers can perform tasks and then inform, refer or handover to others • include an automated alerting facility using text messages, emails and in-system messaging so that clinicians and carers can be notified of key events - a patient under their care being admitted to hospital, for example. Benefits from implementing such functionality are centred on the patient and improving their experience, as well as assisting clinicians in decision-making and improving patient outcomes. These benefits are the key driving-force and reasons for integrating health and social care information and enable providers to work effectively together. A full benefits profile and realisation plan is being developed as part of the Full Business Case. **Benefits for Patients:** • Patients put at the centre of care and are empowered to manage their own care and be part of

			decision-making, ***including who has access to their shared care record*** • Online access to their records and improvement to online transactions e.g. online registration, booking appointments, ordering repeat prescriptions • Improved experience: ▪ Less repetition of health history every time treatment is accessed in different organisations, as up to date information will be available through the data sharing agreements once consent is given ▪ Care is co-ordinated between providers giving patients greater reassurance, confidence and trust in the clinicians treating them • Greater access to health information, data and knowledge, helping to maintain health and wellness, not just treat illness • Receiving text message reminders and screening programmes via mobile phones • Improved communication, can make contact with healthcare more efficient and can improve access for patients, especially those with disabilities • Patient wishes and preferences of care available to all care providers • Increased patient experience due to improved understanding of treatment and recovery process • Improvements in the patient experience due to a reduction in unnecessary admissions, and treatment in more appropriate care settings London Borough of Islington (LBI) Council and Islington CCG, has successfully been awarded £1.3 million funding over 2 years from the Department of Health Digital Care Fund to develop its integrated care programme alongside Pioneer colleagues, partners and providers. The initiative is in the planning and procurement stage and aims to begin roll out in 2016.

26 **27**	Compassion in practice	How your plans will ensure that local provider plans are delivering against the six action areas of the Compassion in Practice implementation plans How the 6Cs are being rolled out across all staff	The approach to promoting compassionate care and the range of recommendations within the '6C's' agenda are integral to the way we commission health services. The '6Cs' were developed in 2012 as we were preparing to become a clinical commissioning group and the principles formed a cornerstone of the CCG Quality Framework. Providers are challenged on all areas of clinical and caring practice with providers through the Clinical Quality Review Groups associated with each Trust contract. Governing Body members with appropriate responsibilities, clinical commissioning leads and commissioning managers attend ward 'walk-rounds' as part of staff and user engagement in the local health economy and as witnesses to clinical practice. We also believe that the extensive opportunities for patient and public participation in commissioning in Islington create a very good source of contemporaneous feedback on quality of care in local services, alongside the statutory oversight function in by Islington Healthwatch. We foster a good relationship with the Care Quality Commission so that in preparation for visits to local services they use the intelligence we have gathered and that their findings are discussed in depth with us so that we can support Trusts in their improvement recommendations. Furthermore, the CCG understands that we need to create and maintain a culture that encourages and supports compassionate, high quality care. The Nursing Strategic Framework, published in July 2013, sets out how we will achieve this. The framework was developed by the Practice Nurse Professional Lead for Islington, in collaboration with the Practice Nurse representative on the Islington CCG Governing Body, the Chief Officer and the Director of Quality and Integrated Governance and Executive Nurse. The following organisations and forums provided input: Whittington Health, University College London Hospitals NHS Foundation Trust, Camden and Islington NHS Foundation Trust; Laamiga Women's Mentoring and Training, Islington Practice Nurse Forum, Islington CCG Governing Body, Islington CCG Quality and Performance Committee and Middlesex University. Additionally, the CCG administer and support annual Islington Nursing Conferences, inviting nurses and patients from a variety of settings, including general practice, district nursing, community specialist teams,

			hospices and local charities, as well as consultants and representatives from social care, the CCG and public health. The theme of the event is to understand how the individual nurse and the collective workforce contribute to compassionate care. We also celebrate the achievements of the past year, highlight what nurses can achieve, and emphasise the idea of nurses as innovative leaders in the development and delivery of health care. At the last conference in September 2014, the CCG had speakers from NHS England, the RCN, other organisations and nurses themselves who have developed and led on innovative projects which improved patient care, via formal presentations and breakout sessions as well patients sharing their positive and negative experiences. The event will be repeated in 2015/16.
28 **29**	Staff satisfaction	An in-depth understanding of the factors affecting staff satisfaction in the local health economy and how staff satisfaction locally benchmarks against others How your plans will ensure measureable improvements in staff experience	***On behalf of Islington CCG*** Islington CCG has not yet conducted a staff survey but plans to do this in 2015/16. More details of this plan will be available for the April submission of the Operating Plan. We are aware that other CCGs in the local area have conducted surveys and dependent on our final agreed approach we may benchmark relevant areas. The CCG regularly uses its internal communication system via the 'Friday News' and the fortnightly all-CCG briefings to discuss/promote NHS whistleblowing procedures. ***On behalf of commissioned services*** When a local Trust conducts its own staff survey, the results are shared within the CCG. Whilst we are not aware of any particularly contentious issues at the moment, where there are clearly difficulties being experience within the workforce, the CQRG will ask the Trust to share improvement plans and demonstrate this improvement against an agreed trajectory. This was the case during 2013/14 during a significant period of change in Camden and Islington Foundation Trust. Currently we are monitoring the impact of a workforce strategy within Moorfields Eye Hospital NHS FT, called 'The Moorfields Way', and

		in order to improve patient experience	are negotiating an associated KPI into the contract for 15/16.
30	Seven day services	How you will make significant further progress in 2015/16 to implement at least 5 of the 10 clinical standards for seven day working	The London Quality Standards support the delivery of improved patient outcomes and experience through seven day working. The implementation of seven day working has been a priority in the local area, particularly at the Whittington Health ICO in both acute and community services. Developments are reported at the Clinical Quality Review Groups for each Trust regarding seven day working regularly. Self-assessments by local provider Trusts including Whittington Health ICO, UCLH and Moorfields have been reviewed separately and together by the CCG Quality and Performance Committee after they have been through CQRG processes. Ambitions and priorities and action plans put in place that will be monitored through the contract, i.e. as part of the Information Schedule/KPIs. Negotiations with local Trust for 2015/16 are underway include local and Regional KPIs related to seven day working. We are aware that there will be National Key Performance Indicators for 5 of the 10 seven day working standards in the NHS Standard Contract but we are including this requirement as a local KPI. We expect NHS Trusts to agree service delivery and improvement plans on how to implement 5 out of 10 clinical standards within available resources. We anticipate the development of a service specification by the end of quarter two with the production of improvement plans on these by the end of Quarter 3.
31	Safeguarding	How your plans will meet the requirements of the accountability and assurance framework for protecting	The current accountability and assurance framework (2013) has been revised and updated to reflect recent safeguarding developments across the health system. The document is currently out for consultation and will be published in April 2015. Changes are currently being reviewed, such as co-commissioning the role of the Named GP in Child Protection.

		vulnerable people	
32		The support for quality improvement in application of the Mental Capacity Act	ICCG work jointly with the council to provide the Mental Capacity Act function on behalf of the CCG. The CCG contributes a significant amount of money to the council for them to provide the MCA function on behalf of the CCG. This arrangement will continue with the Designated Professional having more of an oversight on health activity, including specific focus on gaining assurance from commissioned services around effective and appropriate use of the MCA.
33		How you will measure the requirements set out in your plans in order to meet the standards in the prevent agenda	The CCG understands that there is some variation in provision of training for staff with a range offered from basic awareness to bespoke Prevent Wrap training. During 2015, the CCG will be working with each provider, through their safeguarding committees, to support them to achieve the required 80%.
34	Research and innovation	How your plans fulfil your statutory responsibilities to support research	Islington CCG meets its statutory responsibilities and will continue to encourage high quality, well-governed, clinical and non-clinical research within the health economy. We will build upon the work already successfully led by UCLH, Moorfields Eye Hospital FT, NOCLOR (North London Consortium for Clinical Research) and the North London CLARHAC (Collaboration for Leadership and Health Research and Care). In addition we will work with CNWL in developing stronger SPG wide research governance that will both maximise the opportunities for patients to participate in research and ensure that research is well conducted. An example of where this works is in regards to our flagship integrated care programme. The responsibility of being a Pioneer site for integrated care development in Islington requires us to rigorously

			evaluate our commissioning approach. The concept of 'logic modelling' has been introduced to evaluate the success of the programme. The logic model aims to help tell a story of projects or programmes in a diagram by showing a causal connection between the need you have identified, what you do and how this makes a difference for individuals and communities. To start this work we invited a member of NHSIQ to facilitate an event with all work stream leads with the intention of developing a local logic model and evaluation framework. This workshop took place in October and was co-facilitated by the Islington Public Health team. Subsequent work has been led by the Head of the Programme Management Office who had experience of logic modelling and so supported all leads to think through their projects in a systematic way so that logic models could be produced. The group agreed an aggregate logic model then identified a set of metrics and outcomes that could be used to measure both outputs and outcomes. Despite some challenges, this proved an effective methodology and due consideration is being given to it being utilised across other work programmes as a way of real-time evaluation and research.
35		How you will use Academic Health Science Networks to promote research	Below are some examples of how the AHSN has been used to promote research in commissioning health services: ***a) In support of our application to become a 'Vanguard' PACs*** UCL Partners has supported the recent application to become a 'Vanguard' site for the Whittington and Islington/Haringey CCGs to create a 'Primary and Acute Care System model with Islington Council, Haringey CCG, Haringey Council, Whittington Health ICO and CIFT (please see section 38). Our application has been shortlisted for the workshop on 2 March to determine which PACS will be taken forward. The responsibilities of each partner in the potential scheme is currently being worked up in more detail and this will be provided in the April draft of this submission.

			b) In support of local services Learning Together is an educational intervention that aims to improve outcomes for children and young people that is intended to develop integrated care. It is a fresh approach to the training of healthcare professionals. Clinics are held in GP surgeries with GP trainees and paediatric registrars seeing children together as part of their training programme. The idea is that they learn from each other, share expertise and collaborate with other members of the primary care team, including health visitors and practice nurses. The aim is that the children seen in these clinics benefit by receiving better care. Each of the professionals involved also takes their new skills onto the patients they see after the clinic, adding a new perspective to their work and increasing interaction across primary and secondary care. This flagship project builds on a successful pilot that included Whittington Health, Royal Free London NHS Foundation Trust, Barnet and Chase Farm Hospitals NHS Trust, and GPs in Barnet, Camden and Haringey. UCLPartners has been awarded funding to extend the Learning Together project to include more of our partner organisations across north central and east London. Learning Together is fully supported by the London School of Paediatrics and the London School of General Practice. Evaluation of the project was completed in June 2014. A paediatric registrar and a GP registrar see children or young people in a joint clinic based in a GP surgery, sitting in the same consultation, seeing patients together. The intervention is inter-speciality and has key MDT elements. UCLPartners was funded by Health Education North Central and East London (HENCEL) to evaluate the model and over a six month pilot period UCLPartners collected evaluation data (December 2013 – May 2014): • 848 children were seen in 145 Learning Together clinics • 37 individual paediatric ST5-8 registrars, 40 individual GP ST3-4 registrars made up 44 pairs and most ran a series of four or more clinics together • 40 GP practices hosted clinics

			• 12 NHS Trusts released paediatric registrars In the evaluation: 608 learning logs were completed; 351 families took part in the questionnaire and 125 families took part in follow up interviews. In the retrospective pilot audit of four common childhood conditions 22 GP practices audited notes before, after and during the Learning Together clinics. We may consider using the same approach in future in other areas. ***c) In support of the NCL Five Year Plan Transformation Programme*** UCLP has been asked to facilitate the Clinical Services Review for the development of the key interventions of the NCL Five Year Plan. This area of work is in its incipiency and it may be that more information is available in the April draft of the Operating Plan.
36		How you will adopt innovative approaches using the delivery agenda set out in Innovation Health and Wealth: accelerating adoption and diffusion in the NHS	In order for the CCG to adopt innovative approaches in evidence based practice it is important to link in with the Academic Health Science Network who play a key role to improve health and create wealth, enable the NHS and academia to work collaboratively to identify, adopt and spread innovation and best practice. The role of the NIHR CLAHRC is improve health outcomes and reduce inequalities through applied health research and should ensure that the CCG make better use of research, and ensures that their practice and policy is underpinned by sound research evidence. It is essential that CCGs commission research relevant to their local priorities as part of their duties regarding research and use of evidence. This could Include utilisation of NIHR Research Capability Funding to fund the development of new NIHR research grant applications and use CCG funding to commission new research. In order to facilitate research promotion and engagement it is important that research outcomes are disseminated locally to the CCGs, in addition to conducting Rapid Reviews to find out about evidence based practice in key priority areas.
37			Islington CCG's programme allocation for 2015/16 has been confirmed as £313,358,000 reflecting an

<table>
<tr>
<td></td>
<td>Financial resilience; delivering value for money for taxpayers and patients and procurement</td>
<td>Meeting the business rules on financial plans including surplus, contingency and non-recurrent expenditure</td>
<td>
increase of £805,000 from the position announced in the 2013/14 2-year allocation. However within this, the CCG is expected to meet the costs of resilience activity which has been confirmed as £1,671,000.

The balance between the £805,000 and the £1,671,000 is effectively a cost pressure as NHSE assumptions now state minimum growth as 1.4% rather than the 1.7% announced in 2013/14.

<table>
<tr><th>Islington CCG confirmed 2015/16 allocations (£'000s)</th><th>Programme costs</th><th>Running costs</th><th>Total</th></tr>
<tr><td>Recurrent 2014/15</td><td>307,394</td><td>5,369</td><td>312,763</td></tr>
<tr><td><u>Expected 2015/16 (announced 2013/14)</u></td><td>312,553</td><td>4,871</td><td>317,424</td></tr>
<tr><td>Growth/(Reduction)</td><td>5,159</td><td>(498)</td><td>4,661</td></tr>
<tr><td>Growth/(Reduction) as a %</td><td>1.68%</td><td>(9.28)%</td><td>1.49%</td></tr>
<tr><td><u>Confirmed 2015/16</u></td><td>313,358</td><td>4,871</td><td>318,229</td></tr>
<tr><td>Growth/(Reduction)</td><td>5,964</td><td>(498)</td><td>5,466</td></tr>
<tr><td>Growth/(Reduction) as a %</td><td>1.94%</td><td>(9.28)%</td><td>1.75%</td></tr>
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<tr><td>Change between expected and actual growth</td><td>805</td></tr>
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<tr><td>Assumptions incorporated into allocation:</td><td></td></tr>
<tr><td>1. Minimum growth for 15/16 reduced from 1.7% to 1.4%</td><td>(866)</td></tr>
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2. Resilience funding within baseline	1,671
Net change/CCG pressure	**805**

After applying NHS England planning assumptions, a balanced plan has been produced. However risks around the values and assumptions with acute contracts along with the deliverability of QIPP savings need to be mitigated before a robust position is presented for formal Committee review and Governing Body approval.

In the meantime, the draft position suggests that with a £12m QIPP programme next year, the £6.5m surplus can be achieved.

	Annual Budget 2014/15	Changes from 2014/15 plan to Baseline	2015/16 Opening baseline	Plans after initial Business Rules	2014/16 QIPP Savings	Sum of Final 2015/16 budget
Resource Allocation	323,535,000	(16,141,000)	307,394,000	**330,571,530**	0	**330,571,530**
Acute	200,774,594	(9,140,000)	191,634,594	**203,850,062**	(7,778,027)	**196,072,035**
Non Acute	100,278,036	(898,068)	99,379,968	**114,765,235**	(3,594,640)	**111,170,595**
Programme costs	4,300,707	(958,000)	3,342,707	**3,396,707**	0	**3,396,707**
Operating Costs	5,369,000	(5,369,000)	0	**5,503,225**	(628,228)	**4,874,997**
Reserves and Contingencies	6,363,644	224,068	6,587,712	**(3,392,719)**	12,000,895	**8,608,176**
Total Expenditure	317,085,981	(16,141,000)	300,944,981	**324,122,510**	0	**324,122,510**

			Surplus | **6,449,019** | **0** | **6,449,019** | **6,449,019** | **0** | **6,449,019** Further meetings and discussions will be held between now and the end of March to incorporate any emergent cost pressures, robust QIPP plans and the outcome of acute contract negotiations into the budgets.
38		Clear and credible plans that meet the efficiency challenge and are evidence based, including reference to benchmarks	Below are examples of the planning discipline we have either engaged in as part of developing this year's Operating Plan or are engaged in to support our longer term strategic objectives moving forward. **1. <u>Plan to address New Models of Care as outlined in 'Five Year Forward'</u>** The Five Year Forward View published by NHS England in 2014 introduced the new models of care set out in the Planning Guidance with options being: • Multispecialty community providers (MCPs), which may include a number of variants; • Integrated primary and acute care systems (PACS); • Additional approaches to creating viable smaller hospitals. This may include implementing new organisational forms advocated by the Dalton Review, such as specialist franchises and management chains; and • Models of enhanced health in care homes; • Preventative diabetes programme leads. The CCG has therefore been working with Whittington Health, Haringey CCG and other stakeholders to submit an expression of interest in becoming a 'vanguard' site for the multi-specialty community provider model. We have been shortlisted for the workshop in 2 March to take the strategy forward. Our 'expression of interest' is appended.

			Islington fit with criteria The planning guidance sets out characteristics that applicant sites will need to demonstrate to become a Vanguard for new models of care. The summary below summarises how local work on our four strategic delivery programmes (Integrated Care, Urgent Care, Primary Care and Planned Care) demonstrates a fit with the Vanguard criteria. ***An ambitious vision of what change they want to achieve to the model of care, in order to meet clear identified needs and preferences of their local population;*** • Islington Pioneer programme; • Better Care Fund agreed and supports Pioneer; • Whittington Health Five Year Strategy – population segments agreed with Kings Fund; • Creation of Whittington Health Integrated Care Organisation (ICO) in April 2011; • Value based commissioning pilots in Islington for diabetes and psychosis; • Strength of Islington Joint Strategic Needs Assessment; • Development of the Community Education Provider Network (CEPN); • History of alternative contract forms to support the ICO model, and work on a three to five year contract with the trust starting in April 2015, based on the King Fund recommendation for a block contract with sophistication; • Engagement in emerging UCLH Local Hospital Strategy. ***A record of already having made tangible progress towards new ways of working in 2014;*** • Eight test and learn sites established with general practices working with broader health and care teams as a precursor to developing localities; • Successful introduction of ambulatory care and enhanced recovery at Whittington Health; • Introduction of rapid response services to support admission avoidance with GP and community geriatrician support built in; • Cardiovascular disease (CVD) early mortality reduction through focus on prevention in primary and community services; • Mental health – the positive impact of acute psychiatric liaison service at Whittington Health in reducing admissions, readmissions, length of stay, and time to senior clinical intervention;

			• Hospital at home services introduced at Whittington Health and UCLH, with an integrated service for children across the two trusts; • Mental health services – community investment and the supported reduction in inpatient beds by 33%. ***A credible plan to make move at serious pace and make rapid change in 2015;*** • Integrated Care action plan (Pioneer) indicates a move from pilots in 2014/15 to development at scale in 2015/16, supported by the Better Care Fund; • System resilience plans across health and care services in 2014/15 have delivered improvements in referral-to-treatment (RTT) waiting times and maintained A&E performance at Whittington Health in 2014/15 compared to 2013/14 (maintaining A&E performance not achieved in many other health and care economies; • Significant investment through Better Care Fund (BCF) in locality services including primary care, social care, and continuing care. ***Funded local investment in transformation that is already agreed;*** • CCG historic investment plans from 2013/14 and 2014/15 have placed significant investment in community services at Whittington Health and Camden and Islington Foundation Trust (C&I FT) contracts; • Three-year investment programme in primary care development; • Better Care Fund agreed through the Islington Health and Wellbeing board (HWBB) and has national sign-off; • Incentive schemes over and above the national CQUIN requirement have been built into the C&IFT contract in 2014/15 to support the development of primary care mental health services and to reduce waiting times in advance of planning guidance for the same in 2015/16; • Match funding identified in Islington CCG and Islington Council for implementation of the Person Held Record and Integrated Digital Care Record linked to the application for national Digital Tech Fund monies ***Effective managerial and clinical leadership, and the capacity and capability to succeed;*** • Islington CCG 360 degree stakeholder feedback is broadly positive across the range of stakeholders and above that achieved by peer CCGs in London and nationally;

			• Whittington health and care economy transformation board established with membership from key stakeholders for the multispecialty community provider model; • A strong History of joint working across CCG and Council, with Section 75 agreements in place for adults (now to include Public Health and Better Care Fund) and children; • Provider Section 75 agreements are also in place across health and care services, with Islington Council having agreements with Whittington and C&IFT; • Successful systems resilience delivery locally in for NHS Constitution targets for RTT and A&E – CCG commissioning system leadership established. ***Strong, diverse and active delivery partners, such as voluntary and community sector organisations;*** • Engagement in the Pioneer Programme – Age UK navigators, Healthwatch; • Third Sector forum established by CCG; • Community assets elements of Pioneer Programme – self management programme and patient activation pilot; ***Positive local relationships, for example the support of local commissioners and communities;*** • Islington CCG 360 degree stakeholder feedback is broadly positive across the range of stakeholders and above that achieved by peer CCGs in London and nationally; • I statements for integrated care and making it real driving integrated care development; • Evidence of patient engagement for integrated care, urgent care, children's health strategy and through forums and practice patient participation groups; • High level of engagement from Islington practices in work of the CCG, over and above Constitution signature – Governing Body, Clinical Leads; • Board Link Visit to each practice that informs commissioning intentions (evidenced from Chair's Seminar); ***Willingness to engage with other vanguard sites and national bodies to identify, prioritise and tackle national barriers experienced locally; develop local solutions that can easily be replicated by subsequent sites; and assess progress through a staged development process. This is similar to the integrated care pioneer programme;*** • Demonstration of this through Integrated Care Pioneer programme and work in diabetes year of care;

			• A strong History of joint working across CCG and Council, with Section 75 agreements in place for adults (now to include Public Health and Better Care Fund) and children; • Collaborative commissioning intentions with North Central London (NCL) CCGs. ***A commitment to richer, standardised data to enable real-time monitoring and evaluation of health and care quality outcomes, the costs of change, and the benefits that accrue.*** • Person held record and integrated digital care record business case and supporting data sharing agreements; • Implementation of DOCMAN, Medically Interoperable Gateway (MIG). Early implementation of patient on-line access in general practices as part of CCG's Information and IT Strategy • Engagement with UCLP. **2. <u>QIPP Plans 15/16</u>** The 15/16 QIPP is set at £12m. Acute savings programmes including metrics and contract efficiencies will deliver 65% of the QIPP. The remaining 35% is delivered through non-acute programmes. Transactional savings programmes represent the largest savings opportunity delivering 70% of the savings in acute and non-acute. It is likely QIPP in future years will be more reliant on delivery from transformational schemes. NCL QIPP leads are collaborating to ensure savings opportunities are shared where possible. In addition, collaboration ensures savings per provider are not double counted by commissioner. There is extensive analysis, including the exact financial breakdowns, included in the Operating Plan submission finance return and we would ask that this is cross referenced in assessment of our plans. **3. <u>Islington Better Care Fund</u>**

			As part of developing the Islington Operating Plan for 2014/2016 we have aligned our BCF plans at borough level. The financial model is predicated on a -1.55% reduction from 2014-15 through to 2018/19. Built into this reduction are work programmes around Ambulatory Care Services (ACS), Improved access to Primary and Urgent care and several other integrated care related QIPP projects. The BCF is very much linked to the financial modelling as it is utilising all these elements and including newly defined projects such as Children's services - Hospital at Home, Integrated Liaison & Assessment Team (ILAT) and a scaling up of the existing ACS project to deliver a higher level of Non-Elective reduction. The 2% difference between the 5 year plan and BCF plan are bridged by the above schemes in particular the ramp up of ACS. Integrated care and in particular the reduction of NEL admissions has and will be an ongoing priority, with particular focus around the joint working between the Local Authority, CCG and our main provider, Whittington Health ICO. ***2 – 5 Year Planning Principles*** At borough level in Islington, we have identified the key ingredients of our transformed service offer. We want to see: • An offer of early intervention and prevention for the whole population • Health and care systems and pathways that are co-produced with patients and users • Strong clinical leadership shaping and supporting change • Hospitals that plan and support discharge from the first day of admission • Better access to voluntary and community based services through better information and advice • Joined up care delivered through four localities based around GP practice • Better identification and co-ordination of patients/users at high risk of hospital admission • A programme of supported self-management for children and adults with long term conditions • More personalised service offers through the roll out of personal health budgets and increasing numbers of those who opt for a personal budget • Services that are more easily understood and accessed through single point of access, single assessment processes and 7 day working

			• Better alignment of physical and mental health services, thereby promoting parity of esteem across the health continuum • A skilled workforce that delivers care with dignity and compassion, is motivated to make a difference and is rewarded for its efforts • IT systems that support joined up care by becoming interoperable North Central London CCG's have together agreed a vision for the BCF which is for people to live longer, healthier and happier lives by focusing on their abilities and potential with and without support. Safe and effective support will come from integrated multi-agency health and social care providers working with local people, and their carers, to deliver the best outcomes for individuals and their communities. The aims of the overall NCL BCF are consistent with the Islington BCF plan that focuses on delivery of the Pioneer Programme. Islington works closely with neighbouring boroughs, particularly Camden and Haringey to ensure that when commissioning integrated care programmes we have alignment. However, availability of resource varies between boroughs which means we may develop different solutions. As part of developing the Islington Operating Plan for 2014/2016 we have aligned our plans at borough level. The Council has a programme of transformation work underway within adult social care services, the Moving Forward programme. This programme will ensure the requirements of the Care Act 2014 will be met, and that there is a sustainable social care offer in Islington. This programme is aligned to the BCF and Integrated Care Pioneer through joint oversight arrangements within the Housing and Social Care Management Structure (Service Director for Social Care is SRO for Moving Forward as well as member of Integrated Care Programme Board). Some areas of work sit across both programmes; for example the Locality development, supported by the BCF will be delivered jointly through Moving Forward and the Integrated Care Pioneer. Similarly, the development of personal health budgets is being delivered jointly with the Council using the same brokerage systems for both. This means that we can start to develop joint plans within an efficient and less bureaucratic system. Islington CCG has representation on the UCH Clinical Integration Programme Board that seeks to align the integration initiatives across the organisation with stakeholder commissioners (UCH also have a seat on Islington's Integrated Care Programme Board). Examples of work that have been developed include

			the UCH at Home service that seeks to support early discharge. Further work includes improving rapid response to reduce admissions and reviewing the delayed transfers to ensure Islington residents are discharged in a timely way. The challenge for UCH as a local provider is the number of commissioners with whom it works and therefore different pathways in place. Support around IT inter-operability, being funded through the BCF should mitigate some of this. The Mental Health Advisory Group brings together key stakeholders to oversee the development and commissioning of services and supports for adults with mental health needs. Camden and Islington Foundation Trust is a member of this and also a member of the Integrated Care Board. This group has aligned work with the integrated care programme including providing nurse input into supported housing schemes; developing a mental health offer into the four localities and investing in supporting adults with mental health needs back into employment. The Whittington Transformation Board, a partnership across Whittington Health, Islington and Haringey CCG's and local authorities that aims to provide strategic oversight of major change projects. Integrated care is one of the trust's five strategic goals and there is representation at a senior level on Islington's Integrated Care Programme Board. As Whittington Health is an integrated care organisation it is anticipated that they will benefit from the developments of the BCF particularly around supporting the shift of provision into the community. **4. <u>Evidence of strengthening partnership planning arrangements between London Borough of Islington and the CCG</u>** Islington has a long history of successful joint working between the NHS and Islington Council. The first S31 (now S75) Agreements to allow for joint commissioning and pooled budget flexibilities were signed in 2002 when Islington PCT was first established. The Agreements for Adult's and Children's commissioning were last updated in 2011. At the time a clause was inserted into both Agreements noting the transfer of responsibility to Islington CCG during the life time of the Agreement. Regardless of this the Agreements have automatically novated over to the

			CCG, in line with contact law. However, this refresh is an opportunity to bring the new relationship between Public Health and the CCG within this legal framework as well as incorporating the Better Care Fund (BCF) requirements and Funded Nursing Care, which historically sat as a separate agreement. Although some terminology is outdated, it is recognised that the Agreements have stood the test of time and the focus will be on updating the Schedules. Following discussions with the legal teams acting for the Council and the CCG it is proposed that the main Adult Agreement is restructured so that there are four separate schedules: • Adult joint commissioning • Funded Nursing Care • Public Health (Core Offer and Locally Commissioned Services) • Islington Better Care Fund The advantage of this model is that we can review the schedules on an annual basis and any changes can be incorporated into revised schedules, without needing to change the whole agreement. It builds on the Agreement we already have in place rather than developing a separate agreement solely for the BCF. The updates to the Children's Agreement focus mainly on terminology and Governance. It would be fair to say that, historically, formal governance of the Agreements has been ad hoc. In future it is proposed we adopt the principle of a two tier approach to governance: an Annual Executive level meeting and a quarterly operational/performance level meeting. This will apply across four areas: Adult Commissioning (including funded nursing care), Children's commissioning, Public Health and the BCF. The Annual Executive Adult Commissioning meeting will also serve as the Annual BCF meeting to reduce potential for duplication. Once these groups are set up and established there may be some benefit in combining some of their functions. This can be kept under review. The plan is to have the updated Agreements drafted by the end of March 2015. These will then need to be signed off at Corporate Director level within the Council and by EMT then Strategy and Finance Committee in the CCG, with Governance meetings being established prior to the Agreements being signed off. The first quarterly BCF meeting will take place in the new financial year.

			5. <u>Value Based Commissioning for Diabetes care (as an example of VBC)</u> In Islington diabetes is the second most common diagnosed long-term condition which affects more than 1 in 20 people. It is also the second most common under-diagnosed long-term condition in Islington. People with diabetes also have an increased risk of cardiovascular disease including stroke. Effective management of the risk factors of people with diabetes in primary care can control the disease and its complications. In light of the above, Islington has collaborated with Haringey CCG on one of the three population segments within the North Central London (NCL) wide value based commissioning programme (Older People with Frailty, Diabetes and Mental Health). Each pilot aims to build a common framework of outcomes and look at new contracting mechanisms to incentivise providers to work together to improve outcomes and drive down costs. The ultimate aim for all the pilots across NCL is to commission pathways of care, potentially from lead providers or provider networks that are commissioned to deliver agreed outcomes for particular populations. The CCG has been working with patients, voluntary organisations, providers, commissioners and public health to design a new service model across the whole cycle of care for patients with diabetes. The following providers have been engaged in the development of the Diabetes Integrated Practice Unit (IPU), or service model, design in order to ensure a whole cycle approach to the delivery of Diabetes outcomes: • Whittington Health; • University College London Hospitals; • North Middlesex University Hospital NHS Trust; • Nominated / representative GP practices The projects, their hierarchy of outcomes and plans for the year ahead were agreed in Phase 1. The project is now nearing the end of Phase 2, where we have worked together with patients, voluntary organisations, providers, commissioners and public health to design a new service model (IPU) for

			patients with diabetes. A business case detailing the proposed changes, activity and financial model and proposed contractual changes is currently under discussion for inclusion as either a CQUIN or a material element of contract form for 15/16. **Islington CCG is also engaged with its partners in developing value based commissioning arrangements for Mental Health and Older People. More information can be made available on these areas if requested**.
39		The clear link between service plans, financial and activity plans	The baseline activity for 2014/15 was calculated by taking the actual activity for the first six months of the year (April 2014 to September 2014) and projecting the second half of the year's activity based on the number of calendar days for A&E and non-elective activity, and working days for outpatients and elective activity. This gave us the 2014/15 forecast outturn which formed the baseline for 2015/16. The following methodology was used to calculate the 2015/16 activity plan: • The baseline for each point of delivery was uplifted to take account of demographic growth (1.4% based local planning assumptions). • Emergency activity was reduced by 3.5% to reflect the Better Care Fund initiatives. • Activity reductions were made by provider and point of delivery to reflect the 2015/16 QIPP schemes. Please note that this methodology reflects the establishment of a baseline and initial offers. Contract negotiations are currently underway and will be agreed by the April final Operating Plan submission date where we will be able to categorically guarantee the link on the basis of the agreed contract values and contract form.