Appendix 2: 11th September 2014

Better Care Fund planning template – Part 1 (MASTER v0.06)

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Croydon Council**
Clinical Commissioning Groups	**Croydon CCG**
Boundary Differences	**None[1]**
Date agreed at Health and Well-Being Board:	**11/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£6,423,000**
2015/16	**£23,388,000**
Total agreed value of pooled budget: 2014/15	**£6,423,000**
2015/16	**£23,388,000**

b) Authorisation and signoff

Signed on behalf of the Clinical	**Croydon Clinical Commissioning Group**

Commissioning Group	
By	Mrs Paula Swann
Position	Chief Officer
Date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	**Croydon Council**
By	Mrs Hannah Miller, OBE
Position	Deputy Chief Executive
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	Croydon Health & Wellbeing Board
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

Introduction

The drive toward greater integrated working through the introduction of the Better Care Fund (BCF) is welcomed in Croydon. However, integration is not a new vision for Croydon as we have long 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.

Focused joint working to deliver innovative community-based patient/client-focused services has been much in evidence since 2010/11 through the Council Reablement and Discharge Programme and the Croydon CCG Joint Strategic Transformation Programme.

Through these joint programmes we have been working with partners over the last 3 years to develop and implement our plans for integrated care, upon which we have based our Better Care Fund submission. We have harnessed the excellent leadership that exists in our local health and social care economy to deliver service innovation - even when faced with significant financial challenges - and to deliver change through a whole system approach in line with the aspirations of the Health and Wellbeing Board Strategy (2013-18) [3]. We believe that this commitment to working in partnership both with service providers, but also those who use these services, has helped us lay the foundations for continued and sustainable service development and establish integrated working between health and social care which will now be given additional impetus through the Better Care Fund.

Realising integration is a challenge we believe that will be given additional impetus by the Better Care Fund. However, our joint planning for BCF recognises that integration and continued service development will be undertaken at a 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) [2] which seeks to deliver £65.9 million in savings in order to reach financial balance for the organisation. We believe that our joint track record in delivering joint transformation programmes place us in good stead for dealing with these financial pressures and improving patient/client outcomes.

c) **Related documentation**

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Ref.	Document or information title	Synopsis and links
[1]	Croydon Health and Wellbeing Strategy 2013-18	This strategy sets out Croydon's vision and the long term improvements in people's health and wellbeing that we aim to achieve. It also sets out our priorities for action, as well as indicators that will help us measure progress. The Board expects that both commissioners and service providers will seek to implement the strategy by seeking integration wherever this can deliver better health outcomes, a better experience for patients and service users and better value for money. http://www.croydonccg.nhs.uk/about/CCGMeetings/Board%20papers/Attach%20C1%20-%20HWB%20strategy%20App%201.pdf
[2]	CCG Primary and Community 3 Year Strategy 2013-16	http://www.croydonccg.nhs.uk/SiteCollectionDocuments/CRO%20-%20Primary%20and%20community%20care%20Strategy%20Governing%20Body%20-%20Final%20Version[1].pdf Key aims 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.
[3]	Adult Care Commissioning Strategy	This 2012/13 Council strategy focussed on the key commissioning principles and in-year priorities around prevention, recovery and reablement and supporting long term health and care needs. The strategy is now being revised and updated in light of the establishment of the Integrated Commissioning Unit (ICU), and is informed by our improved knowledge of how we can influence and shape our local market for care and support in the years ahead. http://www.croydon.gov.uk/contents/departments/business/pdf/draft-strategy-public-engagement-2012-03.pdf

Ref.	Document or information title	Synopsis and links
[4]	Croydon Joint Dementia Strategy	Croydon's Joint Dementia Strategy is based on the National Dementia Strategy and recommendations from Croydon JSNA 2011. It has been produced with a number of partners, ensuring an integrated approach to all actions and recommendations. The ambition is to review and revamp the complete Dementia Pathway. http://www.cvalive.org.uk/LinkClick.aspx?fileticket=0Bg-00zAr8Q%3D&tabid=772&language=en-GB
[5]	Croydon Transformation Strategy	Croydon CCG and Croydon Council's joint Transformation agenda for adult community services sets out three main priorities that involve integrated working. These 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: • Single Point of Assessment; • Rapid Response Service; • Enhanced Case Management; • Increased Intermediate Care bed provision [Additional Document not embedded due to file size].
[6]	Croydon JSNA	The Croydon Joint Strategic Needs Assessment (JSNA) enables Croydon CCG and Croydon Council to identify the health and well-being needs and inequalities of the local population, to ensure effective and targeted service delivery. http://www.croydonobservatory.org/jsna/
[7]	Croydon CCG Operating Plan 2014/16	The Croydon CCG Operating Plan highlights: • CCG Challenges; • CCG Successes: 2013/14; • National Priorities; • CCG Priority Programme Areas; • CCG financial position; • CCG Quality enablers.
[8]	Urgent and Emergency Care Strategy	The Urgent and Emergency Care Strategy takes into account the whole system including: NHS 111/ London Ambulance

Ref.	Document or information title	Synopsis and links
		Service and the 5 levels of care (1). Hyper acute Stroke Units / Cardiology Units, (2). Acute General Hospitals, (3). Urgent Care Centre, (4). Primary Care including Walk-in Sites, GP Practices and Pharmacies and Out of Hours and (5). Self-Care. It seeks to maximise capacity at each level through clear service definitions and pathways and improving access at each point. (1). Improving self-care, (2). Improving system access, (3). Improving care and patient flow in ED/hospital, (4). Improving flow for patients leaving hospital, (5). Improving care options in the community.
[9]	Transforming Adult Community Services (TACS) Business Case	The Business case for the TACS Service is now fully operational in Croydon.

Additional Section References:

[1]. *Useful conversions for BCF Planning, Conversions from FCE to Spells_01.pptx*, Lucy McKeown L., Earnst & Young, Internal Presentation Document, BCF Planning, 2014.

[2]. CCG 5 Year Plan Reference, 2014.

[3]. Health & Wellbeing Board, Strategy Document Reference.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

The south west London 5 year strategy – vision

"People in south west London can access the right health services when and where they need them. Care is delivered by a suitably trained and experienced workforce, in the most appropriate setting with a positive experience for patients. Services are patient centred and integrated with social care, focus on health promotion and encourage people to take ownership of their health. Services are high quality but also affordable."

In June 2014, the six south west London CCGs submitted their 5 year strategy for health services across south west London. This strategy, which is the culmination of joint working since January 2014, seeks to address the rising demand for healthcare in south west London, and the quality and financial gaps that exist at present in its provision. The clinical input to the strategy was developed by seven clinical design groups (CDGs), with integrated care being both a CDG in its own right and a major component of the strategy as a whole. Patient feedback was sought as part of this process and used by the CDGs in developing the initiatives in the five-year strategy.

For integrated care services in particular, the vision across south west London is to develop services that:

- help people to self-manage their condition and helps understand how, when and who to access care from when their condition deteriorates;
- help to keep people with one or multiple LTCs and complex needs stable;
- allow people to get timely and high quality access to care when they are ill, delivered in the community where appropriate;
- support people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home
- provide people who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence
- support and provides education to both family and carers to ensure their health and well-being needs are met, and includes support to maintain finances and staying in work, where relevant
- help people requiring end of their life care to be supported to receive their care and to die in their preferred place.

The above reflects the agreed aims of Croydon CCG and Croydon Local Authority. The CCG and Local Authority have localised this vision 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.

Over the next 5 years we will meet the health needs of the people of Croydon in very different

ways, working toward less reliance on hospital care through improved primary and community care provision and continuing to develop our approach which focuses on prevention, self-care and shared decision making. The diagram below gives a high level overview of our plans from 2014/15 to 2018/18:

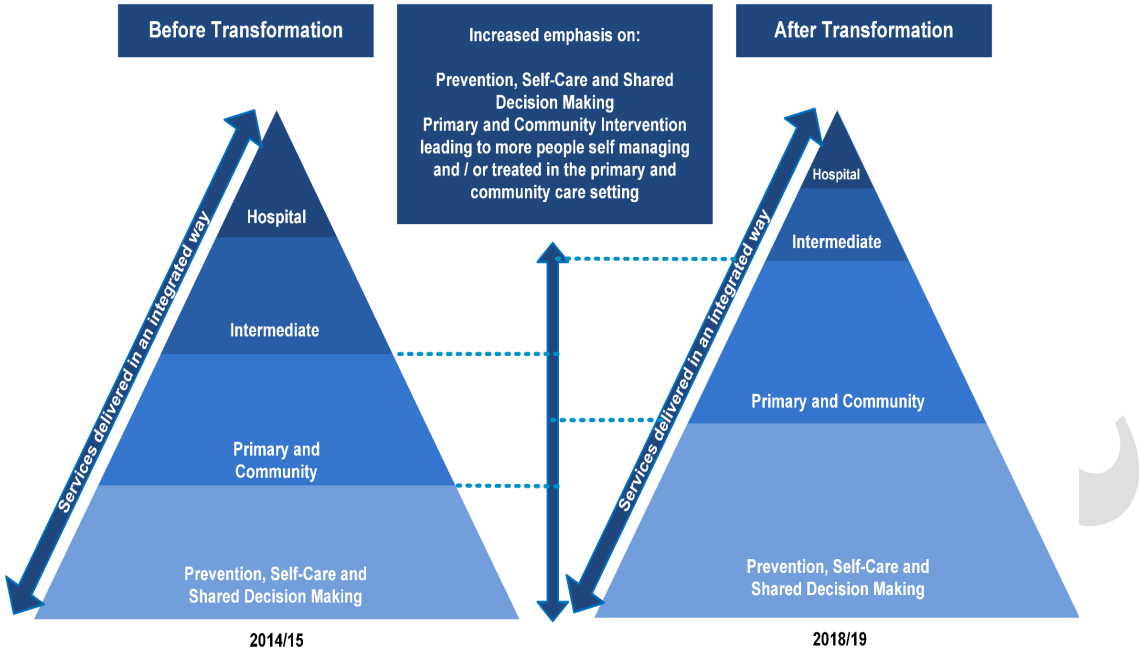

Figure 1- High-level schematic overview of Transformation Plans (2014/15 to 2018/19).

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 established a joint programme focused on reablement and supporting hospital discharge through Department of Health monies for social care, 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, G.P's, key health providers, and the third sector were a key partners. This programme worked in tandem with the CCG's Service Transformation Board to establish and support a range of initiatives which would enable prevention and reablement interventions to deliver the most important outcomes for the public; and respond to the pressures on acute health services. In July 2014 Croydon Council and Croydon CCG brought together these two Boards and formed the Transforming Care Board to oversee the continued delivery of the health and social care integration agenda in Croydon.

Through joint working over the last 4 years a number of key principles were established and will continue to be central to service 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 return 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 “lifetime career in care”. The use of mixed social care and health services to support people in order to get their confidence back and to learn or re-learn activities of day-to-day 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 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, would 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 hospital without a great deal of support so as to ensure they do not re-emerge in A&E.

Our Five Year Focus:

The Transformation Programme, in addition to achieving improvements in quality outcomes is also expected to reduce an over-reliance on hospital services, resulting in people feeling more empowered to manage their own condition(s) and with more provision of care taking place in primary care and community settings.

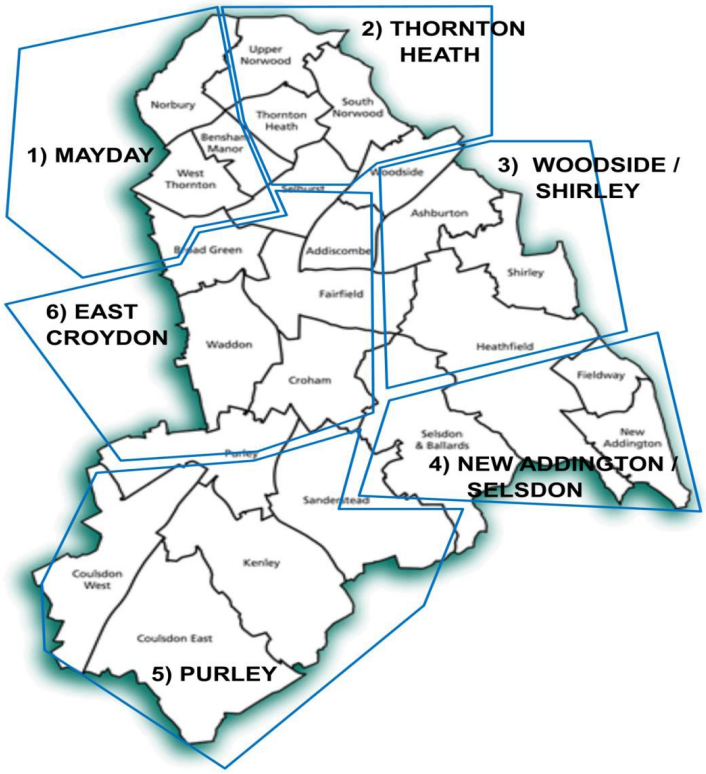

Figure 2- Geographical Distribution of Croydon's 6 Local G.P. Networks.

Primary Care and Community Services form one of the biggest areas of service change with NHS Croydon CCG having developed 6 Geographical Networks with populations up to 80,000 in each. These Geographical Networks comprise: GP Member Practices, Pharmacies, Community Services (including Health, Social and Voluntary) and are supported by Public and Patient Groups, Public Health and Commissioning functions so as to ensure that each Network implicitly understands their communities, in terms of:

- Pockets of deprivation;
- Prevalence of ill health, *e.g.* numbers of people with Long Term Conditions (LTCs);
- People who are vulnerable, including those with a Mental Health Diagnosis, a Learning Disability, Older People, as well as Children and Families requiring additional support;
- How health resources are utilised within their localities.

Focus on Prevention:

With this intelligence, the Geographical Networks are able to work more proactively with Public Health, our Member Practices and our populations to raise awareness around:

- Early detection of illness by attending screening sessions;
- Prevention of ill health, through education and health programmes;
- Identification, through "soft intelligence" within practices and community services and

through Risk Stratification, people who would benefit from a Multi-Disciplinary/Professional Case Management approach to their care;

- Self-care programmes to empower people to manage their long-term condition and avoid ill health exacerbation.

Focus on Self-Care:

All of our pathway service redesign work is focussed on self-care and self-management where appropriate. Recent design work (*e.g.* Mental Health, Diabetes, Cardiology, Dementia, Urgent Care) has included the following steps in the pathway: prevention, early detection, self-care, Self-management, shared decision making and right time, right place, first time service point principles. Supporting this we have invested in the ABCD to work within our networks to empower communities to work with health and social care on improving health, we understand that this is complex area of work as it requires a shift in cultural attitudes, but together with our populations we are committed to delivering healthier, longer lives for all of the population we serve.

Focus on Primary Care:

We are and will continue to work closely with our member practices and our pharmacies to enable people to have health support when they require closer to home. We are working with NHS England Primary Care and our Member Practices to reduce variations in our contracts and to increase the standards through the quality productivity framework. We have developed local enhanced and direct enhanced services that meet the aims of our overall ambitions to maintain people closer to home and to only use hospital services when needed.

This will mean we will review our current existing opening times, and review within our networks hub and spokes to make Primary Care more accessible to meet the needs of our populations

Focus on the Intermediate:

- On-going evaluation of intermediate services; *e.g.* urgent care access points, mental health;

- On-going planned care access points for service provision; *e.g.* access to services above what the G.P. can provide (and which the hospital does not need to provide); as is the case with components of the Urology and Gastrology pathways;

- 7 day reablement for a step-down/step-up approach to reducing lengths of hospital stay and admissions;

- 7 day intermediate care beds for a step-up/step-down approach to reducing lengths of hospital stay and admissions.

Focus on Community:

Within our community services we will, where appropriate, move to a more responsive 7 day working, so as to enable real choice for people to obtain their care close to home. *E.g.*;

- 7 day MDT model which identifies those most vulnerable and case-manages to prevent the need for Older People, Adults and Children identified to keep as well as possible;

- 7 day Rapid Response for those vulnerable populations that require input within 2 hours, and which will prevent the need to go into hospital with comprehensive medical, nursing, therapy and social care response delivered at home (including Care Homes);

- 7 day working where appropriate with Health Visitors / District Nurses / Community Matrons / Community Psychiatric Nurses (CPN's) / Nurse Consultant / Specialists / Midwives / Therapists aligned to the G.P. Networks.

The development of these services within Croydon demonstrates recognition of the interdependency between health and social care in delivering patient outcomes and reducing demand / pressure on hospital admissions. One of the mechanisms to enable us to do this from 2015/16 will be the Better Care Fund. The Better Care Fund will focus our plans on joint initiatives around achieving 'health independence' and 'social independence' within the Primary and Community Care settings. These will be delivered in partnership with our integrated health trust, Croydon Health Services, the South London and Maudsley NHS Trust (SLaM), specialist domiciliary care providers, and the third sector.

We face many challenges over the coming years, with growth in our population against a challenging financial situation across health and social care and we are determined to continue to take forward key service developments at both scale and pace *via* the Better Care Fund.

b) What difference will this make to patient and service user outcomes?

<u>The south west London 5 year strategy – implications for patients and service users</u>

For patients and service users, our aim by 2018/19 is to provide with improved access to services that meet relevant quality standards, with a greater proportion of care provided by multi-disciplinary teams closer to individuals' home. We aim to expand and improve services provided outside hospital, up-skill the workforce, increase specialisation in the community and high quality care out of hospital whenever appropriate. Patients will benefit from services that are more proactive rather than reactive, and that will co-ordinate the efforts of multiple providers in seeking to improve the health and wellbeing of people across south west London.

Across south west London, we want people to experience an uninterrupted journey through services, ensure that patients' families and carers receive education and support, and improve connections to the voluntary sector. In addition, integrated services will make better provision for mental health care to enhance overall wellbeing, independence and 'social capital'.

The drive to achieve the London Quality Standards, and other relevant standards, will result in patients experiencing improved outcomes from healthcare services in south west London. The further separation of elective and non-elective surgery is expected to support a reduction in average lengths of stay and infection rates, and to lead to an improvement in outcomes.

A key driver for the 5 year strategy is to address the health inequalities that exist across south west London. Improvements to services will result in more consistent outcomes for patients, regardless of who they are and where they live.

In line with strategic planning across South West London, Croydon's aim for patients and service users is by 2018/19 is to provide improved access to services that meet the relevant quality standards, with a greater proportion of care provided by multi-disciplinary teams closer to individuals' home. We aim to expand and improve services provided outside hospital, up-skill the workforce, increase specialisation in the community and high quality care out of hospital

whenever appropriate. Patients will benefit from services that are more proactive rather than reactive, and that will co-ordinate the efforts of multiple providers in seeking to improve the health and wellbeing of people across South West London.

We want people to experience an uninterrupted journey through services, ensure that patients' families and carers receive education and support, and improve connections to the voluntary sector. In addition, integrated services will make better provision for mental health care (MH) to enhance overall wellbeing, independence and 'social capital'.

The drive to achieve the London Quality Standards, and other relevant standards, will result in patients experiencing improved outcomes from healthcare services in in Croydon. The further separation of elective and non-elective surgery is expected to support a reduction in average lengths of stay (ALoS) and infection rates, and to lead to an improvement in outcomes.

A key driver for the 5 Year strategy is to address the health inequalities that exist across the Borough. Improvements to services will result in more consistent outcomes for patients, regardless of who they are and where they live.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contributes to this?

South west London context

The strategy as a whole will require fundamental changes to how services are delivered across south west London. Over the next five years, there will be an increasing shift in services from the acute to community services, with the development of more proactive services. Below are the anticipated changes by clinical area, as defined in the strategy by the seven clinical design groups:

- **Children's services** - Investment in community children's services during in advance of rolling-out integrated children's services and the Paediatric Assessment Unit model. The impact on acute capacity would then be assessed with a view to a future consolidation of acute children's services.
- **Integrated care** - Focus on the implementation of BCF plans during 2014/15 and 2015/16, with work in parallel to consider contracting, workforce and IT enablers for improving integration across south west London. Implementation of seven-day working in the community from 2016/17.
- **Maternity services** - All units to achieve 98-hours of consultant obstetric presence by the end of 2014/15, with full compliance achieved by 2018/19. Midwifery-related LQS to be achieved by the end of 2015/16.
- **Mental health** - Series of initiatives to develop capacity in community services, including developing a single point of access, increased access to IAPT and greater provision of home treatment, to be implemented between 2014/15 and 2016/17, with a view to reducing acute in-patient activity from 2017/18.
- **Planned care** - Creation of an implementation plan for a multi-speciality elective centre (MSEC), with Urology services deployed in an elective centre from 2016/17, one further specialty from 2017/18 and three more from 2018/19. Planning to include

consideration of appropriate quality measures and approaches to contracting.

- **Primary care** - Fully networked model of primary care, in line with NHS England plans, to be achieved by 2016/17, with implementation plans for estates improvements and workforce transformation to commence in the same year. Greater emphasis to be placed on MDT working, prevention and supporting self-management.
- **Urgent and emergency care** - Implementation of seven-day working across urgency and emergency care services in SWL by 2015/16, supported by an ambulatory emergency care model. LQS to be achieved in all emergency departments by 2016/17. Further improvements in efficiency and effectiveness, including greater connectivity with other settings, to be pursued through implementation of new IT systems.

Specific to Croydon, the Better Care Fund will enable us 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 co-ordinating 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 co-ordinated 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.

Co-ordination 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 co-ordinated and flexible around the needs of individuals.

We are committed to ensure that the people in Croydon 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 expect this ambition 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 to see consistently high patient/client satisfaction with 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 net reduction in the demand for high cost acute services and reduce demand for higher cost social care packages of care.

Patients should experience a seamless service delivery:

Patients and social care clients have told us through various consultation and listening events that they want greater co-ordination 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 from 50,280 to 80,010.

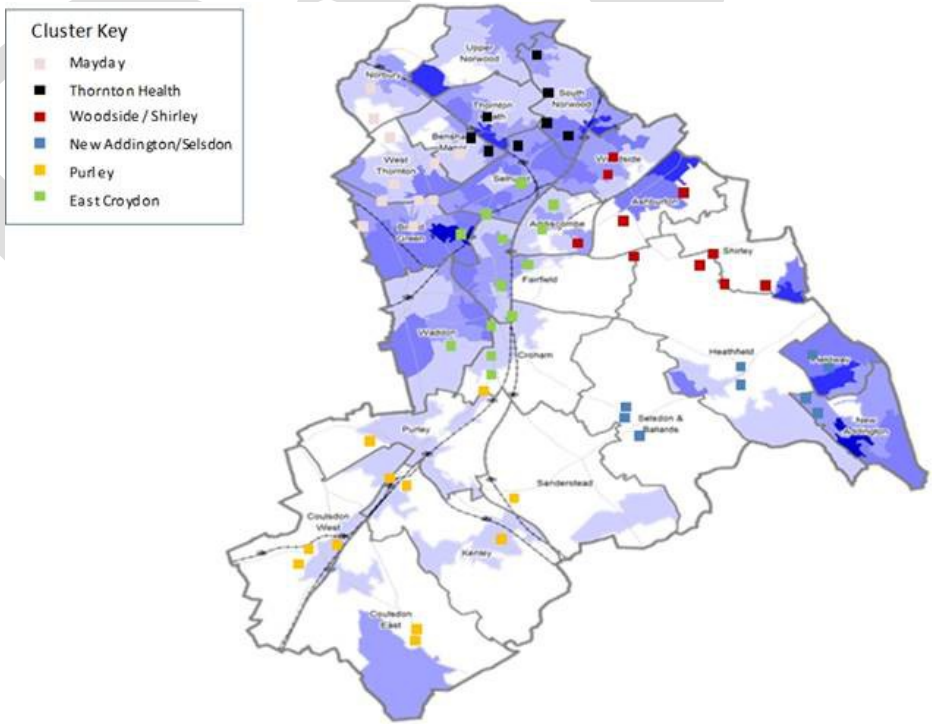

Figure 3 – G.P. Practices from the 6 Networks plotted on Heat Map of Areas of Deprivation in the Borough.

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, therefore, know where there are:

- Pockets of deprivation
- Prevalence of ill health, *e.g.*, 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.
- People with Alcohol or drug dependencies
- High levels of use of services by G.P. Practices within the Networks.

In 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.P.s are using the Croydon Risk Stratification tool to identify patients with levels of need that are likely to lead to increased use of health resources; especially acute services.

The CCG and Croydon Council working with Public Health, Providers and the Public are implementing the Prevention, Self-Care and Shared Decision Making Strategy and by linking this work within G.P. networks are able to target high impact changes through schools, children's centres, G.P. 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, lower hospital admissions, and improved patient satisfaction. The integration between health and social care through the G.P. Networks, 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 both 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 increasingly enabled to direct their care and support in order to ensure they receive the care they need in their own homes and the community. For patients in hospital the reablement process now begins 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 improved integrated discharge policy and procedure. This will ensure a consistent approach through the hospital and ensure that work begins with patients (right from the point of admission) and their families/carers to develop robust discharge plans to ensure that services are in place on the 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 so as 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 continued development of the Multi-Disciplinary Teams (MDTs) linked to each of the 6 G.P. Networks. These MDTs are using risk stratification to improve local knowledge of health need and demand to facilitate local responses in each network catchment. Through this they are developing shared processes and patient pathways linking into a range of reablement and early intervention services.

These MDTs work with the voluntary and community sectors to ensure that those not eligible for Council funded social care services, or not experiencing acute health needs can still receive support to remain healthy and maintain their independence through signposting; the MDTs then monitor patients/clients to ensure that the appropriate services are being accessed in order to prevent any decline through appropriate early intervention. This includes access to reablement services and telecare which 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 (LATC) who will undertake the installation, maintenance, and recycling of the telehealth equipment.

Underpinning all of this is a Rapid Response service that provides support to people in crisis and helps them remain at home. Launched in October 2013, this service provides 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 to their needs. Rapid Response will continue to be

developed and it will be essential to ensure that social care capacity is in place in order 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 are to commission accessible, seamless, quality services, which are personalised and responsive to the changing needs of individuals and families, designed with and for the people of Croydon in mind.

It is expected that integrated commissioning will enable:

- Choice for individuals: including 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 will 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 Responsive: People and their carers will be involved in decisions that affect them and are 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.

Section References

[1]. Reference for Risk Stratification….Solis Risk Stratification Document.

[2]. Reference to be added.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

About our Borough

Croydon Council understands that monitoring population trends is a key activity in understanding the changing profile of the areas it serves as this can provide an early warning of issues that may impact health and social care in the Borough in both the short- and long-term - thus informing and helping the Borough develop local strategies. The Council's Strategic Intelligence Unit monitors these trends and presents them in accessible open formats on a public-facing website known as the Croydon Observatory (www.croydonobservatory.org) [1]. The Croydon Observatory uses the published population statistics available from the Office of National Statistics (ONS) [2] and the Greater London Authority (GLA) [3].

The 2011 Census data shows that Croydon's population [4] was 364,463, with a G.P. registered population [5] 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 [4], some 1.3 percentage points higher than the overall UK national average. There is good evidence to support the observation that the population of Croydon is projected to increase by 16,000 by 2026 [6]. The age profile distribution for registered residents of Croydon (whole Borough) is shown below:

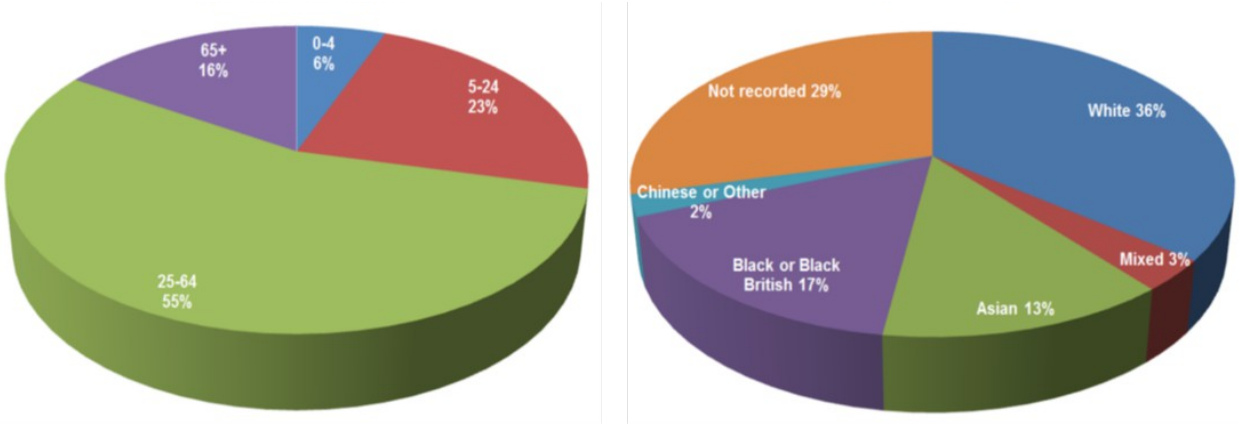

Figure 4 – (left) Age Profile for the Croydon Population. Data from the ONS based on 2011 and (right) Ethnicity Profile for the Croydon Population. Data from the ONS based on 2011 [1].

The Croydon population is highly mobile with large numbers of people moving into and out of the Borough each year. Croydon's population is also ethnically diverse: black and ethnic minority residents making up almost 42% of the population with more than 100 different languages are spoken in total [1].

Amongst those groups more likely to be in need of community care services, 60,000 people are aged 60.This represents slower population growth than the rest of the Borough [4]. 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 owing to an even greater increase in life expectancy than across the whole population. At the time of the last census (2011), over 29,000 people in Croydon were providing informal care to relatives or friends [1, 2].

Life expectancy in Croydon is 79.6 years for men and 82.6 years for women. Compared to national figures across the UK (78.6 years for men) Croydon is slightly better and equitable (at 82.6 years) for women (based on 2008-2010 data) [1,2].

Croydon is a socio-economically diverse borough. It is ranked 19th out of 32 London Boroughs in terms of overall deprivation and the diverse nature is shown with some wards having low levels of disadvantaged residents whilst others, in contrast, have some of the most deprived in England.

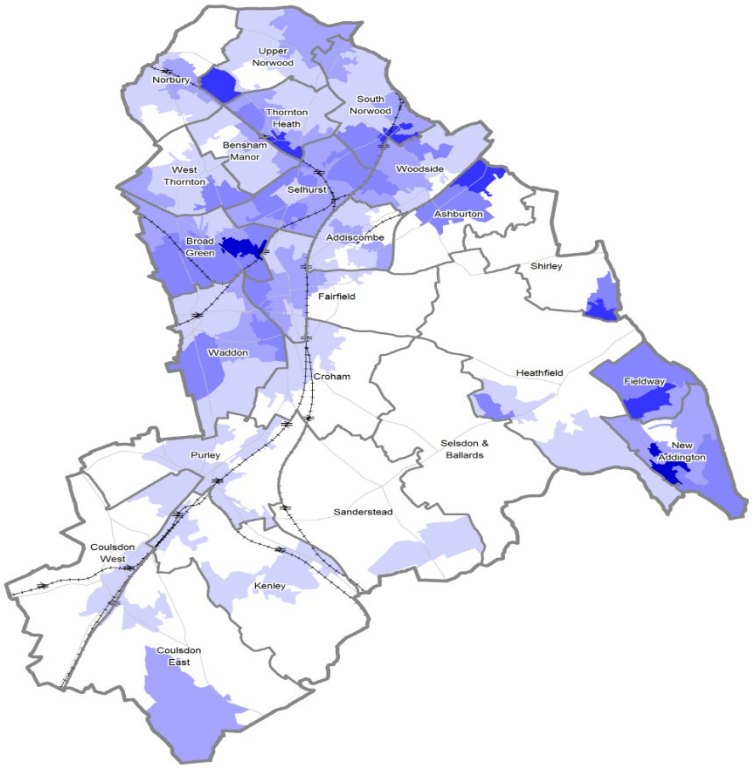

Figure 5 – Heat Map of Croydon Borough showing Nationally agreed Deprivation Index [1].

Income deprivation in particular, affects older people. Pockets of Selhurst and Thornton Heath [7] 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 [7].

Our Population- Social Care

The population for the 65 and over age group is 44,000 (representing some 12.2% of Croydon's total population of 364,463) This will be checked prior to submission. The latest population projection suggests that the number of people over the age of 85 will increase by two-thirds by the year 2029 [1, 2].

The number of people living with one or more long-term conditions is also 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 it is recognised that change will be required 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 [1] and 16,579 adults (aged 18-64yrs) have a physical disability [1].

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 the year 2030 [6].

Life expectancy has increased over the last 10 years for both females and males and 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, in comparison, 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 [2].

Figure 6 – Croydon Population from 2011-2030 for Older People by age band (using ONS population projections) [1, 2].

People with a Physical Disability:

An estimated 16,579 adults (aged 18-64 yrs) in Croydon have a physical disability; this is projected to increase to 18,416 by 2030. Some 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 the 2010/11 period. This number increases to 5,518 when older age groups are included. 65.7% of these people were female. Overall, these numbers are expected to rise to 11,117 by the year 2030, as people live longer with more serious disabilities.

People with a Learning Disability:

There are 5,379 adults (aged 18-64 yrs) in Croydon [1,2] 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 similar sized population which provides additional financial and (other) challenges on the provision of 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 were in permanent residential care and 7 were in permanent nursing care. Otherwise 668 (72.8%) were in other settled accommodation but only 70 (7.6%) were actually in paid employment. A further 79 (8.6%) were engaged in unpaid or voluntary work.

All People (18-64) with a Common Mental Disorder – Projected figures to 2020:

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

People aged 18-64 Years by Gender with a Common Mental Disorder – Projected figures to 2020:

Year / 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

Tables 1 & 2: Population projections for persons with Mental Disorder (Source: Projecting Adults Needs and Service Information (PANSI)) [10].

People with Mental Health Problems

Department of Health statistics show that one in four people will experience some kind of mental illness during their lifetime [8, 9]. Currently 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 having serious mental illness.

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 (see Table 3 below) and approximately two thirds (62.1%) of these 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+ projection of predicted cases to 2020

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

Table 3: Dementia Projection in Croydon: Source: Projecting Older People's Population Information (POPPI) [11].

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 whole lives. However, changes to the make-up of Croydon's population in addition to lifestyle trends are likely to lead to more people requiring 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 [12]. Given that we realise that older people generally have more health problems (and, therefore, utilize more Health and/or Social Care services than younger adults) the importance of this trend cannot be underestimated.

The number of births in Croydon is expected to increase by 10% as the number of women of child bearing age moving into the Borough increases within the next 5 years. This compares to the increasing birth rate of London as a whole of Figure To be added% [13].

In general terms, the health of people in Croydon is mixed compared to the national (England) average. To summarise:

- 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 within the most deprived areas of Croydon than within 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 (TB);
- There are 54,253 adults (aged 18-64 years) in Croydon with a diagnosed mental health problem. 66% of these have less limiting mental health issues such as emotional distress, depression, anxiety and obsessive compulsive disorder (OCD);
- Approximately 3,300 people in Croydon have received a diagnosis of dementia but through prevalence and demographic data there remains the real possibility of substantial growth in numbers by at least 1000 on top of this conservative figure.

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 more than a year, 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 number is likely to rise. People with long term health conditions are the most intensive users of health services. They only make up around 31% of the population, but account for some 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 which is closer to home, so as 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 well mean that many simply won't receive the support they need from family members.

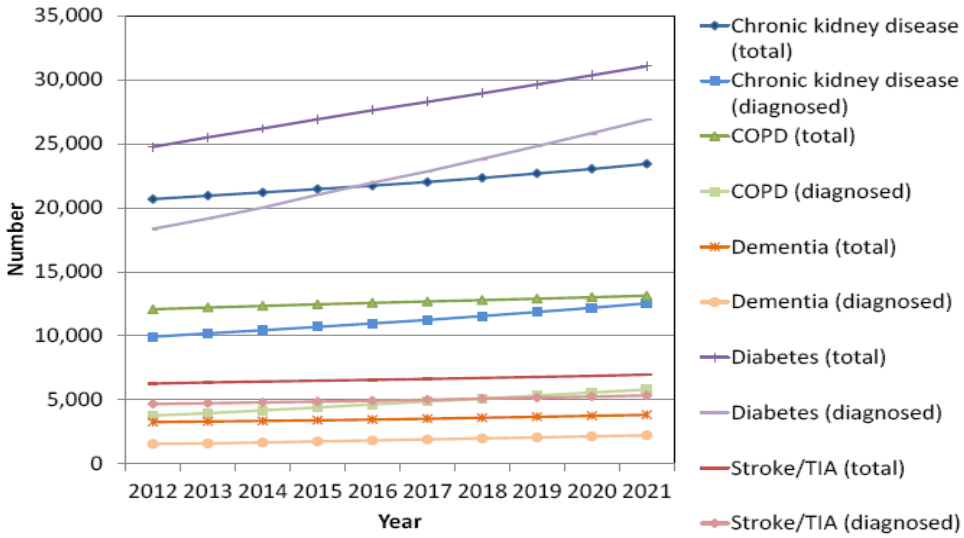

Figure 7 – Long Term Condition (LTC) Projection to 2021 in Croydon (based on G.P. Data) [14].

Section References:

[1]. Croydon Observatory Website, www.croydonobservatory.org.

[2]. Office of National Statistics Website, www.statistics.gov.uk.

[3]. Greater London Authority Website, www.london.gov.uk.

[4]. *Borough Profile Quarterly Report January 14*, Kritah A., Strategic Intelligence Unit, Croydon Council, 8th August, 2014.

[5]. *National General Practice Profiles*, Public Health England Website online calculator resource, http://fingertips.phe.org.uk/profile/general-practice/data.

[6]. ONS & GLA Population Projection Models, Croydon Observatory Website,

http://www.croydonobservatory.org/Populations_Projections.

[7]. See additional Borough Ward Map Enclosure for more detail.

[8]. DoH paper reference on mental illness

[9]. HSJ Reference on mental illness

[10]. *Projecting Adults Needs and Service Information (PANSI)*, www.pansi.org.uk.

[11]. *Dementia Projection in Croydon: Source: Projecting Older People's Population Information (POPPI),* www.poppi.org.uk.

[12]. Reference on Population living longer.

[13]. Reference of average number of births in London.

[14]. Long-term Condition Projection for Croydon: 2012-21.

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 integrated fashion. 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 [1-3](Get details of recent OBC engagement):

- 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 April 2013 The King's Fund identified, due to the ageing population and increased prevalence of chronic diseases, that healthcare will need to move away from an acute care focus towards increased self-care and better integration between primary and community services [3]. In this paper, it identified ten priority areas for Commissioners to drive through the required transformation and detailed the potential impact these would have on health outcomes and patient experience, as summarised below:

#	Priority Area	Health Outcomes	Patient Experience
1	Self-management	Medium	High
2	Primary prevention	High	Medium
3	Secondary prevention	High	Medium
4	Managing ambulatory care sensitive conditions	High	Medium
5	Integrating mental and physical health	High	High
6	Care coordination and integration	High	High
7	End of life care	n/a	High
8	Medicines management	High	High
9	Managing elective admissions	Medium	Medium
10	Managing emergency conditions	High	High

High impact
Medium impact
Low Impact

Table 1: The King's Fund listed Priority Areas for Transformation [3].

In response to these national and local drivers Croydon CCG developed their Transformation Strategy and Primary and Community Care Strategy 2013 [4], both of which reinforce the need to develop more responsive services in the community. The CCG Strategic Transformation Board adopted the Transformation Strategy in 2013. This Business Case reflects the implementation of the strategy to service delivery detailing the transformation of primary and community care services through increasing capacity and introducing more responsive, patient focused services. The planned changes will improve services in most of the ten King's Fund priority areas:

- Improved self-management by providing individuals the support they need to stay at home
- Improved primary and secondary prevention through better co-ordination of care for people with long term conditions through MDTs and access to a single point of assessment
- Better management for people with ambulatory care sensitive conditions with rapid response services available
- Increased integration and care co-ordination through both the single point of assessment and MDT meetings
- Reducing emergency activity by better management of care and directing patients to the

best available services

Ambulatory Care Sensitive (ACS) conditions are long-term health conditions [6] that can often be managed with timely and effective treatment in the community without hospitalisation; implying that a proportion of admissions for ACS conditions – though of course, not all – could be prevented. In April this year The King's Fund published a briefing which outlined the impact that tackling ACS conditions can have on emergency admissions [7]. The report detailed rates of emergency admission for people across the country with ambulatory care sensitive conditions and suggested that these admission rates vary from between 9 to 22 admissions *per* 1000 resident population.

In Croydon there are almost 5,000 admissions *per annum* for patients with ACS conditions – equating at approximately 14 admissions *per* 1000 resident population. If Croydon can tackle just this group of conditions alone and bring it into line with the best rates demonstrated across the UK (as *per* [7]) it would reduce its emergency admissions by *ca.* 6% overall.

The ACS conditions represent a subset of the patients who will benefit from the changes outlined in this Business Case [8]. In addition, the proposed changes will help support admission avoidance for patients with common ailments such as UTIs, or DVT *etc.*, thus increasing the number of admissions that can be avoided to *ca.* 11%. The avoided admissions represent more than just a financial benefit. Each of the individuals will be experiencing better quality care with improved clinical outcomes, the support they need will be identified more quickly and will have better access to services that will help them manage their own care.

Failure to act would see a continued rise in emergency admissions, increased pressure on waiting times in A&E [9] and for elective care. In this possible scenario, the existing system would be tested to breaking point with a continued focus on the Acute Care Model. The increased demand would only be met by focussing more and more acute resources on dealing with emergency care. Health outcomes for individual patients would be far poorer, and local satisfaction with the health service would decline as individuals witness waiting times for both urgent and elective care increasing rapidly.

Section References:

[1]. Client Survey Reference .

[2]. Client Survey Reference 2.

[3]. *Delivering better services for people with long-term conditions, Building the house of care*, Coulter A., Roberts S. & Dixon A., The King's Fund, October 2013.

[4]. CCG strategy doc, 2013.

[6]. ACS Condition reference.

[7]. King's Fund Briefing on ACS.

[8]. Croydon Business Case.

[9]. A&E Attendance Data for Croydon Health Services.

[**]. OND Data Reference 2011 census for Croydon.

Our Transformation:

Over the last 3 years Croydon Council together with Croydon CCG have laid the foundation for a culture of integration and transformation which will continue to be developed through the introduction of the Better Care Fund (BCF). This will see an increasing 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 a 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 already started the process of integration and joint transformation by 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 BCF.

Prevention, self-care and shared decision making

Prevention, Self-care and Shared decision making (PSS) are part of the Croydon CCG and the Local Authority shared strategy [1]. Given the challenges that the Borough faces, both in population health and in financial terms, not prioritising PSS is simply 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 continue to 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 Mobile Apps, websites and Patient Portals [2].

Many of the diseases affecting Croydon residents, such as: cardiovascular disease, chronic obstructive pulmonary diseases (COPD), Type 2 diabetes and cancer – are linked by common and preventable risk factors such as high blood pressure, high blood cholesterol and obesity, and by related major behavioural risk factors such as: unhealthy diet, physical inactivity, tobacco and alcohol use [3-5]. It is estimated that some 80% of cases of heart disease, stroke and Type 2 diabetes and some 40% of cancer cases could be avoided if these risk factors were eliminated in their entirety [3].

While specific prevention services are commissioned by the Council *e.g.* smoking cessation or weight management services, Croydon CCG continues 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, as well as the promotion of wellbeing. We will assess the effectiveness of incentivising these interventions using such levers as LESs (or equivalent) and CQINS.

This will take place both in primary care and through revising contracts with 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 patient tools such as the NHS

BMI healthy weight calculator and tracker for iPhone [4,5, 6].

We will work in partnership across the CCG, Council and NHS England to support the fulfilment of 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. (Please see Programme 1 (page 23) of the 2 Year Operating Plan for details of these).

Section References:

[1]. To be added

[2]. To be added

[3]. To be added

[4]. NHS BMI healthy weight calculator and tracker, NHS Choices, Apple App Store.

[5]. Change4Life drinks tracker, NHS Choices, Apple App Store.

[6]. Other NHS App.

[7]. Evidence-based single option service model details.

[8]. evidence-based single option service model – Best Practice Reference

[9]. CCG's Primary and Community Care 3 year Strategy, reference

[10]. Single-service Option Model.

[11]. Risk Stratification Tool Reference, Solis.

[12]. See additional Local GP Cluster Enclosure for more detail over Figure 1.

[13]. TACS Scheme details – PID *etc*.

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. These 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 and actioned by the CCG, with its partners, and Croydon Council [7] from best practice used across the country [8] and is based on the CCG's Primary and Community Care 3 year Strategy 2013-2016 [9].

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 - are developing a range of early intervention and reablement services which dovetail with the Single-Service Option Model [10] to provide the infrastructure to enable co-ordinated support of the individual so as 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.

The Integrated Single Point of Assessment

This service operates a 24 hours, 7 days a week and provides a triage service whereby G.P.s (and other practitioners) can speak with an experienced community nurse who will either 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 and potential admission.

Rapid Response Service

People that require immediate interventions are referred by the triage nurse to Croydon's new Rapid Response Service. The service allows all patients/clients who need an urgent response to be seen within 2 hours; and for multi-disciplinary community services to be provided as needed - thus giving primary care clinicians the confidence to avoid a hospital admission. The Rapid Response service model is staffed by nurses, physiotherapists, occupational therapists, social workers, mental health specialists, pharmacy, and support workers. Services are 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.

Enhanced Case Management

Patients with long-term conditions account for a significant proportion of emergency admissions to hospital. The service model includes enhancing our case management of this group of patients through the development of G.P. locality aligned multi-disciplinary teams comprising community health and social care staff so as to reduce demand across the whole health economy. The CCG has implemented a clinical risk stratification model across all local G.P. practices which is being used to identify individuals who will benefit most from enhanced case management and integrated service provision. This model – which uses the Johns Hopkins ACS Risk Stratification Tool [11] - 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 the six local G.P. practice clusters [12].

Across community nursing the management of individuals with long-term conditions is being actively reviewed to ensure closer integration between community matrons, health visiting for older people and the community nursing service as a whole. The composite view of GP Practices from the 6 Local Networks overlaid on the Deprived Areas Map of Croydon (shown in Figure 8) is shown below:

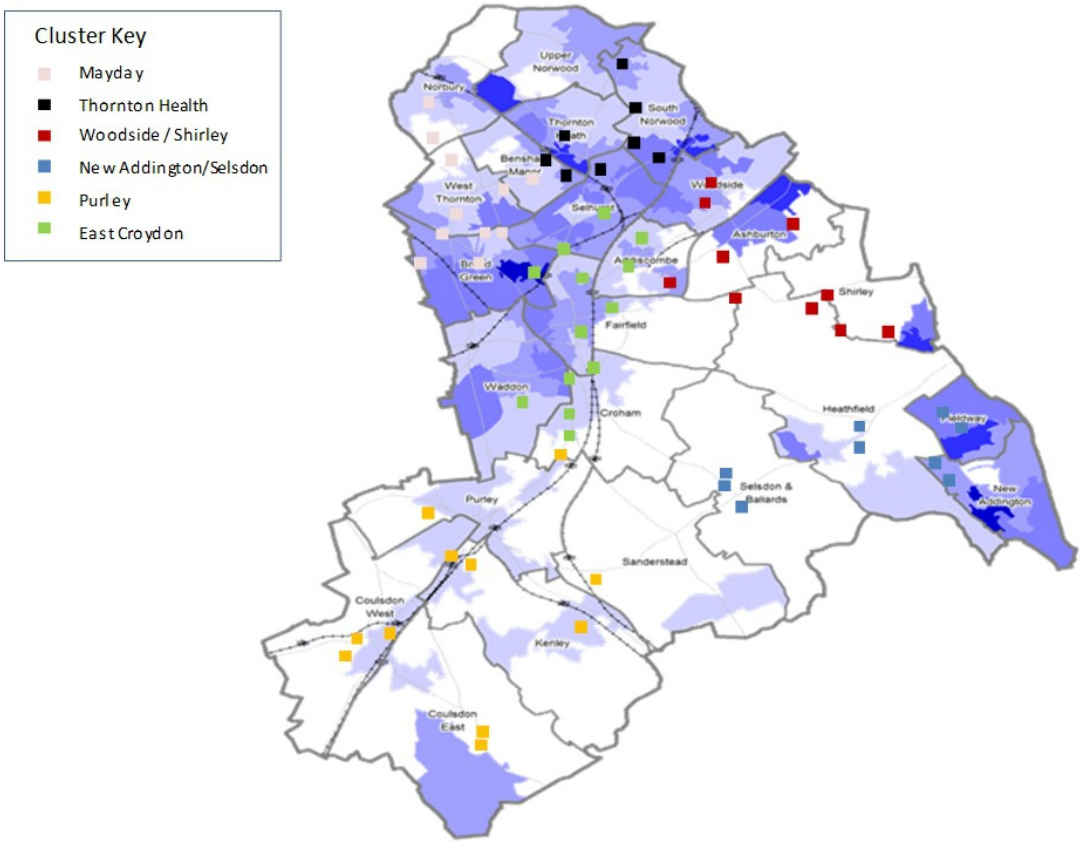

Figure 8 – Composite View of GP Practices from the 6 Local Networks plotted on areas of deprivation.

Increased Intermediate Care

TACS [13] 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 nursing home. The beds are used for up to 6 weeks at a time with the focus on enabling rehabilitative care so in order that that patient can return to their original place of residence once fit to do so.

(Please see Programme 5 (page 33) of the CCG 2 Year Operating Plan for details (check reference)

Added to the above are 5 further related schemes to improve patients care, access, pathways and improve performance on non-elective admission by improving the performance and services within community and primary care settings the five additional key work programmes are:

- Community Diabetes
- Cardiology Pathway Redesign
- Chronic Obstructive Pulmonary Disease Community Service

- Falls and Bone Health (Service for over 65s)
- Direct Listing Pre-op Hernia

2.5 Community Diabetes

A new diabetes model of care has been designed to improve the diabetes service provision in Croydon and enhance GP and patient education. The model will deliver a significant shift in location of care from secondary care to primary care with a greater emphasis on self-management, care closer to home & prevention.

Referrals into the diabetes service will be streamlined through the use of a referral management and booking service.

The new service provides additional diabetes community clinics in Croydon with the new provider providing support to GPs and increasing the skill levels of primary care to increase primary care capacity to absorb most secondary care services.

Patients and other stakeholders will be involved in the design and implementation of diabetes services

Structured patient education programmes will be available.

2.6 Cardiology Pathway Redesign

The model is an integrated and targeted approach to deliver cardiology services with adherence to NICE guidance, innovation and the principle of right care in the right place, first time to ensure that that the needs of Croydon's population are met in the most efficient and equitable way.

- Arrhythmia -Introduction of 12 lead ECG scheme across GP practices.
- Heart failure- use benchmarking to assess and improve end of life care; introduce one stop shop diagnostic and assessment; introduce a community heart failure specialist nurse team.
- Chest pain- development of a consultant led and community based service; appropriate use of angiogram and angiography; stable angina medicines optimisation.
- Cardiology advice service-; provide education and advice to GPs to manage patients 'in house' to increase patients managed in primary care.
- Stable angina- promote the use of NICE guidelines and medicines management as first line treatment.

Patient cohorts that are being targeted are under 75's, BME communities and those patients living in the most deprived areas in Croydon such as Thornton Heath, Woodside and Addington

2.7 Chronic Obstructive Pulmonary Disease Community Service

The redesign of the COPD work stream was initiated in 2013 at that time it was decided that there would be a whole system redesign of COPD delivery.

There are numerous components to the COPD Services. Some of these components are commissioned by the CCG in acute and community setting provided by CHS and Pharmacies. There are also partner services that should identify people at risk of COPD such as the Smoking Cessation Service in Public Health, TACS (Transforming Adult Community Services) and Community Pharmacies. These areas should promote prevention and self-care, signpost those at risk to primary care and if appropriate spirometry testing in order to reduce incidences of emergency responses and A&E admissions.

Key Issues

1. Those with undiagnosed COPD or with the potential for COPD are not being identified

2. The appropriate interventions, treatment and care are not being delivered in the right settings at the right time

3. Whole system resources are not being utilised in an integrated approach and delivery model to encourage prevention and self-care, utilising voluntary support or appropriate primary care.

The above has resulted in higher levels of emergency admissions and inappropriate use of health resources throughout the care pathway.

The estimated prevalence of COPD within Croydon should be in the region of 4% however the recorded prevalence is currently only 0.98%.

The census of 2011 states that the approximate population of Croydon is 365,000 indication that there is a number of 14,600 potential COPD patients and currently only 3,577 patients have been identified suggesting an increase in service need of 11,023.

2.8 Falls and Bone Health (Service for 65+)

Croydon Clinical Commissioning Group (CCG) formed a strategic partnership with Croydon Health and Croydon Council to collaboratively re-design and transform the Falls and Bone Health service to ensure the delivery of coordinated, high quality, patient focused care.

There is a shared vision 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.

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.

There are three distinct priorities, which underpin the Falls and Bone Health Service in Croydon:

- To provide an Integrated Falls and Bone Health Service, with a single point of access supporting high quality clinical outcomes
- To provide a robust specialist Falls and Bone Health Service in line with current NICE, DH and NSF Guidelines, and agreed service specification Providing high quality, personalised care, as close to home as possible
- Link the service with the Single Point of Assessment of the **Transformation of Community Services (TACS)**, developing an agreed pathway between the two services where appropriate

Patients and social care clients have told us through various consultations 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 to enable timely interventions that would prevent health issues developing into a crisis.

2.9 Direct Listing Preop Hernia

As part of the BCF work-streams it is recognised the need to reduce unnecessary attendances and thus improve the patient experience in elective as well as non-elective care. This programme recognises the need to reduce these attendances. The management of most minor surgical procedures were previously organised via the traditional models of care. There is now a recognition that such services can be best delivered in a more efficient way and closer to the patient's home by moving such services into primary care. The New Preop Direct Listing Hernia pathway, a Croydon CCG Local Enhanced Service (LES) facilitates the direct listing of hernia patients through Croydon referral support service (CReSS), the referral service commissioned by CCCG for that purpose.

The patient cohorts targets adults 19 years and over.

With the new pathway the patient is reviewed and diagnosed by the General Practitioner as having a hernia (inguinal). The GP works to an acceptance and exclusion criteria, completes a set of tests including MRSA screening and based on the outcome discusses and directly lists the patient for the procedure as a day case with a surgeon at Croydon Health Services (CHS) where the procedure is carried out. There are no follow up appointments anticipated with this pathway.

Early Intervention and Reablement

Reablement (including the wider hospital avoidance and discharge services) is a pivotal part of the Council's 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 implemented locally by the Croydon Clinical Commissioning Group and it is essential that the Council 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 (and, crucially, not meeting the criteria for intermediate care services) following discharge, 6 reablement beds have been established in a residential home having access to on-site facilities (including gym, adapted kitchen and 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) so as to facilitate their discharge from hospital. A reablement co-ordination team to improve the effectiveness of the existing reablement service and increase the number of people who will benefit from this service post-discharge was launched in April 2014. Following this new team's establishment, pathways are being 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 new social care discharge co-ordinator posts. The post holders 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 has an "independence plan" developed whilst they are in hospital, which will be put in place on discharge and overseen by a reablement co-ordinator. This co-ordinator will work closely with the Adult Community Occupational Therapy (ACOT) service which includes 2.4 reablement funded O.T. 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. These will link patients/clients to other professionals and/or universal community services as 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 co-ordinator 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 has been 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.

The Better Care Fund will be used to continue to embed and develop early intervention and reablement in Croydon and develop an integrated "whole system" approach; including alignment with TACS service development. Analysis of activity and patient/client outcomes in 2014/15 will

further inform the future alignment of health and social care resources to maximise patient/client outcomes, relieve demand on acute services, and manage demand on social care services supporting hospital discharge.

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, end service duplication and improve standards. Additionally, it will increase co-ordination between primary care teams and specialists as well as 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 presenting 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 by 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 partnership with the Council is developing an outcomes-based commissioning approach for Older People's services. Outcome-based contracts act as an approach to joining-up health and social care services in a more co-ordinated way, providing a better patient/service-user experience and minimising costly duplication and overlaps. We are jointly planning and managing these initiatives. We believe it will build upon the provider delivery and co-ordination we are already delivering through the Transformation of Adult Community Services (TACS), plus the governance and commissioning co-ordination we are developing through our new Integrated Commissioning Unit (ICU).

We have been undertaking a thorough and robust process so as to work through the issues and help all of us decide how we move forward with outcome-based commissioning. We are delivering outcomes in partnership with all of the major stakeholders involved including: patients, the general public and current providers, and we have contracted a team of Consultants with expertise in this area to help us undertake this work. The implementation plan has key points of decision on the methodology of taking outcome based commissioning forward for both the Council and the CCG. We believe the outcome-based commissioning initiative to be a stepped process building upon:

1. The integration agenda of the Strategic Transformation Board, TACS and ICU;
2. The CCG and the LBC working collaboratively, including joint workshops of the CCG governing body;

3. Working with key providers already engaged in outcome-based commissioning;
4. Engagement with CCG Member Practices at open meetings;
5. Engagement with external Consultants to aid our understanding of developing the market and contract framework;
6. The Better Care Fund (2014-2016) as a key enabler for this change to be developed.

The new contracting model will impact from 2016-17; however, opportunities for earlier realisation of benefits will be formally kept under review by the ICU (need reference or footnote to mention the procedure required to do this).

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. The framework will be in place in the Summer of 2014. 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 various 'lots' to facilitate the 'call off' of services. Croydon has created a series of 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 support people with both housing and social care needs);
- Personal care (supporting people to be as independent as they can around, for example, toileting, healthy eating, washing and dressing);
- 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 individual).

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" [1]. 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 has been developed that will underpin the Integrated Framework Agreement and will be aligned with the ASCOF [2], the PHOF [3] for public health, the NHSOF [4] and other relevant outcomes. We are using 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.

Section References:

[1]. “Making it Real” and “Thinking Local and Acting Personal” references.

[2]. ASCOF Reference to be added.

[3]. PHOF Reference to be added.

[4]. NHSOF Reference to be added.

Mental Health

Mental Health Services - Older Adults: Service Development.

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

Recent review of Mental Health Older Adults (MHOA) services undertaken in Croydon [1] highlights that the Borough already has a number of both community- and hospital-based services for older people with mental health problems including dementia. These include 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 in this area.

It is recognised that, with the projected increase in the ageing population, demand for mental health services will rapidly increase [2,3] and, therefore, there is a pressing need to reconfigure services to maximise use of resources available, whilst ensuring patients and their carers achieve good outcomes from the services they use. There are a number of areas that need to be redesigned namely:

The development of mental health services is being taken forward through a Mental Health Older Adults (MHOA) project [4] which will seek to redesign services - focusing provision of these 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;
- 3rd Sector service provision – to increase community provision to work with people with dementia or functional mental health issues, who do not reach the 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.
- Complete refocus of the 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.

Mental Health Services for Working Age Adults

Local changes in demographics (age and ethnicity profiles) [5] have resulted in significantly increased demand on our local adult mental health system, across primary, community and secondary services. These upward pressures are currently placing significant pressure on MH Inpatient services, which, in turn, impact on A&E Psychiatric Liaison services [6]. 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 additional mental health problems. The 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 these 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 Psychiatric Intensive care Unit (PICU) compared to a BME population of 48%) 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 within 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 positive changes need to be made going forward.

Please see Programme 2 (page 30) of the CCG 2 Year Operating Plan for details (check reference)

Section References:

[1]. Croydon Review of Mental Health Older Adults (MHOA) Services,

[2]. Reference for MH Services Increasing

[3]. Reference for MH Services Increasing

[4]. Reference to MHOA (different from the Review above).

[5]. Demographics Reference

[6]. Reference to A&E Psychiatric Liaison Services at CUH.

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:

  Continuation, under BCF, of the successful pharmacy reablement schemes.. 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 G.P.s 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, use of the risk stratification tool [1], and piloting the Eclipse software tool[2].

  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 [3] with Croydon University Hospital will be

embedded and will contribute to the reduction of delayed discharges which are due to waiting for discharge medicines.

- Let's deal with this right now:

  The Community Pharmacy minor ailment scheme 'Pharmacy First' [4] will continue to be promoted together with information on self-care for minor conditions [5].

- 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.

Section References:

[1]. Reference for Solis Risk Stratification Model.

[2]. Reference for Eclipse Software.

[3]. Medicines Optimisation CQUIN

[4]. Pharmacy First References.

[5]. Self-Care For Minor Conditions – document references.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The CCG, Local Authority and key providers have a shared vision, strategy and implementation programme for the Transformation programme with key deliverables and milestones across health and social care. Please see below for a diagrammatic description

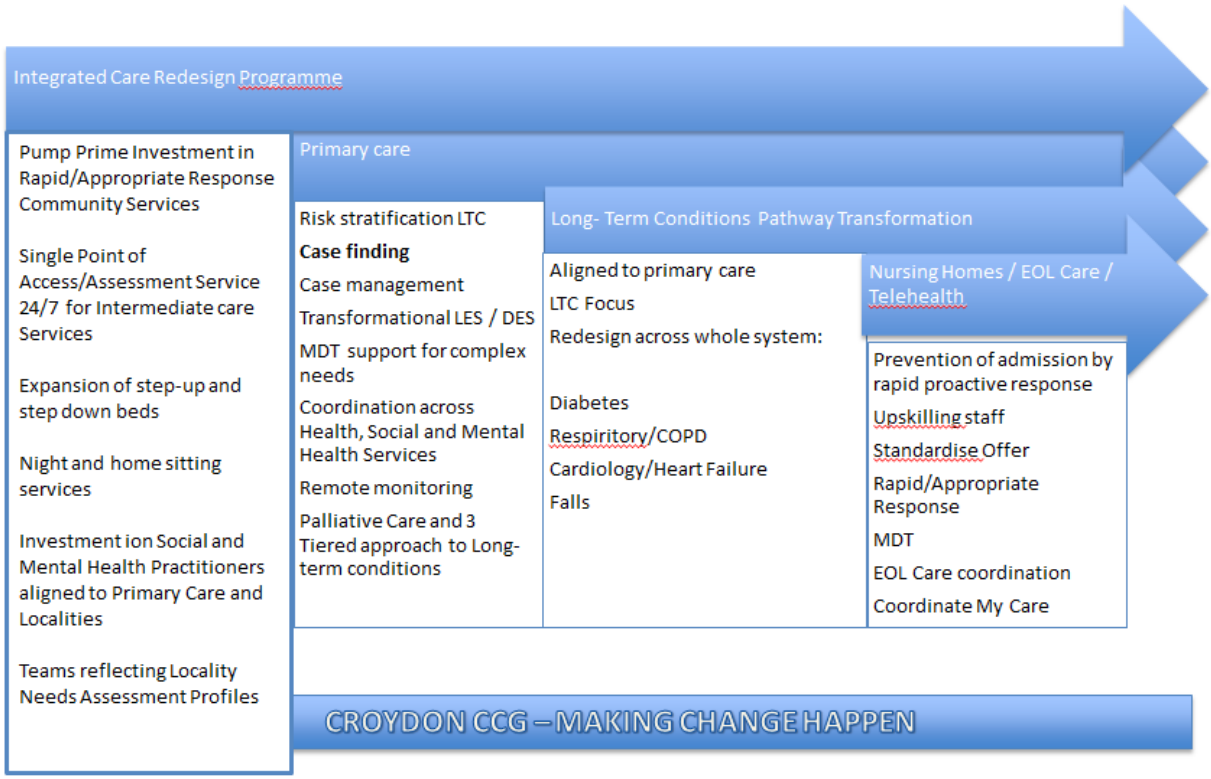

Figure xx

The overall programme has a clear implementation plan and is being monitored via the Transforming Care Board with has joint membership across commissioners and providers including CCG, Local Authority, Acute and Community Providers, Mental Health, the Voluntary Sector and Local Medical Council. Please see Transforming Care Implementation Plan for details.

The CCG via the QiPP Operational Board, which has Local Authority membership monitors on a weekly basis the 6 key Programmes related to the BCF.

Please see the Project Initiation Documents for each of the 6 schemes that include Milestone, KPIs, Performance Reports and key HRG analysis. For an example of the Milestone plan please see below for the Gantt Chart related to the Transforming Adult Community Services.

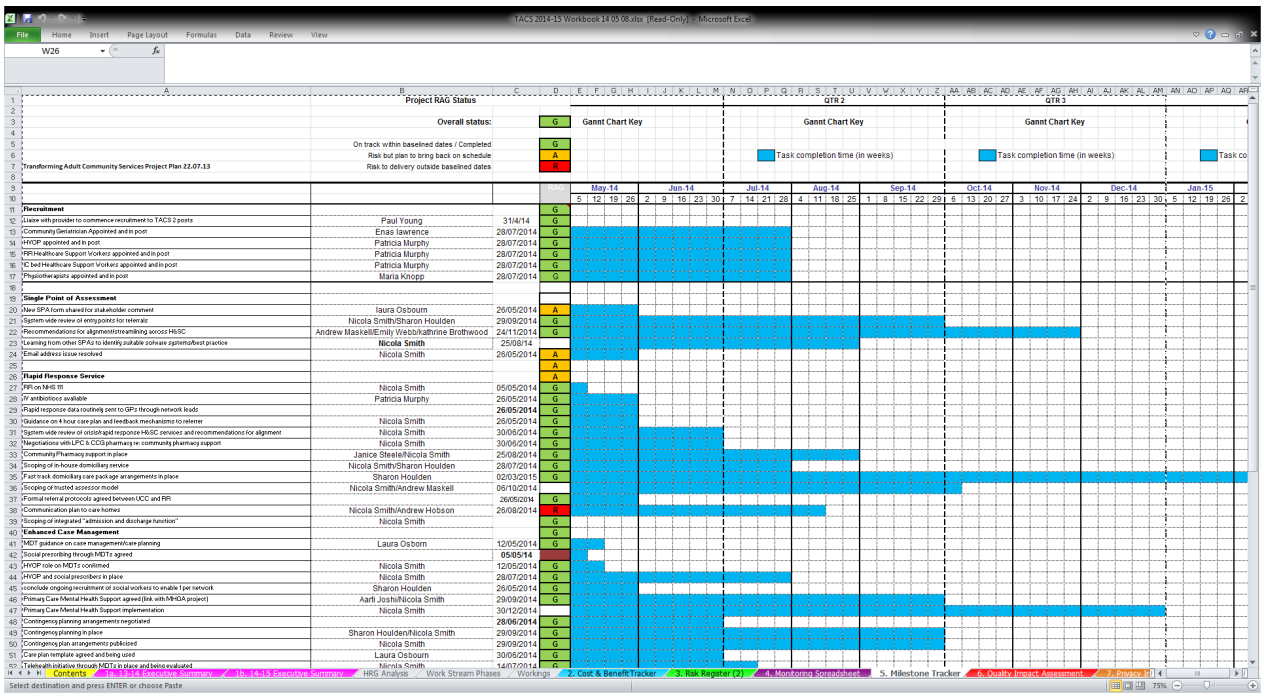

Fig xxx

b) Please articulate the overarching governance arrangements for integrated care locally

Croydon Council, Croydon CCG, health providers, and the voluntary sector have a history of working together over a number of years. This cooperative and partnership working has been embodied through joint programmes such as the Council's Reablement and Discharge Programme, the CCG Strategic Transformation programme, as well as continued work through the Croydon Resilience Working Group.

The implementation of BCF in April 2015 means there is a strategic logic in bringing together the CCG Strategic Transformation Programme and the Council Reablement and Discharge Programme and having joint governance in advance of launch of the BCF. This will enable more coordinated preparation for BCF and strengthen joint working to achieve the vision for integrated working at a time of financial challenge for all organisations in the Croydon health and social care economy. The Transforming Care Board will initially focus on the implementation of the BCF however it will also consider where an integrated strategic approach will improve the care for patients and citizens of Croydon, including 0-18 year olds.

The TCB does not undermine each organisation's duty to fulfil its statutory and local obligations to patients, service users and local people and is intended to support and improve local joint working mechanisms.

Purpose of the Transforming Care Board

The Transforming Care Board (TCB) is currently responsible for:

1. The continued development of a shared vision for integrated care that ensures a high quality, safe and affordable health and social care economy for patients and services

users;

2. The development and implementation of integrated care in Croydon;
3. Support the development and service transformation of integrated care to ensure it fulfils the national conditions and metrics stipulated in the Croydon Better Care Fund Plan (submitted April 2014).
4. To consider the risks associated with the TCB programme and to help resolve issues that arise prior to them becoming more difficult issues locally.

To ensure that:

- Quality of patient/client outcomes and service experience are maximised as a result of service transformation of services;
- The development of integrated care engages all stakeholders within the health and social care economy in Croydon and develops trust and confidence between all organisations;
- Available resources within Croydon are used flexibly in order to maximise benefit;
- National conditions of the Better Care Fund (BCF) are met.

In order to implement our joint vision, members of the Board will support each other in delivering their service transformation and fulfilling their role in developing integrated care in the borough. In particular the Board will:

- Provide overall strategic direction to the programme of service transformation and integration and its priorities;
- Provide oversight and direction to the delivery of the Croydon BCF Plan;
- Agree those priority areas around which all agencies will commit to achieve a transformed, improved and affordable service;
- Identify and bring into the overall programme those existing projects within the Borough that fall within its agreed priority areas;
- Agree the programme of further initiatives and implementation or 'task and finish groups' for delivery, including the financial and contractual elements, and that then feed back to the Board the outcomes and any issues requiring further attention;
- Review the Better Services Better Health programme and how to integrate it into the wider transformation programme;
- Monitor and review services within the Croydon Better Care Fund Plan ensuring it dovetails with the wider transformation programme.
- Ensure that risks identified by the Board are managed and notified as required to individual organisational corporate risk registers.

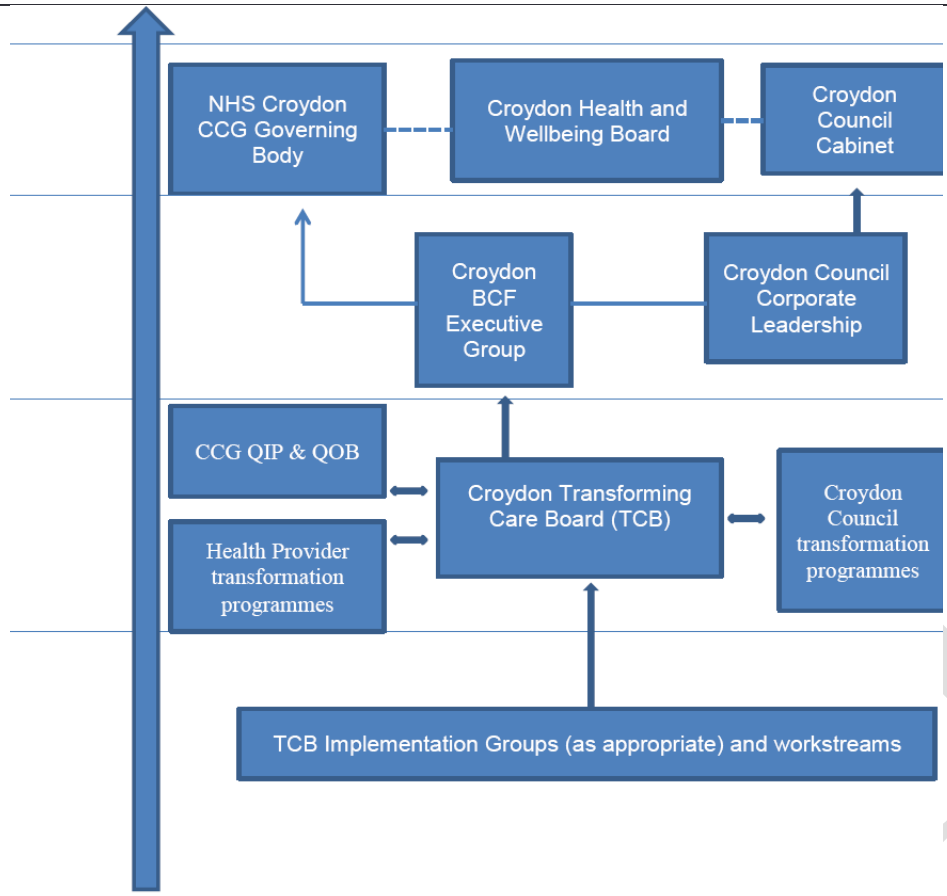

Figure 9 – Schema showing the Integrated Care Governance for Croydon.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Better Care Fund Executive Group

The Better Care Fund Executive Group holds the overall accountability for the delivery of the Better Care Fund Plan. It is responsible for providing the overarching strategic direction, coordination and authorisation of key programme activity. It is also responsible for ensuring the wider strategic alignment of the programme with other change agendas that have interfaces and dependencies with the BCF. The Better Care Fund Executive Group also holds responsibility for initiating, determining and agreeing any subset governance proposed throughout the lifecycle of the programme. Subset governance may be established as and when required to oversee the project management and implementation of specific projects (and or workstreams). Subset governance is referred to in the detailed governance schematic below as BCF Implementation Groups.

Figure 10 – Schema showing detailed Governance Structure of the BCF Executive Group.

Better Care Fund Executive Group

Purpose

The primary purpose of the BCF Executive Group is to:

- Ensure the development, submission, and implementation of a joint 2 year funding plan in line with guidance and timescales set out by LGA/NHS England[1].
- Establish joint governance arrangements are in place to oversee BCF;
- Monitor the delivery, performance and effectiveness of the joint 2 year plan in 2014/14 in readiness for BCF implementation in April 2015; taking appropriate

1 LGA/NHS England: Next Steps on Implementing ITF: 17th Oct 2013

action to address any arising problems / issues as necessary and required.

Objectives

The objective of the BCF Executive Group is to ensure:

i. That funding is used to support social care services which also have a health benefit;
ii. That due regard is paid to Croydon JSNA and Croydon health and social care commissioning plans;
iii. That the funding transfer to the local authority makes a "*positive difference to social care services and outcomes for service users, compared to services in the absence of the funding transfer*".
iv. That the full conditions of BCF are addressed in the 2 year plan:

- Plans are jointly agreed by each organisation;
- Protection for social care services
- 7-day working in health and social care
- Better data sharing, based on NHS number
- Joint approach to assessment and case planning
- Where funding used for integrated packages of care an accountable professional is identified;
- Risk sharing principles are established and contingency plans are established, including redeployment of funding if local agreement not reached;
- Agreement on the consequential impact of changes on the acute sector
-

In addition:

- Agree metrics for local monitoring in readiness for the performance-related element of ITF in 2015/16.

Duties

The duties of the Group include the following:

- Ensure that all decisions made by the group are communicated appropriately within the governance structure of each organisation.
- That appropriate information is made available in order to facilitate the development of joint plan and meet the conditions of full BCF;
- Appropriate resources within each organisation is made available to facilitate the development of joint plan and meet the conditions of full BCF;
- To have oversight of the implementation, delivery and performance of all work streams essential for the delivery of BCF 2 year plan by due date;
- To have oversight of the implementation, delivery and performance of all work streams essential for the delivery of 2014/15 plan (year 1); identifying intervention strategies where difficulties / blockages (risks and issues) are escalated to the Group;
- To ensure that an issues and risk register for the implementation of BCF is maintained, and to respond to issues and risks escalated to the Group;
- Consulting partners on actions in order to assess impact and where possible

obtain buy-in to actions required to meet BCF requirements;

Accountability

The Group is accountable to:

- Croydon Health and Well-Being Board
- Croydon Council Cabinet
- Croydon CCG Governing Body

Better Care Fund Implementation Group(s)

The Better Care Fund Implementation Group(s) (BCFIG) (and work-stream subsets) are to be established and disbanded as required, throughout the life cycle of the BCF programme. The Better Care Fund Implementation Group(s) are delivery focused and will provide the appropriate management for the delivery of projects determined and defined by the BCF Executive Group. The BCF Executive Group will provide the strategic direction that steers the Implementation Groups.

The Terms of Reference for these groups can be added to/tailored to meet the specific requirements of the particular implementation group, but broadly all will follow the objectives and purpose outlined below. As each implementation group is initiated any specifics related to the terms of reference or operational plans for the group are agreed by the BCF Executive Group. For example the Transforming Care Board Implementation Group Terms of Reference has been included.

Core purpose of the BCFIG:

- To ensure that changes required by the BCF programme are planned, managed, co-ordinated and delivered within the scope of cost, quality and time criteria specified;
- To provide appropriate communication to relevant steering groups and boards concerning solution development, and risk and issue management;
- To ensure that solutions developed are done so with due consideration of customer and partner requirements, and with appropriate consideration of the impact of any changes, and that engagement with stakeholders is undertaken in a timely manner.

Planning and Requirements:

To clearly specify requirements of work to be undertaken and delivered including;

- Setting clear expectations of scope (what the work will and will not include);
- Quality criteria (what standards, best practice etc. does the work have to meet, e.g. legal, equality etc.);
- Delivery timescales (when the work has to be produced by);
- Interfaces/dependencies to be managed (what other projects does this activity have to consider);
- Identify resources to carry out the work (who will undertake the work, are they available to carry out the work within the required timescales, does their management need to authorise the time required to complete this);
- Document risks and any mitigating actions identified during project set up;
- Approvals process (including which boards/design authorities/project assurance

groups need to confirm that the work is fit for purpose and sign it off).
- This should all be documented within the relevant organisational project documentation.

Management, Co-ordination & Delivery of Work:

- To work collaboratively to co-ordinate and deliver change;
- To ensure that changes are considered holistically, with awareness of other transformation, change and efficiency programmes;
- To ensure work allocated to the team(s) is authorised;
- To ensure clear accountability for the delivery of tasks, activities and 'products';
- Ensure that tasks, activities and 'products' are delivered to predetermined timescales and costs;
- To ensure that work is monitored, tracked and that progress is reported;
- To provide highlight reports on a six weekly basis to the BCF Executive Group;
- To review, monitor and track defined metrics via the Health and Social Care Portal;
- To ensure that the 'products', processes, procedures developed, meet the requirements of the programme as well as any other quality requirements The review function may be delegated to other subject matter expertise groups, including where appropriate, representation from corporate, partner, customer groups etc.;
- To manage issues arising within determined tolerances, and to escalate to the BCF Executive Group where decisions are required outside of delegated tolerances (specified and agreed in delivery groups / project/work stream set up);
- To take action in relation to managing any risks or issues in accordance to the steer given by the BCF Executive Group;
- To engage customers and partners in the development of solutions to ensure that the benefits of co-production are leveraged, and that the customer experience of the changes is as user friendly, and as easy to navigate as possible;
- To ensure that changes are delivered in as cost effective a way as possible, and that opportunities to create efficiencies are considered and maximised;
- To provide subject matter expertise on current service delivery, and in thinking through and planning the changes;
- To help to ensure business stability is maintained during periods of transitions and ensure that the changes are effectively integrated into the business.

Section References:

[1]. Terms of Reference for the Better Care Fund Executive Group, Croydon Council and Croydon CCG, 2014.

[2]. Terms of Reference for the Transforming Care Board, Croydon Council and Croydon CCG, 2014.

[3]. Croydon Better Care Fund Plan, version 1, April 2014

d) **List of Planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Scheme Ref.	Scheme Name
1	Transforming Adult Community Service (TACS).
2	Community Diabetes.
3	Cardiology Pathway Redesign.
4	Chronic Obstructive Pulmonary Disease (COPD) Community Services.
5	Falls and Bone Health (Service for 65+).
6	Direct Listing Pre-operative Hernia.
7	Reablement and hospital discharge – Improving and expanding care home support.
8	Psychological Support
9	Mental Health Reablement Service
10	Enhanced Staying Put Service
11	Data Sharing: Health & Social Care Portal

5) RISKS AND CONTINGENCY

a) Risk log (USE APRIL 4TH SUBMISSION TABLE AND REVIEW AT BCF EXEC)

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 and any financial risks for both the NHS and local government.

Ref.	There is a risk that…	How likely is the risk to materialise? [L] *(Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely)*	Potential Impact [I] *(Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact)* *And if there is some financial impact please specify in £'000s, also specify who the impact of the risk falls on)*	Overall Risk Factor [L] x [I] *(likelihood *potential impact)*	Mitigating Actions
1	Demand pressures for social care services required to support health outcomes in Better Care plan exceeds projections	3	5	**15**	DASHH Personalisation Economist has undertaken detailed analysis of high cost pressure areas and these have been built into BCF allocations as appropriate.

Ref.	There is a risk that…	How likely is the risk to materialise? [L] *(Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely)*	Potential Impact [I] *(Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact)* *And if there is some financial impact please specify in £'000s, also specify who the impact of the risk falls on)*	Overall Risk Factor [L] x [I] *(likelihood *potential impact)*	Mitigating Actions
					Croydon Council monthly budget monitoring. BCF Executive Group will monitor demand pressure throughout 2014/15 and review 2015/16 BCF accordingly.
2	Inadequate resourcing will restrict the ability of Croydon social care to provide the social work staffing resource to support plans under BCF	2	5	**10**	Planning re social work capacity has taken place through Reablement Board planning for 2014/15 programme. Reablement and Hospital Discharge Board (or future joint Board) to monitor demand pressure and impact on social care resourcing in 2014/15 and make recommendations to BCF Exec accordingly for 2015/16. Realignment of Croydon social work resource to meet additional demand. BCF Executive Group will monitor progress

Ref.	There is a risk that…	How likely is the risk to materialise? [L] *(Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely)*	Potential Impact [I] *(Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact)* *And if there is some financial impact please specify in £'000s, also specify who the impact of the risk falls on)*	Overall Risk Factor **[L] x [I]** *(likelihood *potential impact)*	Mitigating Actions
					throughout 2014/15 and agree actions to be taken in response to under performance.
3	CCG 5 year financial improvement plan could be negatively impacted by introduction of BCF.	3	4	**12**	BCF financial planning taken into account CCG financial position, and BCF allocations have been agreed by joint Council and Social care Executive Group. Detailed and costed CCG Operational Plan – CCG workstreams/services have been planned pre BCF and are **operational**. QIPP programme overseen by CCG Project Management Office and QIPP Operational Board governance structure. CCG have engaged external support (PWC) to support COBIC and the development and infrastructure to deliver QIPP programme.

Ref.	There is a risk that…	How likely is the risk to materialise? [L] *(Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely)*	Potential Impact [I] *(Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact)* *And if there is some financial impact please specify in £'000s, also specify who the impact of the risk falls on)*	Overall Risk Factor [L] x [I] *(likelihood *potential impact)*	Mitigating Actions
					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.
4	Improvements in integrated care, early intervention and reablement services fail to translate into reductions in demand for acute services and/or social care costs.	3	4	**12**	2014/15 will be used to test and refine assumptions with a focus on developing service business cases and service specifications. These services will be project managed using Prince2 principles and will be regularly monitored by a Project Group (Croydon Council Personal Support Division Service Transformation Group). They will report to Council Reablement and Discharge Board or new Board set up under revised governance. BCF Executive Group will monitor progress throughout 2014/15 and agree actions

Ref.	There is a risk that…	How likely is the risk to materialise? [L] *(Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely)*	Potential Impact [I] *(Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact)* *And if there is some financial impact please specify in £'000s, also specify who the impact of the risk falls on)*	Overall Risk Factor [L] x [I] *(likelihood *potential impact)*	Mitigating Actions
					to be taken in response to under performance.
5	Introduction of Care Bill results in significant increase in cost of care provision from 2016 and impact on current planning	2	4	**8**	Strong assurance from Government that full costs of care Bill will be funded Analysis of risk has been undertaken by Croydon Council and this will be used to develop assumptions Monies earmarked under BCF (BCF 22) to manage change.
6	CHS services are enablers in the success of implementing key BCF initiatives and realising the patient outcomes, and financial efficiencies resulting from integrated working. Their failure to perform could impact on key national BCF metrics	3	4	**12**	CCG and LBC to have on-going dialogue with CHS. Managed via CCG contracting arrangements. Development or refinement of integrated patent pathways, policies and procedures (e.g. discharge). CHS are members of the Reablement and Discharge

Ref.	There is a risk that…	How likely is the risk to materialise? [L] *(Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely)*	Potential Impact [I] *(Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact)* *And if there is some financial impact please specify in £'000s, also specify who the impact of the risk falls on)*	Overall Risk Factor [L] x [I] *(likelihood *potential impact)*	Mitigating Actions
					Board to which a number of workstreams that will fall under BCF will report (pending revised governance structures being established).
7	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.	4	3	**12**	Development of health and social care portal through Reablement and Hospital Discharge programme. Engagement with S.W London CSU. I.T and IG Steering Group has been established to oversee all work relating to BCF. This group includes CCG and S.W London CSU

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Croydon CCG and Croydon Council will be working with our integrated health provider to develop a risk sharing agreement in the event of the BCF target for reduction in non-elective admissions being achieved. Croydon CCG and Croydon Council have agreed that the principle underpinning the risk sharing agreement will be based on an "invest to save" policy, as opposed to holding a

performance fund in contingency. The details to be developed include the potential to disinvest from BCF funded workstreams and the reinvestment into services that have greater potential to help manage demand on acute services.

The next steps will be to develop the risk sharing agreement in readiness for the S.75 agreement. A schedule to achieve this is being developed.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

TO FOLLOW

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

TO FOLLOW

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

CCGs in SWL submitted a joint expression of interest for primary care co-commissioning in June of this year. CCG leads, alongside their local authority counterparts recognise that the lack of aligned incentives between commissioning acute, community and social care services with primary care, presents risks to the successful implementation of BCF plans. Stakeholders, including patients and the public, who have engaged on a SWL level, have stressed the importance of improved access to good quality primary care. Co-commissioning primary care is therefore an important element of the BCF.

Since submitting the primary care co-commissioning EOI, CCGs have come together to form the SWL Transforming Primary Care Delivery Group. This includes the NHSE London LAT. This group has overall responsibility to lead the implementation of the Transforming Primary Care strategic plan for SWL. In addition, CCGs are working with NHSE to develop further plans for primary care co-commissioning, currently reviewing which functions are developed locally and under joint commissioning arrangements.

SWL CCGs have identified the following specific benefits of co-commissioning primary care:

- Local knowledge and intelligence of need and patterns of services in general practice, including already commissioned LES contracts to allow more effective commissioning at

the local level

- Better coordination and alignment of already commissioned CCG services with general practice services
- Greater achievement of objectives and plans for transforming primary care in SWL through the 5-year strategic plan and the opportunity to affect change at 'scale and pace'
- Better alignment of current CCG primary care schemes with overall commissioning intentions for primary care. This includes, reducing variation in quality of primary care through implementation of the primary care service specifications (formerly primary care standards), closer monitoring and better relationships with primary care providers and alignment of already CCG commissioned initiatives with core contracting
- Contract design based on local population needs and intelligence, with greater involvement in contract monitoring and management
- Increased scale and pace of enabling factors to transform primary care including estates and workforce

All of these benefits will contribute to the success of the implementation of the BCF and integrated care plans. In particular, better implementation and outcomes for integrated multidisciplinary teams and blurring organisational boundaries where appropriate.

Commissioners in SWL are interested to assume responsibility for joint commissioning of primary care in order to align commissioning and incentives so that:

- There is appropriate support and suitable incentives to build multidisciplinary working with the right level and processes for accountability, improving the care of people with LTCs and complex needs
- Models of general practice provided and improved access to primary care services focus on the needs of the local population, in line with the HWB strategy and social care (as well as the health) needs of the population
- Primary care capacity and changes in service provision and skill mix to support this, align with local plans for expanding community services
- Primary,, community and social care providers work together to reduce health and social care inequalities
- Commissioning intentions for primary care are aligned with those for acute and community provision.

There is potential for core contract monitoring and management to be delivered across SWL, with other CCGs in SW London, influencing those discussions, maintaining control over more service design elements. However the focus for Croydon CCG after clinical and patient engagement is on co-commissioning GP contractual elements related to Outcome Based Commissioning for Over 65s plus ensuring equity of service delivery through supporting quality concerns of GP variation.

Successful outcome based commissioning and co-commissioning could provide a number of benefits for patients, primary care and CCGs, including;

- Focus on outcomes of patient care
- Focus on meeting the needs defined by patients
- Increased integration over care pathways
- Ability to influence primary care commissioning decision making
- Providing a more rounded picture of practices and the level of services provided
- Providing a mechanism to shift money across the system which can be tailored to local need
- Reduce inequalities in health provision across the localities
- Reducing confusion amongst practices over contractual matters

Croydon CCG has had extensive patient, public, stakeholder and GP engagement in relation to Outcome Based Commissioning. Stakeholder engagement events have been held throughout Croydon incorporating a wide range of viewpoints on Outcome Based Commissioning that have included discussion on improving Primary Care. There have also been specific discussions with member practices on Outcome Based Commissioning and the potential of Co-Commissioning at our Open Meeting where practices were represented.

Specific emergency meeting was held with the Clinical Leads of Croydon CCG Networks. The leads defined the scope of the CCGs interest i.e. Contractual adjustments related to Outcome Based Commissioning and Quality concerns.

Co-commissioning has been discussed at each of the Networks plus at the GP Open Meeting.

There has been some national concern by the British Medical Association and Local Medical Committees, and the CCG is aware that some members may be influenced by these views. The CCG has acknowledged these concerns and work with the local LMC and have conversations with individual practices concerned with proposals.

However, we believe that Co-Commissioning will support the CCGs plans to continue to improve the following specific areas:

The continued production of the community contract formally called LES' for:

1. The roll out of Transforming Adult Community Services particularly in relation to the Admission Avoidance DES and how it ties into the CCG's Practice Development and Delivery Scheme (PDDS) that focuses on MDTs. The PDDS also incentivises practices in the use of Rapid Response and Step Up Beds this again will be enforced through Co-Commissioning
2. The Diabetes LES
3. The Cardiology LES
4. The Nursing Home LES
5. COPD LES

Secondly Co-commissioning will strengthen the work already undertaken with NHSE on our Primary Care Lead Centres i.e. Walk-in Centre.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) **Protecting social care services**

i) Please outline your agreed local definition of protecting adult social care services (not spending)

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 very 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.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Funding currently allocated to the council for investment in social care for 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 have been sustained and in some areas increased within the funding allocations for 2014/15 Reablement and Discharge Programme (NHS transfer monies) 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 enabled Croydon Council to fund a range of reablement and early intervention service. This investment is continued in 2014/15 and on the introduction of the Better Care Fund additional resources are required to 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.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

Allocations for Protection of Social Care:

The following allocations have been made within the Croydon BCF Plan:

BCF Reference:		
BCF11:	Early intervention and Reablement:	£0.767m (specialist reablement domiciliary care)
BCF12:	Social Care Community based Services to prevent admission to hospital or care	£0.565m

	home:	
BCF13:	Support services to enable discharge:	£0.500m (including step-down beds)
BCF 21:	Social Care demographic pressures:	£2.632m
	Total:	**£4.464m**

Care Act (2014):

BCF 22:	Costs arising from Care & Social Care Reform:	**£1.152m**

Commentary on Financials:

To be added following update.

Care Act (2014):

At the same time as the BCF is further aiding integration between health and social care partners in Croydon; preparation is also be taking place to facilitate implementation of the Care Bill - as the *Care Act (2014)* from April 2015, together with further developments in April 2016. Whilst there will be additional funding allocations in support of the implementation in 2015/16, made from the national sum of £335m, there is a further £135m nationally which is included within the BCF for 2015/16. Croydon has made provision for these new burdens within its BCF plan by setting aside £1.685m (reference BCF 22). The Croydon Transforming Care Board will monitor take up of these areas during 2015/16 and utilise the resources accordingly.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The BCF funding allocated locally to support the implementation of the Care Act, has been significantly focused on enhancing support to carers, both in the assessment process, and improvement of services provided both to and for carers. Neither of these areas are new to Croydon, and so investment is not targeted at developing new services as such, but rather improving, and expanding upon existing models of service. We are in the process of evaluating and reviewing options for improving the provision of carer assessments so as to make the process less bureaucratic, offer greater choice and control in how the assessment process can be accessed and undertaken, and ensuring that the assessment process is focused on achieving positive outcomes and is not just seen as a 'tick box' exercise.

As can be ascertained from reading our Carer Strategy document we are committed not only to meeting the criteria outlined for April 2015, but also to view the continual improvement of carers services as a longer-term development objective. We are pragmatic in our approach, in the realisation that carers have historically had a reluctance to engage with the council (and our partners across the health and third sector) for support, so we realise that this is an agenda that we must progress as a community. We will work to actively publicise new carers rights (both assessment and services), the improvement to our information and advice provision, as well as to enable effective shaping of the local market. This development objective is threaded through all relevant strategies, and is embedded in the vision of the Council and the joint vision we share with our partners. Our aspiration is that in publicising support available, as well as in

enhanced linkages and signposting across partners, that we will help carers and those they care for access services at an earlier stage thereby preventing needs from escalating, and allowing our residents to experience improved outcomes and a sense of well-being.

A continuing longer term development aspiration is in improving our digital services to enable carers, family members or customers to be able to identify outcomes they wish to achieve, and know how to access relevant services. Although we have already developed some online referral forms we, and have procured a new e-marketplace and information and advice tool, we are looking at how this can be improved further to strengthen our local offer. We are mindful that due to the nature of those who may wish to access services, we need to offer and maintain a variety of channels of access. We are also aware that a significant proportion of those looking for information will use the web in the first instance as a point to gather information; be that customers and carers themselves or other partner agencies. In further developing our online offer we hope that this will allow people to be better informed of their rights, the duty of the council and its partners, as well as provide them with additional tools to be able to help themselves. The introduction of an e-marketplace will also allow our residents a tool to help them shape the local market through creating and publicising market demand. The e-market place tool will give us and our partners a valuable tool for increasing our intelligence on the local market, and help us to shape the market accordingly.

The BCF is has also been allocated locally to support the various training initiatives, both those underway and those planned. As well as training for our internal social care staff on the new legislative framework, we are also focussing training on building resilience, and on ensuring that outcomes and well-being our an integral part of our engagement with customers/patients/carers and their families.

There is considerable work underway regarding our improvement of the transition process to ensure strong and effective partnership working across adults' and children's services. We are looking organisationally at the best way to achieve this outcome both through potential service structural changes as well as through enhanced processes and supporting and embedding change through additional training for staff.

As part of our role in the development of the local market and in helping to shape our local services to meet the needs of our residents, as well as to meet our statutory obligation we have been undertaking a series of recent extensive reviews in areas where we suspected there were weaknesses within the local area. This was to provide us with a more detailed picture of the reality of the situation, to help to inform our local action plan by addressing any areas of weaknesses, as well as to learn from areas of strength in order that we could share this learning across other services. An example of one such recent development is a review undertaken of our local advocacy services. Our BCF funding locally will be invested in helping to bolster areas of service that need a more focused approach namely independent mental health advocacy and other advocacy services.

Oversight and Accountability for Delivery & Service Changes to meet the Care Act:

Croydon Council has established a Care Act Programme Board which has the responsibility of oversight, as well as overall accountability for the delivery of the required changes stipulated within the Care Act. The vision for the board is to deliver the requirements and measures outlined in the Care Act, to provide strategic direction, co-ordination and authorisation of key programme activity, and to ensure the wider strategic alignment of the programme with corporate/ large scale

joint partnership project(s) programme(s) and strategies.

The purpose of the Care Act Programme Board is to;

- Provide oversight and strategic direction to the programme, and manage the integration and interfaces of this programme into the wider transformation agendas and strategies;
- Agree Care Act Programme Plan, including agreeing (or revising as required) proposals for a staged approach to planning, delivery and review of the programme, as well as setting stage tolerances;
- Ensure that risks identified by the Board are managed and notified as required to appropriate organisational risk registers;
- Provide oversight and direction to the delivery of the Care Act Programme Plan;
- Review any feed back to the Board on progress, outcomes and any issues requiring further attention;
- Take decisions as necessary throughout the life of the programme;
- Act as a point of escalation to resolve and manage risks and issues;
- Manage prioritisation of resources across programmes, projects and BAU activity;
- The Board may choose for some elements of governance to be delegated to the Design Authorities; particularly in relation to managing the interface between existing projects and programmes. The level of delegated authority will be agreed at the discretion of the Care Act Board (see Roles and Responsibilities (summary));
- The Board also has accountability for ensuring appropriate legality of changes, and adherence, where appropriate, to council best practice for change and programme management.

Figure 11 – Schema showing High-level Governance arrangements.

Managing the various interfaces between the BCF & Care Act Programme:

Overall accountability and oversight will be provided by the programme boards. In addition interfaces between the programmes are managed through pivotal core group members, at all levels of strategic direction and change delivery bodies. This is to ensure that;

- Interdependencies across the change agendas are managed effectively;
- That change activity is scoped, grouped, scheduled and managed jointly where appropriate, to ensure effective use of investment, as well and staff resourcing;
- That change(s) to service(s) is rolled out in a logical, coherent programme of change in order to maintain high service delivery standards to our customers/patients;
- That maximum leverage and benefits of change can be achieved across all programmes;
- To provider further assurance that key areas of dependencies between the Better Care Fund and Care Act are managed effectively governance bodies within one programme may act as Design Authorities for another programme, project or work-stream;
- In addition project 'Products' and underpinning tasks (e.g. the target operating model design for a revised or new service), have 'Project Product Descriptions' that stipulate stakeholder groups to be consulted during product development, as well as clear sign off routes, to ensure that the quality of the product is deemed fit for purpose by all relevant parties;
- Co-design with partners, and customers is an inherent method to our approach across all our programmes of change.

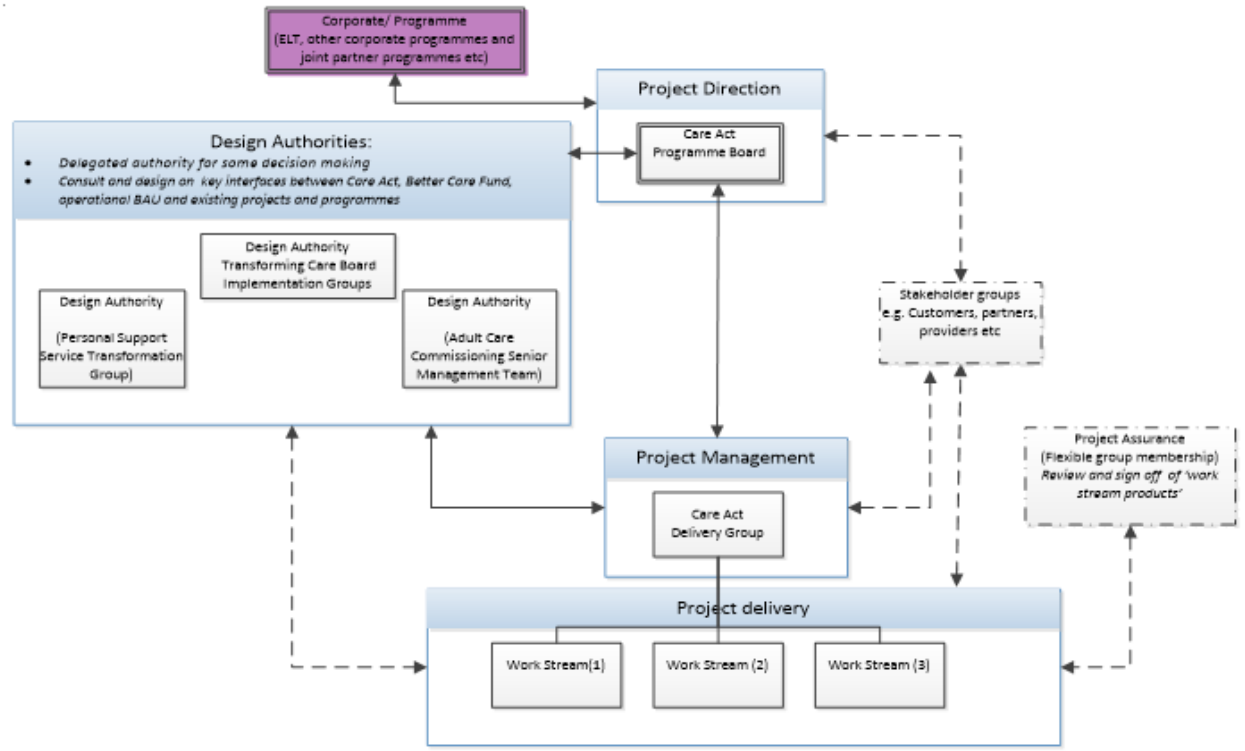

Figure 12 – Schema showing the Project Management functions as part of overall Governance.

Summary of Local Roles & Responsibilities:

Below are high-level descriptors of other key bodies with defined roles within the programme governance and delivery;

- **Design Authority:** delegated authority for some strategic level governance particularly in relation to managing the interfaces between existing projects, programmes and operational business as usual (BAU). The Care Act Working Group will propose which of the following design authorities will need to be consulted about particular elements of design, delivery and implementation. The Care Act Board will determine the level of delegated decision making authority passed to the design authorities;
- **Project assurance:** a group with flexible and mixed membership, responsible for reviewing and signing off work packages/products as fit for purpose;
- **Stakeholders:** Overarching term used to describe all parties with a vested interest in the programme (e.g. customers, internal staff, partners *etc.*). These groups will need to be consulted throughout the design and implementation of the changes required to meet the Care Act;
- **Work Streams:** Established to deliver work packages. Created and disbanded by the Care Act Working Group as required.

v) Please specify the level of resource that will be dedicated to carer-specific support

The local Carers Strategy has been re-written to incorporate changes in legislation, and outlines our vision for the further enhancements of carers services. For further details see the Carers Strategy (reference to be added).

The types of intervention provided locally are intended, through a little help at the right time and in the way which best suit the individual, to help carers to continue with their caring role. In

part the help is of a practical nature enabling carers to carry out essential everyday tasks such as shopping or attending appointments. And in part, the support is intended to better equip carers by ensuring that they get enough rest, stay healthy and emotionally resilient, and become expert in the provision of care. Ultimately, the intention is to ensure that the people cared for are supported in the most appropriate way and that their welfare and independence are not placed in jeopardy. Over the next two years, the strategy will also look into providing individual budgets to the person cared for that will be paid to or used by carers to directly provide services or to micro commission from organisations. In commissioning carers services, the aim will be to ensure that there is a market to buy such services.

Caring can impact on all aspects of carers' lives. For this reason, we are committed to providing and encouraging the development of a wide range of support services, under the priorities set out below, which recognise the need for holistic solutions. The diagram on the following page illustrates a good practice model of comprehensive carer support, describes this mix of universal and specialist services *(Commissioning for Carers: an Action Guide for Decision-Makers, Innovation and Development Agency).* It is essential that professionals providing these universal services understand the needs of carers, are flexible in their approach and can knowledgeably signpost people to appropriate services.

The council allocates resources each year for the commissioning of specialist services mostly through funding for third sector organisations although these agencies also bring their own resources to bear – charitable donations, money from funding applications, time contributed by volunteers and so on. Universal services are funded through mainstream budgets (the council, NHS, central government).

The personalisation of social care, which provides service users with control over their resources and a choice of service, extends also to carers, specifically through handing over the resources in the form of direct payments.

The recent financial climate that local authorities and partners face means that services need to be delivered in an ever cost - effective way. This will influence how we achieve our priorities in practice.

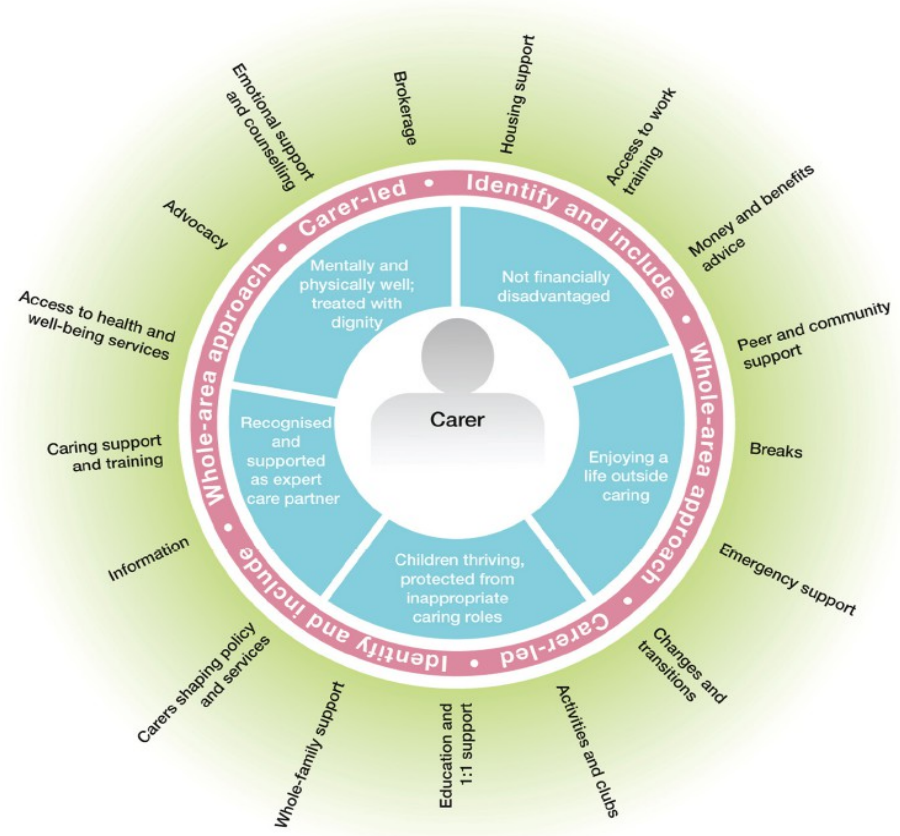

Figure 13 – Model of Comprehensive Carer Support [ref. to be added].

Our Priorities:

The following priorities are designed to minimise the impact of caring on aspects of carers lives, whether it is on their housing, home, family life, income, employment or health. They are also designed to support carers in maintaining a balance between their caring role and their desired quality of life; having choices and being in control and enjoying independent lives.

- Assessment;
- Breaks and emergency respite;
- Information, advice and advocacy;
- Health wellbeing and support;
- Recognition and involvement;
- Young carers;
- Safeguarding;
- Service quality;
- Strategic involvement and joint working.

Please refer to our strategy document for further details of these, as well as an overview of the key commitments we have made locally in order to progress in these areas.

The BCF funding locally has been used to date to fund short-term and respite care (the latter providing temporary relief from the stress and burden of caring). It has been shown to provide decreased perceived stress, burden, anxiety, and somatic complaints, whilst increasing morale [1]. Research on caregivers has consistently shown that carers have poorer health, lower life satisfaction and greater stress than non-carers; with high rates of anxiety and depression [2].

The benefits of respite care in improving outcomes for both carer and cared for include:

- Improving the sense of wellbeing for both carer and cared for;
- Reducing stress between the carer and the person being cared for;
- Provision of additional support, improving the 'coping ability' of both parties;
- Expert care, fun activities and short breaks to increase the opportunity for social activities for the person being cared for;
- Allowing the carer to spend time socialising and interacting with loved ones;
- Strengthening the carers' ability to care; reducing the risk of neglect or possible abuse.

BCF funding will also be used to enhance provision of the Carer Assessment Function which is often refused[2]. Croydon are actively looking into this whole process with the aim that it becomes far more than a box ticking exercise (as is the current perception). One output from the assessment process is likely to be 'Advice Packs' and more individually tailored solutions.

How Carer Support will Impact on Patient-level Outcomes: The Evidence Base:

As part of the integration agenda, as well as to support changes as part of the Care Act, Croydon Council and its partners are looking to enhance services for Carers locally as well as to provide a greater evidence base for the impact that this support is having both on carer outcomes as well as the impact that the support provided has on patient-level outcomes.

The agenda of providing evidence for the provision of service and the link to patient and carer outcomes is highly complex. The local plans for change look to improve our understanding of the benefits that services have for carers, as well as to be able to understand the relationship between the provision of service(s) and the impact these have on patient-level outcomes. We need to ensure that we are mindful of the fact that an intervention may be delivered directly to the carer, or indirectly through providing increased, or more carer-friendly, support to the person receiving care, and ensure that we can relate both of these types of interventions with patient outcomes.

As part of the Care Act Programme our Carers Strategy has been rewritten in order to incorporate the legislative changes in our approach to carers. This strategy offers further focus on the need to be able to evidence the benefits of investment in carers services, as well as to be able to ensure that we continue to base our commissioning strategy for carers on a clear evidence base.

2 Owing to the highly bureaucratic nature of the process.

Our Carers Strategy is built of the principals outlined below (for ease summarised *via* extracted text from *Supporting Carers Early Intervention and Better Outcomes paper published by the Princess Royal Trust for Carers and ADASS in 2010)*;

- Ensure that carers are involved in planning, commissioning decisions and service design;
- Find carers, particularly those most often overlooked, through outreach, partnerships and co-located services;
- Provide tailored information and advice;
- Support carers to be involved in community care planning particularly at the point of hospital discharge, providing carer advocacy where needed;
- Support carers to plan for their own lives, including planning for emergencies;
- Target additional or specific support for older people upon those whose carers will also benefit;
- Provide emotional, practical and peer support; including carer training;
- Provide breaks and opportunities to take up employment and leisure activities;
- Help carers to use health and support services which they need themselves;
- Gather systematic and regular feedback of the outcomes experienced by users and carers, with a focus on independence, well-being and a sense of having a real say and being in control;
- Share feedback on outcomes with health, social care and other agencies.

Our carers services can be grouped into several types of resources which have been set out in the diagram below (based on a diagram in *Supporting Carers Early Intervention and Better Outcomes paper published by the Princess Royal Trust for Carers and ADASS in 2010*). The diagram also references status of work or planned work to enhance our understanding of interventions and services to outcomes.

Figure 14 – Model of Service Planning and Priorities 2014/15 to 2015/16.

Development of our reporting and analysis of the impact of carers services is based on being able to, with greater clarity, understand the degree to which the provision of these services impacts on the achievement of outcomes under the below broad categories;

- Improve health and wellbeing outcomes for patients and recipients of care;
- Improve health and wellbeing outcomes for carers, who suffer disproportionately high levels of ill-health;
- Reduce unwanted admissions, readmissions and delayed discharges in hospital settings;
- Reduce unwanted residential care admissions and length of stays.

(Extracted from the Princess Trust Report: Supporting Carers: The Case for Change)

Quantitative Data:

Considerable work is underway to enhance our quantitative local understanding and monitoring of the relationship between carer support and patient level outcomes. An IT steering group has been established to retain oversight and management of IT related change and to enhance management information within Adult Social Care. This group also manages the linkages and interfaces to support the integration health and social care data and ensures work is scheduled appropriately, and managed as part of a coordinated portfolio of work.

The current focus of enhancement to our understanding of the impact of carer support at both in achieving positive outcomes for carers, as well as outcomes for patients area at several

different stages of a patient/customer journey;

- Early intervention and prevention work through;
    - TACS and MDT's;
    - Information and Advice Services provided universally through organisations such as Croydon Carers Hub, Age Concern and the Citizens Advice Bureau etc., as well as through our strengthened information and advice web presence;
    - Telehealth and telecare;

- Carers support provided (or initiated) through our enhanced local reablement and intermediate care service(s); which will target interventions to prevent hospital admission, or facilitate hospital discharge.

- On-going carers support needs; identified through Carers Assessments, and recorded as part of a plan of support, and linked to the record of on-going support provided to the patient/customer.

- As part of Croydon Challenge (our local council efficiency programme) there is planned to be considerable work on building community capacity and work, social participated and education. At present this programme of work has not yet been initiated but once commenced there will be a work stream that will address the issue of assessing benefits of such initiatives.

- Any addition schemes as required and fulfilling useful criteria.

The development of the Health and Social Care portal, as well as the use of a single patient identifier are being used as a catalyst to be able to provide further granularity of data to be able to more effectively show the relationship between carer support and patient outcomes. In addition carers support through the reablement service as well as to support on-going care needs, are in the process of undergoing enhancements to processes and data capture which will provide us with quantitative data that can interrogated, as well as qualitative data that will be gathered through surveys, and as part of the on-going process of assessment and review.

Due to the nature of the provision of these different levels of carers support, each involve a slightly different method of data capture and interrogation in order to ascertain the impact of this service provision both for the carer, as well as the impact of the provision of these services on patient level outcomes. It addition it must be considered that the range of services available locally to carers is growing and changing, and we need to be mindful of this in designing and adjusting methods of data capture.

Qualitative Data:

We have a history of strong engagement with carers locally on the co-design of services, and through gathering qualitative feedback on interventions provided from questionnaires. Work over the coming year will focus heavily on ensuring that we gain the maximum leverage from this engagement, as well as ensuring that we can link the provision of carers services, at all levels

and depths of service provision to patient outcomes.

Risks Related to Carer Specific Support:

The main risk that exists concerning the delivery of carer-specific support centres on a potential increase in demand and a resultant cost explosion. At present work is underway to forecast and project the potential scale of increased demand and its associated costs. Modelling work will inform us as to whether or not resources may need to be re-profiled to accommodate changes. In addition we have considerable work in train to enhance our information and advice services both through online channels, as well as through our partners and internal staff; we will focus on managing demand through continuing to invest in early intervention and prevention services, and ensure that we are managing expectations appropriately through all engagements with customers and carers.

The converse risk identified is the poor uptake of carer specific support by those eligible; historic trends related to the uptake of demand related to a change in service for carers have shown that demand for services is slow in development (a trend also seen nationally).

We already have plans in place for publicity and engagement with all vested stakeholder groups, including internal staff, partners within health and the third sector, as well as through our well established carer forums. We are confident that this thorough publicity plan, in addition to embedding the offer for carer specific support within our service offers, will ensure that local carers will be well informed of their rights under the *Care Act*.

Section References:

[1]. Sorensen, Pinquart & Duberstein, 2002 (full reference requirement).

[2]. Dow *et al.*, 2004. (full reference requirement).

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The initial plan set aside more for *Care Act* implementation costs than was suggested in the indicative allocations produced by the LGA and NHSE. The changes within the BCF now mean we have set the level of *Care Act* funding exactly as indicated by the LGA and NHSE; so if those estimates prove accurate, this should not affect implementation plans.

b) **7 day services to support discharge**

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Having aligned our strategic plans with the national direction detailed within both the "Every One Counts" Planning for Patients 2014/15 and the London Quality Standards [1,2], we will be developing our current seven day working offer. Our commitment to the provision of more care closer to home requires connectivity of 7 day working right across health and social care including acute, community and primary care.

We currently run seven day cover for all essential Primary and Community services (e.g. community nursing services, social care services, pharmacy and our walk in treatment facilities). This includes extended 7 day provision offering Walk-in GP Primary Care Access as well as cross-Borough cover for urgent care and minor injury services which proves convenient for the communities we serve. Croydon's Community Pharmacy Needs Assessment indicates that there is extensive coverage with a number of 100 hour contracts and access to two pharmacies providing 365 day services with extended hours.

In 2013/14 we expanded our offering with a Rapid Response Community Team aimed at ensuring unnecessary hospital admission avoidance *via* home treatment. These 24/7 services are fundamental in both reducing admissions and increasing discharges. The services may be accessed on a 24/7 basis by the London Ambulance Service, Out-of-Hours, G.P.s, Social Services with access also planned for NHS 111. The services also include access to both Step-Up and Step-Down Beds (including weekends) for admission and discharge. Increased service provision includes access to an expanded Community Integrated Care service (CICs) which creates 24/7 integrated care packages supporting patients and allowing for quicker discharge to homecare settings, with the inclusion of rehabilitation services, therapist care and a night sitting service for those with clinical need. In collaboration with the CICs service, Pharmacy services within our acute provider have been expanded to facilitate weekend discharges.

To further support Croydon Health Services NHS Trust - the main Integrated Trust for the CCG & Local Authority - the CCG have developed a CQUIN in 2014-15 focussing on 7 day discharges, complimented by devised the BCF Local Outcome Metric.

The Reablement and Discharge Programme has provided a shared viewpoint and learning for both the CCG and Local Authority. Funding through this Programme has supported the delivery of a social work team 7 days a week within the A&E department specifically to prevent unnecessary acute admissions by implementing appropriate community-based social care interventions. This service also supports ward discharge. Resilience Funding has further enhanced the service to meet additional demand pressures and provide extended coverage to meet daytime demand peaks. This service will continue to be developed through BCF, and will be the initial focal point to support weekend discharges. Resourcing will be reviewed under BCF on a regular basis to ensure that it accurately reflects demand within Croydon University Hospital. Under this review, the merits of continuing the weekend "Planned Appointment for Vulnerable Patient" offering from our Out-of-Hours provider will be assessed. A more formal review of Resilience Fund development will be provided for the (recently configured) Transforming Care Board.

Additionally, the Council funds a 24/7 emergency call service (Careline Plus [1,2]) to support people in the community. Requests for service from people being discharged from hospital are dealt with inside 24 hours of request. The Council also operates an out-of-hours Emergency

Social Work Duty Team.

The CCG has also developed enhanced services with the Emergency Department provider. These include: 24/7 access to the Psychiatric Liaison Service and increased access to an Alcohol Support Service within the A&E Department. These advancements will continue to be supported in 2014/15 and will be commissioned *via* CQUIN and various investment processes with constant review under BCF, CQUIN and QiPP schemes. Planned enhancements include: enabling greater weekend discharge (with increased health and social care resource), and Mental Health Crisis Team investment.

Section References:

[1].Careline Plus reference (checked… just needs to be added)

[2]. Careline Plus reference (checked… just needs to be added)

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Croydon Council is currently preparing a corporate program of work to capture, maintain and utilise the NHS number, against its care records. In alignment of the requirements of the HSCIC Information Governance Toolkit controls, the authority is looking to ensure that use of the NHS number is both consistent and fully comprehensive across the organisation.

From the 1st April 2015, the Council will be in a position to utilise the NHS Number as the primary key in exchanging care records with other care organisations, such as local health service providers. It is the Council's intention that the NHS Number should be obtained as early as possible in lifecycle of a care case, and used wherever necessary (and wherever possible) to ensure the effective and efficient identification of cross-organisation, cross-discipline case involvement.

The Council has already established that its core care case recording and management solutions are NHS number capable, and is in the process of defining actions for the collection and ongoing maintenance of the NHS Number within its systems. The Council recognises that, in addition to the proposals set out in this submission, the NHS number is a pre-requisite to other planned activities and requirements, including the Child Protection Information Sharing (CP-IS) and Adaptors projects.

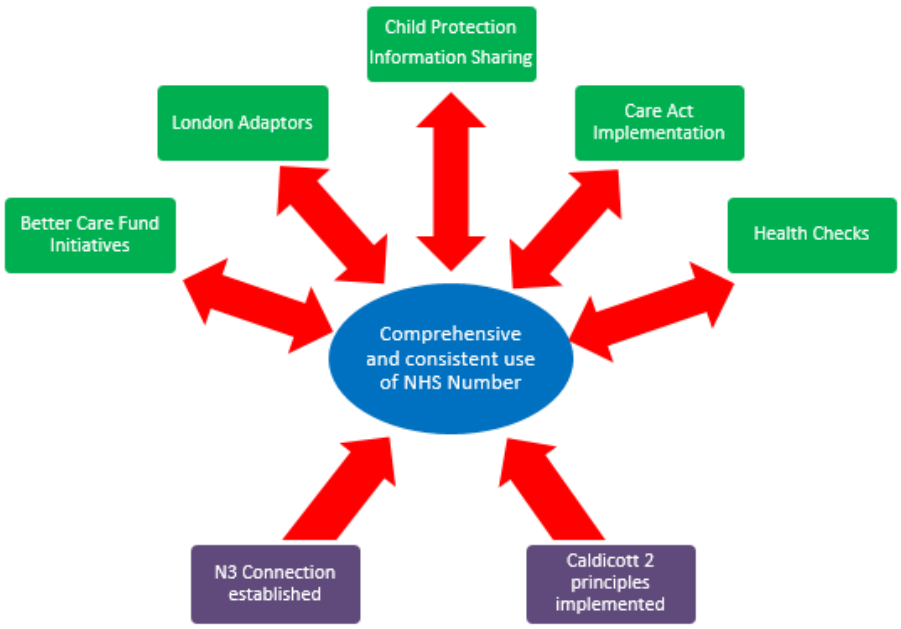

Figure 15 – Schematic showing the interlinking of services with a requirement for the NHS Number.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Croydon Clinical Commissioning Group (CCG) and Croydon Council are committed to actively reducing their overall deficit, and as part of this effort are endeavouring to implement Open Source Standards and Software wherever possible or practicable to do so. The two organisations have actively embraced the notion of Open Source in the main instance to prevent the often expensive practice of Vendor "lock-in" – which is a well-recognised issue within current software procurement processes [1,2]. Indeed, the NHS makes no secret of the fact that this is to move to "product lock-in" whilst avoiding software vendor "lock-in" [1].

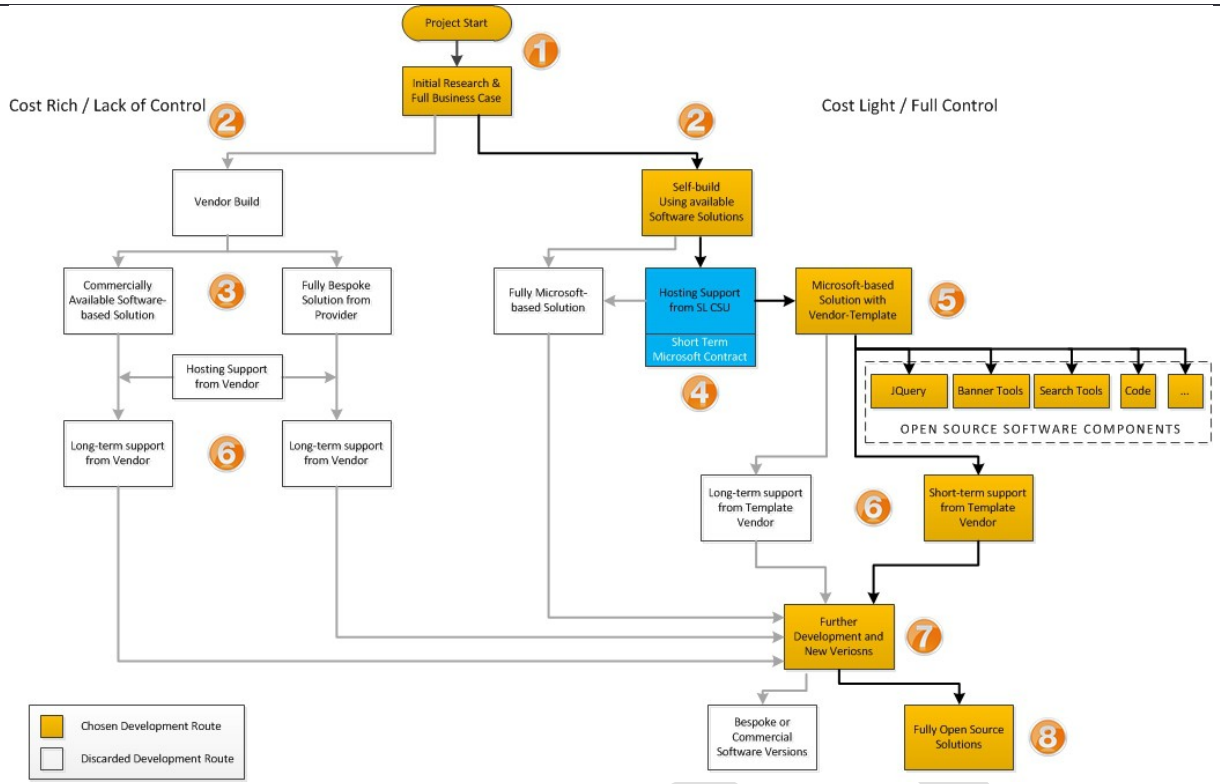

Figure 16 – Pathway to OS Software Implementation showing Progress Made (orange).

In cases where the CCG and Council have had no option but to purchase systems using vendor-specific technology, these have been based on a conscious choice to use the most appropriate technology available for the job at that particular time, and at the lowest cost. In order to clearly demonstrate our shared commitment to the use of Open Source Software, the decisions made in the choice of software solution for the Health & Social Care Portal Project are shown in Figure 1 (the Full Descriptive Process Map is attached) as an example. This solution is seen by SL CSU as a pioneer site for cross-sector data sharing and, as such is a particularly detailed example of the process involved. In this case, research and the full subsequent business case produced clearly identified a number of products which could have been used and, in a similar vein, a number of vendors who would be able to build a complete bespoke solution. Our evaluation identified a large cost throughout the product lifecycle associated purely with vendor lock-in and support arrangements, and consequently, the decision was taken to build the Portal ourselves with much lower cost and greater freedom and control [2].

The overall plan for the creation of the Portal has been confirmed by the Board of the Urgent & Emergency Care Working Group. Progress with the development has been discussed (in suitable depth where required) at each Board, and has been full documented and minuted at these with all Board members having access to these minutes.

As to be expected, when the Portal solution was first developed, the option of using OS software was simply not available. The Microsoft NHS Select Agreement (which ran until 2010) had been heavily responsible for the proliferation of Microsoft-based solution architectures within PCT/CCG and CSUs. This, (and the fact that the SL CSU had only just established as an independent body at the time) severely curtailed the available catalogue of development software solutions open to the Project Team. However, a decision was taken to implement OS software wherever possible within the Project. The current Portal solution contains a mixture of vendor specific code (which may be altered as *per* OS) and full OS modules which can be re-distributed

and which contain JQuery and HTML code [Ref. to be added].

We recognise that there are a number of risks and issues involved in the use of Open Source software solutions. These include the following (with references to the Risk Log (RL) entries in Appendix):

- Support & System Updates: (Ref. RL001) – there may be no option to host the OS software owing to server constraints and the fact that the release of updates may be of a sporadic or even non-existent nature. This is dependent upon CSU policy on this.
- Security & Patching (Ref. RL002) – similarly, 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 Overall Cost (Ref. RL003) - 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 for the work. Similarly, other components may be needed to host the software which may be expensive.
- Information Governance (Ref. RL004) - 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.
- Conflict in Interoperability (Ref. RL005) – as yet unknown conflict in interoperability.

Secured Email Solutions

The Council is also considering the provision of new Secured Email Solutions. The *Care Act (2014)* has resulted in a complete shift in the overall scope of the existing NHSMail service (originally implemented in 2009). This now encompasses secure information exchange across both Health and Social Care - as opposed to simply just Health. Department of Health Documents make clear that the modernisation process for NHSMail will continue until 2019 at the earliest. Croydon Council is committed to implementing a suitable email solution which will enable interaction, as required. In order to do this we have two clear options: (i). operating our own (or another) email solution or (ii). Procuring a hosted email service under the Managed Email Procurement Framework.

Section References:

[1]. *The Integrated Digital Care Fund: Achieving Integrated Health & Care Records*, NHS England, 13/05/2014. Section 3.4 Open Source Solution.

[2]. Other Reference for Vendor lock-in

[2a]. *Full Business Case*, Health and Social Care portal, Carlino S.

[3]. Internal SL CSU change procedures currently promote the use of the Nimbus Business Mapping application to devise plans. A Change Advisory Board Request is raised and passes

through an internal SLT approval process before a Development Guidelines Document is produced.

[4]. Standards - reference to be added.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

The Council is currently in the process of formalising the programme of work required to implement the recommendations arising from the Caldicott review. Discussions are taking place between the Council's Caldicott Guardian and Information Manager, as to how best the recommendations can be met and how this work activity fits with the current Information Management objectives and arrangements. **{MICHELLE RAHMAN TO PROVIDE CLINICAL PRACTICE DETAILS AS REQUESTED}.**

d) **Joint assessment and accountable lead professional for high risk populations**

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

As part of the Unplanned Admissions DES for 2014/15 (more information on this below) practices are required to identify 2% of their high risk population. This 2% has predominantly been identified by using the ACG risk stratification tool but some practices have also used their clinical judgement to review their highest risk list.

From that 2% practices are doing some further work to identify which of those patients are 'very high' risk and would benefit from case management as part of a multidisciplinary team approach. It is estimated that for 2014/15 approximately 2865 patients will be identified in the top 'high risk' group which is in line with the 0.7% described below. This is based on all 60 practices now signing up to the Admission Avoidance DES plus the CCG's Practice Development and Delivery Scheme. The CCG has maintained assurance *via* practice visits and reviewing of MDTs via Community Services, Social Services as well as self-reporting from practices. The following graph shows the roll out of MDTs in 2014-15 in Croydon CCG.

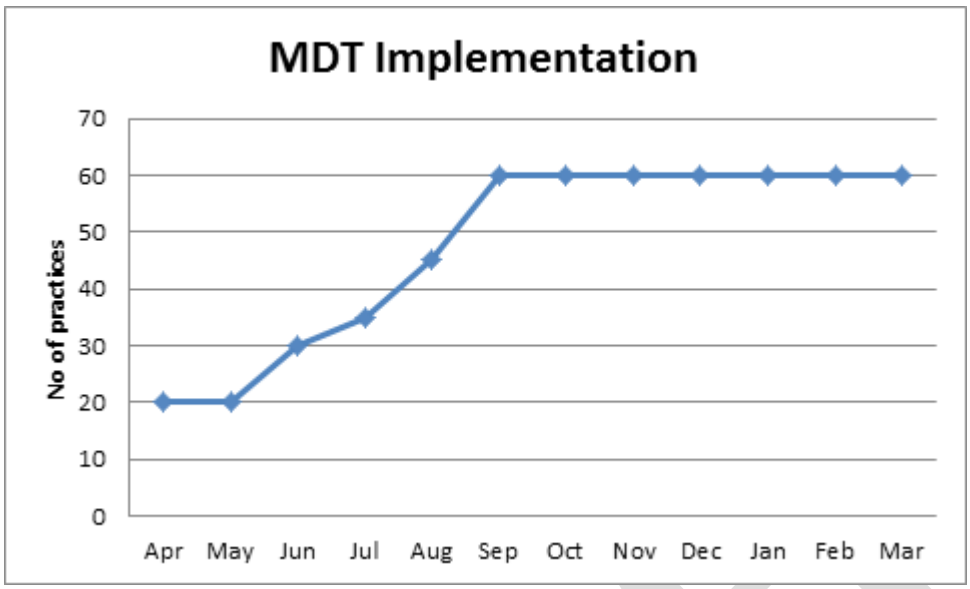

Fig xxx

Please see below for the identified populations that mirror the 2 Year Operating Plan and Five Year Strategy

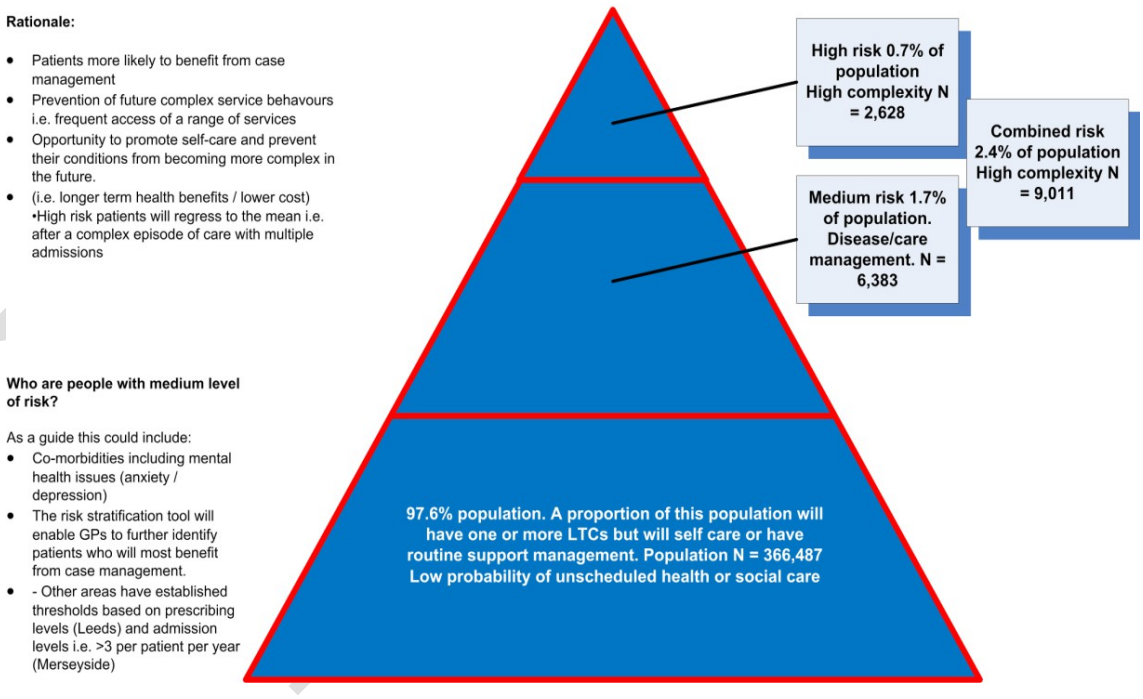

Figure 17 – Population Pyramid of Target Adult Populations in Croydon: High, Medium & Combined Risk.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

There are 6 geographic G.P. networks [1,2] within Croydon and these networks are pivotal in providing a joined up approach to the identification and integrated case management of people at high risk of hospital admission.

The Unplanned Admissions DES for 14/15 requires practices to develop a case management register by identifying 2% of high risk patients, vulnerable older people and patients needing end of life care who are at risk of unplanned admissions to hospital. The practices are then required to develop personalised care plans (PCP) for every patient on the 'case management register' and review these plans at regular intervals.

In addition to the Unplanned Admissions DES, Croydon CCG have implemented a new local enhanced scheme this year called the Practice Development and Delivery Scheme (PDDS) There is a requirement for practices to evidence that they are having monthly MDTs to case manage their high risk population as part of an integrated team

All practices in Croydon have signed up to both the Unplanned Admissions DES and PDDS, the CCG have taken this opportunity to review the approach taken to risk stratification and integrated care planning through Multi-Disciplinary Team meetings (MDT) to reflect the implementation of both of these enhanced services.

Practices are using their 2% case management register and the personalised care planning process to then identify which patients would be suitable for management under the MDT. Each network has a Network Support Team (NST) which currently comprises of the GP, community matron and social worker as core members but if required the team can invite other professionals such as health visitors for older people, mental health, pharmacy and therapists. If the PCP has already been completed for the patient then it is taken to the MDT so the plan can be reviewed by the integrated team for whole systems, coordinated approach. Approximately 5-7 patients are discussed at each meeting and the details of these patients are given to the team members prior to the meeting so they are able to bring any relevant information to the meeting

Through this process a lead professional is allocated to each patient to coordinate their care. This will differ for each care plan and will be the most appropriate professional to coordinate the care of the patient.

There may also be patients that are identified as being 'high risk' and requiring case management that are not part of the 2% case management register, they will be discussed at the MDT in the same way and an integrated care plan will be developed for them

Although 2% of the population will have PCPs in place, it is envisaged that approximately half of the 2% for each practice will be case managed through either the risk stratification MDT or the palliative care MDT. It is predicted that approximately 2865 patients will be case managed through the risk stratification MDTs for 2014/15 – this is based on 5 patients per meeting and takes into account the gradual implementation of the MDTs throughout the year. There will be FYE in 2015/16 in terms of numbers of patients going through the case management process and although there will be a number of the highest risk 2% that are reviewed again through MDTs there will be capacity to move further down the risk triangle allowing a more proactive 'population management' approach

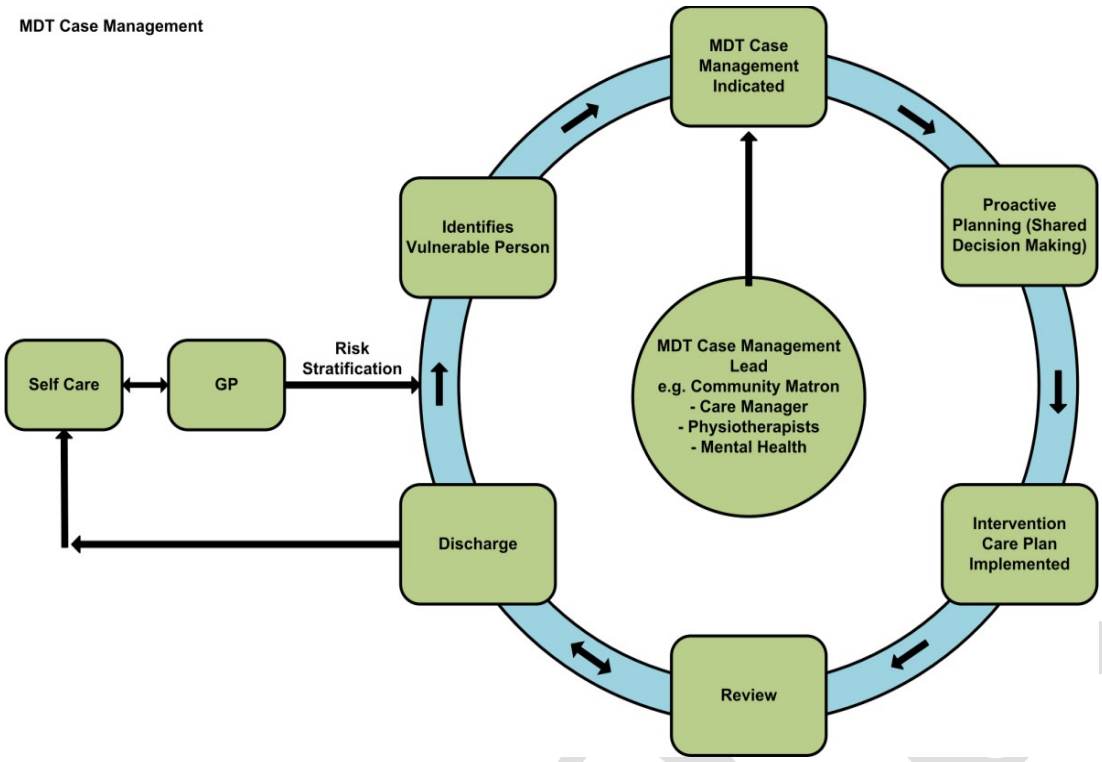

Figure 18 – Multi-Disciplinary Team (MDT) Case Management Lifecycle showing interventions and self-care.

iii) Please state what proportion of individuals at high risk already has a joint care plan in place

TO FOLLOW

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

NHS Croydon Clinical Commissioning Group 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 engages in on-going consultation through a number of forums. These include:

- **The Inclusive Forum** – which 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 to help identify ways to improve services.
- **Older Peoples' Network (OPeN)** - aims to enable Croydon's older people to come together to discuss issues that matter to them and to influence service planning and delivery. OPeN influences services by the lived experiences of older people themselves and acts as a platform to raise issues with policy makers and other agencies, campaign for positive change and improve local engagement.
- '**Making it Real' self-assessment framework** – a series of consultation sessions during November & December 2014 with adult social care, community based, service users and their carers to assess progress for personalisation in Croydon. This included feedback and comment on: reablement services; equipment and adaptation services; carer support; assistive technologies to support independence.

  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, their carers and the public on Health and Wellbeing Boards, 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.

Discussions about the development of integrated services have been held regularly at the Croydon Health and Wellbeing Board; at which voluntary sector organisations are represented. This has been supported through conversations about the priorities under the Better care Fund have been held with patient/client representative groups in Croydon. Meetings have been held with the Older People and Long Term Conditions Partnership, Older Peoples Network (OPeN), attended by representatives from CASSUP, the Inclusive Forum ("Talking about Social Care in Croydon), and the Croydon Charity Service Delivery Group (CCSDG). This on-going commitment to engagement with patients and clients has been welcomed by these groups and will be built on throughout 2014-15 in the lead up to the introduction of BCF.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

The Croydon Health and Wellbeing Board is central in overseeing the transformation of services through the integration agenda in Croydon. 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; as well as NHS England.

The Partnership Groups which are linked to the Health and Wellbeing Board bring together representatives from relevant organisations to set the multi-agency strategic direction for these public services in Croydon. The Groups 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 Groups. The Partnership Groups have a binding governance structure which allows information to be shared through the Boards.

The commitment to partnership working can be demonstrated very clearly through the establishment of the Reablement and Hospital Discharge Board and the Croydon Strategic

Transformation Board.

The Reablement and Discharge Board membership is made up from Croydon Council; 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 workstreams that have reduced the number of people needing acute services and has reduced hospital admissions.

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 has developed a joint picture of current services and initiatives across community health services, social care, voluntary sector & mental health. 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.

ii) primary care providers

TO FOLLOW

iii) Social care and providers from the voluntary and community sector

TO FOLLOW

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

TO FOLLOW

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description (Underway)

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no. 1
Scheme name
Transforming Adult Community Services
What is the strategic objective of this scheme?
Croydon Clinical Commissioning Group (CCG) formed a strategic partnership with Croydon Health and Croydon Council to collaboratively re-design and transform adult community health services to ensure the delivery of coordinated, high quality, patient focused care. There is a shared vision 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. 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. There are three distinct priorities, which underpin the transformation of Adult Community Services in Croydon: *Enhancing care for people with Long Term Conditions* *Reducing Unnecessary Emergency Admissions* *Providing high quality, personalised care, as close to home as possible* Patients and social care clients have told us through various consultations 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 to enable timely interventions that would prevent health issues developing into a crisis.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
<u>Single Point of Assessment</u> The Single Point of Assessment (SPA) is a multi-disciplinary referral hub, available 24 hours a day, 7 days a week that allows referrers to speak with an experienced community nurse who is able to provide advice on available community and social services that may be appropriate for any individual patient, ensuring patients get referred to the most appropriate service.

Advice will be given on the most appropriate service for the patient's needs, including signposting to any social services, mental health or voluntary services that may support a patient to maximise their independence, avoid hospital admission and ensure the totality of their health and social care needs are met.

Referrals can be made for:

- District Nursing
- Rapid Response
- Falls
- Community Matrons
- Continence
- Domiciliary physio
- Tissue viability
- Health Visitors for older people

Rapid Response Service

Referrals for this service provide the opportunity for patients/clients who need an urgent response to be seen within 2 hours. A multi-disciplinary community service is provided to enable that person to remain in their own home where appropriate.

The Rapid Response service model is staffed predominantly by community matrons and therapists but also benefits from input from social workers, mental health specialists, pharmacy, and support workers.

This service is for any adults 18 years and over that are experiencing a health or social care 'crisis'. The types of problems that can be managed through the team are:

- UTI
- Blocked catheter
- Skin and sub cut tissue infections
- Intestinal infection or gastroenteritis
- Superficial injuries or contusion
- Exacerbation of a Long term Condition
- Joint Disorders (non traumatic)
- Nausea and vomiting
- S/C fluids for mild to moderate dehydration
- IV antibiotics for cellulitis

Enhanced Case Management

There has been a strong partnership approach across primary care, community services and social care to establish multidisciplinary teams across the 6 clusters in Croydon.

The CCG purchased a risk stratification tool to enable primary care to identify some of the highest risk patients in their practices. The information generated by the tool is used to support the teams of GPs, Social Workers, Mental Health, Community Matrons, District Nurses and third sector to work collaboratively and provide focused, needs led, timely and enabling care for those identified as requiring support .

There has been significant engagement with the voluntary sector with regard to the

management of these patients; some examples of the key organisations are Age UK, young Carers association, Salvation Army and counselling agencies.

Intermediate Care Beds

The TACs programme 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 step up beds are used for patients at high risk of admission to hospital due to an ambulatory sensitive condition or the exacerbation of a long term condition that has led to a deterioration in the patients general condition.

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.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner – Croydon CCG
Providers - Croydon Health Services

- Croydon council
- SLAM

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There exists a wealth of research evidence to support the proposed model of care. However, the specific findings from the following publications are at the core of the transformation of community services in Croydon;

1) **Supporting people with long term conditions: commissioning personalised care planning - a guide for commissioners (DH 2009).**

A key message is that people with long term conditions should receive more individualised care and services to help them manage their conditions better and achieve the outcomes they want for themselves. Personalized care planning should result in more individualised services; more focus on prevention of disease and complications; greater choice – including supporting people to make healthier and more informed choices; reducing health inequalities; and providing care closer to home. It is maintained that these aspects will have a positive effect on crisis episodes and unnecessary admission to hospital, unnecessary outpatient visits, unnecessary GP visits, admissions to residential and nursing homes and better patient outcomes.

2) **Kings Fund (April 2012), Emergency hospital admissions for ambulatory care-sensitive conditions Identifying the potential for reductions**

The publication considers patterns of emergency admissions for ambulatory care-sensitive conditions (ACSCs) and assesses the potential for reducing such admissions, highlighting the disease areas and patient groups where the greatest reduction can be achieved. The briefing asserts that high levels of admissions for ACSCs often indicate poor coordination between the different elements of the health care system, in particular between primary and secondary care. The briefing also highlights the opportunities for commissioners to improve the quality of care and make savings associated with reducing emergency hospital admissions for ACSCs, by making changes in the management and prevention of these conditions.

3) **The Nuffield Trust (2012) Reducing Emergency Admissions for Ambulatory Care Sensitive Conditions**

The Nuffield Trust report supports the premise that unnecessary hospital admissions for patients with ambulatory care-sensitive conditions can be reduced by giving them good quality preventative and primary care. The research identifies patients with ambulatory care sensitive conditions and track admissions for these conditions over time

4) **Transforming our health care system: Ten priorities for commissioners (The King's Fund (2011)**

The research maintains that the ageing population and increased prevalence of chronic diseases require a move towards prevention, self-care, more consistent standards of primary care. This care also needs to be well co-ordinated and integrated. One key priority is the management of ambulatory care sensitive conditions, which, despite being largely preventable, account for a significant proportion of all acute hospital and these admissions are costly. The report reiterates that maintaining wellness and independence in the community prevents deterioration in conditions and therefore results in better health outcomes, fewer emergency admissions to hospital which are distressing as well as cost savings.
It emphasizes that early identification of ACS patients is crucial if their management is to be successful and GPs are well placed to do this through the use of risk stratification tools and clinical decision support software, expanding vaccination and encouraging active disease management.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The outcomes for TACS are measured by a combination of admission activity and activity from each of the services which feed into the quality outcomes.

The overall outcome measured is based on a reduction in the emergency admission activity for a number of conditions agreed as part of the business case.

Supporting this is a number of KPIs relating to each service which include:

Service	KPI measure
SPA	Total number of referrals to SPA
	No of advice/signposting episodes
	No of referrals resulting in coordinated response across 2 or more services
Rapid Response	Total number of patients referred to Rapid Response Service each month
	Percentage of urgent referrals seen within 2 hours of acceptance of the referral by the clinician
	% of referrals resulting in an admission
	Number of patients admitted 7 days post discharge from the service
IC beds	No of admissions to step up bed
	No of admissions to step down bed
	No of discharges
	ALOS
	Occupancy - Average % over the month
ECM	Percentage attendance by a community matron at the MDT Meeting (or DN as an exception)
	Average length of stay on caseload
	Total number discharged
	No of new patients with care plan and escalation plan in place
	No of patients discharged with self management plan
	Total number of new patients per month
	No patients on caseload for over 90 days

These outcome measures are discussed internally at the QIPP operational board and also at the joint TACS steering group which includes members from Croydon University Hospital, The CCG, Social Services and Mental Health.

In addition to this patient specific case studies are collected to demonstrate how the integration across services is working in reality.

A patient survey is currently being developed to establish if the service users believe their care is now coordinated and providing a positive outcome

What are the key success factors for implementation of this scheme?
- Whole system partnership working - Ownership from all stakeholders - Clear KPIs and quality outcome measures - Communication across health and social care services - GP and other clinician engagement and confidence in the services - Information sharing across services - Effective integrated care planning process with feedback loop

ANNEX 1 – Detailed Scheme Description (Underway)

Scheme ref no. 2
Scheme name
Community Diabetes
What is the strategic objective of this scheme?
To provide a high standard of specialised care for individuals with diabetes and their families
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A new diabetes model of care has been designed to improve the diabetes service provision in Croydon and enhance GP and patient education. The model will deliver a significant shift in location of care from secondary care to primary care with a greater emphasis on self-management, care closer to home & prevention. Referrals into the diabetes service will be streamlined through the use of a referral management and booking service. The new service will provide additional diabetes community clinics in Croydon with new

providers providing support to GPs and increasing the skill levels of primary care to increase primary care capacity to absorb most secondary care services.

Patients and other stakeholders will be involved in the design and implementation of diabetes services

Structured patient education programmes will be available.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Dipti Gandhi, CCG Diabetes clinical lead

Ian Knighton (Replacement), Project Manager

Lorraine Harrison, Project Support

Claudette Allerdyce, Principle Pharmacist

Daniel MacIntyre, Public Health

Ellen Schwartz, Public Health

Croydon Diabetes UK

Bromley Healthcare Company, Community Service Provider

Croydon Health Services, Acute Service Provider

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Evidence base included:

- JSNA for Diabetes
- Public Health analysis (including programme budgeting and previous reviews)
- National guidance on Diabetes (e.g. Diabetes Commissioners Toolkit)
- National Diabetes Audit data
- Good practice within UK
- Guidance and research from Diabetes UK
- Local historic data for diabetes services
- Whole system data (across all sectors of local health economy)
- SUS data
- GP Network/ practice specific data (on spend / referrals / etc.)
- Pharmacy spend and activity data
- Working closely with local branch of Diabetes UK

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Adopting a whole system approach with expectations across all sectors
- Recognition that new model of care has been developed with common themes running across all sectors (e.g. community provider has responsibility of ensure /encouraging referrals to patient education programmes, but also to ensure patients attend / they have a role in primary care education as well as patient care and facilitating the shift of care from secondary to community / primary care – as well as this responsibility also sitting with primary care re referrals and acute re repatriation)
- Development of high level KPIs for the whole system
- Ensuring interlinking of performance management processes with a clinical and activity perspective (e.g. GPs / GP Networks having an input to the performance management processes for the diabetes community contract
- Regular liaison with GP networks to ensure discussion / feedback on the performance of the new model of care and areas for amendment

What are the key success factors for implementation of this scheme?

Community services:

- overall improved HbA1c, cholesterol, and blood pressure control across Croydon
- reduction in the number of diabetes related health complications (including amputations)
- improved patient experience and quality of life maximising their ability to self-manage their condition
- improved patient satisfaction (in respect of ease of access, attention / interaction, individual, knowledge gained, empowerment and age / cultural appropriateness).
- 100% of patients seen offered a personalised care plan / self-management plan
- deliver patient care closer to home at all times
- integrated working in the assessment of care requirements ensuring an appropriate and prompt response to patients with diabetes and related co-morbidities
- reduced mortality from diabetes-related causes (e.g. myocardial infarction, stroke and end stage renal disease)
- following assessment 100% of appropriate patients are referred on to additional services in compliance with NICE guidelines (e.g. cardiology, respiratory, renal, MS, tissue viability, diabetic retinal screening, podiatry and antenatal nurse specialists)
- reduced levels of planned and unplanned hospital admission / attendances for people with primary and secondary diagnosis of diabetes

- reduction in the hospital length of stay for people with primary and secondary diagnosis of diabetes
- increased admission avoidance and early supported discharge for patients with diabetes and other related co-morbidities
- reduction in the number of outpatient referrals made directly with secondary care and follow-up outpatient appointments
- reduction in the number of diabetes patients who are discharged from hospital inpatient / outpatient services being re-admitted within 28 days of discharge
- reduction in London Ambulance Service conveyance rates in response to 999 calls for people with diabetes
- support a shift in care focus where at least 80% of diabetes patient care to be provided in primary and community care settings after the second year of the contract
- optimised treatment through medicines management with 100% of patients, conforming to NICE guidance and local Croydon pharmaceutical guidelines / protocols, working within agreed budgetary targets
- development of prevention strategies for patients, through self-management reducing demands on both primary care and secondary care
- maximising appropriate referrals to structured education programmes for patients with diabetes
- delivery of rolling education programmes and support for primary / community care staff to improve the competencies of specialist and non-specialist professionals that come into contact with people with diabetes through a culture of on-going education / skills development
- an informed and skilled primary and community care workforce that have the capacity and competency to manage the majority of diabetes care locally
- engagement and involvement with voluntary / patient groups (*e.g.* Diabetes UK) to develop and implement joint initiatives to enhance local services (*e.g.* self-care pathways, education & support, counselling) as part of the integrated service pathway
- the achievement of relevant (agreed with commissioners) NHS Outcomes Framework domain indicators for the duration of the contract.
- a significant focus on prevention and self-care aimed to prevent and reduce the use of both primary & secondary care services

Patient Education Programmes:

Improved ability to self-manage condition through:

- Improved glycaemic control
- Reduced BMI, cholesterol & blood pressure
- Increased levels of physical activity
- Increased smoking cessation rates
- Lower levels of depression

- Reduced use of unscheduled care, including LAS
- Reduced levels of emergency hospital admissions

Help to increase participants' self-efficacy, increase motivation and attitudes to self-care, thereby reducing complications and unplanned use of secondary care health services

Patients are able to set their own goals and develop their own personal action plan with regard to their future diabetic management

Patients have a greater understanding of the need to attend screening appointments (e.g. retinopathy, podiatry)

ANNEX 1 – Detailed Scheme Description (Underway)

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no. 3
Scheme name:
Cardiology Pathway Redesign
What is the strategic objective of this scheme?
To commission a programme of service redesign which focusses on five key in interlinked areas: 1. Heart Failure 2. Chest pain 3. Stable Angina 4. Arryhthmia 5. Cardiology Advice Service The redesign's objective is to improve quality of care, increase productivity and prevent ill health within a financially viable environment across community, secondary and tertiary care settings
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The model is an integrated and targeted approach to deliver cardiology services with adherence to NICE guidance, innovation and the principle of right care in the right place, first time to ensure that that the needs of Croydon's population are met in the most efficient and equitable way. Arrhythmia -Introduction of 12 lead ECG scheme across GP practices. Heart failure- use benchmarking to assess and improve end of life care; introduce

one stop shop diagnostic and assessment; introduce a community heart failure specialist nurse team.

Chest pain - development of a consultant led and community based service; appropriate use of angiogram and angiography; stable angina medicines optimisation.

Cardiology advice service-; provide education and advice to GPs to manage patients 'in house' to increase patients managed in primary care.

Stable angina- promote the use of NICE guidelines and medicines management as first line treatment.

Patient cohorts that are being targeted are under 75's, BME communities and those patients living in the most deprived areas in Croydon such as Thornton Heath, Woodside and Addington

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Senior Management Team Lead- Stephen Warren

CUH Provider Lead- Sally Massey

Finance Lead- Marion Joynston

CSU Lead- David Boothroyd

Project Lead- Suzett Polson

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The model was based on current NICE guidance, the Hounslow model and the model and recommendations from South London Cardiac and Stroke Network

Provision across other main providers drawn on such as Kings and St George's.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly data and information reports direct from the provider as well as monthly monitoring via SUS and SLAM data. CSU and finance also receive key information to support the process.
What are the key success factors for implementation of this scheme?
Reducing activity in secondary care including diagnostics and increasing knowledge and care in primary care. Improved quality of care for patients from first point of contact right the way through their treatment journey. Achieving anticipated cost savings as part of QIPP.

ANNEX 1 – Detailed Scheme Description (Underway)

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no. 4
Scheme name:
Chronic Obstructive Pulmonary Disease Community Service
What is the strategic objective of this scheme?
The redesign of the COPD work stream was initiated in 2013 at that time it was decided that there would be a whole system redesign of COPD delivery. There are numerous components to the COPD Services. Some of these components are commissioned by the CCG in acute and community setting provided by CHS and Pharmacies. There are also partner services that should identify people at risk of COPD such as the Smoking Cessation Service in Public Health, TACS (Transforming Adult Community Services) and Community Pharmacies. These areas should promote prevention and self-care, signpost those at risk to primary care and if appropriate spirometry testing in order to reduce incidences of emergency responses and A&E admissions. Key Issues 4. Those with undiagnosed COPD or with the potential for COPD are not being identified 5. The appropriate interventions, treatment and care are not being delivered in the right settings at the right time 6. Whole system resources are not being utilised in an integrated approach and delivery model to encourage prevention and self-care, utilising voluntary support or appropriate primary care. The above has resulted in higher levels of emergency admissions and inappropriate use of health

resources throughout the care pathway.

The estimated prevalence of COPD within Croydon should be in the region of 4% however the recorded prevalence is currently only 0.98%.

The census of 2011 states that the approximate population of Croydon is 365,000 indication that there is a number of 14,600 potential COPD patients and currently only 3,577 patients have been identified suggesting an increase in service need of 11,023.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Proposal:

- Increase the number of spirometry measurements managed through the development of COPD hubs in each GP Network supported by CRT staff. Hubs to provide spirometry, diagnostics & annual measurement allowing focused training & assessment of competence in spirometry by CRT staff.
- Adoption of evidence based clinical pathways (facilitation of diagnosis, management of stable COPD, management of unstable COPD) designed to define interface with secondary care & support reduction in variation in practice and well as reducing hospital admissions
- Expansion of CRT team to proactively identify and address patients at risk and to reduce the rate of COPD complications
- Increase the provision of pulmonary rehabilitation to meet current & future demand and confirm to NICE guidance
- Develop a Primary Care Support service within the CRT Team (support spirometry, support unstable COPD patients at home, provide a telephone advisory service for GPs to reduce hospital admissions).
- Use of CRT nurses to audit GP lists to identify at risk & undiagnosed COPD patients. Also to provide spirometry support to GP network hubs in year 1
- Increased liaison / pathways with smoking cessation in identifying and referring patients for COPD diagnostics
- Use of screen tool with community pharmacists in screening potential at risk people for referral to COPD / GP services (build into winter planning 2014/15)
- COPD case finding (community pharmacists, smoking cessation providers, GP practice)
- Use of above initiatives to provide support & training for primary care clinicians
- Consideration and adoption of appropriate use of telehealth (will require business case)
- Link pathways with other emerging CCG initiatives (e.g. Rapid Response Team, Network MDTs, Single Point of Access SPA, smoking cessation)

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Dr. Yinka Ajayi-Obe - CG Clinical lead / Chair COPD Core Group (Commissioner)
Dr. Ruth Clery - CCG Smoking Cessation lead GP (Commissioner)
Dr. Rosh Siva - Acute Respiratory consultant (Provider)
Avril Gilliam-Hill - Senior Pathways Redesign Manager (Commissioner)
Sally Massey - Manager (CHS) (Provider)

Karen Grindrod - CRT Manager (Provider)
Patricia Robinson - LTC Nurse Consultant (CHS) (Provider)
Patrisha Murphy - Head of Community Nursing (Key Stakeholder)
Katie Cumings / Jimmy Burke - Public Health / Smoking Cessation
Margaret Haastrup - CCG Pharmacy Lead (Commissioner)
Mark Justice - CNCO (Key Stakeholder)
Breatheasy - Croydon British Lung Foundation (Service Users)

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Analysis of local activity data in comparison to estimated local prevalence and variance against national good practice & peer group of CCG's utilising the following sources:

- COPD Commissioning Toolkit
- Croydon Health Observatory
- Health Innovation Network
- The British Lung Foundation
- NHS England – "Breathe better, feel good, do more
- The Projecting Older People Population Information system (POPPI)

PwC undertook benchmarking for Croydon against peer group of CCGs which showed variance in COPD diagnosis and treatment.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

40% reduction in emergency COPD hospital admissions
50% reduction in COPD 1st outpatient appointments (Spec: Respiratory. COPD = 19%)
25% reduction in follow up COPD outpatient appointments (Spec: Respiratory. COPD = 19%) Ratio: 1:2.2
40% reduction in excess bed days at 2014/15 National Tariff @ £192+MFF"

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Development of high level key performance indicators
- Regular liaison with GP networks to ensure feedback and discussion on the performance of the new support & up-skilling and case finding model

What are the key success factors for implementation of this scheme?

Increase in identification, diagnosis with COPD in the community.
Management and review of patients with COPD in the community.
Reduction in emergency hospital admissions for COPD
Reduction of in-patient length of stay and excess bed days

ANNEX 1 – Detailed Scheme Description (Underway)

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no. 5
Scheme name
Falls and Bone Health (Service for 65+)
What is the strategic objective of this scheme?
Croydon Clinical Commissioning Group (CCG) formed a strategic partnership with Croydon Health and Croydon Council to collaboratively re-design and transform the Falls and Bone Health service to ensure the delivery of coordinated, high quality, patient focused care. There is a shared vision 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. 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. There are three distinct priorities, which underpin the Falls and Bone Health Service in Croydon: To provide an Integrated Falls and Bone Health Service, with a single point of access supporting high quality clinical outcomes To provide a robust specialist Falls and Bone Health Service in line with current NICE, DH and NSF Guidelines, and agreed service specification Providing high quality, personalised care, as close to home as possible Link the service with the Single Point of Assessment of the **Transformation of Community Services (TACS)**, developing an agreed pathway between the two services where appropriate Patients and social care clients have told us through various consultations 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 to enable timely interventions that would prevent health issues developing into a crisis.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?

Service Model

The service will provide:

- A single accessible point of entry to a ***multidisciplinary Specialist Falls and Bone Health Service*** available in:
    - Client's own homes
    - In a multi-disciplinary falls clinic (existing services)
    - In Croydon University Hospital
    - In other locations as defined appropriate by the Falls and Bone Health Service
- An appropriate assessment of referrals for patients referred to the service in line with agreed criteria.

- An appropriate multifactorial intervention for patients referred to the service in line with current NICE Guidance.

- Maintenance of an information system that will provide the commissioners with ***all information*** requested within this service specification to monitor the activity and impact of the service. (Although the contacts of the Care of the Elderly consultant is monitored as part of the CHS ACE Team it is important that these contacts within the Falls clinics are reflected within the record of each patients seen by the Falls and Bone Health Team to obtain a clear picture of the workings and outcomes of the Team. CCG will need to consider increasing the consultants' activity as the service progresses.)

- Evidence based falls prevention exercise classes where appropriate.
- Learning and development support to other health, social and voluntary sector care providers (including ED/UCC) on the primary and secondary prevention of falls and osteoporosis and the management and rehabilitation of people following falls through the provision of education sessions and information.
- Support the development and implementation of Falls and Osteoporosis

Protocols in acute care in line with the National Service Framework for Older People and NICE guidance.

- Support onward referrals to the voluntary sector and social care (in particular linking with Reablement services)
- To provide access to pharmacy expertise for patients attending the service

Accessibility/Acceptability

The site(s) MUST be accessible by patients and should be compliant with the Disability and Discrimination Act (2005). All locations must demonstrate their accessibility to main road networks and public transport for those patients where private transport is not an option.

The Service will be delivered with dignity and respect, with due regard to both individuality and confidentiality. The service should be appropriate for the requirements of a patient's age, sex, ethnic origin, religion or disability. The individual needs and wishes of the patient are to be recognised and taken into account when providing the service.

The production of patient information leaflets and all promotional literature will be the responsibility of the Service Provider. The information must be appropriate for the requirements of a patient's age, sex, ethnic origin, religion or disability. The Provider will make available any literature produced by patient support groups and display addresses and points of contact.

The Service will be subject to periodic review by local and occasionally national bodies, in addition to Croydon Borough Partners and GP Clinical Commissioning groups.

Whole System Relationships

The Provider MUST consider ways of fostering relationships and existing links with local consultants, primary and community care providers and recognise the necessity of an service to be managed as part of a 'whole system' approach.

The Service Provider MUST work collaboratively with commissioners, patients, and health and social care providers and voluntary sector organisations.

Interdependencies

The provider will be expected to develop good working relationships with CReSS service in order to facilitate a good working pathway and to minimise unnecessary waiting time for patients.

Relevant Networks and Screening Programmes

The Provider must work in partnership with secondary, primary and community healthcare providers, social care providers and voluntary sector organisations to develop and improve the patient care pathways for the Falls and Bone Health Service.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner – Croydon CCG
Providers - Croydon Health Services

- Croydon Council
- AGE UK

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There exists a wealth of research evidence to support the proposed model of care. However, the specific findings from the following publications are at the core of a Falls Community service for older patients in Croydon and their carers.

5) **NHS services for falls and fractures in older people (national clinical audit by the Royal College of Physicians (17 May 2011)**

Every year, over 500,000 older people attend UK Emergency Departments following a fall and 200,000 suffer fractures due to osteoporosis. Falls and fractures in the over-65s account for over 4 million bed days per year in England alone, at an estimated cost of £2 billion. Falls and fractures often lead to disability and loss of independence, and are the leading cause of accidental death in this age group. Well-organised services, based on evidence-based national standards, can prevent falls and reduce the risk of disability and death from fractures. The most important principle of care is to respond to the first fracture in order to prevent the second. Older people cannot currently be assured that their local NHS services will do this

6) **British Geriatrics Society for better health in old age – Research studies to**

reduce falls in care homes

Falls in care home residents occur 5 times more frequently than those in older adults living in the community. Many of these people suffer injury and there are high associated costs to the NHS. A Falls Management Programme that can reduce falls as well as current community programmes has yet to be established in care homes; possibly because current programmes are not tailored to the care home population, known to experience high levels of cognitive impairment.

7) **Action needed to reduce hospital falls: a "one size fits all" approach will not work – Nice Guideline – June 2013**

Nearly 209,000 falls were reported in hospitals in England between 1 October 2011 and 30 September 2012. While the majority (97%) of these people experienced no or low harm (such as minor cuts and bruises), 90 patients died because of their falls. Around 900 patients experienced severe harm, such as hip fractures and head injuries. Falls cost the NHS an estimated £2.3 billion a year.

While it would be virtually impossible to prevent all hospital falls from happening, Nice guideline calls for doctors and nurses to address the issues that will reduce the risk of patients suffering avoidable harm.

8) **Transforming our health care system: Ten priorities for commissioners (The King's Fund (2011)**

The research maintains that the ageing population and increased prevalence of chronic diseases require a move towards prevention, self-care, more consistent standards of primary care. This care also needs to be well co-ordinated and integrated. One key priority is the management of ambulatory care sensitive conditions, which, despite being largely preventable, account for a significant proportion of all acute hospital and these admissions are costly. The report reiterates that maintaining wellness and independence in the community prevents deterioration in conditions and therefore results in better health outcomes, fewer emergency admissions to hospital which are distressing as well as cost savings.
It emphasizes that early identification of ACS patients is crucial if their management is to be successful and GPs are well placed to do this through the use of risk stratification tools and clinical decision support software, expanding vaccination and encouraging active disease management.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in

headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Croydon Clinical Commissioning Group (CCG) serves a resident population of approximately 370,000. Croydon CCG is responsible for commissioning a range of services including acute, community and mental health, services for their population.

The purpose of this specification is to set out the requirements of a Falls and Bone Health Service for the registered older adult population of Croydon and replaces all pervious specifications for a service.
The service is built on the current Falls service provided by Croydon Health Services and will provide a robust Falls Prevention and a focused Bone Health Service.

The overall outcome measure is based on providing an Integrated Falls and Bone Health Service, with a single point of access supporting high quality clinical outcomes, with a reduction in Emergency admission activity and also the prevention and intervention of Falls patients.

Below is a list of a number of KPIs relating to the service which include:

Service	KPI measure
User Experience	100% increase in numbers of people being triaged by the Falls and Bone Health Se
	100% increase in numbers of people receiving ***multifactorial assessment and in*** Falls and Bone Health Service
	30 patients a month within CHS referred to the team using the agreed criteria for as of osteoporosis
Service User and Carer Experience Improvement	Patients assessed diagnosed and where appropriate prescribed medication by a C prescribing authority in line with current agreed pharmaceutical guidelines
	80% of patients, who fulfil the criteria, ***offered*** a place on an exercise class prog weeks of completing an appropriate assessment
	100% of patients to participate in measurement using the Outcomes Framewo intervention and outcomes recorded. Specific outcomes in relation to these measur further
	100% of patients accepted by the team to receive a Multifactorial assessment, by with referral on to an appropriately skilled clinician, for certain aspects, in line w Guidelines
Access	Commencement of the triage of a referral to the Falls team must follow within 3 wor

Performance and Productivity	receipt of referral
	Commencement of initial assessment /Intervention by a team member must follow v days of acceptance by triage
	Commencement of initial assessment/intervention by the Bone Health Nurse must c 5 working days of acceptance by triage if appropriate
Clinical Audit	Undertake minimum of two clinical audits per year
	95% of patient Outpatient letters and Discharge Summaries to meet minimum data with the provider - CHS
	100% of summary of complaints, incidents and PALS issues received and a summa number, themes and actions to be managed effectively by team
	Reporting on Untoward Occurrences (UTOs) and Serious Incidents (SIs) and lesso reported within 24 hours and Root Cause Analysis (RCA), lessons learnt and recor implemented completed within 45 working days
	Maintain a DNA rate of below 10% of total patient appointments booked
	Total numbers of DNA, by clinicians Exercise classes to be defines separately
	Comply with prescribing formulary Summary Report to NHS Croydon's pharmacy te

These outcome measures are discussed internally at the QIPP operational board and also at the joint Falls steering group which includes members from CHS, Croydon University Hospital, The CCG, Social Services and Mental Health.

In addition to this patient specific case studies are collected to demonstrate how the integration across services is working in reality.

Patient surveys are carried out to establish if the service users believe their care is robustly coordinated and providing a positive outcome.

Project manager involved in lessons learnt exercises from other CCGs and share lessons with the local project team to help keep the service robust and fit for purpose for its patients and commissioners alike.

What are the key success factors for implementation of this scheme?

- Whole system partnership working
- Patient and Public Involvement in their care across the whole health agenda
- Ownership from all stakeholders
- Clear KPIs and quality outcome measures
- Communication across health and social care services
- GP and other clinician engagement and confidence in the services
- Information sharing across services
- Effective integrated care planning process with feedback loop

ANNEX 1 – Detailed Scheme Description (Underway)

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no. 6
Scheme name:
Direct Listing Pre-operative Hernia
What is the strategic objective of this scheme?
To enable a patient centred approach to pre-operative assessment planning by providing an integrated, safe, high quality pre-operative service in primary care, reduce waiting times for inguinal hernia procedures and provide care closer to home for the patient, provide an efficient service that achieves financial balance.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The management of most minor surgical procedures were previously organised via the traditional models of care. There is now a recognition that such services can be best delivered in a more efficient way and closer to the patient's home by moving such services into primary care. The New Pre-op Direct Listing Hernia pathway, a Croydon CCG Local Enhanced Service (LES) facilitates the direct listing of hernia patients through Croydon referral support service (CReSS), the referral service commissioned by CCCG for that purpose. The patient cohorts targets adults 19 years and over. With the new pathway the patient is reviewed and diagnosed by the General Practitioner as having a hernia (inguinal). The GP works to an acceptance and exclusion criteria, completes a set of tests including MRSA screening and based on the outcome discusses and directly lists the patient for the procedure as a day case with a surgeon at Croydon Health Services (CHS) where the procedure is carried out. There are no follow up appointments anticipated with this pathway.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The Direct Preop Listing Hernia project is commissioned and managed by the following: Project Manager (Kwame Amankwa), Clinical Lead (Farhhan Sami), Executive Lead (Michelle Rahmann). It is delivered on a revised pathway where the GP manages the first and follow up appointment and then directly lists the patient for surgery at Day Case theatre at Croydon Health Services and Mr Paul Hurley, surgeon carries out the procedure.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme

- to drive assumptions about impact and outcomes
The evidence for this project has been drawn largely from national and local context (acute trust data) which for 2013 indicated that hernias comprised approximately of 7% of all surgical outpatient visits. The male to female ratio is 8:1 and in men the incidence rises from 11 % per 10,000 person-years aged 16-24 years to 200 per 10,000 person-years aged 75 years or above. The expected target group are patients who can readily be reviewed by their GP to stem the rising waiting times for such assessments in secondary care. In terms of impact, patients are seen quicker by their GP than they would be should they require an acute trust outpatient appointment and at a time and place suitable for them thus enhancing the patient experience. The first steps in the process are now all undertaken by the GP ensuring consistency and continuity. The number of outpatient appointments undertaken at the acute trust is reduced as the patient only requires one appointment where the procedure is undertaken.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
A questionnaire has been sent to the GPs for feedback on their use of the service. Amendments to the scheme have already been made in August based on feedback received from GPs. Data available shows that first and follow up outpatient appointments at the acute trust has reduced since the new pathway has been in place.
What are the key success factors for implementation of this scheme?
Reduction of first and follow up outpatient's appointment for patients with a hernia. Patients receive pre-op hernia treatment closer to home. 100% appropriate referral rate from GP to direct listing for procedure

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no. 7
Scheme name
Reablement and hospital discharge – Improving and expanding care home support
What is the strategic objective of this scheme?
Better audit of infection control/tissue viability in care homes for the prevention of admissions and readmissions to acute care and enable earlier hospital discharge by better management in care homes with and without nursing. To reduce the impact of the transmission of infections including MRSA and Clostridium Difficile that leads to inappropriate admissions to acute care or delay discharge. Metrics • Reduce admissions to acute care due to poor infection control in care homes • Reduce admissions to acute care due to poor tissue viability management in care homes • Decrease the number of days in delays for hospital discharge caused by inappropriate infection control/tissue viability management in care homes
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Project delivery Baseline audits related to tissue viability and infection control carried out in care homes. Areas that require intervention are addressed. The intervention includes training, direct intervention, intensive one to one clinical support on request, clinical observation of practice, role modeling continued support and resident specific interventions/guidance. **Project Officer Role** Conducts baseline audits and collates information to identify areas of required intervention for the project nurses. Collation of statistical information for each intervention to provide the board with activity and outcomes. Quality assurance audits. Networking and liaising with external agencies. Organisation and coordination of training. **Project Nurses Role** Senior health practitioners with a district nurse background including advanced knowledge in infection control and tissue viability. The role requires teacher's accreditation. They have the flexibility to offer clinical support and work within the home setting and offer bespoke training to assist care homes in raising standards in the light of

best practice. Clinical supervision for the project nurses carried out by senior district nurse in Care Support Team.

The project would be delivered by project officer continuing baseline audits related to tissue viability and infection control. Audits to be carried out in care homes with and without nursing including all client groups. Project nurses would continue to support homes in areas that require intervention and raise standards. The intervention would include training, direct interventions, hands on work, role modeling and continued support. Statistical A&E information to also be utilized to target homes with high numbers of potentially avoidable attendance. Linking with CCG nursing home schemes in order to have a coordinated, targeted outcome driven approach to reducing hospital admissions and A&E attendance. Communication and joint working with internal and external teams to raise standards and share information, examples would include -

Joint Working and Links

- Public Health
- HPA
- Infection Control team CUH
- Community Tissue Viability Team
- Continuing Care
- Community Pharmacists
- Rapid Response team
- Cluster Matrons
- London Ambulance Service
- St Christopher's Home Care Team
- Commissioners and Safeguarding Team
- Continence Team

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

N/A

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

To reduce the impact of the transmission of infections including MRSA and Clostridium Difficile that leads to inappropriate admissions to acute care or delay discharge.

Metrics

- Reduce admissions to acute care due to poor infection control in care homes
- Reduce admissions to acute care due to poor tissue viability management in care homes
- Decrease the number of days in delays for hospital discharge caused by inappropriate infection control/tissue viability management in care homes

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£ insert agreed funding for 2014/15

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Reduction of potentially avoidable A&E attendance relating to tissue viability and infection control

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

An analysis of future A&E attendance for homes that the Reablement/CST has engaged with will measure success for the project relevant to the specific work stream (infection control and tissue viability). A reduction in potentially preventable A&E attendance related to tissue viability and infection control including cost savings. This will be quantified using the 'notional' value of £2,835 per attendance as used in the A&E attendance report 2011 – 2012

What are the key success factors for implementation of this scheme?

- Reducing emergency admissions by providing quality training to the nursing home staff in management of care and directing patients to the best available resources in the community.
- Co-ordinated and integrated effort with the external teams to offer efficient service delivery.
- Reduction in safeguarding referrals related to infection control and tissue viability
- Care home staff knowledge and competencies to be enhanced reflecting good practice
- Decrease in homes non-complaint with CQC in related areas
- Decrease in potentially preventable A&E attendance
- Decline in infection control and tissue viability concerns from commissioners when carrying out contract compliance visits.

ANNEX 1 – Detailed Scheme Description

Scheme ref no. 8
Work stream 15
Scheme name
Psychological Support Service
What is the strategic objective of this scheme?
Commission integrated, safe, high quality services in the right place, at the right time
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Project to pilot a psychological therapies service for older adults with a diagnosed long term condition (LTC) (physical), receiving acute care from Croydon University Hospital (CUH). Psychological therapies are to be provided as part of the local IAPT (Improving Access to Psychological Therapies) service provision, following IAPT service model requirements. The likely outcome being shortened lengths of stay in CUH, and reduced re-admissions among the client group. After some discussion with colleagues in CUH, the project was initiated with colleagues treating patients with Chronic Obstructive Pulmonary Disease (COPD), drawing COPD clients from the Hot Clinic, and from the Croydon Respiratory Team (CRT) inpatient and community caseloads. In year two, the project will be extended to include clients with Diabetes and Chronic Heart Disease (CHD).
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The project is commissioned by Croydon CCG and delivered by the South London and the Maudsley NHS Foundation Trust (SLaM). One member of staff was recruited to the service in August 2012, and a further 2.20 wte were recruited to the service in the autumn of 2013.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Clients with LTCs are more likely to have depression and or anxiety; if their mental illness is left untreated, their physical health care is “45% to 75% higher” than would otherwise be the case. Providing this client group with effective therapy should reduce health care costs.

Research evidence suggests that people with any of coronary heart disease (CHD) or Chronic Obstructive Pulmonary Disease (COPD) can make physical health gains after having attendant psychological problems addressed through psychological therapy.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£ insert agreed funding for 2014/15

£175,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The project aims to reduce activity in acute hospitals - all relevant activity reductions will be targeted, although it is anticipated that activity changes will be seen in inpatient wards (admissions and length of stay) and emergency department attendances in CUH and other acute hospitals

It also aims to provide improved health outcomes for people with long term conditions. Research evidence suggests that psychological problems in people with long term conditions add 45% to 75% to the costs of their physical care.

The project has contributed to greater economic efficiency in the delivery of healthcare and there have been therapeutic benefits for the clients that engaged the service. Measuring these in cash terms is difficult to achieve. The project will continue to monitor health service utilisation of those patients that engaged psychological therapies in 2012 and 2013 with a view to calculating the benefit.

81% of patients who completed psychological therapy 'recovered' according to measures common to Improving Access to Psychological Therapies (IAPT) services. This recovery rate is much higher than what is expected from the best IAPT services, where a recovery rate in the region of 50% is considered high performing.

The psychological therapist delivering the service also measured CAT (Chronic Obstructive Pulmonary Disease Assessment Tool) scores at every session. Whilst the project end of year report describes the CAT scores as, "less significant", the end of year evaluation also shows a reduction in health service utilisation in patients that completed treatment, measured by the number of contacts those patients had with CUH services for the treatment of COPD. A degree of caution is warranted in reporting these observations, not least because in the first year of the pilot, the psychological therapies pilot was one of a number of projects operating in CUH to reduce health service utilisation in patients with COPD.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Regular reports to Reablement and Discharge Board **Monthly reporting from the service to CCG commissioners**
What are the key success factors for implementation of this scheme?
Identifying sufficient number of clients with diabetes, cardiovascular disease or COPD to match the capacity of the team of therapists **Staff Recruitment and Retention**

ANNEX 1 – Detailed Scheme Description

Scheme ref no. 9
Work stream 20
Scheme name
Mental Health Reablement Service
What is the strategic objective of this scheme?
Commission integrated, safe, high quality services in the right place, at the right time
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A small reablement service for adult mental health service users with relatively high needs, designed to divert them from care-coordination within the main secondary mental health service. Providing instead a brief but intensive service that aims to restore life skills and build resilience.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The pilot service is commissioned by Croydon CCG and provided by the South London and the Maudsley NHS Foundation Trust (SLaM). Four members of staff have been

deployed in two teams within the SLaM service. The two teams work in alongside the Mood Anxiety and Personality Disorder Clinical Academic Group (MAP CAG) Assessment Teams.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The recent study on the impacts of re-ablement, from the Personal Social Services Research Unit and the University of York, showed that those going through a re-ablement programme experienced a significant improvement in health-related quality of life compared to a comparison group[3]. In addition, the report suggests that re-ablement is cost-effective for local authorities. For the 10 months after a re-ablement programme, people's care costs were around 60% lower than those who had not gone through a re-ablement programme - which significantly outweighed the initial costs of providing the re-ablement service to people." Cited in, "A Vision for Adult Social Care: Capable Communities and Active Citizens" (16 Nov 2010).

Evaluation of the service is not yet complete, and the number of completed cases is as yet relatively small. However, strategically, there is good evidence the service is therapeutically beneficial; the vast majority of clients that have completed their engagement with the service have been successfully discharged, without the need for ongoing social care, nor have they (so far) required further support from the mental health trust.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£ insert agreed funding for 2014/15

£200,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- The latest performance report from the provider (submitted June 2014) shows that over the life of the project:
  - 159 referrals received by the service
  - 77 engaged by the service
  - 54 discharged from the service
  - 23 currently engaged by the service.

1Key outputs to be delivered are:

a Accepts clients referred to it from South London and the Maudsley

3 http://www.csed.dh.gov.uk/homeCareReablement/prospectiveLongitudinalStudy/?parent=5172&child=6450

NHS Foundation Trust (SLaM) care co-ordinators

A third of referrals to the service are made by the Mood Anxiety and Personality Disorder (MAP) Assessment teams in SLaM. A greater proportion of referrals are made from other community teams within local SLaM services.

b **Minimises waiting times for re-ablement**

The service currently has an average waiting time of 5 weeks and 5 days from referral to the first appointment.

c **Successfully discharges clients within six to eight weeks**

Most people are discharged after six to eight sessions although they spend on average 12 weeks engaged by the service prior to discharge. The service advises that clients often find it difficult to attend consecutive weekly appointments, often due to other life commitments.

d **Reduces service users' needs for ongoing social care, whether provided by SLaM or other commissioned providers, or services funded with personal budgets**

Of those discharged to date, about two thirds are discharged with no need for ongoing support from health and social care services. About one third appear to require further ongoing support.

e **Is cost effective when compared with the financial risk to the Council of full personalisation**

Analysis of the cost effectiveness of the pilot is due to be undertaken during the second quarter.

f **Is accepted as effective by service users**

It would appear the service is accepted by those that engage the service. Of those discharged from the service, 96% agree with the decision to discharge, and the outcome tools used by the service indicate the experience was positive.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Regular reports to the Reablement and Discharge Board

Monthly project group meeting to review progress and address issues

Internal financial evaluation of patient pathway

Academic evaluation commissioned from York University

What are the key success factors for implementation of this scheme?

Recruitment of team / no vacant posts

Sufficient referrals to the service

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no. 10
Internal Workstream: WS22
Scheme name
Enhanced Staying Put Service
What is the strategic objective of this scheme?
The Staying Put Agency has 25 years of experience working with older, disabled and vulnerable people and understanding their needs. Helping people by undertaking simple measures can improve and create a safe environment to enable them to love independently/ The aim of the service is to provide a one stop – no wrong door- after care service in conjunction with the six week Reablement service. We would give holistic advice and support to people who have been recently discharged from hospital, to enable them to continue to remain living independently and safely in their own home. The key objectives are: • Prevent readmission to hospital • Reduce the need for costly care packages • Continue to liaise with and monitor client to ensure they are managing and providing ongoing support The service contributes to the aspirations set out in Croydon's Community Strategy 2013-18 to protect vulnerable people. It also supports the strategic objective in the Corporate Plan to *enable more people to live independently* for longer (Objective B3.1) by ensuring people leaving hospital return home to a safe environment and are not readmitted to hospital. The scheme further contributes towards two a strategic objectives set out in the Housing Strategy, *achieving independence through housing support* and *improving health and wellbeing through decent homes and neighbourhoods*, approved on the recommendation of Cabinet (Min ref. A3212) by full council at its meeting on 30 April 2012 (item 16).
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?

The purpose of the service is to look at the issues clients face following discharge from hospital, and finding practical solutions. A dedicated case worker would be assigned to the client and would carry out a home visit to determine what help was needed.

The following are examples of the type of assistance we would provide and the outcomes of what we expect to achieve:

Access - Furniture moving. Minor/major adaptations to provide safe access

Hoarding issues – arrange blitz cleans, access funding. Work with clients to de-clutter property and maintain a safe environment.

Repairs & refurbishment of clients' property – Advice and support to carry out minor and major work to enable independence in the home. Source funding options.

Winter Pressures – Overview of living conditions; provide additional heaters, cooking facilities. Advise on energy efficiency measures, loft insulation etc.

Moving on – Assist in finding alternative accommodation if no longer able to remain in their present home. De- cluttering, packing. Moving, purchase/re cycling of furniture.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The service would be commissioned by the Health and Well Being Board (Croydon)

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Staying Put is a service that has been working with older, disabled and vulnerable people for 25 years. Our experience in this field has resulted in understanding what practical solutions can be provided to enable people to live in a safe environment, and how minor interventions can make a positive difference.

Our experience has evolved over the years and we can cover the following aspects of assistance.

Repairs and Improvements to the home – advice on funding options and project managing the work

Adaptations to the home – level access showers, stairlifts, ramps *etc*.

Facilitating hospital discharge – fitting key safes to provide care packages, blitz cleaning, furniture moving, minor repairs

Arranging for decluttering, blitz cleaning

Gardening service – to maintain gardens, and promote the well being of the client

Welfare Benefits advice – review clients finances and try and maximise income – refer on to Welfare Rights Team.

Moving people to more suitable accommodation, if they are unable to remain in their home. Assist with sourcing accommodation and help with the physical move.

We work closely with other partners Age UK, Carers Groups, Housing Options and will signpost people to appropriate services.

The service receives in the region of 1200 referrals a year from various sources, including health and social care.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£ 80K agreed funding for 2014/15

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Outcomes are to increase the referrals by 25%.

Reduction of avoidable emergency admission
Reduce delayed transfer of care from home
Effectiveness of Reablement
Reduce permanent admission to residential/nursing home
Increase patient and service user experience

Facilitate a safe living environment

Improve quality of life

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Evaluating cases to see whether there has been readmission to hospital
Questionnaires – to evaluate the effectiveness of Reablement. Follow up with clients to find out how they are managing and if any further intervention is required.

Case Studies to demonstrate the multi-disciplinary working with GP's OT's Community

Scheme Reference Number:	**11 Workstream 14: Data Sharing**
Scheme Name:	**Health & Social Care Portal**
What is the Strategic Objective of the Scheme?	The objective of the scheme is to provide a highly visible and usable interface to the cross-sector data which Commissioners and Senior Management require on a daily basis without the need to carry out complex actions on the data in order to answer the management and operational questions required.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?	The Health & Social Care Portal is being developed to aid Commissioners and Senior Management across the current and future health and social care economy. The service will be delivered as a web-based application accessible to multiple service providers and will be made available by our hosts of choice, the SL CSU. Delivery is structured to provide near-instant gratification to certain data requests and predictive analytics. Delivery of the service will be for the main part *via* N3 connection. This will suit NHS organisations, however, non-NHS organisations or organisations without N3 connectivity will need to use a suitable remote access token (*i.e.* RAS/Secure ID or Secure Envoy). The Portal has been successfully tested with these. The target audience for the Portal has been devised during consultation with the service providers. Out of the initial total of 50 planned End Users, there is a current 50/50 split between NHS and Social Care/Other users. User volume calculations were based around the proposed target audience consisting of CEO-level management within Croydon CCG (*i.e.* MD, CFO, and Deputy Directors) as well as Commissioners. Outside of the NHS, the planned user base consists of CEO and CTO-level users and Heads of Service. The user base will be expanded to include standing members of the System Resilience Group (formerly Urgent & Emergency Care Board). This group will include GPs and possibly voluntary sector members.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved	The delivery chain for the Portal consists of an extremely well defined set of service providers and managers across several organisations. Commissioning for the organisations concerned are shown in the following Attachments which detail: data, technical, Board and Named Commissioner feeds (and progress where applicable).

ANNEX 2 – Provider commentary {Discuss with Paula Swann/Hannah Miller}

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Croydon Health & Wellbeing Board
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	*SC : This should be Q.1 ?? surely*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	