Better Care Fund Draft Submission

London Borough of Croydon
Croydon Clinical Commissioning Group

January 12th 2014

Blank

Contents

Introduction

The Better Care Fund (BCF) is a national initiative which introduces a pooled budget between NHS Clinical Commissioning Groups and Local Authorities to provide an opportunity to transform local services so that people are provided with better integrated care and support. This is a journey that Croydon Council and Croydon CCG have already started through joint transformation and reablement programmes, and reinforced through recently launched integrated commissioning.

The BCF will be an important enabler for Croydon to build on the work it has already started and take the integration agenda forward at scale and pace, acting as a significant catalyst for change. It will provide an opportunity to improve the lives of some of the most vulnerable people in our population, giving them control, placing them at the centre of their own care and support, and in doing so, providing them with a better service and better quality of life. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability.

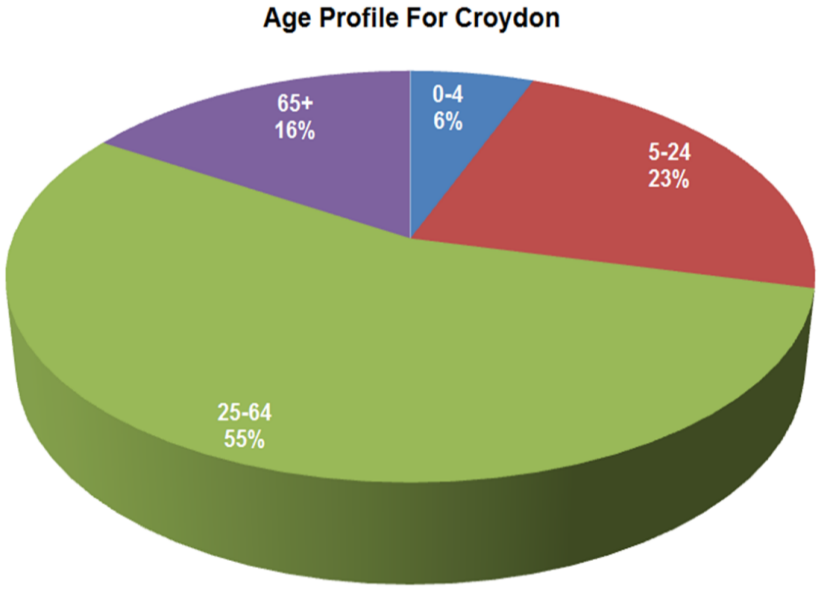
However, the Better Care Fund (BCF) is not new money as the funding is mainly a transfer of revenue from the Clinical Commissioning Group's (CCG's) allocation, and existing capital from the Council's allocation, into the pooled budget, and will present a financial challenge for both organisations. We are looking at BCF as an opportunity to continue to develop new ways of agreeing and stimulating service transformation between health and social care.

We anticipate that BCF will support our shared aim in Croydon of providing people with the right care, in the right place, at the right time, and with the right outcome, through a significant expansion of care in community settings, instead of in hospital or care homes.

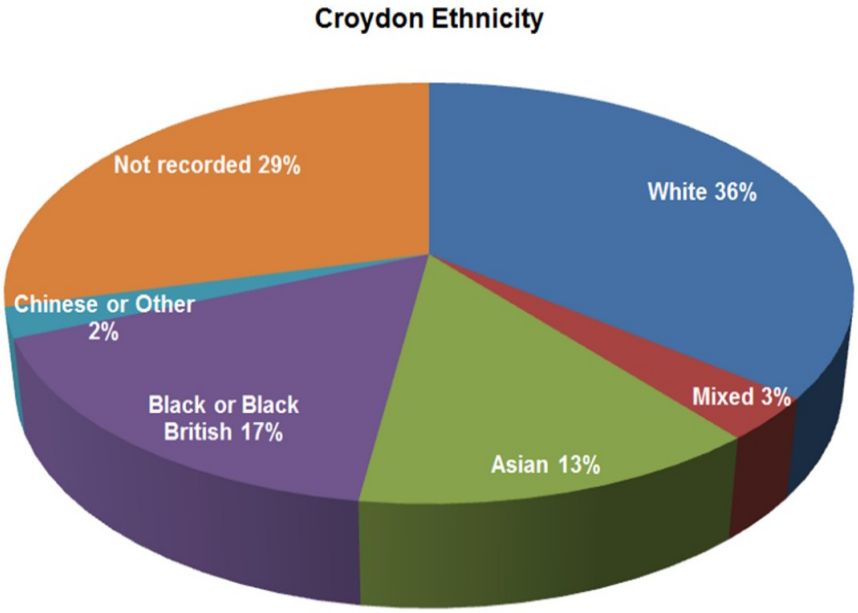
Our Borough

Croydon is an outer London borough bordering Surrey to the south and Lambeth, Lewisham and Southwark to the north. Croydon is London's southern-most borough and covers an area of 87 square kilometers. It is one of London's biggest local retail and commercial centres, with good rail, tram and road links, more than 120 parks and open spaces and some of London's most expensive housing.

The 2011 Census shows that Croydon's population was 364,463, with a G.P registered population of approximately 382,000, making us the largest borough in London. Croydon's population has grown at a faster rate than the rest of England. Over the last ten years Croydon has seen an increase of 28,300 people since the 2001 census (335,100) which represents an 8.4% increase, 1.3 percent points higher than the national average. This population is projected to increase by 16,000 residents by 2026.



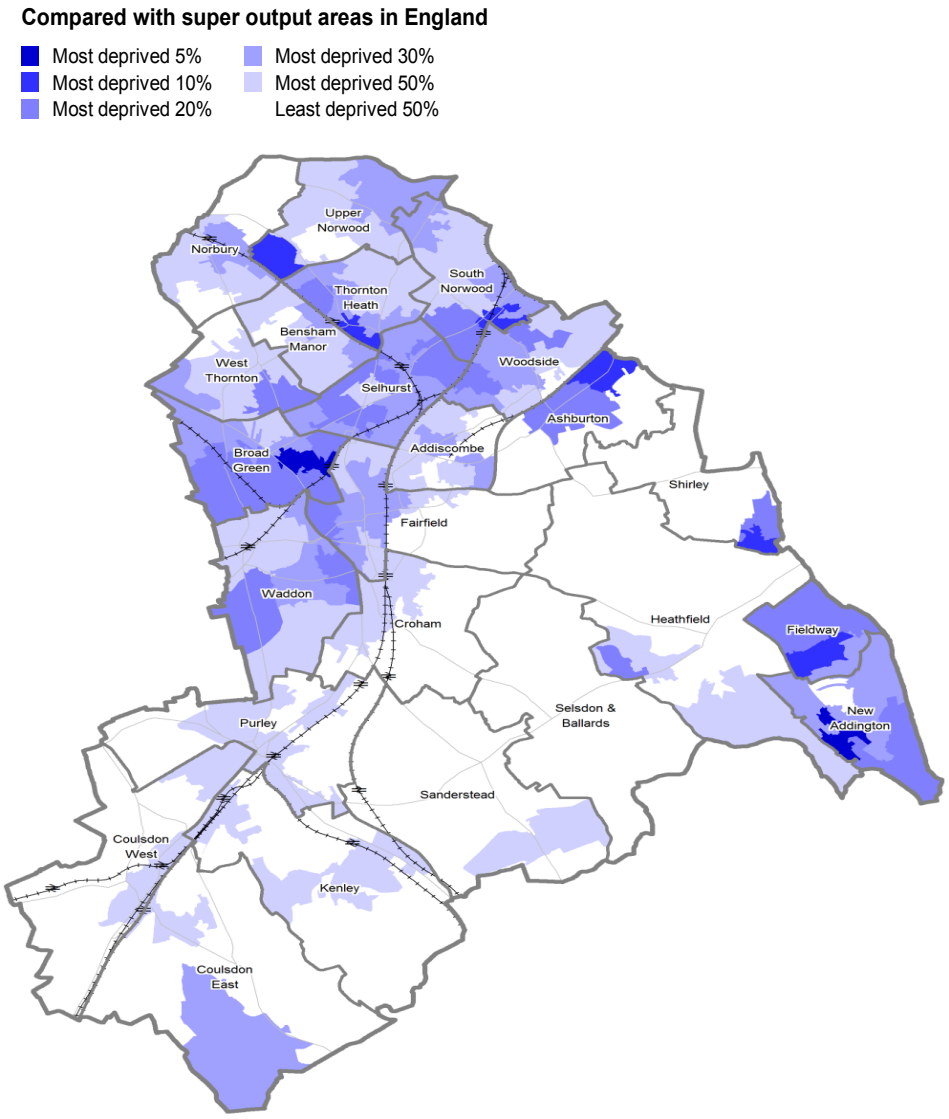
The population is highly mobile with large numbers of people moving into and out of the borough each year. Croydon's population is also very diverse; black and ethnic minority residents make up almost 42% of the population and more than 100 languages are spoken.



Amongst those groups more likely to be in need of community care services, 60,000 people are aged 60 and over, over 6,000 people have a learning disability, nearly 5,000 a serious physical disability, and over 4,000 a severe mental health problem. The number and proportion of older people is growing, as is the number of younger adults with disabilities because of an even greater increase in life expectancy than across the whole population. At the last census, over 29,000 people were providing informal care to relatives or friends.

Life expectancy in Croydon is 79.6 years for men and 82.6 years for women, compared to national figures where life expectancy is slightly less for men at 78.6 years and equivalent for women also at 82.6years (2008-2010).

Croydon is a socio-economically diverse borough. It is ranked 19th out of 32 London boroughs in terms of overall deprivation, it has some wards with low levels of disadvantage and others which are amongst the most deprived in England.



Income deprivation particularly affects older people. Pockets of Selhurst and Thornton Heath have 50% of older people living in what are known as ‘income deprived households’. Areas with highest levels of income deprivation are predominantly in the north and east of the borough.

Housing:

Croydon has approximately 147,000 dwellings of which just over 9% are council housing, 7% registered social housing and 83% private sector housing. In January 2013 the average house price in Croydon was £253,770 which is over £100,000 less than the average for London (£371,361 January 2013).

Our Population- Social Care

The population for the 65 and over age group is 44,000 (12.2% of Croydon's total population of 364,463). The latest projection suggests that the number of people over the age of 85 will increase by two-thirds by 2029.

The number of people with one or more long term conditions is set to increase significantly over the next 20 years in line with an ageing population. This will create pressure on both health and social care services and change will be needed if those systems are to cope with the challenge of enabling people to manage their own health and social care needs.

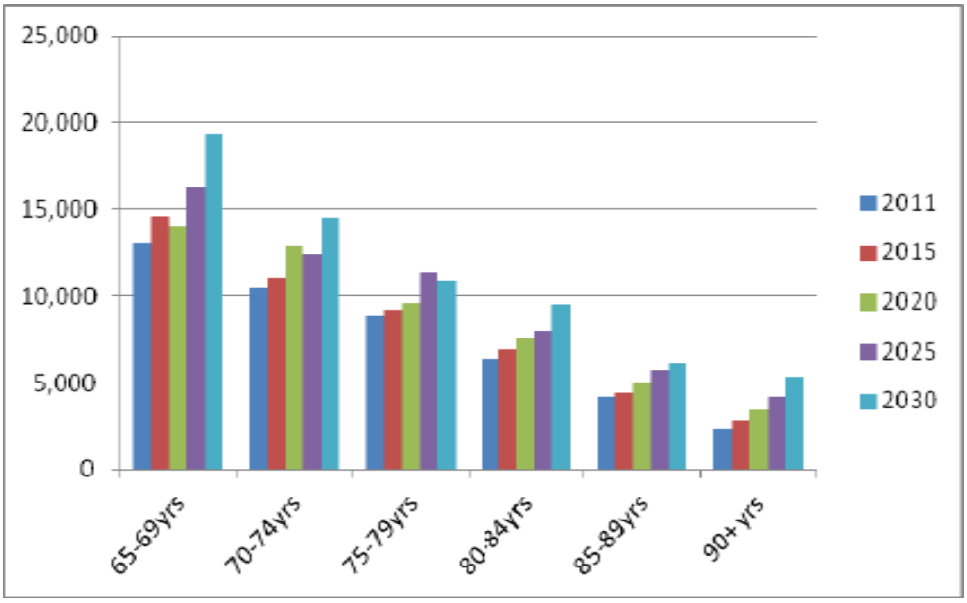
It is estimated that 5,379 adults (aged 18-64yrs) in Croydon have a learning disability and 16,579 adults (aged 18-64yrs) have a physical disability.

Older people:

Older people aged 65 years and over, make up 13.8% of the Croydon population and residents aged 85 years and over make up 1.9%. These proportions are projected to increase to 16.27% and 2.91% respectively by 2030.

Life expectancy has increased over the last 10 years for both females and males. In 2000 – 2004 females were living, on average, 4 years longer than males. Over the ten year period males have seen a 3 year extension to life on average whilst female life expectancy has increased by 2 years.

The greatest projected increase in the older people population is for men over 90 years, with a projected increase of 78% from a total of 900 residents to 2,500. This compares to female residents for this age group where the projected increase is 87% from 1,500 residents to 2,800 (source: ONS)



The diagram shows the population from 2011-2030 for older people by age band (data source – ONS population projections)

People with a Physical Disability:

An estimated 16,579 adults (aged 18-64yrs) in Croydon have a physical disability; this is projected to increase to 18,416 by 2030. 28.7% (4,771) of residents with a physical disability have a severe disability. Consequently, around 10,000 residents of working age have disabilities where we would expect them to need some level of personal care in 2011 and, in fact, 1048 people with a physical disability were receiving social care services in Croydon at any one time during 2010/11. This number increases to 5,518 when older age groups are included. 65.7% of these people were female. Over all numbers are expected to rise to 11,117 by 2030 as we live longer with more serious disabilities.

People with a learning disability:

There are 5,379 adults (aged 18-64yrs) in Croydon with a learning disability; this is projected to increase to 5,790 by 2030. Around 321 residents with learning difficultly (5.5%) are predicted to have a severe learning disability. There are more people in Croydon with learning disabilities than would be expected for a population of our size which provides additional financial and other challenges to social care services. During 2010/11 a total of 976 residents with a learning disability received social care - 93.9% of whom were of working age.

Of those residents with a learning disability receiving support from the council, 259 of them are in permanent residential care and 7 are in permanent nursing care. Otherwise 668 (72.8%) of them were in other settled accommodation but only 70 of them (7.6%) were in paid employment. A further 79 (8.6%) were in unpaid voluntary work.

People with mental health problems

One in four people will experience a mental illness in their lifetime. There are around 105,000 people in Croydon who suffer from depression and mood disorders and there are about 4,000 who have been diagnosed with severe mental illness. Amongst the working age population in Croydon it is projected that by 2021 there will be an increase of 24% in people with a serious mental illness.

All people (18-64) with a common mental disorder- projected to 2020

Year	2012	2014	2016	2018	2020
Number of people	37,454	37,865	38,334	38,817	39,196

Source: Projecting Adults Needs and Service Information (PANSI)

By gender, people aged 18-64 with a common mental disorder, projected to 2020

Year/no of people	2012	2014	2016	2018	2020
Males	14,050	14,225	14,438	14,625	14,788
Females	23,404	23,640	23,896	24,192	24,408

Source: Projecting Adults Needs and Service Information (PANSI)

People with Dementia

There are an estimated 3,300 people living with dementia in Croydon, this is projected to rise by 30% over the next 15 years, reaching 4,500 by 2025 and approximately two thirds (62.1%) are female. Croydon's Dementia JSNA 2011-12 revealed that Croydon has higher dementia needs compared to other London boroughs.

In Croydon the rise in the prevalence of dementia roughly coincides with the increasing number of older people in the borough, but there are also people as young as 45 who have been diagnosed with dementia.

People aged 65+ predicted to have dementia, projected to 2020

Year	2012	2014	2016	2018	2020
No of people	3,225	3,401	3,572	3,782	4,021

Source: Projecting Older People's Population Information (POPPI)

Our Population- Health Needs

It is in everyone's interests to ensure that people are able to maintain their independence and stay healthy throughout their lives. However, changes to the make-up of Croydon's population and lifestyle trends are likely to lead to more people needing care in the future. People are living longer and our population is ageing; the latest projections suggest the number of people aged over 85 will increase by two thirds by 2029. This is an important trend because we know that older people generally have more health problems and need to use health and care services more than younger adults.

There will also be more births as more women of child bearing age move to Croydon; it is expected that the number of births will rise by around 10% over the next five years.

The health of people in Croydon is mixed compared to the England average:

- Life expectancy for both men and women is higher than the England average. However, life expectancy is 9.5 years lower for men and 5.2 years lower for women in the most deprived areas of Croydon than in the least deprived areas

- Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have also fallen

- An estimated 19.7% of adults smoke

- An estimated 24.3% of adults are obese

- There were 6,071 hospital stays for alcohol related harm in 2009/10

- There are 408 deaths from smoking each year

- Breast and cervical cancer screening rates are both significantly worse than the national average

- Croydon is in the 10% worst performing areas for new cases of tuberculosis

- There are 54,253 adults (aged 18-64 years) in Croydon with a diagnosed mental health problem. 66% of these people have less limiting mental health issues such as emotional distress, depression, anxiety and obsessive compulsive disorder.

- Approximately 3,300 people in Croydon have received a diagnosis of dementia but through prevalence and demographic data there is the real possibility of growth in numbers by at least another 1000.

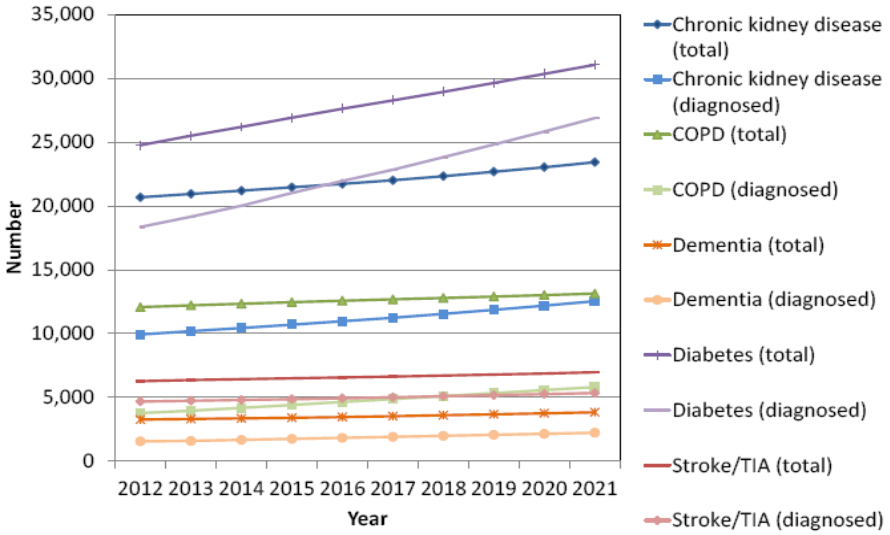
Our Population: Long Term Conditions

It is expected that many more people will be living with long term health conditions in the future. By this we mean health problems that are present for over a year or more, such as diabetes, heart disease, respiratory problems, asthma and epilepsy. People often have more than one of these conditions, especially as they get older. Three out of every five people aged over 60 suffer from a long term condition and as the population ages; this proportion is likely to rise. People with long term health conditions are the most intensive users of health services. They make up around 31% of the population, but

account for 52% of GP appointments and 65% of planned hospital appointments.

In the future many people who have long term conditions will need better organised care, closer to home, to help them self-manage their conditions and live as independently as possible. This is especially important, given that social trends – such as the increase in single-person households and people living further from their extended family – may mean many people won't receive the support they need from family members.

Projected number of long term conditions in Croydon's population, 2012-2021



Source: Projections based on data from Croydon general practices

Our Challenges

In order to improve the health and wellbeing of people in Croydon it is essential that Croydon Clinical Commissioning Group (CCG), Croydon Council (Social Care, Public Health, and Housing) work together in an increasingly integrated way. The challenges we face require a collective and joined-up response across health, social care, and housing to innovate and improve services for the people of Croydon. What people have told us through various forums is they want:

- Services that are efficient with no duplication of work;
- Professionals who have information they need to work with them effectively;
- Services that can be accessed at a time and place and in a language and format that suit their needs;

- Access to a range of services to meet their individual needs and preferences;

- Full understanding of the services available and how to use them – including who to call if their condition worsens;

- Confidence in knowing what to do to maximise their own health and well-being;

- On-going and trusting relationship with the professionals they deal with.

In Croydon the Council and the CCG have started the journey toward integration but there is still progress to be made. The need for greater integrated working is highlighted by the real service challenges that need to be addressed in Croydon. These include:

- Bottom 10% of satisfaction with ability to see a G.P quickly;

- Bottom percentile for patient experience at Croydon University Hospital (CUH) for last 3 years;

- Rates for emergency admissions are higher compared to other areas and are also higher than 3 years ago;

- Rates of emergency readmissions to hospital within 28 days of discharge is significantly higher in Croydon than the national average;

- Higher rate of A&E attendance and variable performance in meeting the 4 hour waiting target.

These challenges need to be faced at time of increasing financial pressure on both the CCG and the Council

The CCG inherited a budget deficit from the preceding PCT and in response have instigated a 5 year Financial Improvement Plan (2013-18) which seeks to deliver £65.9 million in savings in order to reach financial balance for the organisation.

The 2013 Government Settlement for local government was harsh and as a result Croydon Council will be required to make further savings in the region of £100 million between 2014 and 2018. This effectively means that the Council's budget will reduce by circa 30%.

In addition to this the Council will need to prepare for the potential impact of the Care Bill which is expected to receive Royal Assent in 2014 and will result in significant increase in the cost of care provision from April 2016. Whilst the government has committed to paying for the costs of the reform in full the scope of the proposed changes means that there are substantial financial risks for the Council as scope and complexity of the reform suggest that

Government financial modelling is imprecise. If the introduction of the Care Bill reforms is underfunded there will be a substantial impact on social care funding plans in Croydon.

It is essential that the progress that Croydon Council and CCG has made to date is sustained over the next 5 years in order to deliver health and social care service improvements and the cost efficiencies required in health and social care. The Croydon Joint Health and Wellbeing Strategy 2013 - 2018 sets out 3 strategic goals:

1. Increased healthy life expectancy and reduced differences in life expectancy between communities

2. Increased resilience and independence

3. A positive experience of care

In Croydon we face many challenges over the coming years with growth in our population at a time of tightening resources. We are determined that by implementing our transformation programme and developing more integrated working we will maximise the resources available to us to ensure that we can continue to deliver high quality services to the populations we serve.

Better Care Fund - Plan Details

Service provider engagement

The Croydon Health and Wellbeing Board has been central in overseeing the transformation of services through the integration agenda in Croydon. It is this agenda that will be continued through 2014/15 and the introduction of the Better care Fund in 2015/16.

Alongside the local authority, the CCG and Healthwatch, the Board has membership of a wide range of stakeholders including representatives from: provider organisations such as Croydon Health Services (CHS) and South London and Maudsley NHS Foundation Trust (SLaM); services such as the police and fire service; the voluntary sector through the Charity Services Delivery Group and Croydon Voluntary Action; and faith groups in the Borough through Faiths Together in Croydon.

The Partnership Boards which are linked to the Health and Wellbeing Board bring together representatives from relevant organisations to set the strategic direction for these public services in Croydon. The Boards monitor performance and promote partnership working at all levels which includes joint commissioning of services where a partnership response is beneficial. Croydon has a history of strong partnerships with the voluntary sector and this is reflected in the Partnership Boards. The Partnership Boards have a binding governance structure which allows information to be shared through the Boards.

The commitment to partnership working can be seen through the establishment of the Reablement and Hospital Discharge Board and the Croydon Strategic Transformation Board.

1. The Reablement and Discharge Board membership is made up from the local authority; Croydon's Clinical Commissioning Group, Croydon Health Services, and the voluntary sector and oversees the programme of investment in initiatives funded by the Department of Health investment monies for social care to deliver health outcomes. The Board has:

    - Over the past three years allocated and evaluated the £11 million investment in social care to deliver health outcomes.
    - Funded 22 initiatives which have reduced the number needing acute services and has reduced hospital admissions.

2. The Croydon Strategic Transformation Board (CSTB) is responsible for the:

- Development of a shared vision for integrated care models that ensures a high quality, safe and affordable health and social care economy for patients and service users
- Implementation of that joint vision

The Board is currently working to pull together a joint picture of current services and initiatives across community health services, Social Care, Voluntary Sector & Mental Health. Its membership is made up of the local authority, CCG, CHS and SLaM, and the voluntary sector. The challenge will be to align them to the Better Care vision and understand how they can work together in a more co-ordinated way – improving communication and integrated working across organisations.

Patient, service user and public engagement

NHS Croydon Clinical Commissioning Group, Communications and Engagement Strategy commits to ensuring that we regularly communicate and engage with our population, the wider health and social care community and our local stakeholders to maintain public trust and confidence in services for which we are responsible. The strategy also sets out how we will involve our population and stakeholders through the planning and engagement cycle (Croydon CCG Communications and Engagement Strategy, 2012).

In developing the Integrated Strategic Operating Plan, the NHS Croydon Clinical Commissioning Governing Body has worked with Member Practices, Patients, Providers and the Public to develop the goals and priorities reflected throughout the plan.

Patient participation groups at G.P network level and wider public forums will help to ensure we continually capture views and suggestions about services and service development.

Croydon Council engage in on-going consultation through a number of forums. These include:

- **The Inclusive Forum -** provides adult social care service users and their carers with the opportunity to comment on a full range of issues that affect adult social service users in the borough with events held every year.

- **Croydon Adult Social Services Users Panel (CASSUP) -** a group of service users, carers of service users and Croydon residents who have a strong commitment to improving services and championing the interests of service users. The panel works in partnership with officers and service providers to raise key concerns regarding adult social care in Croydon and identify ways to improve services.

- **'Making it Real' self-assessment framework** – a series of consultation sessions during Nov & Dec 2013 with adult social care,

community based, service users and their carers to assess progress for personalisation in Croydon.

- **What is 'Making it Real'?** - the 'Making it Real' framework was developed by National co-production Advisory Group and a range of national organisations which are part of the programme 'Think Local, Act Personal'. It is built around "I" statements which express what people expect to see and experience if personalisation is working well. For example people might report, "I have the information and support I need in order to remain as independent as possible."

- **The Mobility Forum -** the Croydon Mobility Forum reviews and makes recommendations to improve access and facilities in Croydon for older people and those with disabilities. Elected forum members, representing voluntary sector workers, service users and carers with disabilities, meet with councillors, senior council staff, taxi organisations, Transport for London and bus and rail companies to discuss how best to improve services in Croydon.

Healthwatch Croydon – an independent consumer champion created to gather and represent the views of the people who use services, carers and the public on the Health and Wellbeing Boards set up by local authorities, provide a complaints advocacy service and report concerns about the quality of health care to Healthwatch England. At a local level Croydon Healthwatch will work to help local people get the best out of their local health and social care services and is all about local voices being able to influence the delivery and design of local services.

Vision for Health and Care Services

Please describe the vision for health and social care services for this community for 2018/19.
- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our Vision

Our aim is to work with the diverse community of Croydon, using our joint resources wisely to transform and provide safe, sustainable, effective, high quality, patient/client centred services. Our belief is that health and social care services should empower people to understand and take responsibility for the management of their health, and the care and support they need to lead lives of independence within their home and community.

This is not a new vision for Croydon as we have recognised the necessity of partnership working and the mutuality of health, social care and housing in enabling people to maintain their health, well-being and independence. We have established a joint programme focused on reablement and supporting

hospital discharge through the Department of Health monies for social care (social care to benefit health) exploring how investment in social care can deliver positive health outcomes. In order to maximise the impact of this important and limited funding for investment in social care Croydon Council established a joint Reablement and Hospital Discharge Board, of which the CCG is a key partner, to establish and support a range of initiatives which would enable a range of prevention and reablement interventions to deliver the most important outcomes for the public; and respond to the pressures on acute health services. The Board established a number of key themes that will continue to be central to developments through the Better Care Fund:

- *Prevention is better than cure.*

  The best treatment and best service is one that is able to not only treat someone early but also increase the delay in the person having to come back for further help.

- *Let's deal with this right now.*

  For many minor illnesses, living alone, minor accidents and other life changing events can destroy the confidence and competence of many adults including having to use expensive acute and secondary health services and equally having a "life time career in care". The use of mixed social care and health services to support people to get their confidence back and to learn or re-learn activities of daily living will provide a better long term solution by enabling sustainable long term living at home in their own community/area.

- *I don't need to go to hospital*

  To avoid hospital admission and to make use of community health and social care budgets to support people to use other alternatives.

- *Not one more hour*

  Inevitably, some people will have to access short term acute care in a hospital setting. This has to be managed to ensure event emergency admissions are planning discharge and post hospital care using shared information and data. Better use of services in A&E will continue to reduce waiting times and reduce admissions as social and health care interventions will enable return to home wherever that is after treatment.

- *No quick returns*

  Getting people home and out of hospital is a key part of reducing costs and meeting the needs of individuals who in the main prefer not to be in hospital. Preventing people from returning is a difficult balance and relies on follow on services being available and easily accessible. Most importantly it is keeping in touch with people who

have left without a great deal of support to ensure they do not re-emerge in A&E.

The Better Care Fund will enable this work to continue and complete the journey from partnership working to integrated working between health and social care. Over the next 5 years this will be based on the following principles :

- **Co-ordination around individuals**, being clear who our priority patient/client groups are, ensuring there are clear health and social care pathways for those groups, which will enable joint targeting of resources to meet their specific needs;

- **Patients should experience seamless service delivery,** with agencies involved in their recovery and support working together and sharing information as agreed with the individual to ensure needs can be responded to in a timely and flexible way.

- **G.Ps playing a central role,** as a key primary health care provider; and organising and coordinating patients' care and support in the community;

- **Increase healthy life expectancy and reduced differences in life expectancy between communities,** in order to reduce health inequalities within the Borough and demand on acute services;

- **Increased Independence,** by providing care and support at the right time and at home to enable people to recover and regain the skills and confidence to manage their own health and be active members of their chosen community;

- **Active joined up case management within each care setting,** to enable a coordinated response which will empower people to manage their own condition, take control of the care and support they need, and deal with crises as they occur without calling on hospital acute services, or relying on on-going expensive social care services.

- **A joint approach to commissioning**; to focus on preventing ill-health, supporting self-care including through personalisation, enhancing primary care, and providing care in people's homes and in the community.

Coordination around individuals:

The desired outcome of the Croydon "vision" is for people to feel that they are supported by health, social care, and housing services working together to help them manage their health and support them to continue to live at home. The type and level of health and social care interventions that people need will

vary at different times in their lives so it is important that services will be coordinated and flexible around individuals.

We want people in Croydon to know that they will be able to access the right care, at the right time, in the right place, in the right quantity, delivered to a high quality. We would expect this to translate into patients' conditions being better managed and their reliance on acute health services, especially A&E, and social care services being greatly reduced.

Our aspiration is that we will see consistently high patient/client satisfaction at the services we provide.

In order to achieve this there is a need to shift the service culture from a reactive model where there is a dependence on higher cost acute services to a preventative model with lower cost community focused services supporting greater self-management at home. We believe this will result in a reduction in the demand for high cost acute services and reduce demand for higher cost social care packages of care.

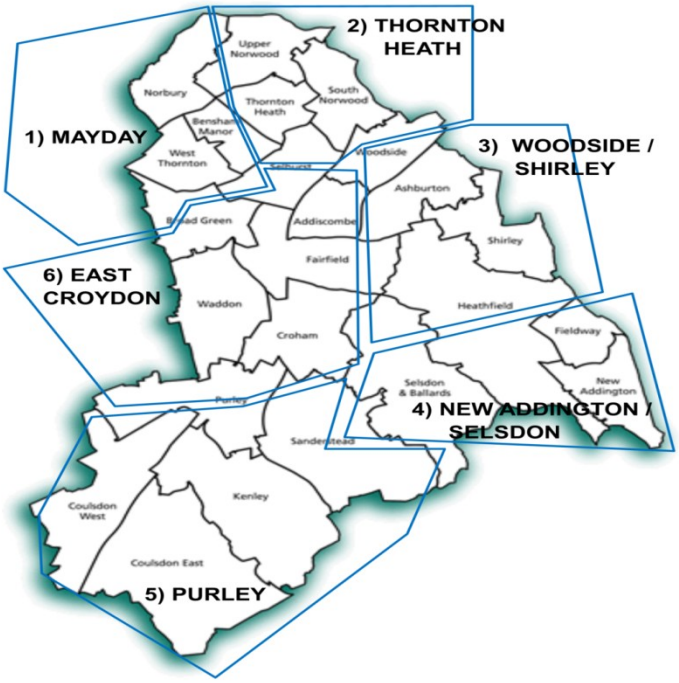
Patients should experience seamless service delivery

Patients and social care clients have told us through various consultation and listening events that they want greater coordination between health and council services that play a key role in providing their support. To have services that talk to each other and share agreed information about joint patients/clients to enable timely interventions that would prevent health issues developing into a crisis that would lead to a hospital admission or high cost social care package.

Better Care Funding will enable us to continue the development of coherent pathways which enable health, social care, housing, and the third sector to work together more effectively.

G.Ps playing a central role: Croydon's 6 Networks

One of the biggest areas of service change will continue to be developed within Primary and Community Services. NHS Croydon CCG has developed 6 Geographical Networks with populations ranging between 50,280 to 80,010.



Croydon's 6 Networks

Within our Geographical Networks we have a wealth of Business Intelligence and Public Health information relating to our populations and current use of services. We know where there are.

- Pockets of deprivation
- Prevalence of ill health, example numbers of people with long term conditions
- People who are vulnerable including those with a Mental Health Diagnosis, People with a Learning Disability, Older People and Children and Families needing additional support
- High levels use of services by GP Practices

Within these Geographical Networks we are working within multidisciplinary teams (Health and Social Care) to support more people to remain in their own home by identifying early those who may require more support. GPs are at the centre of knowing about the needs of their population and by working as member practices of the clinical commissioning group are able to influence sustainable commissioning of quality services. G.Ps will use the Croydon risk stratification tool to identify patients with levels of need that is likely to lead to increased use of health resources; especially acute services

The CCG also as a priority area and with Commissioners, Public Health, Providers and the Public are working on implementing the Prevention, Self-Care and Shared Decision Making strategy and by linking this work within

networks are able to target high impact changes through schools, children's centres, GP Practices, Pharmacies and other community based services.

Increase healthy life expectancy and reduced differences in life expectancy between communities

Strong primary care is associated with reducing health inequalities, better value for money, reduced urgent care activity care activity, lower hospital admissions, and improved patient satisfaction. The integration between health and social care through the G.P networks, the engagement of Public Health and housing will be essential in tackling issues behind health inequalities and being part of the integrated approach to be developed over the next 5 years.

The use of telecare and telehealth technologies will continue to be key tools for G.P's and community health services in reducing health inequalities in the borough whilst managing demand as the move from acute to primary care services gathers pace.

Increased Independence

People will be enabled to direct their care and support in order to enable them to receive the care they need in their own homes and the community. For patients in hospital the reablement process will begin when they are still on the wards through a multi-disciplinary team approach which identifies patients who will benefit from reablement post discharge. Greater coordination between health and social care in hospital will continue to be developed in 2014 through an integrated discharge policy and procedure. This will ensure a consistent approach through the hospital and ensure that work begins with patients from point of admission and their families/carers to develop robust discharge plans that will ensure services are in place on date of discharge.

A lead professional with responsibility for whole system oversight will be assigned to support people post discharge and ensure services support that individual to recover and regain the functionality, skills, and confidence to maximise their independence at home and in the community.

It is expected that these interventions will have a positive impact on: supporting an already good record of enabling timely and safe hospital discharges and keeping delayed transfers of Care (DToC) to a minimum; reducing the number of patients returning to hospital within 28 days, and reducing the social care package of care costs resulting from supporting hospital discharge.

Active joined up case management within each care setting

Over the next 5 years health and social care will work together in an integrated way through the development of the Multi-Disciplinary Teams (MDTs) linked to each of the 6 G.P networks. These MDTs will use risk stratification to improve local knowledge of health need and demand to facilitate local responses in each network catchment. Through this they will develop shared processes and patient pathways linking into a range of reablement and early intervention services.

These MDTs work with the voluntary and community sector to ensure that those not eligible for Council funded social care services, or not experiencing acute health needs can receive support to remain healthy and maintain their independence through signposting; with the MDTs then monitoring patients/clients to ensure that the appropriate services are being accessed in order to prevent any decline through appropriate early intervention. This will include access to reablement services and telecare which will provide targeted input with the aim of preventing the need for acute services or a longer term social care package of care.

This will be supported through G.Ps and health professionals having access to telehealth technologies to enable the monitoring of patients without requiring them to take up surgery time, and help maximise the capacity of community nursing services by releasing them to focus on high needs patients. G.Ps will be supported through the continued development of a central telehealth triage service currently hosted by the Community Matron Service, and the Council's local authority trading company (Croydon Care Solutions Ltd) who will undertake installation, maintenance, and recycling of equipment.

Underpinning all of this will be a Rapid Response service that will provide support to people in a crisis and help them remain at home. Launched in October 2013 this service can provide health and social care interventions at short notice in order to avoid a hospital admission, stabilise the individual, and provide the opportunity for a range of early intervention services to be made available to the individual as appropriate. Rapid Response will continue to be developed over under Better Care and it will be essential to ensure that social care capacity is in place to respond to the demands of this new service through the Better Care Fund.

It is expected that these interventions will play a key role in reducing pressure on acute services, especially A&E by enabling health and social care interventions within the community.

Joint approach to commissioning

In December 2013 the Council and the CCG established an Integrated Commissioning Unit (ICU). By moving to an integrated approach to commissioning the Council and CCG will achieve quality improvements in

health and wellbeing within a diminishing financial envelope by acting on opportunities for realising greater efficiency and effectiveness. Its objectives will be to commission accessible, seamless, quality services, personalised and responsive to the changing needs of individuals and families, designed with and for the people of Croydon.

It is expected that integrated commissioning will enable:

- Choice for individuals, with clear information on what services and resources are available to support them in meeting their needs;
- Accountability: The ICU will, as required by the commissioning parties engage with communities about what is achievable within available resources and ensure best value from its resources, so that key targets and key priorities are delivered;
- Personal Control: Care and support are provided in a manner that enables people to maximise control over their own life and environment;
- Respectful and responsiveness: People and their carers will be involved in decisions that affect them and encouraged to play an active role in their communities;
- Partnership: By working in partnership with service users, carers, providers, the voluntary sector and staff from all agencies and communities, better services will be delivered;
- Prevention: Supporting people at home for longer through early access to support, care and health promotion

Description of Planned Changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:
1. The key success factors including an outline of processes, end points and time frames for delivery
2. How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Our Transformation:

Croydon Council and Croydon CCG have begun to lay the foundations which will embed a culture of integration and transformation. This will see an emphasis on providing community focused interventions that will:

- Focus on prevention, health education, and effective self-management;
- Provide services focused on providing comprehensive person centred care;
- Provide services focused on a proactive planned approach for meeting people's needs;
- Provide a single point of contact that is readily accessible and which has community rapid response services to prevent the need for hospital attendance/admission;

- Ensure that primary health, community health and social care services are aligned through multi-disciplinary team approach;
- Engage with people and communities about their care and support and the way services are designed and delivered.

The Council and the CCG have begun the process of integration and joint transformation through establishing the following elements which will continue to be developed in 2014/15 and will form the infrastructure for further integration and service development through the Better Care Fund.

1. Prevention, self-care and shared decision making

Prevention, self-care and shared decision making (PSS) are part of Croydon CCG and the Local Authority shared strategies. Given the challenges that the borough faces, both in population health and financial terms, not prioritising PSS is not an option.

A preventative approach is taking place alongside treatment and service provision at all levels. Patients as part of the delivery of clinical pathways are and will be involved in decisions relating to their health whenever possible. The CCG and the Local Authority have taken a progressive approach to the use of telehealth but also the use of new technologies such as Apps and websites.

Many of the diseases affecting Croydon residents – cardiovascular disease (CVD), chronic obstructive pulmonary diseases, type 2 diabetes and cancer – are linked by common and preventable risk factors such as high blood pressure, high blood cholesterol and overweight, and by related major behavioural risk factors: unhealthy diet, physical inactivity, tobacco and alcohol use. It is estimated that 80% of cases of heart disease, stroke and type 2 diabetes and 40% of cancer cases could be avoided if these risk factors were eliminated.

While specific prevention services are commissioned e.g. a smoking cessation or weight management services, Croydon CCG aims to embed prevention interventions within encounters between Croydon's service providers and service users wherever possible. These can include brief interventions around diet, physical activity, smoking, alcohol and drug use, and promoting wellbeing. We will assess the effectiveness of incentivising these using levers such as LES (or equivalent) and CQINS.

This will take place both in primary care and through revising contracts with our providers so that preventative approaches are embedded within their services. Wherever benefits are likely, these will include the use of communications such as text messages or tools such as the Department of Health endorsed BMI iPhone tracker.

We will work in partnership with Croydon Council and NHS England to support them in fulfilling their objectives around prevention and addressing the determinants of health in areas such as screening, health promotion, employment and housing

The development of clinical pathways involves the creation of recommended shared decision making and self-help tools for patients. For instance the CCG is promoting the use of Apps and websites specifically targeted at back pain and recovery.

2. Transforming Adult Community Services (TACS)

Croydon CCG and Croydon Council's joint Transformation agenda for adult community services sets out three main priorities that involve integrated working, which are:

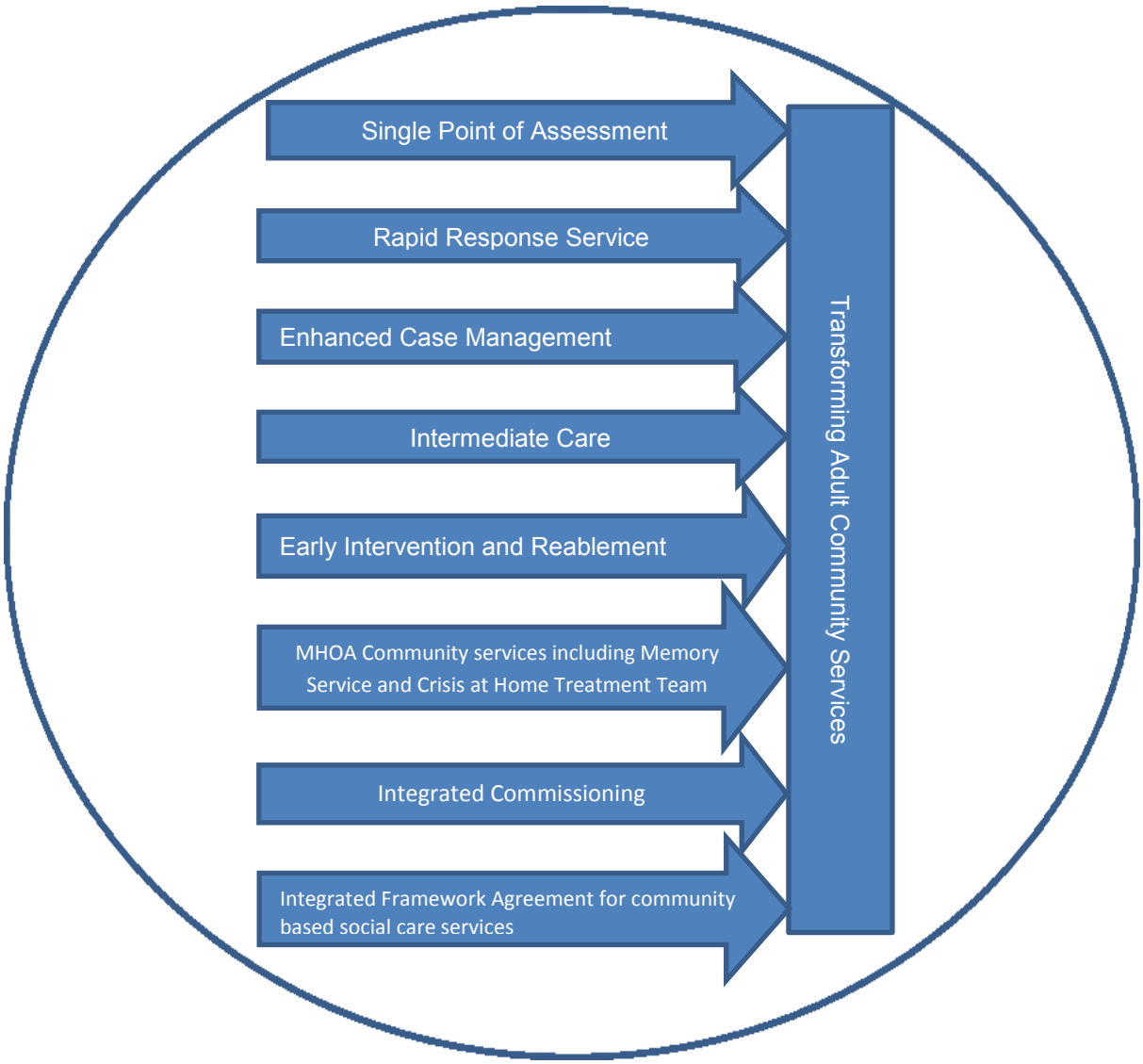
- Enhancing care for people with Long Term Conditions;
- Reducing Unnecessary Emergency Admissions;
- Providing high quality, personalised care, as close to home as possible.

An evidence based single option service model has been developed by the CCG, with its partners, and Croydon Council from best practice used across the country and is based on the CCG's Primary and Community Care 3 year Strategy 2013-2016. Four areas are identified for focused change, which are:

- Single Point of Assessment;
- Rapid Response Service;
- Enhanced Case Management;
- Increased Intermediate Care bed provision;

Croydon Council and the CCG through the Reablement and Hospital Discharge Programme is developing a range of early intervention and reablement services which dovetail with the single service option model to provide the infrastructure to enable coordinated support of the individual to avoid unnecessary use of acute services and maintain independence within their own home.

All elements demonstrate Croydon's commitment to integration and our intention to use the Better Care Fund to continue our work in realising the potential it provides for enabling better outcomes for people in Croydon.



2.1 The integrated Single Point of Assessment

This service will operate 24 hours, 7 days a week. The service will provide a triage service whereby GPs and other practitioners can speak with an experienced community nurse who will advise on community service options or refer the client to the appropriate health team, for early intervention support through Intermediate Care services, or for a community care assessment, as appropriate, to ensure the client receives the right support whilst avoiding unnecessary A&E attendances.

2.2 Rapid Response Service

People that require immediate interventions will be referred by the triage nurse to Croydon's new Rapid Response Service. The service will allow all patients/clients who need an urgent response to be seen within 2 hours and

multi-disciplinary community services provided as needed thus giving primary care clinicians the confidence to avoid a hospital admission. The Rapid Response service model will be staffed by nurses, physiotherapists, occupational therapists, social workers, mental health specialists, pharmacy, and support workers. Services will be provided in the person's own home wherever possible, or in intermediate care beds, with the rapid response team working closely with community health and social care services.

2.3 Enhanced Case Management

Patients with long term conditions account for a significant proportion of emergency admissions to hospital. The proposed service model therefore includes enhancing our case management of this group of patients through the development of GP locality aligned multi-disciplinary teams of community health and social care staff to reduce demand across the whole health economy. The CCG has implemented a clinical risk stratification model across all GP practices which are being used to identify individuals who will benefit most from enhanced case management and integrated service provision. This is being coupled with a new approach to case management through integrated working by community health, social care and mental health services and the introduction of regular multidisciplinary meetings centred on six GP practice clusters.

Across community nursing the management of individuals with long term conditions will be reviewed to ensure closer integration between community matrons, health visiting for older people and the community nursing service as a whole.

2.4 Increased Intermediate Care

TACS has enabled the introduction of 12 Intermediate Care beds, located in a local nursing home. These beds are used as step up (admission avoidance) or step down (rehabilitation after discharge). The beds are supported by Croydon Intermediate Care Team (CICS) who provide the community geriatrician and therapy input. Nursing Care is provided by the home. The beds are used for up to 6 weeks and the focus is on enabling rehabilitative care so that the patient can return to their original place of residence once fit.

3. Early Intervention and Reablement

Reablement (and the wider hospital avoidance and discharge services) are a pivotal part of the DASHH current transformational agenda, both in terms of improving outcomes for patients/customers, and for the delivery of efficiency to both health and social care budgets. There are significant developments being planned and implemented locally by our partners in the Croydon Clinical Commissioning Group and it is essential that our reablement offer fits into this wider holistic development of health and social care services.

The Reablement and Hospital Discharge Programme has funded the development of an occupational therapy and social care reablement service which supports patients to regain functional, practical, and social skills and confidence to enable them to regain independence within their own home and community following a period of hospitalisation. For patients being discharged from hospital but who are not quite ready to go home (but do not meet the criteria for intermediate care services) following discharge, 6 reablement beds have been established in a residential home which has access to on site facilities (including gym, adapted kitchen, consultation rooms) where O.Ts and social care reablement staff can provide input to enable the individual to return home. There are also 4 reablement flats (within 2 special sheltered housing schemes) which are used to support people to develop skills and confidence in living alone, with the security of staff being present on site, as a step towards returning to their own home.

Next steps in developing reablement in Croydon

It is important that reablement planning starts as early as possible when a patient is identified as potentially needing the support of community care services (Section 5.2) to facilitate their discharge from hospital. We are working to establish a reablement coordination team to improve the effectiveness of the existing reablement service and increase the number of people who will benefit from this service post-discharge. Once this new team has become established, pathways will be developed to extend reablement services as part of admission avoidance.

Croydon Council has already invested in additional social work capacity in its Adult Care Team working in Croydon University Hospital to support hospital discharge through establishing 2 social care discharge coordinator posts. These workers will work with hospital colleagues to develop the culture and practice at ward level to promote and support post discharge reablement with patients and their families.

Each patient will have an independence plan developed whilst they are in hospital, which will be put in place on discharge and overseen by a reablement coordinator. This coordinator will work closely with the Adult Community Occupational Therapy (ACOT) service which includes 2.4 reablement funded OT posts, and will ensure that provider organisations deliver reablement interventions, as prescribed, to maximise the patient's ability to regain skills and confidence to become as self-caring as possible, and will link patients/ clients to other professionals and / or universal community services where appropriate. These reablement worker posts will be established early in 2014/15 within the Short Term Assessment and Reablement Team (START).

Patients/clients may receive a mix of "reablement" services that will best meet their individual needs, and the reablement coordinator will track their progress both during and after the period of reablement. This will enable us to make

sure that the right mix of support is in place to avoid unplanned readmission to acute services.

A community based falls and bone health service is being launched to work alongside reablement services and will be part of the menu of community based services that will support early intervention for people identified through the G.P clusters and Rapid Response to prevent unplanned admission to acute services.

4. The Integrated Commissioning Unit (ICU)

The drivers for integrating health and social care commissioning in Croydon include the recognition of a new architecture for the NHS, the transfer of Public Health to the Council and the major challenge of meeting the needs of an ageing population in which chronic medical conditions are increasingly prevalent.

Croydon Council and Croydon Clinical Commissioning Group (CCG) have created an integrated, co-located commissioning unit for health and social care, with dual accountability to the CCG for health services and to the Council for adult social care and a range of children's services. From 2014 integrated commissioning arrangements will become a key part of the CCG's and the Council's operating framework. This work will serve to help us move beyond policy and the assumed benefits in terms of maintaining stability through organisational reform.

An integrated approach between the NHS and the Council will focus on:

- Preventing mental and physical ill health;
- Supporting self-care (including through personalisation);
- Enhancing primary care;
- Providing care in peoples' homes and community, where this can be done more appropriately than in hospital settings.
- achieving better outcomes for and with service users and patients
- delivering greater efficiencies, empowerment and productivity

The development of an Integrated Commissioning Unit (ICU) will support the move to a whole systems approach, reducing the pathways into accessing health and social care services. The integrated health and social care commissioning unit will have the scope to improve service performance, stop service duplication and improve standards. Additionally, it will increase co-ordination between primary care teams and specialists and between health and social care.

Through the establishment of an ICU, the intention is to consolidate and develop our current joint commissioning arrangements across the Council and CCG, extending and strengthening them in the areas of adult social care and health as well as a range of children services. The four main challenges are:

- Changing demography;
- Rising demand;
- Changing expectations; and
- Reduced resources.

To meet these challenges both organisations will be commissioning solutions in very different ways and, where it serves the interests of patients and service-users, the process will be completed in an integrated way together assessing population needs, prioritising outcomes, procuring products and services, and managing service providers.

This development will help to tackle the barriers experienced in the past around integrated commissioning and combine the best of both resources from the following areas:

- Information analysis and population needs assessments;
- Market analysis;
- Service specification;
- Provider engagement
- Patient service experience;
- Tendering / a process of selection of suitable providers;
- Development and mobilisation of contracts;
- Monitoring of service quality and efficacy;
- Management and control of budgets and evaluation;
- Cataloguing all contracts and funding streams across health, social care and public health;
- Personalisation;
- IT systems and data sharing.

Croydon CCG in conjunction with the council is seeking to develop and implement a COBIC (capitated outcomes based incentivised commissioning) approach for Older People's services. COBIC contracts, after working with clinicians across a health economy and engaging patients to find out what outcomes they want, transfer appropriate risk to providers and create the circumstances and incentives that allow them to innovate and profit from success – provided costs are managed and outcomes delivered.

5. Integrated framework agreement

Designing, procuring and delivering integrated services forms a key element of our drive toward integration, involving the development of an integrated framework agreement to procure care; support and health related community based services. Both organisations have recognised that if we continue to fragment our approach to purchasing services, relying on several different arrangements within the Council and the health service, we will not achieve person centred co-ordinated care that is affordable.

A framework agreement can be divided into 'lots' to facilitate the 'call off' of services. Croydon is intending to create lots that include:

- Housing support (aiming to keep people at home, avoid homelessness and the health and social impact this brings);
- Integrated care and support (designed to be enabling and supports people with both housing and social care needs);
- Personal care (supporting people to be as independent as they can around toileting, healthy eating, washing and dressing for example);
- Continuing health care (preventing people from being re-admitted to hospital by providing care in the community);
- Integrated social care and health provision (especially designed to support early discharge, prevention of admission, improved access to reablement and rehabilitation services and to provide medical and social intervention at the most appropriate time for the person).

A key theme underpinning the integrated framework agreement is the ability to call off services using individual outcomes. These could be social care or health related outcomes or both. Croydon is already signed up to "Making it Real" and "Thinking Local and Acting Personal". Outcome statements can be used to call off services and can be articulated with 'I' statements, therefore becoming closely aligned with Making it Real, for instance:

- "I would like to become more independent and go to the shops/exercise classes on my own";
- "I would like to make new friends in the community";
- "I would like to live with other people".

The new approach being adopted by Croydon will involve an integrated framework agreement across care client groups that will deliver:

- Greater choice for those individuals that require commissioned services;
- A person centred, co-ordinated and an integrated approach across social care, health and housing;
- An approach that uses outcomes to define the services that are delivered to and around the individual;
- The use of Personal Budgets and Personal Health Budgets;
- The reinvestment of social care and health funding where outcomes are achieved;
- The development of longer term relationships with fewer providers;
- Ensuring that through these relationships providers are monitored effectively and deliver high quality services across social care, health and support services.

An outcomes based service specification is being developed that will underpin the integrated framework agreement and will be aligned with the ASCOF, the PHOF for public health, the NHSOF and other relevant outcomes. We will also use an outcomes based contract for the framework agreement. The contract could involve rewarding providers, where outcomes are achieved, resulting in the funding being reinvested. The reward could involve high achieving

providers accessing a larger volume of business during the term of the framework agreement or having their services extended over and above providers who do not achieve individual outcomes.

The delivery of an integrated model of provision such as this will deliver a number of strategic outcomes that we will share, such as:

- Developing a shared market of providers that deliver affordable integrated services
- Aligning the vision and values of the NHS and local authority - wanting to achieve the same thing for our service users, patients and tenants and ensuring we really talk to each other and cooperate and co-ordinate;
- Utilising, embedding the culture of and learning from a true outcome based commissioning exercise;
- Finding and delivering ways to make savings at the same time as improving outcomes – **together**.

6. Mental Health

6.1 Mental Health Services- Older Adults: Service Development.

The needs of people with mental health issues run through the transformation of adult community services in Croydon and will be an integral element in the services described above.

Recent review of Mental Health Older Adults (MHOA) services undertaken in Croydon highlights that the borough already has a number of both community and hospital based services for older people with mental health problems including dementia, such as memory services, community mental health teams, carer's support, equipment services, major adaptations, telecare/telehealth, domiciliary care as well as neighbourhood luncheon clubs, faith groups etc. However, it has been concluded that a lack of integration between health and social care is leading to duplication of work and an inefficient use of resources; which is potentially impacting on the maximisation of patient/client outcomes.

It is recognised that with the projected increase in the ageing population demand for mental health services is going to increase and therefore there is a great need to reconfigure services to maximise use of resources available whilst ensuring patients and their carers achieve good outcomes from services they use. There are a number of areas that need to be redesigned namely:

The development of mental health services will be taken forward through a Mental Health Older Adults (MHOA) project which will seek to redesign services focusing provision of services in the community with the explicit aim of reducing reliance on in-patient hospital services. The areas the project will focus on are:

- Integration of community mental health services – which focus it skills on complex work needing specialist input
- Health and Social Care Integration in respect of Community Mental Health Teams;
- Third sector service provision – to increase community provision to work with people with dementia or functional mental health issues, who do not reach eligibility threshold of the community mental health team.
- Access to Intensive Home Treatment Services – provide intensive input when in crisis and avoid need for inpatient care.
- Refocus of Memory Service;
- Provision of Crisis and Home Treatment team, A&E liaison and in-reach into nursing and residential homes to reduce/avoid both A&E and inpatient activity;
- Reduction in in-patient care.

6.2 Mental Health Services for Working Age Adults

Local changes in demographics (age and ethnicity profiles) have resulted in significant increased demand on our local adult mental health system, in primary, community and secondary services. These upward pressures are currently placing significant pressures on MH Inpatient services, which impact in turn on A&E Psychiatric Liaison services. This demand pressure on the local system is manifest through enhanced difficulties of making suitable discharge arrangements for people who are admitted to hospital because of an acute physical health need or emergency but who also have serious mental health problems as well. The developing MH Strategy seeks to address these pressures and includes the following key themes:
:

- The need for a greater focus on prevention, early intervention and mental health promotion, peer support and personalised services, including the use of personal budgets where the evidence shows they can have a significant impact on delivering good outcomes
- Reducing admission rates given that these are significantly higher (21%) above average for the most statistically similar CCGs by
  - Investing in CRHT/Community services to reduce admissions and streamline access to services
  - Reviewing the effectiveness of the winter funding initiative around Psychiatric liaison
  - Working with the police on Mental Health & Policing Street Triage Proposals
  - Ensuring access to psychological support is improved
- Reducing admission rates for BME groups currently 40% for acute and 70% for PICU compared to a BME population of 23% by working closely with BME communities
- Working in an integrated way with physical health around more psychological therapy support for Medically Unexplained Symptoms and

ensuring we embed in physical health pathways as a way of investing in IAPT going forward
- Ensuring that MH services play a key part in the MDTs linked to risk stratification and the transformation agenda.
- Discharging a greater numbers of clients to primary care and review of community provision
- Making better use of the voluntary sector

To help tackle the above we are progressing patient/service user flow modelling to understand the "as is" pathway and what changes need to be made going forward.

7. Medicines Optimisation

The mainstay treatment for the majority of conditions is medication and we know that up to 50% are not taken as the prescriber intended leading to wasted resources (estimated at £500,000 per annum in Croydon) and poorer outcomes for individuals, potentially leading to increased health and social care needs. There is also evidence that between 5% and 17% of hospital admissions are due to adverse events linked to medication. It is estimated that 80% of these events are predictable and therefore potentially preventable. The predicted increase in the number of older people and those with multiple long term conditions will mean that this is an area needs to be integrated into the transformation agenda.

Agreement has been made to develop a Joint Medicines Policy across Croydon CCG, the Local Authority and Croydon University Hospital to support the key aims of ensuring safe standards of practice, maintaining independence and working collaboratively.

The medicines optimisation strategy will include activities that will contribute to the following areas:

- Maintaining independence
  - Exploring how development of the successful pharmacy reablement schemes can be continued. These involve pharmacists making domiciliary visits to housebound residents to ensure that they are getting the best use from their medicines and to address any safety or non-adherence issues that are identified

- Prevention being better than cure
  - To enhance the support given to GPs and MDTs with regard to clinical review of medication for older people with the aim of reducing the incidence of adverse drug events; through involvement in care homes services, the risk stratification tool, and piloting the Eclipse software tool.

- Further development of the initiatives to aid the identification of non-adherence including a focus on enhancing the skills of primary care within a shared decision making consultation.

- Not one more hour
  - The Medicines Optimisation CQUIN with Croydon University Hospital will be embedded and will contribute to the reduction of delayed discharges due to waiting for discharge medicines.

- Let's deal with this right now
  - The Community Pharmacy minor ailment scheme 'Pharmacy First' will continue to be promoted together with information on self-care for minor conditions.

- No quick returns
  - Improved referral pathways to be developed /strengthened linking in pharmacy support schemes with step down beds, enhanced case management, single point of assessment and early intervention and reablement.
  - Further expansion of the referral pathway for 'high-risk' persons from CUH pharmacy team to the CCG pharmacy team.

Integration Aims & Objectives

Please describe your overall aims and objectives for integrated care and provide information on how the integration transformation fund will secure improved outcomes in health and care in your area.
Suggested points to cover:
• What are the aims and objectives of your integrated system?
• How will you measure these aims and objectives?
• What measures of health gain will you apply to your population?

Plan for Croydon's whole system integration

Croydon's whole system transformation vision for an integrated care and support model is founded upon:

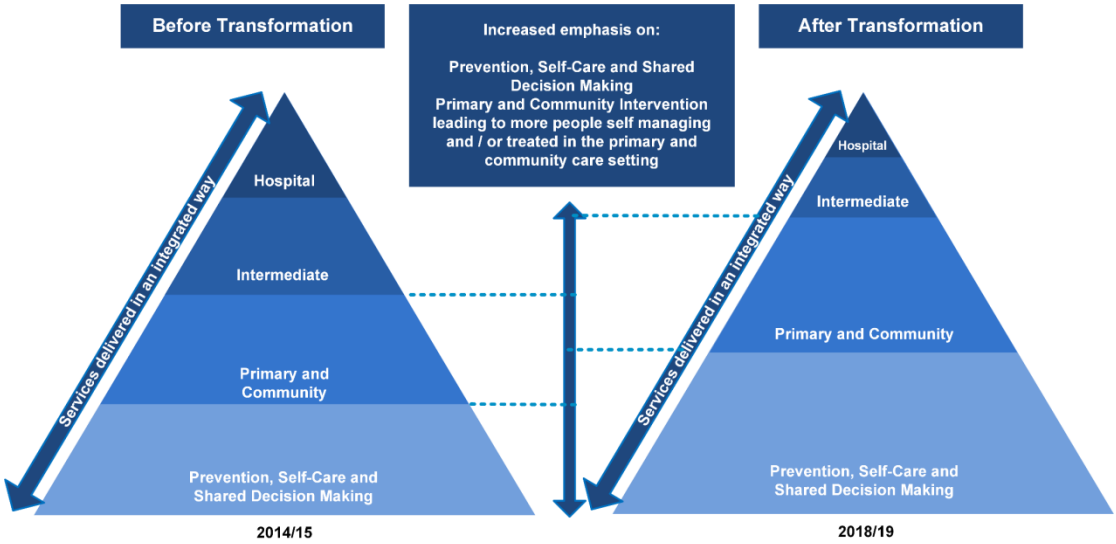
- Integrated, evidence and outcome based commissioning and contracting through the ICU across health, public health, adult and children's social care and housing support;
- Integrated person centred provision such as a single assessment point for health, intermediate and rapid care as close to home as possible and joined-up case management enhancements through the CCG/social care transformation agenda;
- Integrated personalised provision across physical and mental health, social care and housing support for individuals who repeatedly cross organisational boundaries and are disproportionately vulnerable through an integrated framework agreement;

- Strong strategic intelligence, excellent borough profiling, risk stratification and joint strategic needs assessment;
- High quality affordable provision and strategic relationships with our providers and partners where commissioners and providers agree to share financial risks and gains, incentivise joint working through methods similar to innovation incentives and commissioning for quality and utilising innovative procurement practices;
- Innovation, collaboration and commitment to effective change.
- Well developed, whole system demand management techniques and ethos.

The processes underpinning the commissioning and procurement infrastructure will become integrated, including the different pathways into services. Duplication will be avoided as an integrated service can be called off to perform functions that that would ordinarily be carried out by two different services. This provides more seamless services for Croydon residents.

A key theme that will run through the integrated infrastructure will be the prevention of ill health and deterioration of health which is underpinned by the CCG's prevention; Self- management and Shared decision Making Strategy. The single point of assessment and rapid response service will enable people to access preventative advice and services quickly, as well as access other appropriate services. The Integrated Commissioning Unit will develop evidence based commissioning strategies with a strong focus on prevention, outcomes and personalisation.

The new infrastructure will deliver high quality, cost effective community based social care and health services that can enable people to remain in the community and prevent them moving into residential care or hospital and achieve the things they want. People tell us "I do not want to go to hospital", and that they want to be able to say "I am in control of planning my care and support." And say that "My support is coordinated, co-operative and works well together and I know who to contact to get things changed". In working to achieve this outcome it is anticipated that the balance of where service is provided will shift from acute to primary and community based services which will place emphasis on prevention, and developing self-care and self-management.



Both the CCG and the Council are committed to ensuring that health and social care data is linked through using the NHS number as the agreed identifier. Work has taken place to confirm that this is possible on the Council AIS system and the Council is committed to adopt the NHS number identifier by April 2015.

The Better Care Fund will provide the platform over the next five years to continue to deliver this vision. We will manage and track outcomes through continuing to invest through the Better Care Fund in the development of a health and social care portal which will enable data to be shared across health and social care partners (with agreed information governance) and presented in reports that will enable joint strategic decision making based on real time or near time information. The portal will support the development of G.P networks in the borough and be able to provide data reports to G.P practice level.

Both the CCG and the Council will continue to undertake patient/client satisfaction surveys.

Implications for the Acute Sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

NHS Croydon CCG 2 Year Operating Plan and Better Care Fund plan will result in a shift of activity out of the acute sector and into community delivering care closer to the home. The plans build upon CCGs Primary and Community Care (April 2013) or 'Out of Hospitals' Strategy and will create improved patient care within a sustainable health economy. NHS Croydon CCG and the Council have worked extensively with our main Acute and Community Health Care Provider (Croydon Healthcare Services - CHS) to produce a shared vision of the future of healthcare service. The work has culminated in

the development of a joint Business Case to Transform Adult Community Services (TACS) plus creating shared clinical pathways. The shared vision and programme has agreed activity assumptions plus potential cost improvements in the Acute Provision, including bed closures, whilst also re-investment levels in the integrated community and support services. This shared vision and delivery programme will serve local need through better integration of services and reduce the need for people to be treated in hospital and deliver the same or better outcomes in a cost effective way.

The joint vision of both Croydon Clinical Commissioning Group and Croydon Health Services NHS Trust as outlined in the TACS Business Case points to the shared aim is to ensure that the services we commission and provide to our population are of the highest quality care, delivered at the right time and in the right place appropriate to their needs.

The improvements set out in the business case are key enablers to us meeting our existing planned 17.5% reduction in non-elective admissions over the next 5 years. It is recognised with the introduction of the Better Care Fund that this ambition will need to be stretched further.

In April 2013, NHS Croydon CCG published their Primary and Community Care strategy. This business case reflects the key aims of the strategy which are;

- Engagement with people and communities about their care and the way services are designed and delivered
- Prevention/ Public Health: A focus on prevention of ill health, self-care through education
- Shifting the balance of care from secondary to community and primary care
- Integrated Care Pathways and working around aligned 6 GP Geographical Networks
- Premises
- Information and technology
- Workforce, leadership and network development

The demand for healthcare across the UK is rising due to an ageing and growing population as well as increased prevalence of people living with long term conditions. Croydon is no different and traditional models of care will not provide efficient and effective care in the long term. This business case outlines the first steps in transforming the provision of primary and community care in Croydon, so that it can rise to the challenge of increased demand by introducing a new model of care. There are three distinct priorities, which underpin the transformation of Adult Community Services in Croydon:

1. *Enhancing care for people with Long Term Conditions*
   In Croydon, people are living longer and the population is ageing. The latest projections suggest the number of people aged over 85 will increase by two thirds by 2029. It is expected that many more people will be living with long term health conditions in the future. Long term conditions have been defined as health problems that are present for over a year or more, for example diabetes, heart disease, respiratory problems, asthma and epilepsy. It is essential that our community teams are fully equipped to support people with Long Term Conditions in the most proactive, supportive and effective way possible.

2. *Reducing Unnecessary Emergency Admissions*
   The rates for emergency admissions in Croydon are higher than in many other areas of the country - additionally, they are higher than they were three years ago. It is known that admissions can be avoided using different models of care across the health system, most notably in community and primary care

   By enhancing the community "footprint" and giving primary and community staff the resources and capacity to be able to adequately support some of these patients, we can deliver better clinical outcomes.

3. *Providing high quality, personalised care, as close to home as possible*
   Patients consistently tell us that they do not like going into hospital. Being able to be supported in their own home, in a familiar and unthreatening environment is very important and can enhance both their physical and mental health and outcomes. We want to up skill, increase and equip our adult community staff to be able to continually increase the numbers of people who can receive personalised, responsive care in this way.

All planned improvements will knit together with existing community services to provide a comprehensive menu of coordinated care and support that will transform, streamline and modernise the way care is provided in Croydon.

Added to these improvements in Community Service provision is an extensive work plan that considers the Whole System redesign of five key

Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The involvement and support of the Croydon Health and Wellbeing Board, and Health Watch, play a crucial role with overseeing the development of the integration work. The Health and Wellbeing Board in Croydon is linked to the decision making structures within both the CCG (CCG Board) and the Council (Council Cabinet) and has representation from both organisations.

The various Partnership Boards which are linked to the Health and Wellbeing Board bring together representatives from relevant organisations to set the strategic direction for these public services in Croydon. The Boards monitor performance and promote partnership working at all levels which includes joint commissioning of services where a partnership response is beneficial. Croydon has a history of strong partnerships with the voluntary sector and this is reflected in the Partnership boards. The Partnership Boards have a binding governance structure which allows information to be shared through the Boards.

An example of the commitment to integration can be seen through the development of the Reablement and Discharge Board. The Board membership is made up from the local authority, Croydon's Clinical Commissioning Group, Croydon Health Services, and the voluntary sector and has achieved the following for example:

- Over the past three years the reablement and discharge board has allocated and evaluated the £3.7 million investment in social care to deliver health outcomes. for
- The Board has so far funded 22 initiatives which have reduced the number needing acute services and has reduced hospital admissions.

National Conditions

1. Protecting social care services

a) Please outline your agreed local definition of protecting social care services.

Protecting social care services in Croydon is essential as it is imperative to ensure that the Council is sufficiently resourced to fulfil its statutory responsibility to provide social care support to people who have eligible needs. This is increasingly a challenge at a time of increasing demographic pressure, increasing complex care and support demands, and higher public expectation. The Council's commitment to supporting Croydon University Hospital to manage demand on acute services by facilitating timely and safe hospital discharges has added additional pressure on social care budgets. Over recent years this pressure has only been part met though additional funding from the Department of Health. If social care is to continue to provide this support to health and meet its statutory responsibilities then the cost pressures it faces will need to be reflected through allocation of the Better Care Fund.

The Council, working with the CCG, has used the Department of Health 'social care to benefit health' monies to try and manage demand pressures faced by health and social care through investment in early intervention and reablement services. The purpose of these services is to provide a range of interventions with the aim of:

- Reducing demand on acute services;

- Reducing the demand for long term high cost social care services.

By proactively intervening to support people at the earliest opportunity and by providing targeted support following hospital discharge, the intention has been to enable people to maximise their independence and stay within their own homes whenever possible. The shared focus has been on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, helping people take responsibility for and control of their care and support with services being there when they are needed most.

b) Please explain how local social care services will be protected within your plans.

Funding currently allocated under the Department of Health investment in social care to deliver health outcomes has been used to enable the local authority to continue to provide social work assessment both on the wards and in emergency care (A&E) in CUH to clients who have eligible social care needs, and information and advice to those who are not eligible.

The Council has grant funded and provided investment through the Reablement and Hospital Discharge Programme to several voluntary sector organisations to provide support post discharge for people who are not eligible for social care funded support.

The investments in social work, reablement and early intervention services, and the voluntary sector will need to be sustained, if not increased, within the funding allocations for 2014/15 and on the introduction of the Better care Fund in 2015 if this level of offer is to be maintained. The delivery of 7 day services and in particular the requirements of the new Care Bill will require additional resource since assessments will need to be undertaken for people who did not previously access Social Services.

Additional social worker capacity has been added to support the development of the G.P network MDTs, Croydon Health Service Rapid Response Service, and the Single Point of Assessment. This investment will need to be maintained.

The Department of Health investment in social care to deliver health outcomes monies has provided the investment for a range of reablement and early intervention services and it is proposed that this investment is continued in 2014/15 and on the introduction of the Better Care Fund with the possibility that additional resources be invested in social care to deliver enhanced rehabilitation / reablement services which will reduce hospital readmissions and admissions to residential and nursing home care.

A key on-going issue for social care will be the management of the pressure on its budgets resulting from the support it gives in enabling timely and safe hospital discharge. The social care delayed transfer of care statistics since 2010 has shown that the Council has been extremely successful in supporting discharge, but this has come at a high cost with complex packages of care

being required to maintain people at home. Funding through various schemes under the Reablement and Hospital Discharge programme has responded in part to the additional cost pressures from providing social care support post discharge; as well as contributing to offsetting the impact of demographic pressure on social care budgets.

In addition, the pressure to support patient discharge has led to an increase in demand for specialist equipment. This has placed a pressure on the pooled specialist equipment budget which has had to be offset from social care budgets.

These budget pressures aligned with the costs of an ageing population will mean that investment in social care will need to be increased under Better Care Funding if adult social care support to health is to be maintained.

2. 7-day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy)
Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Within our strategic plans and in alignment with national direction detailed within Every One Counts Planning for Patients 2014/15 and the London Quality Standards, we are working towards increasing our current seven day working offer.

We are committed to providing more care closer to home and we know in order to deliver this we need connectivity of 7 day working across the whole system, acute, community and primary care and across professions health and social care.

We already have a seven day cover for all of our essential Primary and Community services e.g. community nursing services, social care, pharmacy and our walk in treatment facilities

In 2013/14 we expanded the offer by introducing the rapid response community team with the aim of ensuring that people could avoid an unnecessary hospital admission if they could be treated at home. Through winter funding 7 day working was also enhanced within the emergency department and on the wards, for both health and social care, and we also increased the number of step down beds open over a 7 day period.

Throughout 2014/15 we will be reviewing what has worked well and through the implementation of CQUINs /BCF/ QiPP we will further enhance the weekend offer by investing in further services where it makes sense to do so, this will include mechanisms for more discharges to take place at weekends

from our local Hospital Trusts, investment in Mental Health Crisis Teams and further investment in Community Health and Social Care services.

3. .Data-sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practise and in particular requirements set out in Caldicott2.

Information Sharing (MOU-ICU)

We fully recognize the need to share both data and information appropriately across a broad range of service areas and outline our plan to do so in order to provide the greatest possible benefit to our local community, our staff and our healthcare colleagues. Our basic principles of information sharing are to:

- Provide each other with the information to help promote each other's objectives as necessary within the agreed information sharing protocols;
- Integrate engagement activities wherever possible, so as to ensure a coordinated and joined-up approach to involving Croydon residents in service design/re-design and decision making. In short, in decisions that directly affects them.

Measurement of Success

In order to monitor and measure the success of the initiatives, it is necessary to use well defined measures of success. In the current case, these will include:

- Increased sharing of information (where appropriate) to support needs assessments and service planning for the community;
- Arrangements for the underpinning of integrated service delivery and commissioning by the use of effective information sharing arrangements (ISAs).
- The use of mutually agreed accepted information sharing protocols.

Specific Measures to Share Information

In order to effectively facilitate the sharing of information, several specialist projects have been planned and subsequently embarked upon. Whilst each may be considered a separate project in its own right, the outcomes may be specifically combined to further enhance and expand the capacity for sharing information with our NHS partners. A brief description of the projects is provided:

Use of the NHS Number as the Primary Identifier

The NHS number is recognized as the primary field with which to link data across Health and Social Care. Current capability for the Council's current Social Care Records system (AIS/SWIFT) to record and use the NHS Number already exists, however, up to the present time this has happened on an infrequent basis. Switching to the use of the NHS Number as primary identifier has already been achieved by several other Local Authorities, so the scope exists for Croydon to readily achieve this. The use of the NHS Number is currently classed as "*weakly pseudonymised information*" and this needs to be adhered to with appropriate staff having access to the NHS Number according to accepted IG regulation and advice. The NHS Number project seeks to rapidly alter this situation by the following measures:

1). Rapidly instilling a culture of use of the NHS Number in parallel to the Social Care Record numbers used in the AIS and SWIFT system.

2). Encouraging partner organizations to use the NHS number. For example, reminding local GPs to use the NHS number when writing to Social Care about a Client.

3). Similarly, ensuring that all correspondence going to 3rd parties contains the Client's NHS Number where information governance allows.

4). In depth technical consideration of the issue of pairing NHS Numbers with SWIFT/AIS identifiers, including working closely with our healthcare colleagues and the Health & Social Care Information Center (HSCIC) to achieve this.

5). Technical consideration and drive to trace NHS Numbers for Client records where these are currently lacking.

6). Implementing changes to the AIS SWIFT Solution as necessary including working with 3rd party suppliers and NHS bodies (such as the HSCIC) to achieve this.

7). Allowing data sharing from SWIFT into other systems – *i.e.* the Health & Social Care Portal which will integrate SWIFT data and information according to NHS Number, thus facilitating a greater depth of analysis than currently achievable.

Project Roadmap for the full uptake of NHS Number within Social Care

The following diagram shows the NHS Number adoption roadmap for the Project. This is a 6 month project with the sole aim of establishing the use of the NHS Number as the primary identifier between Health and Social Care. During this project, the Batch-tracing method will be used to turn around the SWIFT client IDs into NHS numbers.

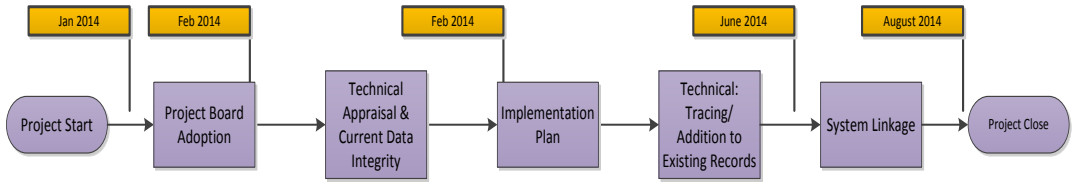


Figure 1 - NHS Number Adoption Timeline.

Implementation of an N3 Network to facilitate Health & Social Care Information Sharing

In order to effectively share information with our NHS healthcare partners, it is recognized that there also needs to be a direct link in terms of information systems. This is now seen as a vital requirement and the N3 Project will look at multiple issues with a specific view to: (i). facilitating a culture of joined-up working and (ii) allowing rapid access to health and social care information and records for the relevant cross-sector teams (or individuals). This joined-up data flow is most readily achieved by the implementation of an NHS secure N3 network. This project will specifically allow for the following:

1). Fast and efficient data and information transfer between both health and social care.

2). Ensure security and integrity of data and information during transfer and upon receipt of information.

3). Further reduce the barriers to sharing NHS and Social Care data – including some which is currently prohibited under Information Governance regulation.

4). Allow for future systems compatibility – specifically, joining systems to allow joint working between the health and social care partners.

5). Allowing for the creation of appropriate information sharing within the new Integrated Commissioning Unit (ICU) within the Local Authority and CCG.

Project Roadmap for the implementation of NHS N3 Network by the Local Authority

This Section shows the roadmap of implementation for the N3 Project over 5 months maximum.

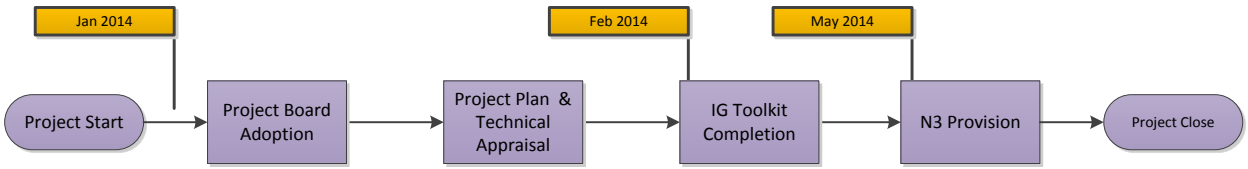


Figure 2 - NHS N3 Network Implementation Timeline

The Health & Social Care Portal

The Health & Social Care Portal Project will provide a shared information resource enabling both Health & Social care staff to view statistical analyses across the whole of the health and social care landscape. The Portal consists of 10 integrated websites which allow the view to compare and contrast information from a diverse set of feeds as well as interrogate data in a simplified and user friendly environment. For example, the ASCOF Part 1 Dashboard provides an accurate view of Health and Social Care Delays over multiple years and as a value *per* 100k of the local Population. This is shown in Figure 3 (below). In order to help with issues such as seasonal pressures, we are building a degree of interactivity into the solution to allow for rapid planning based upon local trends.

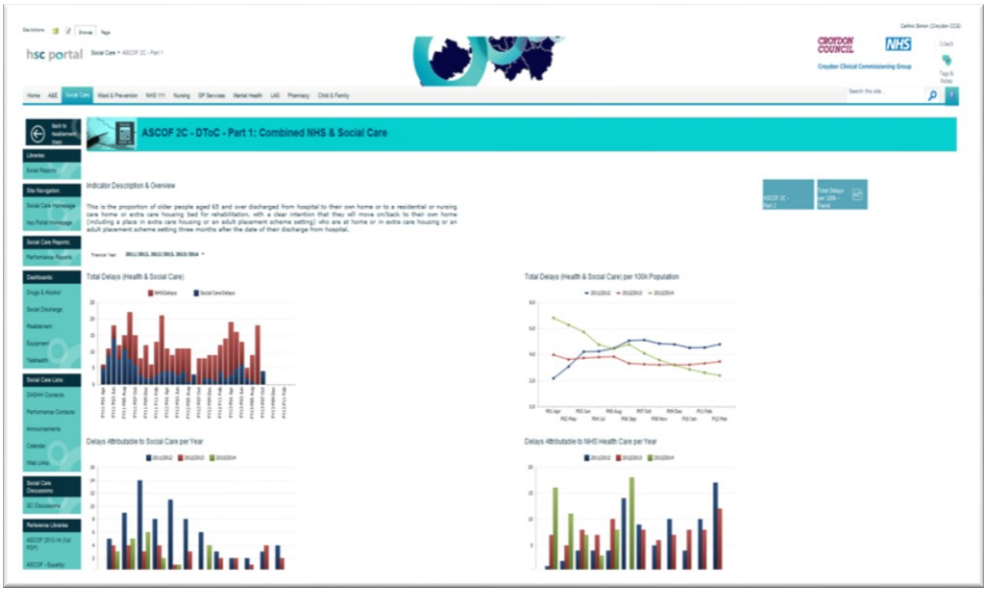


Figure 3 - ASCOF - Part 1 Health & Social Care Attributable Delayed Discharges Dashboard.

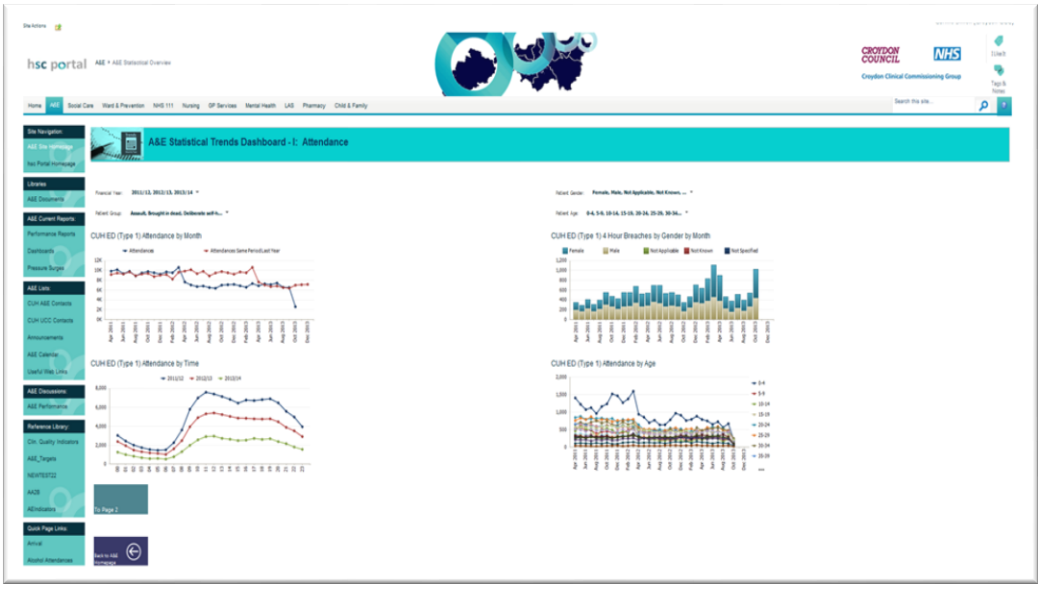


Figure 4 - A&E Attendance Trends Dashboard.

Commitment to use Open Source Software

The council will endeavour to demonstrate its commitment to the adoption of Open Source software. However, this should be placed in context with the NHS's adoption of this which has only recently started to happen as a direct result of the closure of the Microsoft Select Agreement in 2010. Whilst the recent announcement that the re-designed NHS National Spine (known as Spine 2) will be developed using (mostly) Open Source software is highly laudable, heading as it does a move away from the current Oracle Data

Warehouse to Open Source technologies [1], designed to save the taxpayer money, in truth, little is stated about niche development and support costs. Such a large scale system and its associated resources means there is a clear cost advantage, however, this may not be evident in the case of smaller systems.

The current NHS legacy of many years of the Microsoft Select Agreement means that the majority of development tools and platforms within the NHS are predominately based around Microsoft architectures. Secondly, finding a "professional" Open Source solution for data sharing using the required Open Source Architectures would tend towards only the revised SAP Mobile Platform with its vast cost association and potential lack of compatibility/interoperability with NHS Systems. Whilst there can be no doubt that many Open Source systems are of high quality, many issues exist with the practical use of these. In brief, some of these are detailed here:

- Support and Updates – it is likely that release of Open Source software updates will be of a sporadic nature and (in some cases) even non-existent posing a massive security risk.

- Security Patching – where an issue exists, the nature of Open Source Software means that there may not be an immediate patch or fix for what could be a major issue.

- Project Cost - Development and Hosting/Maintenance of Open Source Software may be more expensive compared to regular software as developers and engineers may be few and far between and may charge a premium.

- Security - Development Security is an issue with a BYOT "bring your own Tools" mentality persisting leading to security and (potentially) Information Governance issues. Conventional software locks the developer to a particular toolkit and skill set.

- Information Governance – use of conventional software often permits the locking of content or allows content to be directed at targeted individuals or User Groups (a good example of this is any page in Microsoft SharePoint). The use of Open Source software may not allow for this or, more worryingly, may be hacked by an enthusiast to bypass this. In addition, IG tools are built into regular products to deal with, *e.g.* Freedom of Information Requests. This may not be the case with Open Source software.

Areas where Commitment to Open Source Software may be made

[1] This will be built using Riak data store, Redis, Nginx, Tornado, and RabbitMQ in addition to some proprietary technologies.

Whilst is not recommended that Open Source Solutions be adopted *per se*, there are areas in which the Council could adopt these. A few of these are shown below:

- Development of the Health & Social Care Portal has been carefully planned to use a solution which is extremely well documented and secure. To this extent, it may be seen to have the reach of open source software. The use of an advanced reporting solution on top of this bears this out.
- Other Projects such as the Home Truths Project may adopt Open Source software but this is currently in the planning stage.

Commitment to Information Governance Control

The Health & Social Care Portal Project involves close collaboration with the local CSU and CCG. Although no fully defined contract is in place for this, a Memorandum of Understanding (MoU) nonetheless exists between all parties which adhere The Council is fully committed to the use of IG Control and is currently working with our CCG Colleagues to ensure that these are in place and are effective. For example, the NHS Number Project will use the current version of the IG Toolkit to assess progress at regular stages.

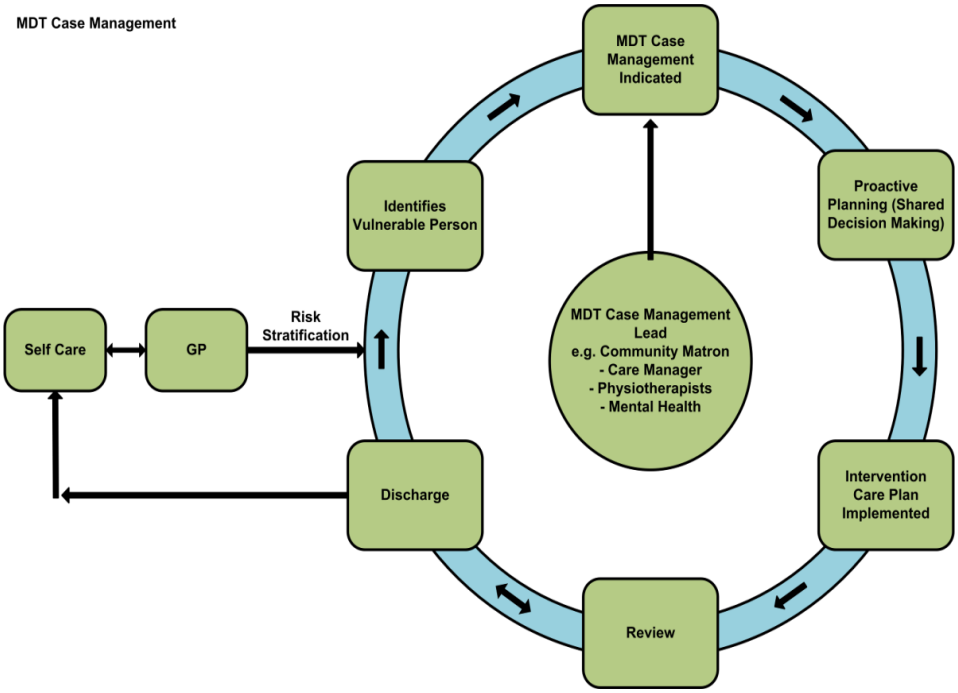
One of the central tenets of the Health & Social Care Portal Project concerns the use of both raw statistical data and Patient confidential data. As such, IG plays an important part in the planning and build of each and every portal page. Planning ensures that the Caldicott2 regulations/suggestions are adhered to with pseudonymised data being used wherever possible. Close cooperation throughout all stages of the H&SC Project with the Council's Caldecott Guardian continues to ensure that IG plays a pivotal role in the system's development.

4. Joint-assessments and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

There are 6 geographic G.P networks within Croydon and these networks will be pivotal in providing a joined up approach to the management of people at high risk of hospital admission.



G.Ps are central to coordination of care and support for their patients and multi-disciplinary teams are being established and aligned to these networks to support G.Ps with this responsibility. Patients identified through risk stratification are reviewed at monthly MDT meetings where the network support team (NST), made up of a social worker, mental health advisor, community matron, therapists, and G.Ps, are present. Each member of a network NST is expected to case-manage as appropriate across disciplines in order to ensure patient needs are addressed.

Funding from the Department of Health social care to benefit health monies has already been allocated through the Council's Reablement and Hospital Discharge Programme in 2013 to expand social work capacity to support the development of G.P networks in Croydon. This funding will need to continue and be supported through Better Care Fund.

Croydon - Target Adult Populations

(High, Medium and Combined Risk)

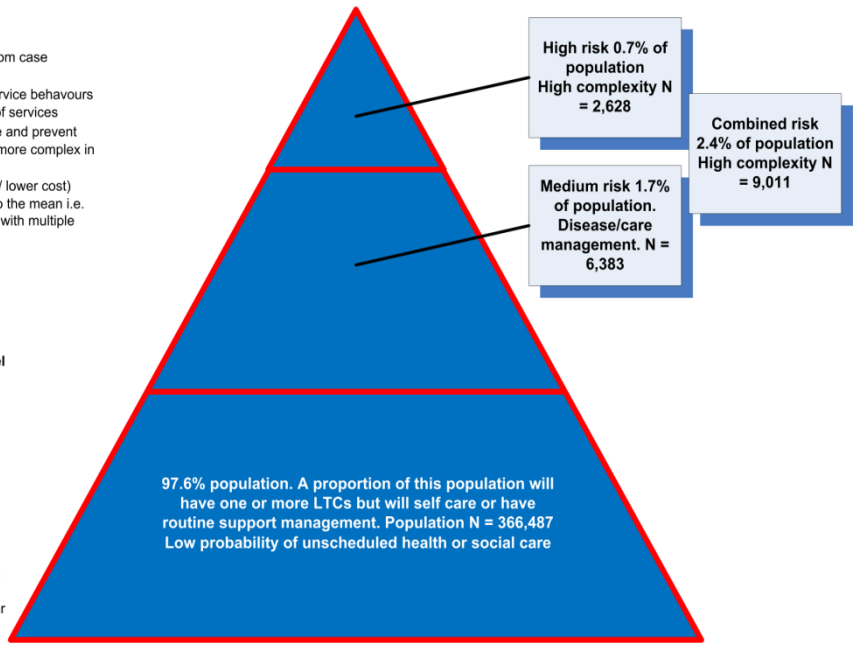
Rationale:

- Patients more likely to benefit from case management
- Prevention of future complex service behavours i.e. frequent access of a range of services
- Opportunity to promote self-care and prevent their conditions from becoming more complex in the future.
- (i.e. longer term health benefits / lower cost) •High risk patients will regress to the mean i.e. after a complex episode of care with multiple admissions

Who are people with medium level of risk?

As a guide this could include:

- Co-morbidities including mental health issues (anxiety / depression)
- The risk stratification tool will enable GPs to further identify patients who will most benefit from case management.
- - Other areas have established thresholds based on prescribing levels (Leeds) and admission levels i.e. >3 per patient per year (Merseyside)



Appendix 1 – Outcomes and metrics

To be tabled at Health and Wellbeing Board – 12th February 2014

Appendix 2 – Finance: Summary of the total health & care BCF spends.

To be tabled at Health and Wellbeing Board – 12th February 2014

Appendix 3 Key Risks

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

	Risk	Risk Rating	Mitigating Actions
1	Demand pressures for social care services required to support health outcomes in Better Care plan exceeds projections	High	DASHH has undertaken detailed analysis of high cost pressure areas and factored into 2014/15 and 2015/16 allocations.
2	Inadequate resourcing will restrict the ability of social care to provide the social work staffing resource to support plans under BCF	High	Reablement and Hospital Discharge Board to make recommendations following review of funding proposals for 2014/15. BCF Executive Group will monitor progress throughout 2014/15 and agree actions to be taken in response to under performance.
3	Inadequate resourcing will restrict the ability of social care to support social care services to support plans under BCF	High	Reablement and Hospital Discharge Board to make recommendations following review of funding proposals for 2014/15. BCF Executive Group will monitor progress throughout 2014/15 and agree actions to be taken in response to under performance
4	CCG 5 year financial improvement plan is undermined by introduction of BCF.	High	BCF financial planning to be agreed by joint Council and Social care Executive Group. BCF Executive Group will monitor progress throughout 2014/15 and 2015/16 and agree actions to be taken in response to any issues arising and adjust plans in liaison with Health and Wellbeing Board.
5	Improvements in integrated care, early intervention and reablement services fail to translate into reductions in demand for acute services and/or social care PoC's	High	2014/15 will be used to test and refine assumptions with a focus on developing service business cases and service specifications. BCF Executive Group will monitor progress throughout 2014/15 and agree actions to be taken in response to under performance.

	Risk	Risk Rating	Mitigating Actions
6	Introduction of Care Bill results in significant increase in cost of care provision from 2016 and impact on current planning.	High	Analysis of risk has been undertaken by Croydon Council and this will be used to develop assumptions and Central Government reassurances regarding additional costs being covered centrally.,
7	The limitations of BCF set metrics and the complexity in monitoring performance to patient outcomes impacts on pay by performance element of BCF.	High	Work will be undertaken by Croydon Council SCCP, Croydon Council Performance Team, and CCG to refine and agree outcome measures during 2014/15 BCF Executive Group will monitor progress throughout 2014/15 and 2015/16 and agree actions to be taken in response to any issues arising. Contingency plan to be in place in line with BCF Technical Guidance.
8	CHS are a key player in the success of implementing key BCF initiatives and realising the patient outcomes, and financial efficiencies resulting from integrated working.	High	CCG and LBC to have on-going dialogue with CHS. Development or refinement of integrated patent pathways, policies and procedures (e.g. discharge).
9	Failure to deliver data sharing between health and social care will undermine ICU and integrated service delivery (G.P MDT's, Single Point of Assessment, and Rapid Response) and the realisation of benefits of integrated working and BCF.	High	Development of health and social care portal through Reablement and Hospital Discharge programme. Engagement with S.W London CSU.