For General Release

REPORT TO:	**CABINET 29 September 2014**
AGENDA ITEM:	**10**
SUBJECT:	Improving health and social care outcomes for over 65s in Croydon: A new approach to commissioning integrated provision (Phase 2 Report)
LEAD OFFICER:	Hannah Miller, Executive Director of Adult Services, Health and Housing and Deputy Chief Executive
CABINET MEMBER:	Councillor Louisa Woodley, People and Communities
WARDS:	All

KEY DECISION REFERENCE NO.: 1314 This is a Key Decision as defined in the Council's Constitution. The decision may be implemented from 1300 hours on the expiry of 5 working days after it is made, unless the decision is referred to the Scrutiny & Strategic Overview Committee by the requisite number of Councillors.

Outcomes for Residents of the Borough / CORPORATE PRIORITY / POLICY CONTEXT:

- The purpose of this report is to show how health and social care services in Croydon could work together in better ways to serve local people. Its vision is that people should experience well co-ordinated care and support which is truly person-centred and helps people to maintain their independence into later life.
- The report's main focus is on services for the over 65s, given that we have an ageing population, and the outcomes that people have said are important to them - that make a genuine difference to their health, well-being and quality of life.
- The proposals in this report support the Council's key strategic priorities with regard to promoting and sustaining independence, well-being and good health outcomes for Croydon residents. The proposals are also aligned with Croydon Clinical Commissioning Group's vision of "longer, healthier lives for all the people in Croydon".
- The paper draws on first-hand experience and feedback from local people who have been extensively engaged to explore their views of health and care in later life, It brings together a number of recommendations from existing strategies that have been developed jointly with the Council's health partner, Croydon Clinical Commissioning Group (CCG): these include the Older People's Strategy, the Joint Health and Wellbeing Strategy 2013-18, the Integrated Mental Health Strategy 2014-19 and Dementia Strategy. However, in recommending a whole systems approach to integrated commissioning and service delivery, the report aims to go further than before and takes a more pro-active and transformational position. The

individual and their family will be at the centre of Croydon's health and care system, ranging from the promotion of good health and well-being, through early intervention and support and, when needed, the delivery of treatment and care services. Croydon's older people and their families should expect to experience seamless, joined- up care and health provision of consistent quality and high standard. In a nutshell, services will be arranged around them and their needs, rather than their having to fit in with how health and social care professionals structure or organise services.

- The paper has been co-produced by Croydon Council and Croydon Clinical Commissioning Group (CCG) who have worked collaboratively to identify how improvements could be achieved by taking a whole systems approach to care and health in a time of constrained resources. The recommendations build on a long history of joint work in Croydon, including recent developments in delivering whole person integrated care through the Better Care Fund (BCF), but strengthen and significantly extend the BCF approach.

- It should be noted that although the "Croydon Challenge" has a different timeframe, this Outcomes-Based approach reflects the Council's ambitions to enable independence, liveability and growth. In particular, the overarching outcome domains are aligned to strategic Council priorities to increase healthy life expectancy, facilitate increased community and citizen resilience, and ensure enhanced high quality community-based care and support.

- In relation to older adults, the recommendations support an approach which gives due focus to the personal strengths of individuals, supporting them to make informed decisions (including in conjunction with their main professional support) about their care and health needs, whilst simultaneously enabling the mobilisation of community and third sector support. Community support can have particular importance in tackling issues such as loneliness and social isolation amongst older people, in providing support to family carers, and in ensuring Croydon continues its progress in becoming a dementia-friendly place. Due weight is also given in the paper to re-ablement and early intervention to maximise people's opportunities to maintain independence and reduce reliance on others. With regard to domiciliary or residential care provision for people with the highest levels of need, the recommendations will enable improved partnership working with providers across these sectors focussing on quality standards and the recruitment and retention of a skilled and valued workforce.

- The paper builds on the Council's commitment over several years to integrate health and social care commissioning and service delivery with NHS partners with the goal of achieving good value quality care. In summary, there are a number of different ways that people expressed their views during the engagement stage. But they have been brought together into the following five over-arching domains for this programme, which are designed to enable people to:

  ~ stay healthy and active for as long as possible

~ access the best quality care available in order to live as they choose and as independent a life as possible

~ be supported as an individual, with services specific to them

~ be supported to manage any long-term condition they may have, and experience improved control and reduced complications

~be supported by a member of the health and social care team who has had the training and has the specialist knowledge to understand how their health and social care needs affect them

- This programme has taken into account the requirements set out in the Care Act 2014. Many of the proposals directly support this and future provider(s) will be required to respond as the full impact is identified. In particular, the outputs from this phase (phase 2) are rooted in the engagement completed with Croydon service users to understand their needs. It supports the requirement to maintain and develop a range of sustainable high-quality provision for service users to choose from. It also enables personalisation and incentivises providers to work with individuals to agree and deliver services that meet their needs.

FINANCIAL IMPACT

Based on international and UK evidence it is anticipated that the Council and CCG could realise between 10-15% savings in relation to spend on over 65s across the lifetime of the contract. These savings would be as a result of an agreement with the CCG and the outcome of the contracting process. The timing and size of the anticipated savings would be confirmed in phase 3.

The Leader of the Council has delegated to the Cabinet the power to make the decisions set out in the recommendations below

1. RECOMMENDATIONS

Cabinet are recommended to agree that:

a. the Council proceed to phase 3 of the ‘Improving Health and Social Care outcomes for over 65s programme’ based on the principles outlined in this report, subject to the Croydon Clinical Commissioning Group Governing Body agreeing to move to phase 3 at their meeting on 7 October 2014

b. phase 3 comprise the following detailed work to be undertaken over the next

ten to twelve months as set out in section 3:

- Outcomes: The draft framework set out in appendix 1 provides details of the outcome domains that residents have identified as most important. This framework will be developed as a basis for contract requirements and dialogue with providers in phase 3 of the programme and will allow for the identification of additional or alternative indicators. The framework will be aligned with the Council's challenge outcomes and emerging performance framework, developing a suite of high-level measurable indicators.
- Governance and accountability: Phase 3 will develop a robust governance structure which ensures accountability at all levels of the programme, including strategic commissioning, provider management, statutory assessment and decision making, and performance monitoring. This will also ensure that the Council is able to meet new responsibilities emerging from the Care Act 2014. Options for aligning the Council and CCG as commissioners will be defined, including models which facilitate robust client side monitoring and provider management arrangements.
- Scope, timing and phasing: The Council contracts and budgets currently identified as being in scope of the contract are set out in section 3.6 of this report alongside those of the CCG. This will form the basis of dialogue with providers. Phase 3 will further develop the programme's phasing and implementation plan in dialogue with providers, including final options and recommendations regarding the Council and CCG services to be in scope.
- Delivery model: Development of a provider alliance delivery model is the preferred option for the Council and CCG. During phase 3, the Council and CCG will require providers to develop the appropriate legal and commercial structures which will enable them to respond to the requirements of the programme. Providers will be expected to engage with Croydon's community and voluntary providers to ensure a clear and prominent role for this sector which makes best use their experience and expertise.
- Contract design and payment mechanism: Taking account of the scale of transformation across health and social care and the likely need for investment, phase 3 will clarify and confirm the benefits and risks associated with the proposed contract term of 8 years plus extension of 2 years (8+2). A capitated[1] based outcome payment model will be designed

1 A capitation based payment means that providers are given a fixed amount per to cover some (partial capitation) or all (full capitation) of the healthcare needs of a specified group of people for a specified period of time. In addition, provider(s) can be rewarded for achieving enhanced outcome targets

to ensure development of a payment mechanism which incentivises the achievement of outcomes.

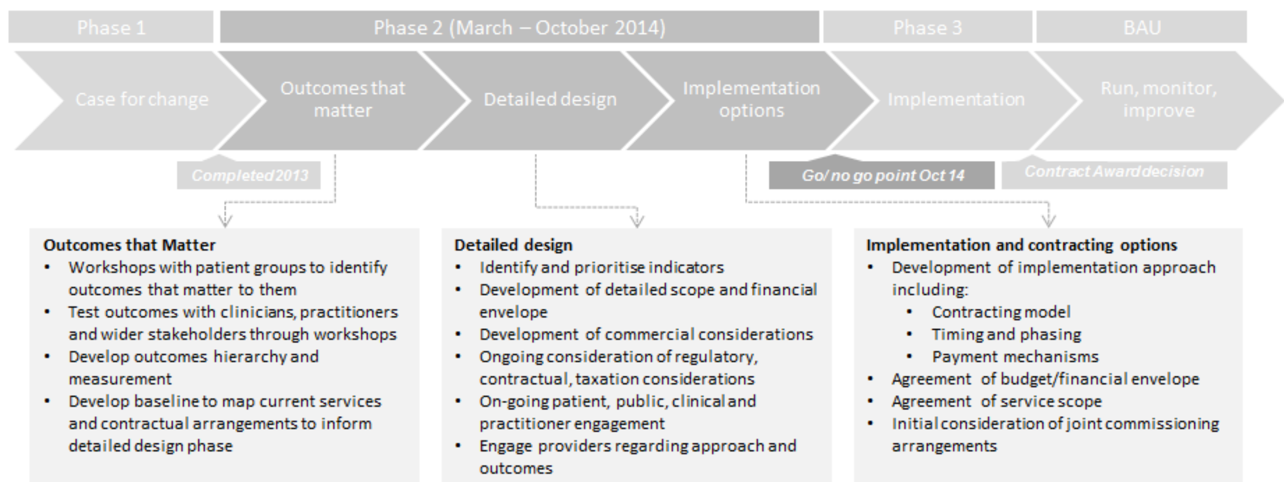
c. the procurement strategy for integrated health and care provision for over 65’s using the Most Capable Provider approach, as detailed in the report

d. progress to phase 4, including recommendations for contract award, will be subject to a further report and decision of Cabinet

Cabinet are asked to note that a parallel report to this is also being prepared for consideration and decision by the CCG’s Governing Body in regard to proceeding to Phase 3. Agreement by both the Cabinet and CCG will be needed in order to proceed to Phase 3 and the detailed work involved in preparing the groundwork for the full range of benefits outlined in this report through an outcome-based contracting approach.

2 EXECUTIVE SUMMARY

2.1 Work has been taking place across the council and CCG overall several months on a Programme called “improving health and social care outcomes for over 65s” (the programme). This report details the work completed during the most recent phase of the Programme and seeks agreement to proceed to the next phase (phase 3)[2]. A similar report and suite of recommendations will be considered by the CCG. The main stages and activities that have taken place within phase 2 are outlined below:



2.2 In 2013 the Council and the CCG initiated a programme to explore alternative models to improve the health and social care system for over 65s and ensure development of a strong independence model. To support its delivery a

2 The phase 1 report, as submitted to the Croydon CCG Governing Body (24/09/2013) can be read here: http://www.croydonccg.nhs.uk/about/CCGMeetings/Board%20papers/Enclosure%205%20-%20Commissioning%20for%20outcomes%20for%20over%2065s%20in%20Croydon%20-%20updated%20pack_01Aug13.pdf

programme board was established, chaired by a CCG lay member and included representation from both Croydon Council and Croydon CCG:

- Croydon Council: Executive Director of adult services, health and housing, Director of Integrated Commissioning, Director of Finance
- Croydon CCG: Chair, Chief Officer, Chief Finance Officer, Director of Commissioning and, Director of Quality and Governance
- There was also representation from NHS England at each of the meetings

2.3 The programme provides an opportunity for the Council to use its community leadership role to sustain good quality health and social care services, including a thriving local hospital and community based care at home. There are three broad reasons for integrating health and social care services:

- Delivering health and care services that better meet people's needs;

- Improving health and care services through innovation, collaboration and integration;

- Realising efficiencies in the system which includes influencing demand, supporting people into greater independence and self-care, reducing duplication, and enabling the effective transfer of funding across the health and care economy.

2.4 Reflecting the 'independence' and 'liveability' themes currently being addressed through the Council's Challenge programme, the Council and CCG have been working hard to achieve integration in commissioning through the creation of the Integrated Commissioning Unit (ICU) and service delivery through multi-disciplinary teams.

2.5 Integrated commissioning and service delivery provides a platform for improving outcomes for individual citizens and communities. The starting point for this programme was to ask service users and patients about the outcomes that mattered to them. This led to development of an outcome framework which can be used to incentivise providers to deliver services in a way that meets the outcomes local people want, to an agreed standard of care and at an affordable price.

2.6 The programme reflects the Council's ambitions to enable independence, liveability and growth. In particular, the overarching outcome domains are aligned to strategic Council priorities to increase healthy life expectancy, facilitate increased community and citizen resilience, and ensure enhanced high quality community-based care. The five overarching outcome domains for this programme are to enable citizens to:

- stay healthy and active for as long as possible

- access the best quality care available in order to live as they choose and as independent a life as possible

- be supported as an individual, with services specific to them

- be supported to manage any long-term condition they may have and experience improved control and reduced complications

- be supported by a member of the health and social care team who has had the training and has the specialist knowledge to understand how their health and social care needs affect them

2.7 To support delivery of integrated care, the Council and CCG need to consider alternative approaches to contracting. The recent Independent Commission on Whole Person Care[3] suggested that the health and social care system needs to align incentives and performance measures to reward early intervention and prevention and - in the long term – the sustained wellbeing of older people

2.8 The Council services currently in scope for the programme are:

- Extra care, special sheltered, residential and nursing care services
- End of life care
- Community /home based domiciliary care and support
- Equipment and adaptations
- Older people support and prevention services

2.9 It is proposed that other Council services for older people would be aligned and integrated as part of the whole system approach. However, in the immediate phasing, these services would remain under existing governance structures to ensure robust accountability for statutory decision making:

- Social care assessment and case management
- Personal support brokerage
- Integrated multidisciplinary teams, including social work and reablement teams

2.10 This report draws on international and national evidence to provide a set of recommendations about how the Council, in partnership with the CCG, can respond to these challenges. This report includes a number of sections, and each has its own recommendations for consideration. The table below provides a summary of the report:

Section	Summary
3.2 Background and rationale	• The OBC programme was established to design a model for commissioning and contracting which would incentivise providers to deliver health and social care services in a way that achieves the outcomes local people want, at an affordable price and to

3 http://www.yourbritain.org.uk/agenda-2015/policy-review/whole-person-care

	guaranteed standards of care. • An integrated approach to OBC provides an alternative option which allows the Council and CCG to influence demand, make best use of funding sources, reduce back office costs and wastage, and manage whole system risk
3.3 Population	• There is a strong case for focusing on over 65s in Croydon. • Croydon has a growing and ageing population, placing increased pressures on the health and care system. • The pressures on the system from this age group are increasing, and will continue to rise if nothing is done. The number of over 65s living in a care home, for example, is projected to grow by nearly 24% by 2020. A third of this group of people suffer from one or more long term health conditions, imposing significant long term costs on the NHS, many with associated social care needs with significant direct costs to the Council.
3.4 Outcomes that matter	• A strong consensus emerged through public engagement for five key areas in which people wanted to see outcomes improved. • Engaging local people to understand their needs and wishes sets the framework in which the provider alliance will deliver health and care services. This will be supported by the elements below which, together, will enable providers to deliver a wider-range of quality health and care services that can be tailored to meet the needs of individual service users. This supports the general responsibilities set out in the recent Care Act.
3.5 Governance and accountability	• To commission integrated care on an outcome and capitated basis the Council and CCG will need to consider in detail how they would work together to procure, monitor and manage a contract on the scale set out in this report.
3.6 Scope, timing and phasing	• In order to be able to deliver against these outcomes, service providers will need to be able to access and influence a broad range of services from across the entire range of health and social care provision. This will give provider organisations flexibility to help improve people's independence and well-being by enabling investment in services to prevent or delay the deterioration or exacerbation of conditions. • It is important that with an outcome based contract, the provider has sufficient flexibility to determine which services to deliver, when and to whom, as long as agreed outcomes are achieved. • Choice and the range of provision will be maintained within the future delivery model so that service users can benefit from a range of high-quality care services. In particular third sector involvement is maintained, and increased. • The way that contracts and services would be incorporated into the scope of the contract will be discussed and agreed n dialogue with providers throughout phase 3 of the programme.
3.7 Delivery	• The breadth of scope and the requirement for new models of

Model	care that realise the outcomes for all older people in Croydon means that no single provider will be in a position to deliver these outcomes. This means that providers will need to agree how they will work together in new partnerships. • The preferred model reflects a combination of an alliance and joint venture in which providers would come together to manage the contract. This model is referred to as a 'provider alliance' for the purposes of this paper. Within this arrangement the providers would form a collaborative alliance that will hold and deliver against a single contract with the commissioners.
3.8 Contract Design and Payment Mechanism	• Given the scale of transformation across health and social care and the likely need for transformation investment , UK and international evidence indicated a contract term of 8 years with provision to extend for a further 2 years (8+2)s • The payment mechanism is the process that sets out the method by which the flow of funds from commissioners is distributed through to the provider(s) participating in the contract. • Following consideration of a number of options, 'capitation based payment' is considered the most suitable mechanism for the programme. This means that providers are given a fixed amount per person to cover some (partial capitation) or all (full capitation) of the health and social care needs of a specified group of people for a specified period of time. • Provider(s) are incentivised to achieve outcomes and can be rewarded for achieving enhanced outcome targets. • Capitation encourages providers to co-ordinate care across the services for the target population group
3.9 Implementation and Next Steps	• The preferred option is the Most Capable Provider approach. This would include a process to give the preferred most capable provider alliance an opportunity to demonstrate that they can deliver the required integrated care outcomes. It would include 'assessment gateways' based on agreed criteria. • If the provider alliance is unable to demonstrate sufficient capability against the agreed criteria this would trigger an intervention from the commissioners. This may result in a competitive dialogue process

3.DETAIL

3.1 Introduction

3.1..1 The move towards Outcomes Based Commissioning (OBC) to support the integrated delivery of health and social care is a way of recognising the importance of asking the community what results they wanted to see achieved and looked for whatever new delivery model allowed providers of services to use their expertise to design solutions to achieve those results, or 'outcomes'.

3.1..2 As the Independent Commission on Whole Person Care report commissioned by the Labour party[4] recently commented, the challenge for the welfare state in 2014 is different from the one that existed at its inception in 1948. Broadly, the main challenge in 1948 was infectious disease; now it is people with multiple long term conditions, poor mental health, disabilities and frailty.

3.1..3 This report recognizes that; '*nationally, over two thirds of the money spent by the NHS and social care is on this group of people, who for the most part (but by no means exclusively) are experiencing the diseases of old age. Most people over 65 have more than one long term condition, over 75 two or more. In short you collect more as you get older. Sometimes people's problems are just a consequence of getting very old. Good care for these citizens requires us to look at them and their health and care needs as a whole. Yet in many ways the health and care system remains very similar to that of 1948; based on hospitals and focused on specialties that look after a person's body parts, not the person as a whole*'.

3.1..4 For several years, the Council and CCG have been working in partnership to achieve integration both in commissioning and at the point of service delivery. Recently this has been exemplified in the Better Care Fund (BCF) programme (previously known as the Re-ablement Fund) and the development of an Integrated Commissioning Unit (ICU) led by a Council Director (Director of Integrated Commissioning Unit)[5]. It has also been achieved through the establishment of multi-disciplinary health and social care teams, including the Transforming Adult Community Services (TACS) model, which aims to enhance personalised care for people with long term conditions, and integrated hospital-based social work teams.

3.1..5 In 2013, to realise further benefits of integration, the Council decided to work with the CCG and commit to a process looking at the whole of the health and social care system for older people. Instead of simply redesigning services and customer journeys, the Council and CCG decided to go back to first principles and ask Croydon people what outcomes they are seeking from the whole system. Then next step would be to ask providers, 'if we can find a way, can you create more effective solutions for meeting those outcomes'. The OBC programme was established to design a model for commissioning and contracting which would incentivise providers to deliver health and social care services in a way that achieves the outcomes local people want, at an affordable price and to guaranteed standards of care.

3.2 **Background and Rationale**

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4 http://www.yourbritain.org.uk/agenda-2015/policy-review/whole-person-care

5 More information about the Integrated Commissioning Unit can be found on the following page:
https://secure.croydon.gov.uk/akscroydon/users/public/admin/kab12.pl?operation=SUBMIT&meet=17&cmte=CAB&grpid=public&arc=1

3.2..1 Outcome Based Commissioning is an approach to purchasing public services that rewards both value for money and delivery of better outcomes that are important to patients and service users. It is well established outside the UK and in other public services, but is relatively new to the NHS and social care.

3.2..2 The Independent Commission also concluded that '*Budgets need to be treated as a whole across health and social care... Yet it is the view of this Commission that – at this current time – the merging of organisations to achieve this would be inadvisable, expensive, and would delay the benefits achievable through a more collective commissioning approach…. any recommendations that we make in relation to the structures of the system need to build upon the current arrangements'*.

3.2..3 OBC is a vehicle for implementing integrated health and social care for the population group which stands to benefit most. Few councils/CCGs have made progress from thinking about integrated care to implementing it. Croydon could be at the leading edge of change by implementing a solution that builds in sustainability in terms of both quality and resources.

3.2..4 There are three broad reasons for adopting an Outcome Based Commissioning approach:

- **Delivering health and care services that meet patient and service users needs:** People who use services are often disempowered by a reactive care system that focuses more on dealing with problems after they arise than prevention. Similarly, current funding and payment systems often reward activity rather than outcomes that matter to patients. OBC puts resources in the right place in the system to maximise value.

- **Improving health and care services through innovation, collaboration and integration:** People, particularly those with long-term or complex conditions interact frequently with health and care services. However, the care they receive can be fragmented and varied; while individual organisations may perform well the system as a whole can be poorly coordinated and confusing. OBC is an enabler for whole person care and support.

- **Realising efficiencies in the system.** Outcome based commissioning is based on the premise that there are opportunities to improve efficiencies within the current system. The evidence base from other developed systems (Internationally and in the UK) is showing that capitated and outcomes based contracts with integrated delivery has led to improved outcomes for service users and efficiency savings of 10-20% or more, depending on scope.

3.2..5 The Council faces a number of particular pressures in relation to services for over 65s and has gone as far it can to drive efficiencies from its existing social care model. Direct delivery elements of service are 90% outsourced, and provider costs are highly competitive. The only way to reduce costs further

without changing the delivery model would be to reduce eligibility levels- which will no longer be an option from April 15 - and/or reduce quality (e.g. by cutting staff costs further). As such, the only route to sustainability is to reduce demand or to access new funding sources. Integrated care, supported by an outcome based contract, opens up a number of options:

- **Influencing demand:** In the current, fragmented model there is no incentive for providers to manage an effective transition from hospital into community-based care. Care home beds are filled by people discharged from hospital, sometimes too quickly, without the right support to look after themselves in their own home. Often people end up in expensive residential care, or back in hospital - both of which could have been avoided if the system worked together more effectively. Under OBC, the accountable provider alliance would be incentivised to meet outcomes that are set by the public and commissioned by both health and social care commissioners. This could mean financial penalties if more people are placed in care homes than should be. Evidence from OBC programmes in Germany is that this leads to a 15% reduction in nursing home admissions. While Croydon is currently below the London average for permanent care home admissions per 100,000 people over 65, there remains scope for improvement[6].

- **Funding sources:** The NHS strategy is to shift resources into community provision and away from expensive acute provision. Reductions in nursing home admissions are achieved through more care at home, better home-based rehabilitation and reablement, and specialist treatment at a primary care level. This needs to be resourced. There is a risk to councils that this will create additional funding pressures if funding does not shift too. For example, there is likely to be an intentional shift to using social care resources and away from hospital care. The Better Care Fund is designed to facilitate this progress and signal the way ahead. Finding ways of achieving this transfer sustainably is required in order to incentivise social care services to be confident with absorbing additional demand; by making activity and finance part of a single, fluid system. The OBC model could ensure an equitable distribution of costs and benefits across the system, by operating pooled budget-type and/or risk and gain-share principles.

- **Reducing back office costs and wastage**: A high level of outsourced services means a high level of transactions and a heavy burden in contract management and monitoring for quality. Both the CCG and the Council would address their models of strategic and micro-commissioning, as well as direct delivery, in a new system of joint provisioning. Greater system complexity with high numbers of providers can lead to higher levels of resource needed to avoid wastage in the system (e.g. managing to avoid voids in block bed management and removal of duplication). OBC presents an opportunity to include shared back office support (contract management, payment processing) as well as rationalisation of functions where there are

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6 http://ascof.hscic.gov.uk/Outcome/721/2A(2)

areas of numerous ‘hand-off’ and cross-organisational invoicing. Taking 20% of costs out of a system which is highly fragmented is not unusual

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- **Managing risk:** The risk to both the Council and the CCG is that the cost of health and social care will grow inexorably. Both organisations have multi-million pound annual savings programmes, whilst the demographic demand pressures continue to increase. There is no ‘big idea’ to absorb this pressure. Whilst the risk to both organisations of ‘doing nothing’ is well known, the risk of both commissioners ‘going it alone’ is that serious cost shunting will be exacerbated if there is no mechanism to counter the pressures in the system and the health system is incentivised to push further secondary health care to the level of community care.

3.3 **Population: Over 65s in Croydon**

3.3..1 There is a strong case for paying special attention to the group of people who are aged 65 and over in Croydon. Croydon has a growing and ageing population, placing increased pressures on the health and care system. The total registered population across Croydon CCG’s six geographical networks is currently 377,570. Over 65s represent nearly 13% of this population – 47,390 people[7] and this is expected to grow by more than a fifth in the next 10 years. The pressures on the system from this age group are increasing, and will continue to rise if nothing is done. The number of over 65s living in a care home, for example, is projected to grow by nearly 24% by 2020. A third of this group of people suffer from one or more long term health conditions, imposing significant long term costs on the NHS and Social care to varying degrees.

3.3..2 It is also known that improvements are possible based on national benchmarks:

- a measure of the independence of patients living at home is the number of older people still at home 91 days after leaving hospital. For Croydon 65.3% were still at home following discharge in 2012/13 compared with 81.4% for London overall[8];
- patients over 65 account for the majority of all hospital emergency bed days, placing a large cost on the system. There is large potential for high rates of emergency bed use by over 65s to be reduced[9];

3.3..3 There are also practical reasons for focusing on over 65s as a group. They are a stable group, with low rates of migration in and out of the borough. 98% of older Croydon residents are registered with a local GP and so are easy to identify.

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7 Croydon CCG Primary and Community Strategy, v3.1

8 South West London 5 Year Strategic Plan

9 Imison et al, 2013, ‘Older People and Emergency Bed Use: Exploring Variation’. The Kings Fund

3.3..4 By focusing on commissioning services that reflect the outcomes that matter for over 65s and developing the appropriate contractual arrangements, it is anticipated that the system will be better able to respond to these challenges over the next 10 years. Given the demographics of Croydon, doing nothing is not an attractive option.

3.4 Outcomes that matter

3.4.1. A strong consensus emerged through the public engagement work for five key areas in which people wanted to see outcomes improved:

- Able to stay healthy and active for as long as possible
- Can access the best quality care available in order to live as I choose and as independent a life as possible
- To be supported as an individual, with services specific to me
- To be supported to manage my long-term condition and experience improved control and reduced complications
- To be supported by a member of the health and social care team who has had the training and has the specialist knowledge to understand how my health and social care needs affect me

3.4.2. These outcomes are consistent with findings from previous engagement work completed by the Council and CCG and there is confidence that they have resonance with the wider public. They provide commissioners with a mandate for proceeding and they align closely with the Council and CCGs' existing visions for integrating health and social care around the needs of patients and service users.

3.4.3. People articulated a set of outcome goals that provide a more detailed picture of what people want to see from their health and social care services. The outcomes are supported by a range of indicators including both and qualitative and quantitative measures. 27 candidate indicators have been identified as those which would be most suitable for including as part of the payment mechanism in the contract (i.e. providers would be financially rewarded for achieving them). These indicators include those that (if met) would drive the system towards a financially sustainable future (e.g. reduced hospital admissions, fewer admissions to residential care homes, more prevention and self-care).

3.5 Governance and accountability

3.5.1To commission integrated care on an outcome and capitated basis, the Council and CCG will need to consider in detail how they would work together to procure and manage a contract on the scale set out in this report.

3.5.2 Defining governance structures for both commissioning and management of a capitated OBC contract is a key phase 3 workstream. This will include development of a robust governance structure which ensures accountability at all levels of the programme. Options for aligning the Council and CCG as commissioners will be defined, including models which facilitate robust client side monitoring and provider management arrangements. Options for the client side model will be refined in line with the scope and financial envelope to ensure these meet the requirements of both the Council and CCG in terms of provider management, statutory assessment and decision making, and performance monitoring.

3.5.3 In the immediate phasing, to ensure robust accountability for statutory decision making, it is proposed that some Council provision for older people remains out of scope. These services would remain under existing governance structures, but would be aligned and integrated as part of the whole system approach. In particular, this provides an opportunity to consider options for a single assessment process across health and social care. Although it remains a priority to provide a single process which best facilitates the achievement of individual outcomes, there are further details around statutory functions and accountability that will be fully explored and tested as part of phase 3. This will also ensure that the Council is able to meet new responsibilities emerging from the Care Act 2014.

3.5.4 Where social care services are to be provided on a capitated basis, the Council must ensure that these, and other, statutory obligations are met. In particular the Council must ensure that it retains statutory decision-making about whether individuals meet eligibility criteria. Furthermore, the Council will ensure that provider(s) meet all obligations relating to eligibility criteria in full and that there are strong contractual levers to enforce this obligation.

3.6 Scope of services

3.6.1 In order to be able to deliver against the outcomes set out above, providers will need to be able to access and influence a broad range of services from across the entire range of health and social care provision. This is based on the premise that a broader scope will enable providers to innovate and develop new models of care. During this work several permutations of scope have been explored and this has resulted in the conclusion, developed through a series of working groups with CCG and senior Council officers that the groups of contracts and budgets set out in the table below should be included in scope from the outset of the contract. Overall, this scope results in an annual financial envelope for the contract of c.£175m based on current spend. This breaks down as £139m from the CCG and £36m from the Council.

3.6.2 A number of services remain outside of scope, such as care assessment and case management, personal support brokerage, London Ambulance Service and Core Primary Care. However it is anticipated that there is potential for these services to be considered for inclusion during the lifetime of the contract

as data quality is improved and contracting and governance arrangements are made clear. Nonetheless it will be of central importance that any development in this direction would fully satisfy the Council's governance and accountability responsibilities.

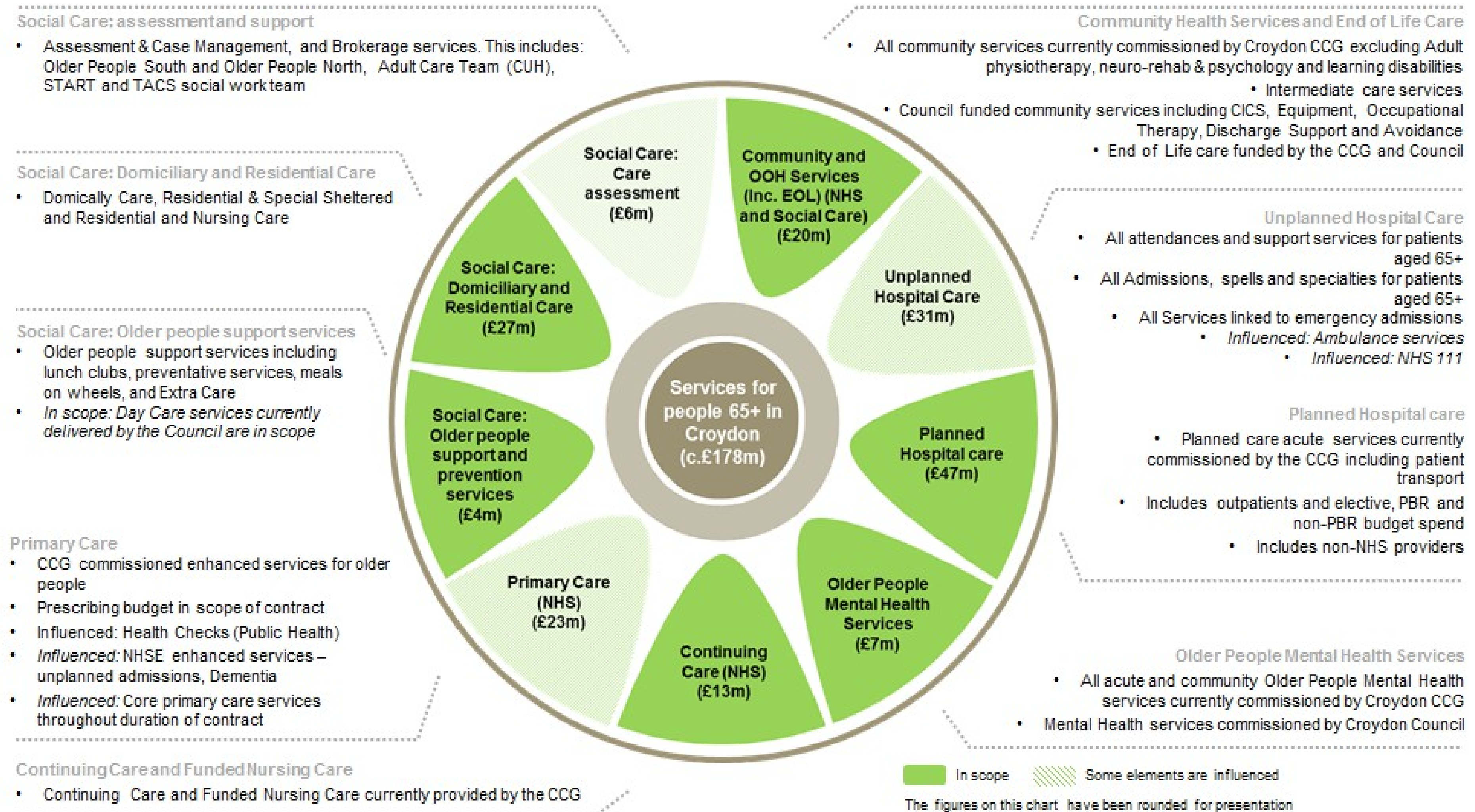
3.6.3 It is important to note that with an outcome based contract, the provider has significant flexibility to determine which services to deliver, when and to whom, as long as the agreed outcomes that matter to patients and service users are achieved. The purpose of identifying a list of contracts and budgets in scope is to help calculate the size of the contract and to identify those services that commissioners would no longer directly purchase in future. The focus on outcomes will require the provider(s) to innovate with new integrated models of care, joining services around the needs of the public, and moving away from previous organisational silos.

3.6.4 It is expected that provider(s) will manage the delivery, and potential expansion, of personal budgets and personal health budgets within the agreed contract budget and will develop the appropriate infrastructure to support this. The advantage of including personal budgets in an Outcome Based Contract is that it will provide flexibility to providers in how they are integrated into their model of care. Social-care commissioners have an obligation to assess individuals for FACS (Fair Access to Care Services) and provide care when certain thresholds are reached.

3.6.5 Through the contracting process commissioners can request provision by a certain provider(s); both the CCG and Council have indicated that the role of the voluntary sector should be maintained and strengthened.

3.6.6 If it is agreed to proceed, during phase 3 the scope would be discussed with providers through the implementation approach set out in section 3.8. This would enable commissioners to explore the future delivery model with the potential provider(s) which would include consideration as to how services could be incorporated and delivered both through transition and beyond.

3.6.7. The figure below provides a summary of the services in scope of the contract and those which will need to be influenced by providers. It should be noted that within each category of service some contracts and budgets are out of scope.

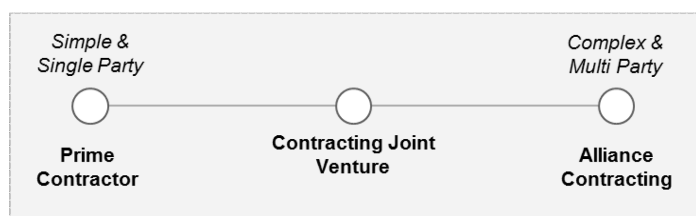


3.7 Delivery Model

3.7.1 The breadth of the scope and the requirement to develop and deliver new models of care that realise the outcomes for all older people in Croydon means that no single provider will be in a position to deliver this contract. This means that providers will need to agree how they would work together in new partnerships.

3.7.2 To enable the Council and CCG to let a single contract, providers would need to identify an accountable body that is accountable for managing the delivery of health and care services for older people in Croydon

3.7.3 Three main options have been considered: prime contractor; alliance; and joint venture. These models have been chosen as they represent the spectrum of models available and it is possible that the provider(s) could propose a model that is a hybrid of these standard models.



3.7.4 Having considered these options it is proposed by officers that the Council and CCG's preferred model should reflect a combination of an alliance and joint venture in which providers would come together to manage the contract. This model is referred to as a 'provider alliance' for the purposes of this paper.

3.7.5 Within this structure the providers would come together and form an alliance that would hold and deliver against a single contract with the commissioners. This would combine the collaborative benefits of Alliance Contracting with the clear, defined contracting structure of the Joint Venture model. Key features of this model would include:

- Performance is judged on the overall outcome measures of the contract, aligning the interests of the different providers.
- Providers would have collective responsibility for delivering the outcomes and this would be set out in a contractual agreement between them along with the appropriate governance arrangements.
- Within the agreement providers would still need to agree a single performance/partnering framework ("Contractual JV agreement") defining how the provider(s) operate in delivering the outcomes.
- Enable Commissioners to issue a single contract to an accountable group of providers. It may be possible for one organisation within the Provider Alliance to hold it on behalf of the other organisations.
- Providers would be encouraged to bring in additional parties into the alliance to improve capability and capacity, for example, the third sector.

3.7.7 While commissioners should identify a preferred model in order to inform the design of the contract, they should avoid enforcing an overly detailed, specific delivery model on the provider(s). Providers would be allowed to suggest their preferred delivery model with supporting rationale as part of their proposal.

3.8 Contract Design and Payment Mechanism

3.8.1 The payment mechanism is the process that sets out the method by which the flow of funds from commissioners is distributed through to the provider(s) participating in the contract. Following the consideration of a number of options 'capitation based payment' was considered the most suitable mechanism to enable providers to deliver integrated health and social care. These would be supported by outcome based payments that are aligned to incentivise delivery.

3.8.2 The capitation fee will be set on a per-person basis for the in-scope population identified in section 3.3. The fee would be negotiated through dialogue with providers, but the starting point has been to calculate the current per-person cost of delivering the services in scope and to adjust this for cost inflation and predicted population changes over the next ten years.

3.8.3 Given the scope of services and the evidence from other capitated systems about the efficiency gains that providers are able to generate by having freedom to invest in prevention and optimisation of pathways, capitation fees have been calculated against a 'do nothing' baseline and at 10%, 15% and 20% reduction against that baseline. The contract would need to be negotiated at a point at which the commissioners 'affordability target' (not included in this paper) would be met.

3.8.4 An outcome based payment would sit alongside the capitation regime and would provide an additional incentive to achieve the outcome goals developed as part of this phase.

3.8.5 The duration of a contract is central to facilitating the delivery of transformational change and enabling the provider(s) the opportunity to realise the agreed outcomes. Drawing on UK and international evidence, taking into account the scale of transformation across health and social care and the likely need for transformation investment, a contract for 8 years with a possible extension of 2 years (8+2) is recommended. It will be possible to build review points and break clauses into the contract.

3.9 **Implementation and Next Steps**

3.9.1 If a decision is taken to move proceed, the Council and CCG would intend to provide a single contract for managing and delivering services for over 65s in Croydon, having set out a preference for a 'provider alliance' model. Two main options were considered for negotiating and implementing the contract: (1) Full Competitive Dialogue process (open procurement of new service) and (2) Most Capable Provider(s) (MCP) approach. A summary of these two options is provided below:

Competitive Dialogue	• Full market competition for the complete pathway involving a pre-qualification process to evaluate the provider pool to determine which is the best placed to deliver the services • For complex requirements (such as this), or those requiring innovation, a dialogue process to discuss with bidders the possible solutions can be used to understand the exact nature of the tendered services and the constraints on potential solutions • Incumbent providers are able to bid for contract
pableMost	• No competitive tendering process undertaken although development of a robust process to determine if existing providers are the most capable • Process to give the identified most capable provider(s) an

3.9.2 When considering the potential routes commissioners identified a number of design principles;

- Ensure the stability of the current system for the whole population
- Maintain an element of competition to encourage innovation and value for money
- Retain the ability for new parties to enter into the local health and care economy
- Require providers to become accountable for transformation and innovation
- Maintains choice and competition within the delivery of services – both through this process and in future delivery
- Recognise fixed points, such as existing estate, within the system that will need to be maintained and utilised

3.9.3 In considering the possible approaches against the principles above it was agreed that the MCP approach best met the principles set out above. The MCP process gives potential most capable provider(s) an opportunity to demonstrate that they can deliver the required integrated care outcomes. The provider(s) will be assessed against agreed criteria at 'assessment gateways'. If the provider(s) is unable to meet the criteria or expectations at either gateway this may trigger an intervention from the commissioner (at their sole discretion). This would be proportional to the level of non-achievement against the criteria. The ultimate intervention would be to initiate a competitive dialogue process.

3.9.4 Commissioners will be required to identify one or more providers that are capable of delivering integrated services of improved quality and efficiency for people over 65 in Croydon. This would require the commissioner to use a transparent test based on a range of criteria against which existing providers would be assessed. This would be developed in phase 3.

3.9.5 The following would be the key delivery workstreams for the next phase of the programme:

- Finalise design
- Develop integrated commissioning vehicle
- Preparation of contract documents
- Development of MCP assessment milestones & criteria
- Deliver capability assessments
- Support evaluation of capability assessments milestones
- Shadow running
- Support negotiation of contract
- Project management (Governance, Project Management, Communications and, Engagement)
- The timing of activities to deliver the above outputs is summarised in the following high level delivery plan for the MCP route.

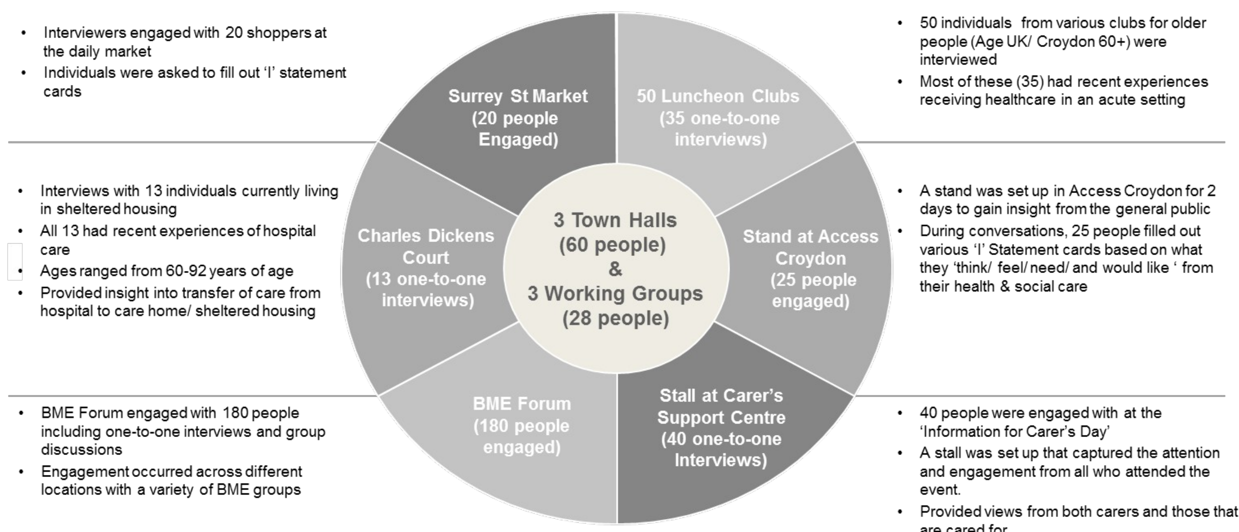
3.9.6 To ensure that the work delivered in phase 2 is built upon, the following activities need to be delivered at the beginning of phase 3.

- Agreed governance process for the Council and CCG.
- Agreed joint commissioning delivery vehicle (MOU, formation of joint commissioning vehicle)
- Updated population assumptions (address known out of scope areas)
- Updated depository of existing contracts
- Updated CCG and Council budget information
- Contractualise scope of services (based on a full review of all existing CCG and Council contracts)
- Contractualise the Outcomes Framework against the updated scope of services
- Updated financial envelope against the updated scope of services
- Development of a fit for purpose data room for providers

4. CONSULTATION

4.1 As set out above, the move towards outcomes based commissioning (OBC) is a way of recognising the importance of working with the community to identify the results they want to see achieved in relation to health and care services. These ‘outcomes’ would set the framework within which providers of services could design solutions to achieve them.

4.2 In line with the general duty to involve individuals and the wider community, an extensive phase of testing and co-design was put in place. The town hall events and working groups were central to the co-design and these were supported by a number of additional activities that are summarised below (A full report on this work and key messages is in background document 3). Overall 400 individuals provided input and the views and opinions gathered were fed back into the process to support the development of and verify the detailed outcome design.



The outputs from the consultation and engagement exercise set out above directly informed the development of the outcome framework.

5 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

5.1 Revenue and Capital consequences of report recommendations

The current total annual spend in scope for this project is £175m. The Council element is £36m and the CCG element is £139m.
The proposals in this report suggest that costs could be reduced by between 10 and 15 % through an outcomes-based approach. Given the preparation period for a project of this scale, a cashable savings component is not expected to begin until towards the end of 2016/17, but with fuller savings benefits from 2017/18.
In 2013/14 actual Council expenditure for in-scope services was some £37m and therefore if savings were to be generated as anticipated they would amount to be between £3.5m- c£5.5m per annum based on 2013/14 costs. The impact of these savings would support both the containment of cost pressures in the current older people's budget areas, which are facing substantial demand, along with efficiency savings arising from the proposed contract approach described in this report.

5.2 The effect of the decision

The decision to proceed to phase 3 of this project will result in the need for further external project support which is being funded from the corporate transformation reserve.

5.3 Risks

Risk Cat.	Description	How does the risk materialise?	Impact	Who can control the risk	Potential mitigation / Commercial position
Design	The risk that the transformed services do not deliver the required outcomes.	The design of the transformed services underestimates the capability gap of the as-is services or mis-interprets the outcome indicators.	Provider receives partial payment for sub-standard outcomes. Further investment is required to transform services further. Project becomes uneconomical and may not continue.	Given the accurate information on the as-is service and well understood outcomes from the commissioner, the providers will design the future service solution. Therefore it is well placed to manage this risk.	Commissioner to provide accurate and complete vendor due diligence information to providers. Co-operative development and agreement of outcome indicators during dialogue.
Build	Transitioning from existing services	Delays in delivering the transformed services.	Required outcomes not delivered on time and likely need to extend the costly double running of existing services.	Providers are best placed to manage the transition risk as they hold the design risk. Providers should have the capabilities and experience of transitioning services.	Use of contractual planned transition long stop dates. Provider pays additional double running costs until transition completed. Careful evaluation and selection of providers with the required track record.
Financing	Overrun of transition costs.	The predefined level of financial investment to transform the services is insufficient. Cost overruns caused by underbid transition costs or transition subcontractors' delays or defects.	Project becomes economically unviable as providers would not make acceptable returns.	Providers are best placed to manage the transition risk as they hold the design and transition risks. Providers should have the capabilities and experience to accurately develop the transition costs as part of their proposal. Providers should have experience and capabilities to manage subcontractors during the transition period.	Commissioners to check & challenge and evaluation of proposed transition costs. Parent Company Guarantee Ensure the involvement of risk-taking private-financing perspectives early on, for example, can ensure a more professional and disciplined approach to strategy, risk and project management, and deal structuring.
Operating	The demand for services per head increases beyond the expected level.	Provider required to deliver more services for the given capitated payment per head	Total system delivery cost does not provide the commissioner with the required savings. Project becomes unprofitable for provider.	The total system cost of all activities should be shared between the providers in order align incentives, promote closer collaboration and drive efficiencies, allowing providers to decide on the best activity mix.	Potential provider losses capped against a given range of demand for services per head. Contract to include transparent calculation of capitated budget that commissioners manage and receive. Define capitated payment for key age groups to reflect demand risk profile
Operating	The contract definition of the	The contract definition of the target population	The contract definition of the target population	The contract definition of the target population group could be amended	• The contract definition of the target

	target population group could be amended to include a cap & collar mechanism.	group could be amended to include a cap & collar mechanism.	group could be amended to include a cap & collar mechanism.	to include a cap & collar mechanism.	population group could be amended to include a cap & collar mechanism.
Operating	The risk that system wide quality outcomes are not met through investment and reform.	Providers focus on delivering services with minimum resource investment to enhance profit margins.	Sub-standard outcomes and failure to deliver wider system cost efficiencies.	The total system cost of all activities should be **shared between the providers** in order align incentives, promote closer collaboration and drive efficiencies, allowing providers to decide on the best activity mix.	• Commissioners to carefully evaluate proposed investment and reform during dialogue. • Use of financial incentives in the payment mechanism to share wider system costs savings from investment and reform. The sharing of system cost savings should be tailored to the maturity of the provider's solution through the term of the contract.

***5.4* Options**
Continuing to review and negotiate individual contracts is unlikely to deliver the same efficiencies and productivity gains that could be achieved through the development of an integrated, outcome based contract for over 65s.

As set out in the body of the report, the Council has gone as far it can to drive efficiencies from its existing social care model. The direct delivery parts of the service are already 90% outsourced, and provider unit costs are highly competitive. The only way to reduce costs further without changing the delivery model would be to reduce eligibility levels- which will no longer be an option from April 15 - and/or reduce quality (e.g. by cutting staff costs further). As such, the only route to sustainability is to reduce demand or to access new funding sources. Integrated Care, supported by an outcome based contract, potentially opens up a number of options.

Financially there is a bigger risk to the Council in not pursuing the integration of health and social care commissioning as this would potentially undermine the efficiencies already achieved through an integrated approach in Mental Health and Learning Disability. Both the Council and CCG would work through the Executive Board to ensure the savings generated fall proportionately and equitably between the CCG and Council budgets.

***5.5* Future savings/efficiencies**

Based on international and UK evidence it is anticipated that the Council and CCG collectively can realise between 10-15% savings in relation to spend on over 65s across the lifetime of the contract. These savings would be as a result of an agreement with the CCG and the outcome of the contracting process. The timing and size of the anticipated savings would be confirmed in phase 3.

(Approved by: *Lisa Taylor – Head of Finance and Deputy S151 Officer*

6. COMMENTS OF THE COUNCIL SOLICITOR AND MONITORING OFFICER

6.1 The Council Solicitor comments that legal advice has been sought from Wragge Lawrence Graham & Co LLP throughout the development of this project. This advice takes into account considerations for both the Council and CCG. In procurement terms there are a number of risks and benefits associated with both the MCP approach and competitive tenders. Particularly, each has different areas of strengths and weakness in terms of understanding the market and service user's needs, process requirements, provider relationships and delivering best value. In legal terms the principle risk of the MCP approach would appear to be that it is an untested approach in the new environment of the NHS (Procurement, Patient Choice and Competition) Regulations 2013. However, in deciding to follow the MCP approach, the key messages and conclusions arising from the advice received are as follows:

6.2 The procurement of health and social care services falls under Part B of Schedule 3 to the Public Contracts Regulations 2006, allowing the Commissioners significant flexibility for procuring older people's services.

6.3 Commissioners are recommended to test and document any assumptions about the existence of cross border interest as part of their decision process about which service delivery model and procurement option to use.

6.4 Where there is unlikely to be any cross-border interest in services being commissioned, Commissioners are not bound by EU procurement law to competitively tender the services contract, but the CCG may still need to consider competitive tendering in order to comply with the *NHS (Procurement, Patient Choice and Competition) (No 2) Regulations 2013*.

6.5 Commissioners would need to make a balanced judgment about what is their best service delivery model, based upon their knowledge of the local health and social care economy. A managed procurement process rather than a Competitive Tender can be used to identify the 'best' provider. Introduction of the new European procurement regulations, depending on the timing, may require the use of the managed procurement process to be reviewed.

6.6 When procuring services, it should be noted that the CCG has a statutory duty to procure them from one or more providers that are most capable of delivering services of improved quality and efficiency (and on an integrated basis) and that provide best value for money. The Council does not have a parallel explicit duty beyond obtaining value for money, but would welcome the principle of improved quality.

6.7 Should the Commissioners decide that there is an obvious most capable provider for older people's services, taking into account the health economy in the round, it must articulate a clear rationale for not engaging in a formal procurement and demonstrate how they have tested that a provider is the most capable.

6.8 The Commissioners would need to assess the extent of each potential most capable provider's (an 'MCP') capability by reference to specific criteria that address the aims and objectives of the procurement.

6.9 A positive outcome of the evaluation process for a MCP would enable Commissioners to work with the identified provider(s) to develop contractual terms and move towards delivery of the new service model.

6.10 It should be noted that it would be possible for a potential MCP to fail the evaluation. The fall-back position in this circumstance is likely to be to move to a Competitive Tender.

6.11 The alternative to using a managed process to identify the MCP is to run a Competitive Tender following a formal procurement process. For complex requirements or those requiring innovation, a dialogue process can be followed to enable discussion with bidders about possible solutions.

6.12 From a procurement law perspective, running a Competitive Tender (with or without a mandated element) is the option which presents the lowest risk since it involves an objective assessment of a range of bids in which quality and value for money are assessed and in which all interested parties can take part. The lower risk of challenge needs to be balanced against identified key risks however, including the possible de-stabilisation of services and reputational risk.

6.13 It would be possible to mandate the use of a particular provider within the chosen service delivery model, with the mandated provider having been identified using Competitive Tendering or via the Most Capable Provider Option.

(Approved by: Gabriel MacGregor, Head of Corporate Law on behalf of the Council Solicitor and Monitoring Officer)

7 HUMAN RESOURCES IMPACT

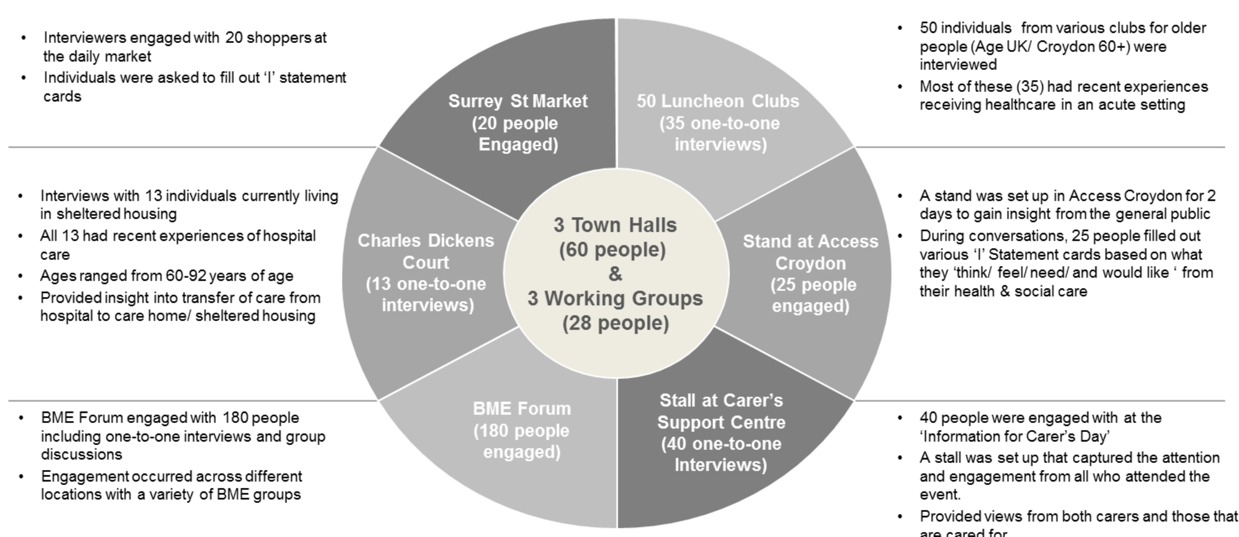
7.1 There is no immediate HR impact on LBC staff as a result of the recommendations in this report. However in future, the Council would need to determine the most appropriate way to ensure that it optimally adapts to working in this efficient and outcomes driven way; in this regard any proposals that would subsequently have a material impact on staff should be referred to Human Resources and adhere to all Council policies and procedures.

(Approved by: Michael Pichamuthu on behalf of the Director of Human Resources)

8 EQUALITIES IMPACT

Engagement to develop outcomes that matter to residents in Croydon

8.1 As set out in section 4, over 400 people in Croydon have been engaged in the process. This involved patients and service users over 65, carers and other members of the public. The activities have been summarised below and a full engagement report is available in background document 3.



8.2 The aim of this programme and the outcome s, outcome goals and indicators that have been generated as a result of this engagement also reflect the indicators set out in the Council's Equality Strategy. These outcomes will be used to monitor and reward provider performance over the lifetime of the contract. This will enable and incentivise improved service delivery for older people within Croydon:

Equality Strategy Indicators

To improve health and social care by providing better care in later life:

- Social care clients receiving self directed support (giving local people the option of deciding how their personal budget for care is spent)
- People who say they are treated with respect and dignity in their treatment
- Up take of flu jabs
- Achieving independence through rehabilitation/intermediate care
- Support older people to live independently
- Proportion of deaths at home
- People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently

Outcomes for over 65s

- Able to stay healthy and active for as long as possible
- Can access the best quality care available in order to live as I choose and as independent a life as possible
- To be supported by a member of the health and social care team who has had the training and has the specialist knowledge to understand how my health and social care needs affect me
- To be supported as an individual, with services specific to me
- To be supported to manage my long-term condition and experience improved control and reduced complications

Needs of older people in Croydon

8.3 There is a strong case for paying special attention to the group of people who are aged 65 and over in Croydon.

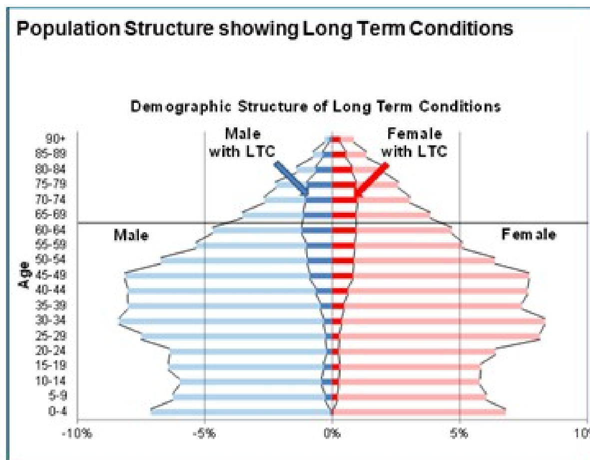
8.4 Croydon has a growing and ageing population, placing increased pressures on the health and care system. The total registered population across Croydon CCG's six geographical networks is currently 377,570. Over 65s represent nearly 13% of this population – 47,390 people[1] and this is expected to grow by more than a fifth in the next 10 years. The pressures on the system from this age group are increasing, and will continue to rise if nothing is done. The number of over 65s living in a care home, for example, is projected to grow by nearly 24% by 2020. A third of this group of people suffer from one or more long term health conditions, imposing significant long term costs on the NHS.

8.5 We also know that improvements are possible based on national benchmarks:

- a measure of the independence of patients living at home is the number of older people still at home 91 days after leaving hospital. For Croydon 65.3% were still at home following discharge in 2012/13 compared with 81.4% for London overall[2];
- patients over 65 account for the majority of all hospital emergency bed days, placing a large cost on the system. There is large potential for high rates of emergency bed use by over 65s to be reduced[3];

8.6 There are also practical reasons for focusing on over 65s as a group. They are a stable group, with low rates of migration in and out of the borough. 98% of older Croydon residents are registered with a local GP and so are easy to identify. Similarly, many existing measures within health and social care already focus on this cohort as 'older adults'

8.7 By focusing on commissioning services that reflect the outcomes that matter for over 65s and developing the appropriate contractual arrangements it is anticipated that the system will be able to respond to these challenges over the next 10 years.



Increase in conditions for people 65+ in Croydon

Metric	Increase by 2016	Increase by 2020
Over 65s with a life limiting Long Term Condition	+ 8.1%	+ 17.6%
Over 65s with depression	+ 8.7%	+ 17.3%
Over 65s with Dementia	+ 10.8%	+ 24.7%
Over 65s suffering from a fall	+ 9.8%	+ 20.1%
Over 65s hospitalised because of a fall	+ 7.1%	+ 17.4%
Over 65s unable to manage at least one self-care activity	+ 9.2%	+ 19.5%
Over 65s living in a care home	+ 10.2%	+ 23.9%
Over 65s living alone	+ 8.2%	+ 17.2%

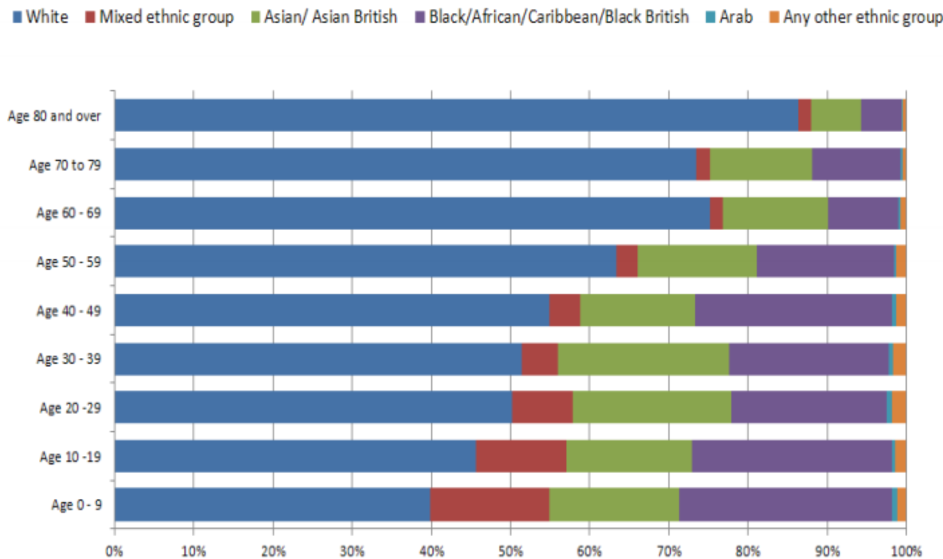
Source: POPPI data: http://www.poppi.org.uk

Summary of population

8.8 The total registered population across Croydon CCG's six geographical networks is currently 377,570. Over 65s represent nearly 13% of this population – 47,390 people[1] and this is expected to grow by more than a fifth in the next 10 years.

8.9 Se set out in the chart below. People over 65 in Croydon are more likely to be white. However, over the next 10 years this profile may change as the percentage of white people decreases[10].

10 http://www.croydonobservatory.org/population/



8.10 About 23% of Older People across Croydon receive pension credit which is has stayed relatively constant since 2004. This is in line with the England average and is below the London average of 29%[11].

8.11 Many Older people will also be affected by other factors including poverty, disadvantage, nationality and ethnicity[12]. In Croydon people of pensionable age receiving pension credit is in-line with the England average (22%) and below the London Average (28%)[13].

Potential impact on Equalities

8.12 Having completed section 1 of the report a further quality analysis is required. This will be initiated as part of phase 3 of the programme (starting October) and will be developed to reflect the outcomes of the dialogue with provider organisations.

8.13 The outputs of the analysis will be published alongside any decision to award a contract and would also be built into any contract monitoring processes. The full impact assessment is attached in appendix 2.

9 ENVIRONMENTAL IMPACT

9.1 The table below sets out considerations against potential environmental impacts

Impact Area	Potential Impact (high / med / low / No Change)	Comments
Energy use and associated carbon dioxide	No immediate change	As a result of the recommendations set out in

11 http://www.croydonobservatory.org/profiles/profile?profileId=57

12 http://www.jrf.org.uk/sites/files/jrf/older-people-support-full.pdf

13 http://www.croydonobservatory.org/profiles/profile?profileId=57

emissions		this report it is anticipated that there will be no immediate change to the environmental areas set out in this table. The future model for health and care services will be defined during phase 3 and this may identify opportunities to improve environmental impact. Full details will be scoped during phase 3 and outlined in the report to Cabinet
Water use	No immediate change	
Use of natural resources	No immediate change	
Pollution to air, land or water	No immediate change	
Waste	No immediate change	
Transport	No immediate change	
Biodiversity	No immediate change	

10 CRIME AND DISORDER REDUCTION IMPACT

10.1 There are no Crime and Disorder reduction impacts as a result of this report

11 REASONS FOR RECOMMENDATIONS/PROPOSED DECISION

11.1 To support the delivery of integrated care health and care economies need to consider a different approach to contracting. The recent Independent Commission suggested that the system needs to align incentives and measure performance in ways that reward early intervention and prevention and - in the long term – the sustained wellbeing of older people

11.2 In response to the ‘independence’ and ‘liveability’ challenges the Council and CCG have been working hard to achieve integration both in commissioning (through the formation of an Integrated Commissioning Unit[14]) and at the point of service delivery through multi-disciplinary teams

11.3 The recommendations set out in this report build on the work completed to date to improve health and care services for patients and service users who are over 65 in Croydon. A significant proportion of the money spent by the NHS and social care is on this group of people, who for the most part (but by no means exclusively) are experiencing the diseases and related conditions of old age. Most people over 65 have more than one long term condition, over 75 two or more.

12 OPTIONS CONSIDERED AND REJECTED

12.1 Throughout the development of the report a range of options were developed through consultation and reviews of other health and care

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14 Link to the original Cabinet paper proposing the establishment of the integrated commissioning unit: https://secure.croydon.gov.uk/akscroydon/users/public/admin/kab12.pl?operation=SUBMIT&meet=17&cmte=CAB&grpid=public&arc=1

economies. These were, then considered in working groups consisting of senior officers of the Council and CCG. The table below summarises the options considered for the appropriate sections of the report along with the preferred option. The full appraisal of these options is set out in the full report that has been provided as background.

Section	Options considered	Preferred Option
Outcomes that matter	Throughout the outcome design a number of potential outcomes and combinations of indicators were developed. Through working groups with the public, clinicians and technical teams a preferred shortlist was generated.	The proposed outcome framework is set out in the report and attached as a background document
Delivery Model	Three main options have been considered: • prime contractor; • alliance; • joint venture. These models were chosen as they represent the spectrum of models available. While commissioners can state a preference it is possible that the provider(s) could propose a model that is a hybrid of these.	The preferred model is a provider alliance which is a hybrid of alliance and joint venture models. This will be used to inform the contracting approach.
Payment Mechanism	Based on international evidence there are four main options for consideration. These are: 1. Fee for activity 2. Episode based payments 3. Block Payments (Service based & no financial sanctions) 4. Capitation and outcome	The preferred option is for a capitation and outcome payment mechanism as this best supports the delivery of the project objectives.
Contract Duration	Based on examples from the UK and internationally. To date, Outcome Based contracts in the UK have been, or are intending to be, let for 5 years – with the exception of Staffordshire (10 years). Internationally contract duration is typically longer – a minimum of 10 years.	Drawing on this evidence it is therefore intended to develop a contract for 8 years with a possible extension of 2 years (8+2). The initial 8 year contract includes any time needed for shadow running before full contract commencement.
Implementation	There were two main options that have been considered during this process:	The preferred approach is the MCP

	1. Full Competitive Dialogue process 2. Most Capable Provider(s) (MCP) approach	approach

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BACKGROUND PAPERS - LOCAL GOVERNMENT ACT 1972
Appendices:

1. Proposed outcome framework for over 65s in Croydon
2. Improving health and social care outcomes for over 65s in Croydon: Equalities analysis

Background documents exempt

Appendix 1: Proposed Outcome Framework for over 65s

This appendix summarises the outcomes, outcome goals and potential outcome indicators for the use in a contract for services for over 65s in Croydon. It should be considered alongside the phase 2 report on '*Improving health and social care outcomes for over 65s in Croydon: A new approach to commissioning integrated provision'.*

Outcome 1: I want to stay healthy and active for as long as possible

Ref	Outcome Goal	ndicatorIncentivised	Ref	Potential Outcome Indicator	Source
1.1	manage memory loss & dementia		1.1.1	Estimated diagnosis rate for people with dementia	PHOF
1.2	eat well and keep active from a younger age	I	1.2.1	Proportion of physically active people over age 55, 65, 75 years	PHOF/Sport England's Active People Survey
1.3	access information, that is consistent, in a format that is accessible and understandable to me		1.3.1	Proportion of patients and carers who report that they know who the first point of contact or lead professional was for all aspects of their care.	Cambridgeshire (CCG to implement survey)
1.4	expect and access proactive and preventative care	I	1.4.1	Injuries due to falls in people aged 65 and over	PHOF/data from the Information Centre for Health and Social Care - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates
			1.4.2	Proportion of people in scope who state they found it easy to find information and advice about support, services or benefits	ASCOF/Carers Survey
			1.4.3	Proportion of those people who received short-term services during the year, where no further request was made for ongoing support	ASCOF
			1.4.4	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services	ASCOF
			1.4.5	Enable Older people to get major aids and adaptions to their homes	Local Croydon LBC Indicator
			1.4.6	Percentage of items of equipment and adaptations delivered within 7 working days	Local Croydon LBC Indicator
1.5	feel that my wider social networks [including faith groups] are involved and supported to help me stay well		1.5.1	Proportion of patients and their carers who report they were told about other services that were available to someone in their circumstances, including voluntary sector services, District Council services (including housing support) and local community support or activities.	Cambridgeshire (CCG to implement survey)
1.6	feel that I and my family are supported to help me stay well		1.6.1	The proportion of carers who report that they have been included or consulted in discussion about the person they care for	ASCOF/Carers Survey
			1.6.2	Proportion of people in scope who found it easy to find information and advice about support, services or benefits	ASC survey
			1.6.3	Proportion of people in scope who report that they are satisfied with the care and support services they receive	ASC survey

			1.6.4	Proportion of those people who received short-term services during the year, where no further request was made for ongoing support	ASCOF/Carers Survey
1.7	access appropriate choices about services		1.7.1	Proportion of patients and carers who agree that: - they have been involved in the planning of their care and are aware of the treatment options available; - they understand all the elements of their care, including the medicines they have been prescribed; - their choices and preferences are reflected in their care plan.	Cambridgeshire (CCG to implement survey)
1.8	have equality of access to services regardless of where I live and my financial status		1.8.1	Proportion of patients who indicate that they were able to obtain a consultation with a GP within 2 working days	GP Patient survey
			1.8.2	Access to community mental health services by people from BME groups	CCG Outcome Framework
1.9	live as active a life as possible	I	1.9.1	Number and rate of unplanned (or avoidable) acute admissions in people age 65 years or more	Hospital Episode Statistics
		I	1.9.2	Health related quality of life in people over 65 with long term conditions	Adult Social Care Survey (ASCS)
		I	1.9.3	Life expectancy at age of 75 for males and females	Office for National Statistics
		I	1.9.4	Rate of unplanned hospitalisations per 100,000 population aged 65 and over for chronic ambulatory care sensitive conditions	NHAIS (Exeter) Systems & Hospital Episode Statistics (HES) Continuous Inpatient Spells (CIP)
1.10	live as sociable a life as desired		1.10.1	Proportion of people who use services and their carers who reported that they had as much social contact as they would like	ASCOF/Adult Social care Combined Activity Return
			1.10.2	Self reported wellbeing	PHOF
			1.10.3	Whether the patient was told they had a care plan.	GP Patient survey
1.12	plan for old age - Practically e.g. finances, personal care ...life skills		1.12.1	Is there a plan in place to assist the individual in addressing the necessary life skills to cope with everyday life	Oxfordshire (CCG to implement survey)
1.13	expect and have access to proactive and preventative care	I	1.13.1	Number and rate of excess seasonal deaths	ONS Excess winter mortality index

Outcome 2: I want access to the best quality care available in order to live as I choose and as independent a life as possible

Ref	Outcome Goal	IndicatorIncentivised	Ref	initial Candidate Indicator	Source
2.1	meet my full physical, mental and social potential		2.1.1	Number and rate of hip fractures (or fragility fractures) in people aged 65 years of more	HES
			2.1.2	Proportion of adults in contact with secondary mental health services who live independently, with or without support	ASCOF/Adult Social care Combined Activity Return
		I	2.1.3	Proportion of people aged 65 and over who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services.	ASCOF/Adult Social care Combined Activity Return
		I	2.1.4	% people in the target population at home 31 / 91 days after discharge to place of care other than home.	HES
		I	2.1.5	Emergency readmissions within 30 days of discharge from hospital for those aged 65 and over.	HES
2.2	plan for a more dependent future... whilst I can		2.2.1	Is there a plan in place to assist the individual in addressing the necessary life skills to cope with everyday life	
2.3	plan for old age - Practically e.g. finances, personal care ...life skills		2.3.1	Is there a plan in place to assist the individual in addressing the necessary life skills to cope with everyday life (no data source)	
2.4	live "at home, not in a home" for as long as safely possible and for as long as I choose, including by self-care		2.4.1	Deaths at home from all causes: percent, all ages, 3-year average	HSCIC Compendium
		I	2.4.2	Intensive home care as a percentage of intensive home and residential care	Collection method to be developed by CCG
			2.4.3	% increase in people remaining at home	Croydon Strategy
			2.4.4	Permanent admissions to residential and nursing care homes, per 100,000 population	ASCOF/Adult Social care Combined Activity Return
			2.4.5	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services	ASCOF
			2.4.6	Percentage of vulnerable people who are supported to maintain independent living	NI_142
			2.4.7	Permanent admissions to residential and nursing care homes, per 100,000 population	ASCOF
			2.4.8	Enable Older people to get major aids and adaptions to their homes	Local Croydon LBC Indicator
			2.4.9	Percentage of items of equipment and adaptations delivered within 7 working days	Local Croydon LBC Indicator
			2.4.10	Percentage of people dying at home	
2.5	know how to access services		2.5.1	Proportion of patients and carers who report that they know who the first point of contact or lead professional was for all aspects of their care.	Cambridgeshire (CCG to implement survey)
2.6	feel that my wider social networks [including faith groups] are involved and supported to help me stay well		2.6.1	Proportion of patients and their carers who report they were told about other services that were available to someone in their circumstances, including voluntary sector services, District Council services (including housing support) and local community support or activities.	Cambridgeshire (CCG to implement survey)

2.7	feel safe in my home		2.7.1	The proportion of people who use services who feel safe	ASCOF/Adult Social care Combined Activity Return
			2.7.2	Percentage of concluded safeguarding investigations where action under safeguarding resulted in risk reduction or removal	Local Croydon LBC Indicator
2.8	feel safe in my community		2.8.1	Proportion of people who use services who say that those services have made them feel safe and secure	ASCOF/Adult Social care Combined Activity Return
2.9	can access opportunities to meet my desire for social activities & choose when and where I meet others and socialise		2.9.1	Proportion of people who use services and their carers who reported that they had as much social contact as they would like.	ASCOF/Adult Social care Combined Activity Return
2.10	Expect that their carers and families feel supported to help people to maintain my wellbeing		2.10.1	Overall satisfaction of carers with social services	ASCOF/Carers Survey
		I	2.10.2	The proportion of carers who report that they have been included or consulted in discussion about the person they care for	ASCOF/Carers Survey
2.11	access transport and travel options		2.11.1	Proportion of over 65s who know how to access transport options available to them	No data source identified
			2.11.2	proportion of people in scope who report that they can get to all the places in their local area that they want to	ASC survey
2.12	access respite care when needed		2.12.1	Number of caregivers who receive in-home respite service for a minimum of 4 hours per week	No data source identified
			2.12.2	Percentage of caregivers who agree they have the support and resources needed to continue caregiving for at least 6 more months	No data source identified
2.13	access appropriate housing		2.13.1	Number of people over 65 living in temporary accommodation	No data source identified
			2.13.2	Number / % of over 65s who are effectively homeless	No data source identified
			2.13.3	Enable Older people to get major aids and adaptions to their homes	Local Croydon LBC Indicator
			2.13.4	Proportion of people in scope who report that their home is designed to meet their needs	ASC Survey
2.14	access appropriate assistive technologies to support my access to services and my independence		2.14.1	Proportion of patients and carers who report that they felt those involved with their care worked as a team (including communicating well together, sharing information and co-ordinating care).	Cambridgeshire (CCG to implement survey)
			2.14.2	Proportion of patients and carers who report that their history and care plan was known and used by all involved in their care.	Cambridgeshire (CCG to implement survey)
2.15	manage the process of gradual deterioration in: eyesight, hearing & mobility and mental capacity including self care		2.15.1	Percentage of people that received an NHS Health Check of those offered (NHS Health Check programme)	NHS Health Check programme
2.16	experience a timely recovery to maximum possible level of health	I	2.16.1	Emergency readmissions within 30 days of discharge from hospital for those aged 65 and over.	HES
		I	2.16.2	Proportion of people aged 65 and over who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services.	ASCOF/Adult Social care Combined Activity Return

Outcome 3: I want to be supported by a member of the health and social care team who has had the training and has the specialist knowledge to understand how my health and social care needs affect me

Ref	Outcome Goal	Incentivised indicator	Ref	initial Candidate Indicator	Source
3.1	be assured that when something unexpected happens, my next of kin and GPs are contacted early to find out about me		3.1.1	Proportion of patients and carers who report that they felt those involved with their care worked as a team (including communicating well together, sharing information and co-ordinating care).	Cambridgeshire (CCG to implement survey)
			3.1.2	Proportion of patients and carers who report that their history and care plan was known and used by all involved in their care.	Cambridgeshire (CCG to implement survey)
3.2	experience appropriate translation services		3.2.1	Score for patients who reported that when they had important questions to ask a health and social care professional they always got answers they could understand	Measuring for quality improvement
3.3	manage the level of pain experienced		3.3.1	% who feel that their health care provider did everything they could to control pain. (The Royal College of Anaesthetists)	Royal College of Anaesthetists
3.4	expect care from the right person at the right time in the right place	I	3.4.1	% of patients and carers who report that the care they receive is delivered in a place that is convenient / accessible to them	CCG to implement survey
		I	3.4.2	Vulnerable patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	Enhanced Service for avoiding unplanned admissions
3.5	expect care that is on time and punctual		3.5.1	proportion of people who feel that they were seen within a reasonable time	No data source identified
3.6	have appropriate help to navigate my way through the system	I	3.6.1	Proportion of patients and carers who report that they know who the first point of contact or lead professional was for all aspects of their care.	Cambridgeshire (CCG to implement survey)
3.7	expect information that is in line/coordinated with the care I receive		3.7.1	Proportion of patients and carers who report that their history and care plan was known and used by all involved in their care.	Cambridgeshire (CCG to implement survey)
3.8	expect integrated and co-ordinated healthcare, social care and voluntary sector involvement		3.8.1	Did the different people treating and caring for you (such as GP, hospital doctors, hospital nurses, specialist nurses, community nurses) work well together to give you the best possible care?	Cancer Survey 2010
			3.8.2	Proportion of patients and carers who report that their history and care plan was known and used by all involved in their care.	Cambridgeshire (CCG to implement survey)
3.9	expect to be respected and treated as individual even in a group with a similar need	I	3.9.1	The proportion of patients who would recommend their hospital to a friend or family member (the friends and family test)	NHS England
			3.9.2	What are the views of inpatients on whether they were treated with dignity and respect?	NHS surveys - adult inpatient, outpatients

			3.9.3	What are the views of outpatients on whether they were treated with dignity and respect?	NHS surveys - adult inpatient, outpatients
3.10	expect and receive support to ensure appropriate treatment / feel I am a partner in decisions about my care		3.10.1	Patient experience of the doctor involving them in decisions about their care.	GP Patient survey
			3.10.2	Patient experience of the nurse involving them in decisions about their care	GP Patient survey
3.11	expect that the care I receive will be safe		3.11.1	(Directly standardised) Mortality rate number of people over 75 years of age from potentially avoidable causes	ONS
3.12	expect to be respected as a whole person (holistically) and not a single condition including social, cultural and psychological aspects		3.12.1	Proportion of patients and their carers who are in contact with services and report that they are treated with respect and dignity by all staff involved in their care.	Cambridgeshire (CCG to implement survey)
3.13	expect to have a plan in place that anticipates crises		3.13.1	Proportion of patients and carers who agree that: - they have been involved in the planning of their care and are aware of the treatment options available; - they understand all the elements of their care, including the medicines they have been prescribed; - their choices and preferences are reflected in their care plan.	Cambridgeshire (CCG to implement survey)
			3.13.2	Proportion of people aged 65 years of over with a care plan who report they know what to do and who to contact in an emergency.	Oxfordshire (CCG to implement survey)
			3.13.3	Proportion of older people using services (or their carer) that report: o there is a care plan o that they have been involved in producing o that the care plan describes service aims that they recognise and agree with o that progress towards those outcomes is a good or better than expected	Oxfordshire (CCG to implement survey)
3.15	receive information that is in line/coordinated with the care I receive		3.15.1	Patients and carers report that: - they were not in hospital or a care setting for longer than medical necessary - their care was arranged and co-ordinated without unnecessary delays.	Cambridgeshire (CCG to implement survey)
3.16	expect to receive good care when in a crisis		3.16.1	Patient experience of A&E services	NHS Outcomes Framework

Outcome 4: I want to be supported as an individual, with services specific to me

Ref	Outcome Goal	Incentivised indicator	Ref	initial Candidate Indicator	Source
4.1	expect care from the right person at the right time in the right place		4.1.1	Number of people with terminal conditions who die within 24hours of admission to hospital	HES
			4.1.2	Proportion of patients and carers who report that they felt those involved with their care worked as a team (including communicating well together, sharing information and co-ordinating care).	Cambridgeshire (CCG to implement survey)
4.2	expect consistency of care between providers		4.2.1	Did the different people treating and caring for you (such as GP, hospital doctors, hospital nurses, specialist nurses, community nurses) work well together to give you the best possible care?	Cancer Survey 2010
			4.2.2	Proportion of patients and carers who report that they know who the first point of contact or lead professional was for all aspects of their care.	Cambridgeshire (CCG to implement survey)
			4.2.3	Proportion of patients and carers who report that their history and care plan was known and used by all involved in their care.	Cambridgeshire (CCG to implement survey)
4.3	access information, that is consistent, in a format that is accessible and understandable to me		4.3.1	Proportion of people and carers aged 65 years or more understand what care and support they are supposed to have	Oxfordshire (CCG to implement survey)
4.4	expect integrated and co-ordinated healthcare, social care and voluntary sector involvement		4.4.1	Did the different people treating and caring for you (such as GP, hospital doctors, hospital nurses, specialist nurses, community nurses) work well together to give you the best possible care?	Under development nationally
			4.4.2	Proportion of patients and carers who report that they know who the first point of contact or lead professional was for all aspects of their care.	Cambridgeshire (CCG to implement survey)
			4.4.3	Proportion of patients and carers who report that their history and care plan was known and used by all involved in their care.	Cambridgeshire (CCG to implement survey)
4.5	expect that the care I receive will be safe		4.5.1	NHS '"Safety Thermometer" scores	NHS England
4.6	expect my feedback will be listened to and effect change where appropriate		4.6.1	Proportion of patients who know where to access information on how their health and social care provider has addressed complaints	No data source identified
4.7	expect to be respected as a whole person (holistically) and not a single condition including social, cultural and psychological aspects		4.7.1	Proportion of patients and their carers who are in contact with services and report that they are treated with respect and dignity by all staff involved in their care.	Cambridgeshire (CCG to implement survey)
4.8	experience care that is tailored to me, physically psychologically and socially, including with regard to issues around privacy		4.8.1	The proportion of patients who would recommend their hospital to a friend or family member (the friends and family test)	NHS England
			4.8.2	Proportion of people using services who report they were treated with dignity, compassion and respect	Oxfordshire (CCG to implement survey)
4.9	experience care that is timely including to prevent deterioration and promote recovery		4.9.1	Emergency readmissions within 30 days of discharge from hospital for those aged 65 and over.	HES
			4.9.2	Proportion of people aged 65 and over who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services.	ASCOF/Adult Social care Combined Activity Return
			4.9.3	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services	ASCOF

			4.9.4	proportion of those people who received short-term services during the year, where no further request was made for ongoing support	ASCOF
4.10	experience consistency of care between carers		4.10.1	Did the different people treating and caring for you (such as GP, hospital doctors, hospital nurses, specialist nurses, community nurses) work well together to give you the best possible care?	Cancer Survey 2010
			4.10.2	Proportion of patients and carers who report that they know who the first point of contact or lead professional was for all aspects of their care.	Cambridgeshire (CCG to implement survey)
			4.10.3	Proportion of patients and carers who report that their history and care plan was known and used by all involved in their care.	Cambridgeshire (CCG to implement survey)
4.11	feel supported to care for myself where appropriate		4.11.1	Proportion of people using social care who receive self-directed support, and those receiving direct payments	ASCOF/Adult Social care Combined Activity Return
			4.11.2	Enable Older people to get major aids and adaptions to their homes	Local Croydon LBC Indicator
			4.11.3	Percentage of vulnerable people who are supported to maintain independent living	NI_142
4.12	feel I am a partner in decisions about my care, including identifying risks		4.12.1	Patient experience of the doctor involving them in decisions about their care.	GP Patient survey
			4.12.2	Patient experience of the nurse involving them in decisions about their care.	GP Patient survey
4.13	receive information that is in line/coordinated with the care I receive		4.13.1	Proportion of patients and carers who report that they felt those involved with their care worked as a team (including communicating well together, sharing information and co-ordinating care).	Cambridgeshire (CCG to implement survey)
			4.13.2	Proportion of patients and carers who report that their history and care plan was known and used by all involved in their care.	Cambridgeshire (CCG to implement survey)

Outcome 5: To be supported to manage my long-term condition and experience improved control and reduced complications

Ref	Outcome Goal	Incentivised indicator	Ref	initial Candidate Indicator	Source
5.1	meet my full physical, mental and social potential		5.1.1	Returning to usual place of residence following hospital treatment: fractured proximal femur	HSCIC Compendium
			5.1.2	Returning to usual place of residence following hospital treatment: stroke	HSCIC Compendium
5.2	live "at home, not in a home" for as long as safely possible and for as long as I choose, including by self-care		5.2.1	Number and % of people with stroke reporting improvement in activity	No data source identified
5.3	expect high quality services that are appropriate to me		5.3.1	NHS '"Safety Thermometer" scores	NHS England
5.4	Long-term conditions	I	5.4.1	Proportion of people with a long term condition screened each year for depression, anxiety and other common mental health disorders	HES
5.5		I	5.5.1	Quality of life measurement in people aged over 65 (EQ5D) – annual measurement (undertaken, e.g. at same time as flu vaccination)	CCG to implement survey
5.6		I	5.6.1	Percentage of people aged 65 and over that have had enough support from local services or organisations in the last 6 months to help manage their condition(s)	Quality Watch
5.7		I	5.7.1	Rate of unplanned hospitalisations per 100,000 population aged 65 and over for chronic ambulatory care sensitive conditions	NHAIS (Exeter) System/HES
5.8		I	5.8.1	Proportion of people with a written care plan, agreed with their GP, nurse and/or other healthcare professional, and used to manage their health day to day	Enhanced Service for avoiding unplanned admissions
5.9	End of Life		5.9.1	Bereaved carers' views on the quality of care in the last three months of life	ONS Bereavement survey
5.10	Falls/Fragility Fractures		5.10.1	Proportion of people aged 65 and over who have had a 'Timed Up & Go' test and/or a 'Turn 180° test' and an appropriate onward care plan based on the results	
			5.10.2	Number and rate of hip fractures (or fragility fractures) in people aged 65 years of more	Clinical outcome (CDS/SUS data)
			5.10.3	Proportion of individuals aged 65 and over who have experienced a fall who experience another fall which results in injury within six months. (Clinical outcome	(CDS/SUS data)
5.11	Diabetes		5.11.1	Proportion of people with diabetes who, in the last 12 months, have had recorded measurements of their blood glucose, blood pressure and cholesterol, and have an appropriate onward care plan based on the results	QOF
			5.11.2	Proportion of people with diabetes who experience a complication of diabetes	
			5.11.3	% of people over 65 with diabetes admitted in a diabetic emergency readmitted for a diabetic emergency within 30 days	CCG Measure
			5.11.4	People over 65 with diabetes admitted with ketoacidosis per 10,000 patients	CCG Measure

5.12	COPD		5.12.1	Proportion of people with COPD who regularly complete an appropriate COPD 'wellness' measure, such as the CCQ (Clinical COPD Questionnaire) and use it to monitor their COPD status and develop a care plan with their healthcare professionals	No data source identified
			5.12.2	Proportion of emergency COPD hospital admissions	CCG Measure
5.13	Cardiovascular Disease		5.13.1	Heart failure: Proportion of people with heart failure that have access to a specific disease management programme that includes structured education, support and follow-up for patients, especially after diagnosis and unplanned hospital admission	No data source identified
5.14			5.13.2	Stroke: Proportions of people who have had a stroke that complete and show improvements over time in the Stroke Impact Scale (version 3.0)	No data source identified
5.15	Cancer		5.15.1	Proportion of cancers diagnosed at Stages 1 or 2 (i.e. early diagnosis)	PH Outcomes Framework
5.16	Dementia		5.16.1	Proportion of people with dementia who have been supported to develop person-centred outcomes, which are then monitored and delivered by healthcare services	No data source identified

Appendix 2: Equality Analysis Form

An Equality analysis enables us to target our services, and our budgets, more effectively and understand how they affect all our communities. It also helps us comply with the Equalities Act 2010.

For more information about when you should carry out an equality analysis, who should do this and the support available, go to the equality analysis intranet page.

This form has four sections

1: decide whether a full equality analysis is needed. If not, you do not complete sections 2-4.
2: gathering evidence
3: determining actions
4: decision and next steps

Appendix One – Decision-making process

Appendix Two - data broken down by Protected Characteristics

Name of document	**Improving health and social care outcomes for over 65s in Croydon: A new approach to commissioning integrated provision**			
Versio n	Date reviewe d	Date of next review	Reviewed by	Changes made
V1.0	26/08/14			

1. Decide whether a full equality analysis is needed		
1.1 What are you analysing?		
Question	**Guidance**	**Answer**
What is the name of your change or review?	The change or review may involve: o policies, strategies and frameworks o budgets o plans, projects and programmes o staff structures (including outsourcing) o the use of buildings o commissioning (including re-commissioning and de-commissioning) o services (for example, how and where they are delivered) o processes (for example thresholds, eligibility, entitlements, and access criteria)	This EqIA relates to the project to develop an integrated outcome based health and social care contract for over 65s in Croydon. The project is currently at the end of Phase 2 and is recommending that the Council proceeds to phase 3 of the programme which involves drawing up a detailed contract and entering into negotiations with the identified potential provider(s) ahead of contract award. It does not propose any new services or models of care. As such, this project relates to both strategy and commissioning.

Why are you doing this?	For example, we are considering cutting a service.	• To respond to demographic challenges and pressures caused, primarily, by an aging population. • To improve co-ordination of health and care services for over 65s
What is likely to be different when you have finished?		• A greater level of co-ordinated care for complex patients and services users • Greater levels of patient satisfaction • Improved outcomes for patients and service users over 65
What will be the main outcomes or benefits from making this change?		• Population outcomes in relation to quality of life and quality of care • A more sustainable health and care system
What stage is your change at now?	See appendix one for the main stages at which equality analyses need to be started or updated. In many instances, an equality assessment will be started when a report is being written for a committee. If that report recommends that a project or programme takes place, the same equality assessment can be updated to track equality impacts as it progresses. If the project or programme includes commissioning or de-commissioning, the same equality assessment can be updated again.	• Development of procurement strategy report – pre-award.

An equality analysis must be completed before any decisions are made.

If you are not at the beginning stage of your decision making process, you must inform your Director that you have not yet completed an equality analysis.

1.2 Who could be affected and how?

Question	Guidance	Answer
Who are your internal	For example, groups of Council staff, members	• Councillors

stakeholders?		• Adult Social Care Finance and Contract teams • Adult Social Care commissioning teams (including case management and assessment)
Who are your external stakeholders?	For example, groups of service users, service providers, trade unions, community groups and the wider community?	• Service users and patients over 65 • Carers • NHS Providers • Social Care Providers • Croydon Clinical Commissioning Group
Does your proposed change relate to a service area where there are known or potential equalities issues?	Please answer either "Yes", "Don't know" or "No" and give a brief reason for your response. If you don't know, you may be able to find out on the Croydon Observatory (http://www.croydonobservatory.org/)	**Yes**: The proposed project relates to over 65s. This group in particular have an increasing number of Long-Term Conditions. They are also more reliant on health and social care services as well as other community provision. Many will be affected by other factors including poverty, disadvantage, nationality and ethnicity (JRF, 2013). It is important to maintain and improve the level of access older people have to services in Croydon, particularly for those from protected groups. Provider organisations will be expected to demonstrate how these groups are being supported through the delivery of the contract.
Does your proposed change relate to a service area where there are already local or national equality indicators?	You can find out from the Equality Strategy (http://intranet.croydon.net/corpdept/equalities-cohesion/equalities/docs/equalitiesstrategy12-16.pdf). Please answer either "Yes", "Don't know" or "No" and give a brief reason for your response	**Yes**: The aims of this project are to improve health and social care outcomes for over 65s in Croydon. These outcomes have been developed through consultation with the public and reflect the objectives and indicators set out in the equality strategy. As such it aims to have a positive impact in these areas. This project relates to the objective: To improve health and social care by providing better care in later life The indicators within the equality strategy that this project will support to deliver are:

		• Social care clients receiving self-directed support (giving local people the option of deciding how their personal budget for care is spent) • People who say they are treated with respect and dignity in their treatment • Up-take of flu jabs • Achieving independence through rehabilitation/intermediate care • Support older people to live independently • Proportion of deaths at home • People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently
Would your proposed change affect any protected groups more significantly than non-protected groups?	Please answer either "Yes", "Don't know" or "No" and give a brief reason for your response. For a list of protected groups, see Appendix Two.	**Yes**: As the proposed change is related to services over 65 there is potential that this cohort of service users would be affected over-and-above those below a younger age. All protected groups that are over 65 will be incorporated into the contract and the various issues faced by this group would be managed accordingly. The proposed implementation approach reflects the need to maintain the stability of services for the whole population. As such many of these services would still be delivered in Croydon by the same provider. As such it is expected that services for other patient groups will also increase through enhanced integration and co-ordination. The provider(s) would be required to demonstrate this in any plans or proposals. Where the provider(s) propose any significant service alterations then these would be subject to their own EqIA.

Would your proposed change help or hinder the Council in eliminating unlawful discrimination, harassment and victimisation in relation to any of the protected groups?	Please answer either "Yes", "Don't know" or "No" and give a brief reason for your response	**Yes**: The proposals will support the Council to eliminate discrimination as these services will promote independence, dignity in care and diversity. Focusing on measuring the outcomes that have been developed with people in Croydon will support hold providers to account. In addition, through the delivery of services providers should demonstrate how protected groups are being supported.
Would your proposed change help or hinder the Council in advancing equality of opportunity between people who belong to any protected groups and those who do not?	Please answer either "Yes", "Don't know" or "No" and give a brief reason for your response	**Yes**: This project is targeted at over 65s in Croydon who are, on average, higher users of services than adults under 65. Moreover, this age group is more likely to contain more complex patients with both long term health and social care needs. While providers will be incentivised to co-ordinate care for complex patients within this cohort many health and care services will remain universal. As such those service users under 65 will continue to receive the same services as currently provided. Furthermore, it is anticipated that many complex patients under 65 will benefit from increased co-ordination and information systems that will need to be established. Within the over 65 populations there are a number of groups who have different experiences or are less likely to access certain services. It is also important that, when services are being delivered, they are sensitive to different cultural and social needs. This will be opportunity to ensure all providers on the framework have equal opportunity policies and that, for example, staff have been adequately trained to work with people with different disabilities and ethnic backgrounds. In addition, through an annual report published by providers it will be possible to identify the different groups accessing services.

Would your proposed change help or hinder the Council in fostering good relations between people who belong to any protected groups and those who do not?	Please answer either "Yes", "Don't know" or "No" and give a brief reason for your response	**Yes:** Evidence suggests that there is an inter-relationship between physical disability and restriction, loss of social relationships, depression – which together exacerbate functional decline. Services and/or support that focus on more than one aspect of need are likely to be more effective. This project incentivises providers to deliver joined up, co-ordinated care for this population group which will include the need to address social isolation. As such this should promote dignity in care and improve positive attitudes towards people with disabilities.

1.3 Decision

If you answer "yes" or "don't know" to ANY of the questions in section 1.2, you should undertake a full equality analysis. This is because either you already know that your change or review could have a different/significant impact on protected groups (compared to non-protected groups) or because you don't know whether it will (and it might).

Decision	Guidance	Response
No, further equality analysis is not required	Please state why not and outline the information that you used to make this decision. Statements such as ‘no relevance to equality’ (without any supporting information) or ‘no information is available’, could leave the Council vulnerable to legal challenge. **You must include this statement in any report used in decision making, such as a Cabinet report**	

Yes, further equality analysis is required	Please state why and outline the information that you used to make this decision. Also indicate - when you expect to start your full equality analysis - the deadline by which it needs to be completed (for example, the date of submission to Cabinet). - where and when you expect to publish this analysis (for example, on the Council website). **You must include this statement in any report used in decision making, such as a Cabinet report.**	Having completed section 1 of the report a further quality analysis is required. This will be initiated as part of phase 3 of the programme (starting October) and will be developed to reflect the outcomes of the dialogue with provider organisations. The outputs of the analysis will be published alongside any decision to award a contract and would also be built into any contract monitoring processes.
Officers that must approve this decision	Name and position	Date
Report author		
Director		
Please email this completed form to data.equalities@croydon.gov.uk, together with an email trail showing that the your director has approved it.		
1.4 Feedback from the corporate equalities team		
Name of equalities officer		
Date received by equalities officer	Please send an acknowledgement	
Should a full equality analysis be carried out?	Note the reasons for your decision	
Please send this document to **- the person responsible for making the decision** **- democratic services, the corporate programme office or procurement as appropriate in time for the relevant decision making meeting**		

2. Evidence Considered

List the documents and information that have been considered as part of this review to enable reasonable judgments to be made on the assessment of impact.

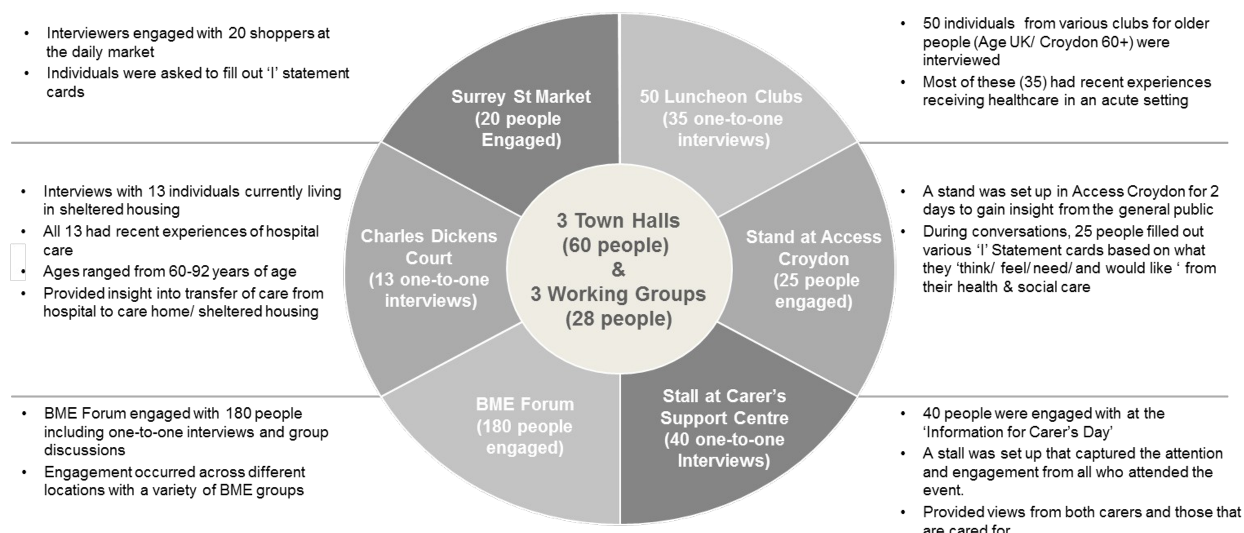
This section needs to include consultation data and desktop research (local and national data).

Quantitative Data	Qualitative Data

A summary of the qualitative and quantitative data collected as part of this project is set out below.

Engagement to develop outcomes that matter to residents in Croydon

As set out in section 4, over 400 people in Croydon have been engaged in the process. This involved patients and service users over 65, carers and other members of the public. The activities have been summarised below and a full engagement report is available in background document 3.



The aim of this project and the outcome s, outcome goals and indicators that have been generated as a result of this engagement also reflect the indicators set out

in the Council's Equality Strategy. These outcomes will be used to monitor and reward providers performance over the lifetime of the contract. This will enable and incentivise improved service delivery for older people within Croydon:

Equality Strategy Indicators

To improve health and social care by providing better care in later life:

- Social care clients receiving self directed support (giving local people the option of deciding how their personal budget for care is spent)
- People who say they are treated with respect and dignity in their treatment
- Up take of flu jabs
- Achieving independence through rehabilitation/intermediate care
- Support older people to live independently
- Proportion of deaths at home
- People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently

Outcomes for over 65s

- Able to stay healthy and active for as long as possible
- Can access the best quality care available in order to live as I choose and as independent a life as possible
- To be supported by a member of the health and social care team who has had the training and has the specialist knowledge to understand how my health and social care needs affect me
- To be supported as an individual, with services specific to me
- To be supported to manage my long-term condition and experience improved control and reduced complications

Needs of older people in Croydon

There is a strong case for paying special attention to the group of people who are aged 65 and over in Croydon.

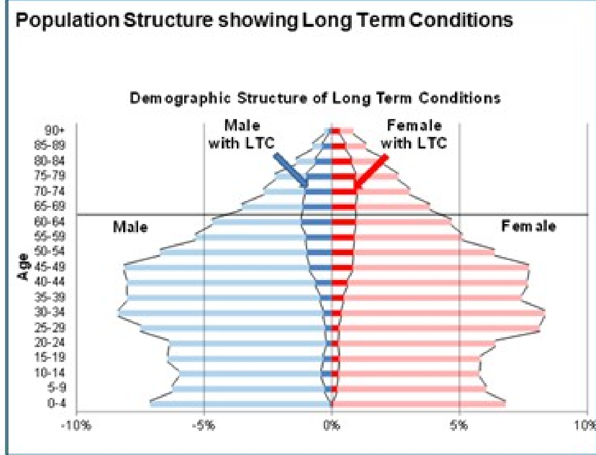
Croydon has a growing and ageing population, placing increased pressures on the health and care system. The total registered population across Croydon CCG's six geographical networks is currently 377,570. Over 65s represent nearly 13% of this population – 47,390 people[1] and this is expected to grow by more than a fifth in the next 10 years. The pressures on the system from this age group are increasing, and will continue to rise if nothing is done. The number of over 65s living in a care home, for example, is projected to grow by nearly 24% by 2020. A third of this group of people suffer from one or more long term health conditions, imposing significant long term costs on the NHS.

We also know that improvements are possible based on national benchmarks:

- a measure of the independence of patients living at home is the number of older people still at home 91 days after leaving hospital. For Croydon 65.3% were still at home following discharge in 2012/13 compared with 81.4% for London overall[2];
- patients over 65 account for the majority of all hospital emergency bed days, placing a large cost on the system. There is large potential for high rates of emergency bed use by over 65s to be reduced[3];

There are also practical reasons for focusing on over 65s as a group. They are a stable group, with low rates of migration in and out of the borough. 98% of older Croydon residents are registered with a local GP and so are easy to identify. Similarly, many existing measures within health and social care already focus on this cohort as 'older adults'

By focusing on commissioning services that reflect the outcomes that matter for over 65s and developing the appropriate contractual arrangements it is anticipated that the system will be able to respond to these challenges over the next 10 years.



Increase in conditions for people 65+ in Croydon

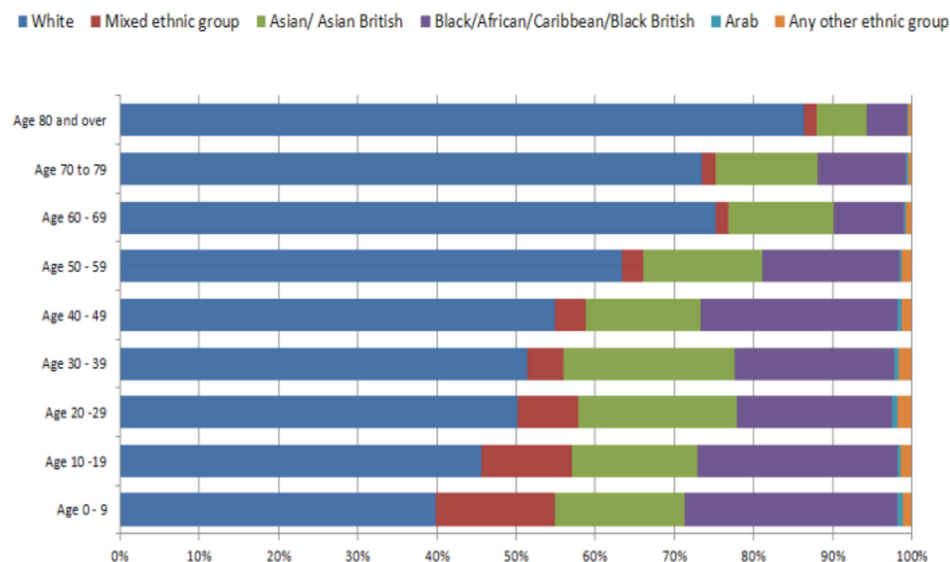
Metric	Increase by 2016	Increase by 2020
Over 65s with a life limiting Long Term Condition	+ 8.1%	+ 17.6%
Over 65s with depression	+ 8.7%	+ 17.3%
Over 65s with Dementia	+ 10.8%	+ 24.7%
Over 65s suffering from a fall	+ 9.8%	+ 20.1%
Over 65s hospitalised because of a fall	+ 7.1%	+ 17.4%
Over 65s unable to manage at least one self-care activity	+ 9.2%	+ 19.5%
Over 65s living in a care home	+ 10.2%	+ 23.9%
Over 65s living alone	+ 8.2%	+ 17.2%

Source: POPPI data: http://www.poppi.org.uk

Summary of population

The total registered population across Croydon CCG's six geographical networks is currently 377,570. Over 65s represent nearly 13% of this population – 47,390 people[1] and this is expected to grow by more than a fifth in the next 10 years.

Se set out in the chart below. People over 65 in Croydon are more likely to be white. However, over the next 10 years this profile may change as the percentage of white people decreases[15].



About 23% of Older People across Croydon receive pension credit which is has stayed relatively constant since 2004. This is in line with the England average and is below the London average of 29%[16].

Many Older people will also be affected by other factors including poverty, disadvantage, nationality and ethnicity[17]. In Croydon people of pensionable age receiving

15 http://www.croydonobservatory.org/population/

16 http://www.croydonobservatory.org/profiles/profile?profileId=57

pension credit is in-line with the England average (22%) and below the London Average (28%)[18].

There is an inter-relationship between physical disability and restriction, loss of social relationships, depression – which together exacerbate functional decline. So services/support that focus on more than one aspect of need are likely to be more effective[19]

While not age specific there are a number of other areas that will be need to be monitored and considered throughout the contracting and delivery process[20]

Access

- 42% of gay men, 43% of lesbians and 49% of bisexual men and women have clinically recognised mental health problems compared with rates of 12% and 20% for predominantly heterosexual men and women 4 lesbian, gay and bisexual people may, for example, be reluctant to disclose their sexual orientation to their GP, because they anticipate discrimination, and then fail to receive appropriate health care.

- Type 2 diabetes is 3.5 times more prevalent in South Asians than Europeans. However, a Diabetes UK survey of South Asian members found that only 16% of those responding had attended a course to help manage their diabetes

- Personal Social Services Adult Social care Survey results informed the integrated framework for community based services[21] indicated that high numbers of clients using domiciliary care are white women over 70. There are more categorised under the 'White' ethnic group (323 or 69.9% of the total), than all

17 http://www.jrf.org.uk/sites/files/jrf/older-people-support-full.pdf

18 http://www.croydonobservatory.org/profiles/profile?profileId=57

19 http://www.jrf.org.uk/sites/files/jrf/1954-older-people-services.pdf

20 http://www.england.nhs.uk/wp-content/uploads/2013/08/6eds-equal-anal2011.pdf).

21 http://www.croydon.gov.uk/contents/departments/community/pdf/eqia/eaframewok.pdf

remaining ethnic groups combined. There is almost double the number of white females than males. In addition, there are more white females alone than the total numbers of non-white ethnic groups.

Patient Experience

- According to the NHS In Patient Survey, Asian/Asian British patients were 20% less likely to give a positive response to the question "Overall, did you feel you were treated with respect and dignity while you were in the hospital?" when compared to the White British group. This is similar for emergency departments.
- A 2013 report by Croydon BME Forum recommended that Mental Health providers should 'provide services which offer patient-centred care, which accounts for individual needs and involves service users in all decisions about treatment and medication[22].
- People from black and minority ethnic groups equally want access to individualised services, as above, but may have particular needs, for example for interpretation, sharing experiences in community centres or information[23]
- Older people from black and minority ethnic communities stress that they want access to the same services as everybody else, but that they also want understanding that some services must be responsive to religion and culture[24]
- There is a widening diversity amongst the 65+ age group as the gap between male and female life expectancy narrows and the UK's black and minority ethnic communities age. There is also increasing variation in people's lifestyles and domestic arrangements, with more 'out' lesbian and gay older people (some of whom are in civil partnerships) and more people who are divorced or who never married. A recent Joseph Rowntree Foundation Report[25] states; *'Good services strike the balance between appreciating a person's individuality whilst also understanding them as members of different groups, communities and networks'.*

Potential impact on patients and service users under 65

While there is a strong case for focusing service improvements on patients over the age of 65. Through the development of this contract and any associated service models consideration should be given to any potential impact for patients and service users under the age of 65.

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22 http://www.offtherecordcroydon.org/media/16451/mind_the_gap_web.pdf

23 http://www.jrf.org.uk/sites/files/jrf/1954-older-people-services.pdf

24 http://www.jrf.org.uk/sites/files/jrf/1954-older-people-services.pdf

25 http://www.jrf.org.uk/sites/files/jrf/older-people-support-full.pdf

2.1 Analysing Impact

Use the table below plot and identify where there is a potential impact on any of the staff and customers/service users by protected characteristic arising from the change.

The cells of the matrix should be filled in as below:

Key	
O	Indicates where the impact is unknown on Service Users/Staff, This is due to evidence not being available to indicate otherwise (neither positive nor negative impact).
P	Indicates the change may have a potential Positive Impact on Service Users/Staff
N	Indicates the change may have a potential Negative Impact on Service Users/Staff
P/N	Indicates the change may have both Positive and Negative Impacts on Service Users/Staff

		Protected Characteristics								
Services		**Age**	**Disability**	**Gender Reassignment**	**Pregnancy and Maternity**	**Race**	**Religion and Belief**	**Sex**	**Sexual Orientation**	**Marriage and Civil Partnership**
Service Provision	**Availability**	P/N	P	P	O	P	P	P	P	O
	Experience	P/N	P	P	O	P	P	P	P	O

Services		Protected Characteristics								
		Age	Disability	Gender Reassignment	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation	Marriage and Civil Partnership
	Access	P/N	P	P	O	P	P	P	P	O
	Independence	P/N	P	P	O	P	P	P	P	O

Description of Impact – Service User Related				
Service Area	**Protected Group**	**Description of Potential Positive Impact**	**Description of Potential Negative Impact**	**Evidence Source**
All	Patients and Service Users over 65	This proposal could enable and incentivise provider organisations to improve care for over 65s in Croydon. These improvements would take into account access and patient experience of the whole population. It will also help address the specific challenges this group face such as independence.		http://www.croydonobservatory.org/population/
All	Patients and service users under 65	Commissioners will continue to procure services for the remainder of the population which are outside the scope of this contract. Many of the same services and pathways will be delivered by the same organisations to the wider population. It is anticipated that patients in different cohorts	The remainder of the population will continue to use health and care services provided in Croydon. There is a risk that developing a larger contract to incentivise integrated services for over 65s may have an impact on this group.	Phase 2 report / Croydon observatory

		will benefit from these proposals. Providers will be asked to demonstrate how they will achieve this.		
Hospital based services	Asian/Asian British patients	Focusing on the delivery of outcomes expressed by patients across Croydon means that provider organisations will be incentivised to improve patient experience for these groups. It is however, important that feedback from these patients is captured.		NHS England: http://www.england.nhs.uk/wp-content/uploads/2013/08/6eds-equal-anal2011.pdf
All	All protected groups	Focusing on the delivery of outcomes expressed by patients across Croydon means that provider organisations will be incentivised to improve patient experience for these groups. It is important that feedback from all groups is captured.		NHS England: http://www.england.nhs.uk/wp-content/uploads/2013/08/6eds-equal-anal2011.pdf
Home care 18+	BME Groups over 65	There are currently a low number of BME groups over 65 accessing home care services. The contracting process offers the opportunity to articulate this challenge and to work with providers to respond.		SWIFT / integrated framework EqIA (http://www.croydon.gov.uk/contents/departments/community/pdf/eqia/eaframewok.pdf)
	Men over 65	There are currently a low number men over 65 accessing home care services. The contracting process offers the opportunity to articulate this challenge and to work with providers to respond.		

Description of Impact – Employment Related				
Service Area	**Protected Group**	**Description of Potential Positive Impact**	**Description of Potential Negative Impact**	**Evidence Source**
Adult Social Care	TBC	The impact on Council staff has not been determined at this stage of the programme and should be revisited during the development of the future operating/delivery model.		Phase 2 Report
Provider Organisations	TBC	As a result of this project new models of care may be developed which could have an impact on staff. These changes have not been quantified at this stage and should be revisited during the development of any future models of care.		Phase 2 Report

2.2 Is there any evidence missing? If so, how will you gather this missing evidence?

If you do not have all the evidence you need to make an informed decision, talk to your departmental equality lead about practical ways to gather it. For example, if you do not have time to conduct a survey, is there a way can increase your understanding before undertaking more robust research at a later date? Perhaps by meeting with stakeholders. The depth and degree of any consultation or research will be determined by the relevance of the change or review to different groups. Those who are likely to be directly affected should be consulted. Read the corporate public consultation guidelines before you begin (http://intranet.croydon.net/finance/customerservices/public_consultation/default.asp).

If you really cannot gather any useful information in time, then note its absence as a potential negative impact and describe the action you will take to gather it in section 3. Insert new rows as required.

Do not continue onto stage 3 until your departmental equality lead is satisfied that you have gathered all the evidence you need.

Protected Group	Evidence missing	Description of potential negative impact
Disability	Further information to capture the number of older people living with a disability is needed	Services should be able to accommodate the needs of disabled people to avoid potential negative impacts. This will include the ability of disabled people over 65 in accessing services.
Gender Reassignment	While it is anticipated that the numbers within this group are low there is limited information about the number of service users in Croydon from this protected group	Without this information it will be difficult to monitor access to services.
Pregnancy and Maternity	N/A	It is not expected that there will be an impact on this group given the scope of the project.
Religion and Belief	Further information about specific barriers faced by each group on their experience of accessing services	Without this information it will be difficult to monitor access to services and their experience of service delivery.

Sexual Orientation	There is limited evidence on the sexual orientation of the over 65 population. However, as set out above it is anticipated that this group will increase through the duration of the contract.	Without this information it will be difficult to monitor access to services and their experience of service delivery.
Marriage and Civil Partnership	N/A	It is not expected that there will be an impact on this group given the scope of the project.

3. Determining Actions

The overall potential impact is the likelihood of the impact multiplied by the strength of that impact. The higher the score, the more significant the impact. The tables below identify actions to be taken to minimise negative impacts or maximise positive impacts within the programme.

Key

Likelihood score		
5	Most certain	In more than 80% of the circumstances
4	Most likely	In 51-80% of circumstances
3	Possible	In 21-50% of circumstances
2	Unlikely	In 6-20% of circumstances
1	Rare	In 5% of circumstances or less

Strength score	Degree of impact	Proportion of protected groups affected
5	Very great impact	Several protected groups in more than one category (e.g. religion and gender) would be differently affected (compared to non-protected groups).
4	Great impact	Several protected groups in one category (e.g. religion) would be differently affected (compared to non-protected groups)
3	Some impact	All of one protected group would be differently affected (compared to non-

Strength score	Degree of impact	Proportion of protected groups affected
		protected groups)
2	Little impact	The majority of one protected group would be differently affected (compared to non-protected groups)
1	Minimal impact	A minority of one protected group would be differently affected (compared to non-protected groups).

3.1 Minimising Potential Negative Impacts								
Ref	**Protected Group**	**Potential Negative Impact**	**Likelihood Score**	**Strength Score**	**Overall Impact Score**	**Action**	**Action Owner**	**Date Action will be completed**
N1	Adults under 65	Providers focus on services for over 65s	2	3	6	Through contracting process ensure that providers demonstrate how services for population groups out of scope are maintained and improved	Brenda Scanlan	April 16
N2	Adults over 65	Some services are no longer offered by provider alliance	2	4	8	The provider alliance is incentivised to continue to deliver a range of services to meet the needs of patients. This will be managed through the implementation of the contract and the monitoring of the contract. The provider alliance will be expected to maintain choice for service users. These services would be delivered by a range of providers including the third sector.	Brenda Scanlan	April 16
N3	All groups	Service changes or new models of care may have an impact on certain groups who are over 65	3	3	9	Request that providers complete an EqIA for any proposed service change or new models of care and publish them alongside any decision	Brenda Scanlan	April 16
N4	All groups	Service changes or new	3	3	9	Request that providers	Brenda	April 16

3.1 Minimising Potential Negative Impacts

		models of care may have an impact on the population and protected groups under 65				complete an EqIA for any proposed service change or new models of care and publish them alongside any decision	Scanlan	
N5	All groups	Some groups may be less likely to access services	3	3	9	Request that providers publish an annual report summarising access to services by patient groups. This can be used to monitor equality of opportunity and access to services	Brenda Scanlan	Ongoing
N6	All groups	Services should reflect cultural and other specific needs from protected groups	3	3	9	Request that the provider(s) have up-to-date equality policies and can demonstrate staff have had the adequate training	Brenda Scanlan	April 16 and ongoing

3.1 Maximising Positive Impacts

Ref	Protected Group	Potential Positive Impact	Likelihood Score	Strength Score	Overall Impact Score	Action	Action Owner	Date Action will be completed
P1	All protected groups	Patient experience for all protected groups within the over 65 population is improved	3	3	9	Establish mechanism to capture patient experience from all protected groups over 65.	Brenda Scanlan	April 16

3.1 Maximising Positive Impacts

P2						Link outcome payments to patient experience scores from all protected groups		
P3	BME groups over 65	Increase the uptake of services for this population group	3	3	9	Articulate gaps in current provision to providers and seek responses to address through the contracting process.	Brenda Scanlan	April 16
P4						Use the outcome framework to incentivise providers to support this population group.	Brenda Scanlan	April 16
P5	Men over 65	Increase the uptake of services for this population group	3	3	9	Articulate gaps in current provision to providers and seek responses to address through the contracting process.	Brenda Scanlan	April 16
P6						Use the outcome framework to incentivise providers to support this population group.	Brenda Scanlan	April 16

4. Decisions

4.1 Based on the information in sections 1-3, what are you going to do?

Decision	Definition	Yes/no
We will not make any major change to our project because it already includes all appropriate	Our assessment shows that there is no potential for discrimination, harassment or victimisation and that our project already includes all appropriate actions to	**Yes**

actions	advance equality and foster good relations between groups.	
We will adjust our project	We have identified opportunities to lessen the impact of discrimination, harassment or victimisation and better advance equality and foster good relations between groups through our project. We are going to take action to change our project to make sure these opportunities are realised.	
We will continue our project as planned because it will be within the law	We have identified opportunities to lessen the impact of discrimination, harassment or victimisation and better advance equality and foster good relations between groups through your project. However, we are not planning to implement them as we are satisfied that our project will not lead to unlawful discrimination and there are justifiable reasons to continue as planned.	**Yes**
We will stop our project	Our project would have adverse effects on one or more protected groups that are not justified and cannot be lessened. It would lead to unlawful discrimination and must not go ahead.	
4.2 Next steps		
You may find it useful to consult Appendix One before completing this section.		
Does this analysis have to be considered at a scheduled meeting?	If so, please give the name and date of the meeting.	Cabinet, 29 September 2014
When and where will this equality analysis be published?	An equality analysis should be published alongside the policy or decision it is part of. As well as this, the equality assessment could be made available	As appendix of cabinet report

	externally at various points of policy development. This will often mean publishing your analysis before the policy is finalised, thereby enabling people to engage with you on your findings.	
When will you update this analysis?	Please state at what stage of your project you will do this and when you expect this update to take place. If you are not planning to update this analysis, say why not.	In advance of contract award and through dialogue with provider(s)
4.3 I confirm that the information in sections 1 - 4 is accurate, comprehensive and up-to-date		
Officers that must approve this decision	**Name and position**	**Date**
Report author		
Director of Corporate Services		
Email this completed form to data.equalities@croydon.gov.uk, together with an email trail showing that the director is satisfied with it.		
4.4 Feedback from the corporate equalities team		
Name of equalities officer		
Date received by equalities team	Please send an acknowledgement	
Feedback on decision		
Please send this to the report author and democratic services, corporate programme office and procurement team as		

appropriate

Appendix one: decision making processes

You may only need to develop one equality analysis, updating it as you move from proposing the change to monitoring its implementation.

In many instances, an equality assessment will be started when a report is being written for a committee. If that report recommends that a project or programme takes place, the same equality assessment can be updated to track equality impacts as it progresses. If the project or programme includes commissioning or de-commissioning, the same equality assessment can be updated again.

Budget setting
For department budget setting, check that each line will have already have appropriate equality analysis under one of the other decision making processes. The corporate budget will be covered under the process for the report to full Council.

How to use this table
This table outlines the key Council decision making processes. Select the process on the top row that you are currently involved in, then read down the column to find out what to do when.

Decision making process	**Report to committee, cabinet or full Council**	**Project management**	**Programme management**	**Commissioning**
Key contact	Solomon Agutu	Tanwa Idris	Tanwa Idris	ccb@croydon.gov.uk

Link to process	Report Writing Instructions and Templates	Corporate Programme Office (CPO)	Corporate Programme Office (CPO)	Procurement Board
Develop section one of the equality analysis	When you start writing your report	Business case	Gateway 1/2	When you start writing your procurement strategy report
Develop full equality analysis	Before you submit your report to CMT	Project initiation document	Gateway 3	
Revise full equality analysis	When full Council, cabinet or committee decision made or at key stages in any action plan included in the report	At the end of each project stage	At the end of each tranche	If the award report goes to Corporate Services Committee and as part of contract monitoring schedule
Write final full equality analysis	At the final stage of any action plan included in the report	Post project review	Gateway 6	Final monitoring stage
Who to send the equality analysis to	Corporate equality team and democratic services	Corporate equality team and project team	Corporate equality team and programme team	Corporate equality team and procurement team

Appendix two: data broken down by Protected Characteristics

The information below is taken from the 2011 census unless otherwise indicated.

Age groups	**Number of people**	**Percentage**

0-4 years	27,972	7.7%
5-7 years	14,388	4.0%
8-9 years	8,708	2.4%
10-14 years	23,130	6.4%
15 years	4,912	1.4%
16-17 years	9,934	2.7%
18-19 years	8,720	2.4%
20-24 years	23,591	6.4%
25 -29 years	27,692	7.6%
30-44 years	82,439	22.7%
45-59 years	70,488	19.4%
60-64 years	17,029	4.7%
65-74 years	23,155	6.4%
75-84 years	15,318	4.2%
85-89 years	3,881	1.1%
Over 90 years	2,021	0.6%
People with long term illnesses or disabilities	**363,378**	

<table>
<tr><td>Blind or visually impaired</td><td colspan="2" rowspan="8">These categories were not recorded as such in the 2011 census. However, this did record that there were 24,380 people (6.7%) whose day to day activities were limited a lot by long term illness or disability and 28,733 (7.9%) whose day to day activities were limited a little (Office of National Statistics)</td></tr>
<tr><td>Deaf or hearing impaired</td></tr>
<tr><td>Other communication impairment</td></tr>
<tr><td>Mobility impairment</td></tr>
<tr><td>Learning difficulty or disability</td></tr>
<tr><td>Mental health condition</td></tr>
<tr><td>HIV, multiple sclerosis or cancer</td></tr>
<tr><td>Other (please specify)</td></tr>
<tr><td>Gender</td><td></td><td></td></tr>
<tr><td>Male</td><td>176,224</td><td>48.5%</td></tr>
<tr><td>Female</td><td>187,154</td><td>51.5%</td></tr>
<tr><td>Ethnicity</td><td>Number of people</td><td>Percentage</td></tr>
<tr><td>White British</td><td>171,740</td><td>47.3%</td></tr>
<tr><td>White Irish</td><td>5,369</td><td>1.5%</td></tr>
<tr><td>White Gypsy or Irish Traveller</td><td>234</td><td>0.1%</td></tr>
<tr><td>Other White background</td><td>22,852</td><td>6.3%</td></tr>
<tr><td>Black African</td><td>28,981</td><td>8.0%</td></tr>
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Black Caribbean	31,320	8.6%
Other Black background	12,955	3.6%
Bangladeshi	2,570	0.7%
Chinese	3,925	1.1%
Indian	24,660	6.8%
Pakistani	10,865	3.0%
Other Asian background	17,607	4.8%
Mixed White and Black Caribbean	9,650	2.7%
Mixed White and Black African	3,279	0.9%
Mixed White and Asian	5,140	1.4%
Other Mixed background	5,826	1.6%
Arab	1,701	0.5%
Other ethnic group (please specify)	4,704	1.3%
Religion	**Number of people**	**Percentage**
Buddhist	2,381	0.70%
Christian	205,022	56.40%
Hindu	21,739	6.00%

Jewish	709	0.20%
Muslim	29,513	8.10%
Sikh	1,450	0.40%
No religion/faith	72,654	20.00%
Other (please specify)	2,153	0.60%
Sexual orientation		
Lesbian	There are no figures from the 2011 census. However, it is estimated that there were 20,370 lesbians, gay men, bisexual and transgender people living in Croydon in 2001. (London LGBT)	
Gay		
Bisexual		
Transgender		
Transgender	See above	
Pregnancy or maternity		
Pregnant	These categories were not recorded as such in the 2011 census. However, there were 5,720 live births in 2011 (Office of National Statistics)	
On compulsory maternity leave		
Marriage or civil partnership		
Married	122,013	42.9%

In civil partnership	796	0.3%