Agenda Item 8 - Handout

NHS Croydon Clinical Commissioning Group

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Improving health and social care outcomes for over 65's: Health and Well Being Board (Croydon)

22nd October 2014

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Why are we doing this – the case for change

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There are increasing challenges on the health and social care system:

- Croydon has both a growing and ageing population
- Increasing numbers of patients are living with long-term conditions
- There is potential for Croydon to improve performance in care for patients over 65 in order to match other London boroughs
- The CCG and the Council both face significant financial challenges

We want to look at doing things differently in Croydon to meet our challenges and create services that:

- are more joined up
- incentivise proactive health management, improve outcomes and user/patient experience
- are focused on outcomes not activity
- put the users/patients at the centre of their care
- use health and social care resources more effectively

How will the people of Croydon benefit?

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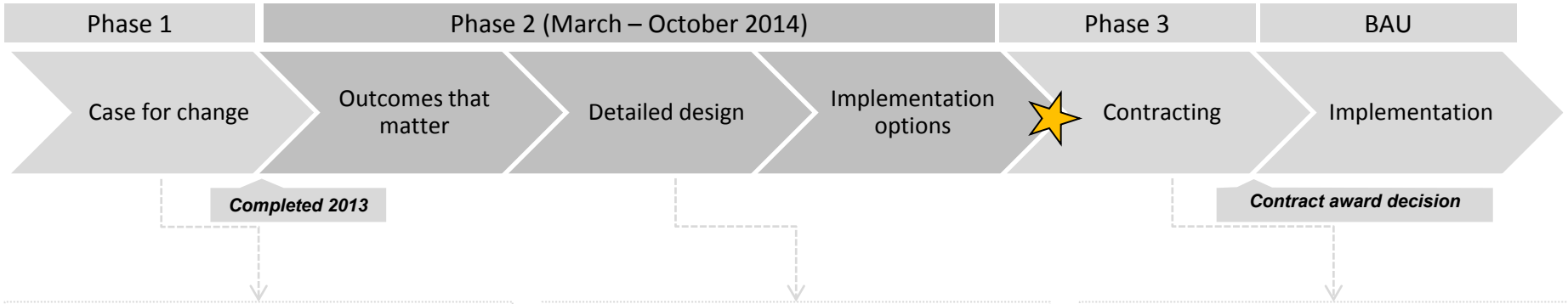
1. Increased focus on whole-person care
   - Aligns service OBC aligns incentives across the care economy to deliver the outcomes that matter to patients and the public
   - Rewards outcomes and not just activity - OBC puts resources in the right place in the system to maximise value
2. Enabling collaboration and integration
   - Improved patient and service user experience through reduced fragmentation
   - Providers are supported, and incentivised, to collaborate in order to deliver whole person care
   - Delivery of improved models of care
3. Realising efficiencies in the system
   - Promotes investment in prevention, quality improvements and working practices
   - Can reduce duplication across the system
   - Opportunities to deliver care in lower cost settings
   - Evidence suggests that efficiencies of 10-15% are possible

Where we are in the process



Phase 1: Case for change

- Developed in 2013
- Outlined the potential benefits of developing an outcome based approach to commissioning older peoples services in Croydon, and to outline the estimated scale of the potential financial opportunity achievable through this approach.

Phase 2: outcome design and contracting options

- This report is the output from phase 2.
- Involved the development of the outcomes framework, confirmation of scope and preferred implementation approach.
- 29 September Croydon Council and 7 October CCG decision made to proceed to next stage.

Phase 3: Contracting

- Issues to be resolve:
  - Joint Commissioning
  - Funding
  - Assessment functions in scope
- Detailed dialogue with providers

Over 65s in Croydon

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

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

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

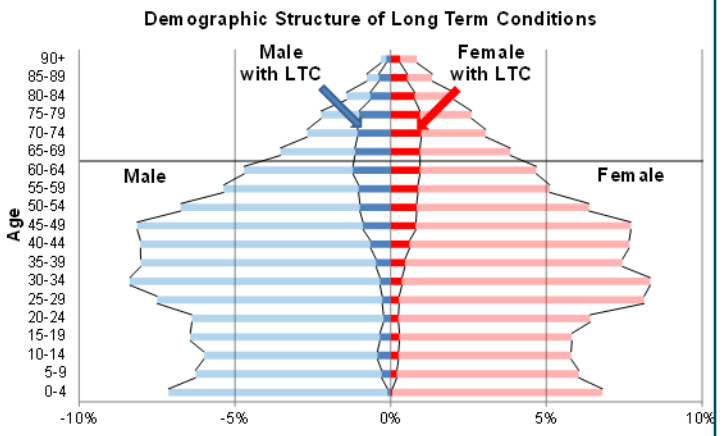
- a measure of the independence of patients living at home is the number of older people still at home 91 days after leaving hospital. For Croydon 65.3% were still at home following discharge in 2012/13 compared with 81.4% for London overall[2];
- patients over 65 account for the majority of all hospital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

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

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

Given the demographics of Croydon, doing nothing is not an attractive option.

Population Structure showing Long Term Conditions



Increase in conditions for people 65+ in Croydon

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

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

1. Croydon CCG Primary and Community Strategy, v.3-1
2. South West London 5 Year Strategic Plan
3. Imison et al, 2012, 'Older people and emergency bed use: Exploring variation', *The King's Fund*

Outcomes that matter

There was a strong consensus which emerged through the public engagement work for five outcome domains that reflect the needs of patients and service users. These domains are set out below and provide the basis for the outcome framework:

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

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

The outcomes are supported by a range of indicators including both quantitative and qualitative measures. 27 candidate indicators have been identified as those which would be most suitable for including as part of the payment mechanism in the contract (i.e. providers will be financially rewarded for achieving them). These indicators include those that (if met) will drive the system towards a financially sustainable future (e.g. reduced hospital admissions, fewer admissions to residential care homes, more prevention and self care).

Data for some indicators is not currently being collected and/or reported. As such commissioners and providers will need to work together to develop new data collection and reporting mechanisms. However, in the interim it may be possible to use existing measures as a proxy. Similarly, as set out below, both commissioners and providers will be required to collect and report nationally mandated measures.

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

Outcome Domain 5 was developed to demonstrate that some of the outcome goals relate to specific clinical indicators.

Any clinical condition, such as diabetes, cancer or musculoskeletal care, could be the topic for its own outcome based contract. In Croydon, with a focus on older people, it is likely that the target population will have at least one long term condition. Therefore the issue is less each clinical condition, and more the successful management of co-morbidity and healthy older age.

The selection of outcomes and appropriate indicators for Domain 5 therefore prioritises measures that are each relevant to a range of long term conditions. It was agreed that it was important to highlight a number of key clinical disease areas or pathways which would be included as part of the outcome framework. These are: Diabetes, COPD, Cardiovascular Disease, Dementia, End of Life, Cancer, Falls (fragility fractures). To reflect this a number of specific measures reflecting these conditions have been incorporated into the framework and are set out in appendix 2.

National/regional frameworks and standards

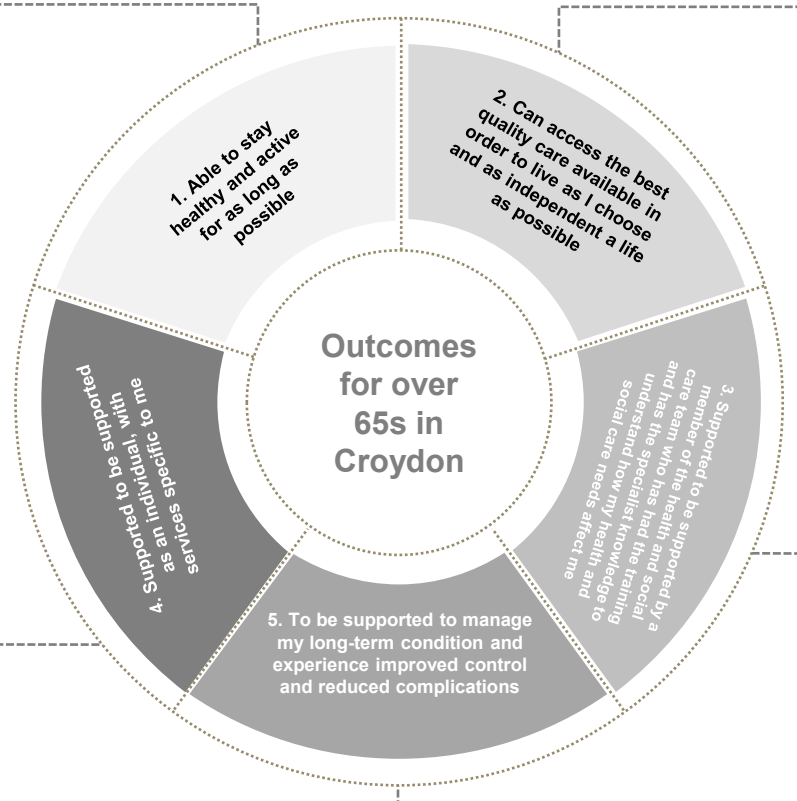
Whilst the outcome framework represents the CCG and Council's requirements and expectations of performance; this is in addition to other reported measures, many of which are mandatory within the Healthcare Standard Contract (for example standards such as waiting times) and specific reports (with specific timeframes and implications) such as SUI reporting.

These standards will need to be included in the contract with any associated requirements. They have therefore not been incorporated into the framework set out in this report.

Outcome domains and outcome goals

- Manage memory loss & dementia
- Eat well and keep active from a younger age
- Access information, that is consistent, in a format that is accessible and understandable to me
- Expect and access proactive and preventative care
- Feel that my wider social networks [including faith groups] are involved and supported to help me stay well
- Feel that I and my family are supported to help me stay well
- Access appropriate choices about services
- Have equality of access to services regardless of where I live and my financial status
- Live as active a life as possible
- Live as sociable a life as desired
- Plan for old age - Practically e.g. finances, personal care
- Expect and have access to proactive and preventative care

- Expect care from the right person at the right time in the right place
- Expect consistency of care between providers
- Access information, that is consistent, in a format that is accessible and understandable to me
- Expect integrated and co-ordinated healthcare, social care and voluntary sector involvement
- Expect that the care I receive will be safe
- Expect my feedback will be listened to and effect change where appropriate
- Expect to be respected as a whole person (holistically) and not a single condition including social, cultural and psychological aspects
- Experience care that is tailored to me, physically psychologically and socially, including with regard to issues around privacy
- Experience care that is timely including to prevent deterioration and promote recovery
- Experience consistency of care between carers
- Feel supported to care for myself where appropriate
- Feel I am a partner in decisions about my care, including identifying risks
- Receive information that is in line/coordinated with the care I receive



- Meet my full physical, mental and social potential
- Live "at home, not in a home" for as long as safely possible and for as long as I choose, including by self-care
- Expect high quality services that are appropriate to me
- Pathway specific measures

covering:

- Long-term conditions
- End of Life
- Falls/Fragility Fractures
- Diabetes
- COPD
- Cardiovascular Disease
- Cancer
- Dementia

- Meet my full physical, mental and social potential
- Plan for a more dependent future... whilst I can
- Plan for old age - Practically e.g. finances, personal care
- Live "at home, not in a home" for as long as safely possible and for as long as I choose, including by self-care
- Know how to access services
- Feel that my wider social networks [including faith groups] are involved and supported to help me stay well
- Feel safe in my home
- Feel safe in my community
- Can access opportunities to meet my desire for social activities & choose when and where I meet others and socialise
- Expect that their carers and families feel supported to help people to maintain my wellbeing
- Access transport and travel options
- Access respite care when needed
- Access appropriate housing
- Access appropriate assistive technologies to support my access to services and my independence
- Manage the process of gradual deterioration in: eyesight, hearing & mobility and mental capacity including self care
- Experience a timely recovery to maximum possible level of health

- Be assured that when something unexpected happens, my next of kin and GPs are contacted early to find out about me
- Experience appropriate translation services
- Manage the level of pain experienced
- Expect care from the right person at the right time in the right place
- Expect care that is on time and punctual
- Have appropriate help to navigate my way though the system
- Expect information that is in line/coordinated with the care I receive
- Expect integrated and co-ordinated healthcare, social care and voluntary sector involvement
- Expect to be respected and treated as individual even in a group with a similar need
- Expect and receive support to ensure appropriate treatment / feel I am a partner in decisions about my care
- Expect that the care I receive will be safe
- Expect to be respected as a whole person (holistically) and not a single condition including Social, cultural and psychological aspects
- Expect to have a plan in place that anticipates crises
- Receive information that is in line/coordinated with the care I receive
- Expect to receive good care when in a crisis

The scope of the contract

Summary of scope

The figure below provides a summary of the services in scope of the contract. Whilst the ambition is to maximise the range of services in scope, for a number of services there are challenges to overcome such as data quality and contracting arrangements. However the CCG and Council are committed to resolving these challenges and phasing these services in during the lifetime of the contract.. The following pages provide additional detail on each service area and a full breakdown is included in appendix 3. The following page provides an exact breakdown of the contract value.

Social Care: assessment and support

- Assessment & Case Management, and Brokerage services. This includes: Older People South and Older People North, Adult Care Team (CUH), START and TACS social work team

Social Care: Domiciliary and Residential Care

- Domically Care, Residential & Special Sheltered and Residential and Nursing Care

Social Care: Older people support services

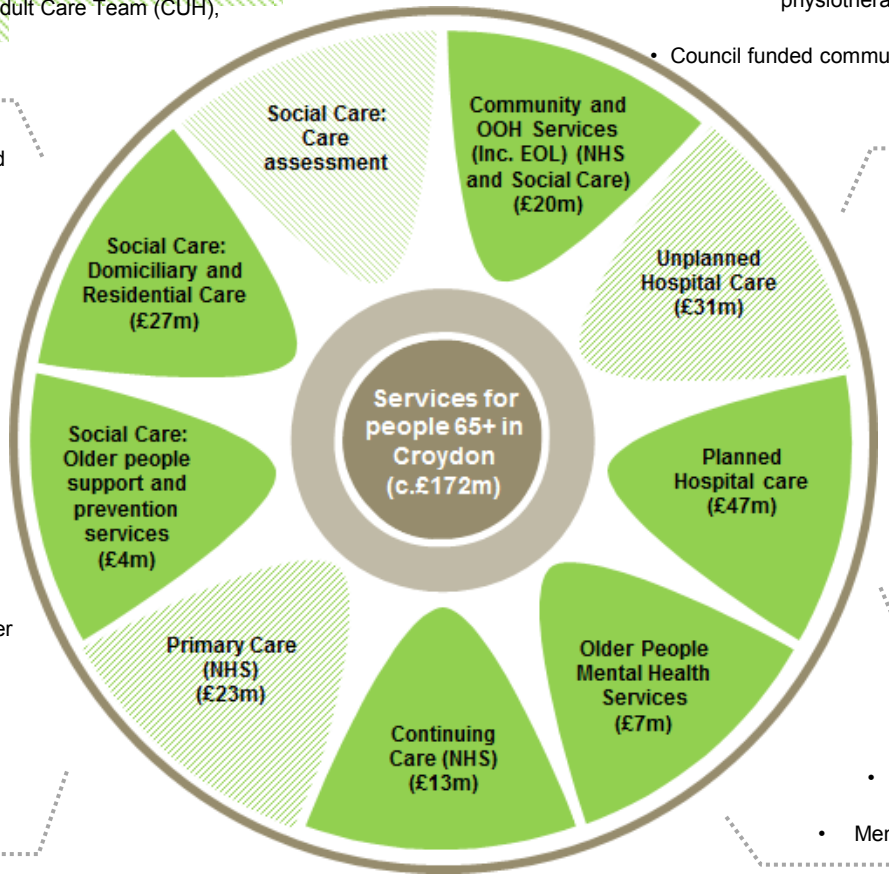
- Older people support services including lunch clubs, preventative services, meals on wheels, and Extra Care
- *In scope: Day Care services currently delivered by the Council are in scope*

Primary Care

- CCG commissioned enhanced services for older people
- Prescribing budget in scope of contract
- Influenced: Health Checks (Public Health)
- *Influenced:* NHSE enhanced services – unplanned admissions, Dementia
- *Influenced:* Core primary care services throughout duration of contract

Continuing Care and Funded Nursing Care

- Continuing Care and Funded Nursing Care currently provided by the CCG



Community Health Services and End of Life Care

- All community services currently commissioned by Croydon CCG excluding Adult physiotherapy, neuro-rehab & psychology and learning disabilities
- Intermediate care services
- Council funded community services including CICS, Equipment, Occupational Therapy, Discharge Support and Avoidance
- End of Life care funded by the CCG and Council

Unplanned Hospital Care

- All attendances and support services for patients aged 65+
- All Admissions, spells and specialties for patients aged 65+
- All Services linked to emergency admissions
- *Influenced: Ambulance services*
- *Influenced: NHS 111*

Planned Hospital care

- Planned care acute services currently commissioned by the CCG including patient transport
- Includes outpatients and elective, PBR and non-PBR budget spend
- Includes non-NHS providers

Older People Mental Health Services

- All acute and community Older People Mental Health services currently commissioned by Croydon CCG
- Mental Health services commissioned by Croydon Council

In scope

Some elements not immediately in scope, but to be brought in scope ASAP

The figures on this chart have been rounded for presentation

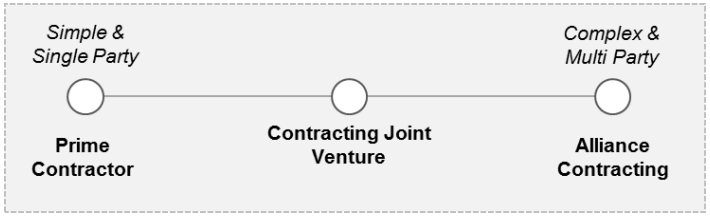
Delivery Model

Delivery models

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

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

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



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

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

Key features of this model would include:

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

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

Payment mechanisms

The payment mechanism is the process that sets out the method by which the flow of funds from commissioners are distributed through to the provider(s) participating in the contract.

Following the consideration of a number of options 'capitation based payment' was considered the most suitable mechanism to enable providers to deliver integrated health and social care. These would be support by outcome based payments that are aligned to incentivise delivery.

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

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

An outcome based payment will sit alongside the capitation regime and will provide an additional incentive to achieve the outcome goals developed as part of this phase. This would operate on a cost plus or budget minus basis.

Contract design and duration

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

Legal and procurement considerations for implementation

Legal advice has been sought throughout the development of this project from Wragge Lawrence Graham & Co LLP. This advice takes into account considerations for both the Council and CCG.

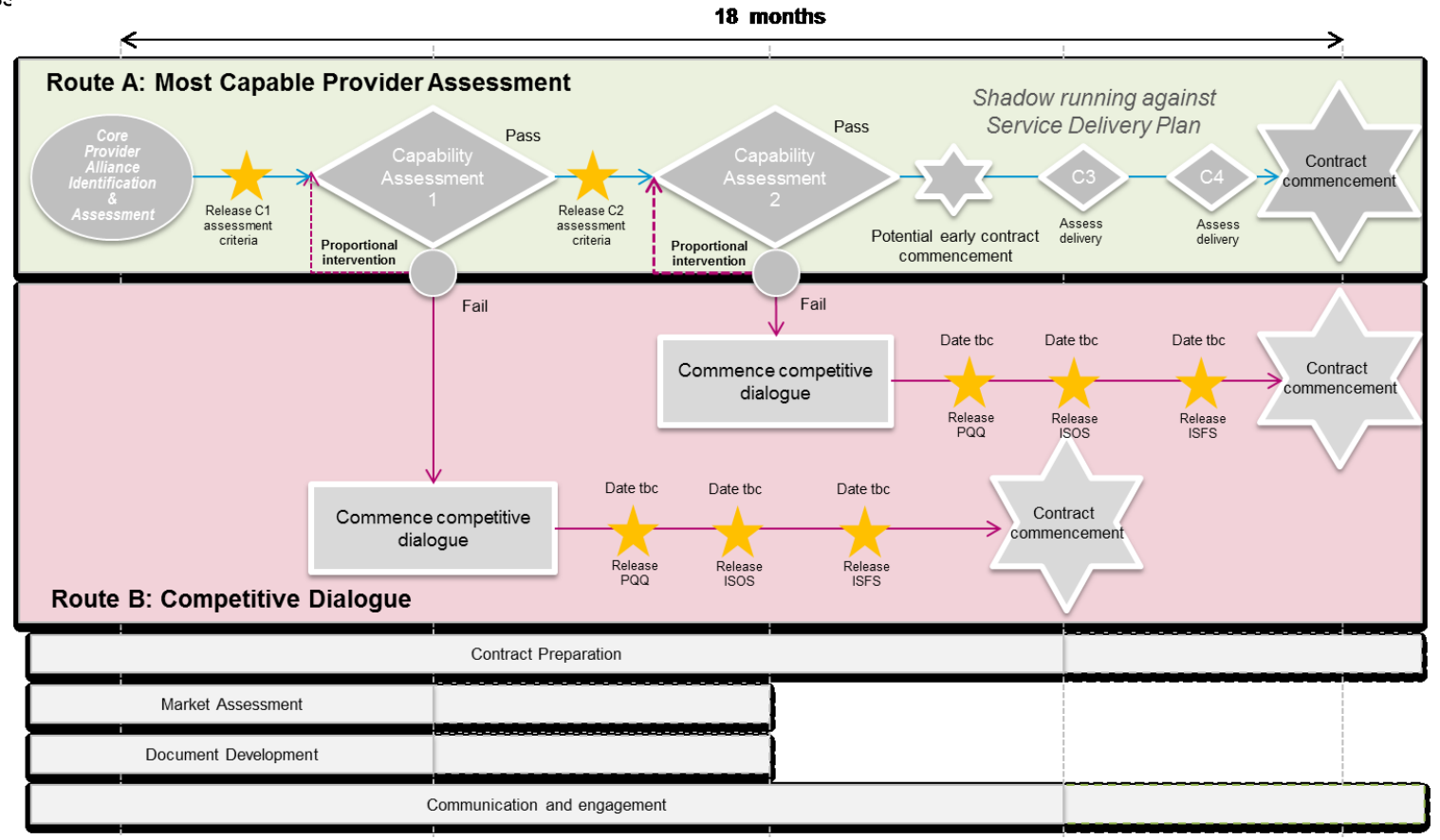
In procurement terms there are a number of risks and benefits associated with both the MCP approach and competitive tenders. Particularly, each has different areas of strengths and weakness in terms of understanding the market and service user's needs, process requirements, provider relationships and delivering best value. In legal terms the principle risk of the MCP approach would appear to be that it is an untested approach in the new environment of the NHS (Procurement, Patient Choice and Competition) Regulations 2013.

The key messages and conclusions arising from the advice received are set out in section 10 of this report. It should be noted that further legal and commercial issues will need to be clarified prior to procurement start for the options presented.

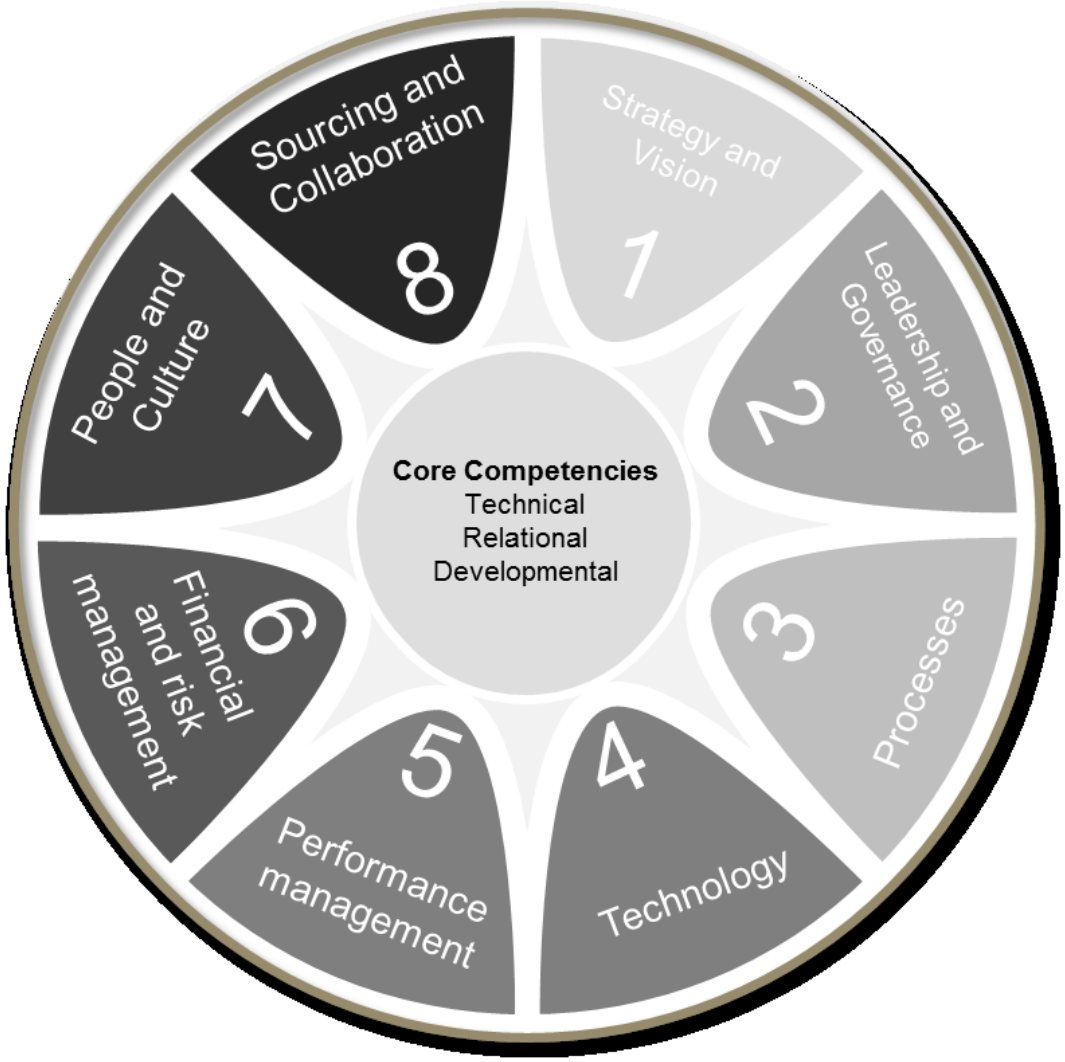
Implementation

The Council and CCG intend to provide a single contract for managing and delivering services for over 65s in Croydon and have set out a preference for a 'provider alliance' model. Two main options that have been considered for negotiating and implementing the contract: (1) Full Competitive Dialogue process (open procurement of new service) and (2) Most Capable Provider(s) (MCP) approach.

The CCG and Council's preferred option is the Most Capable Provider approach. This will include a process to give the identified most capable provider(s) an opportunity to demonstrate that they can deliver the required integrated care outcomes. This includes 'assessment gateways' based on agreed criteria. Failure to meet the criteria or expectations at either gateway may trigger an intervention from the commissioner (at their sole discretion). This will be proportional to the level of failure. The ultimate intervention will be to initiate Route B. Depending on progress made against the capability assessments it may be possible to commence the contract at an earlier date.



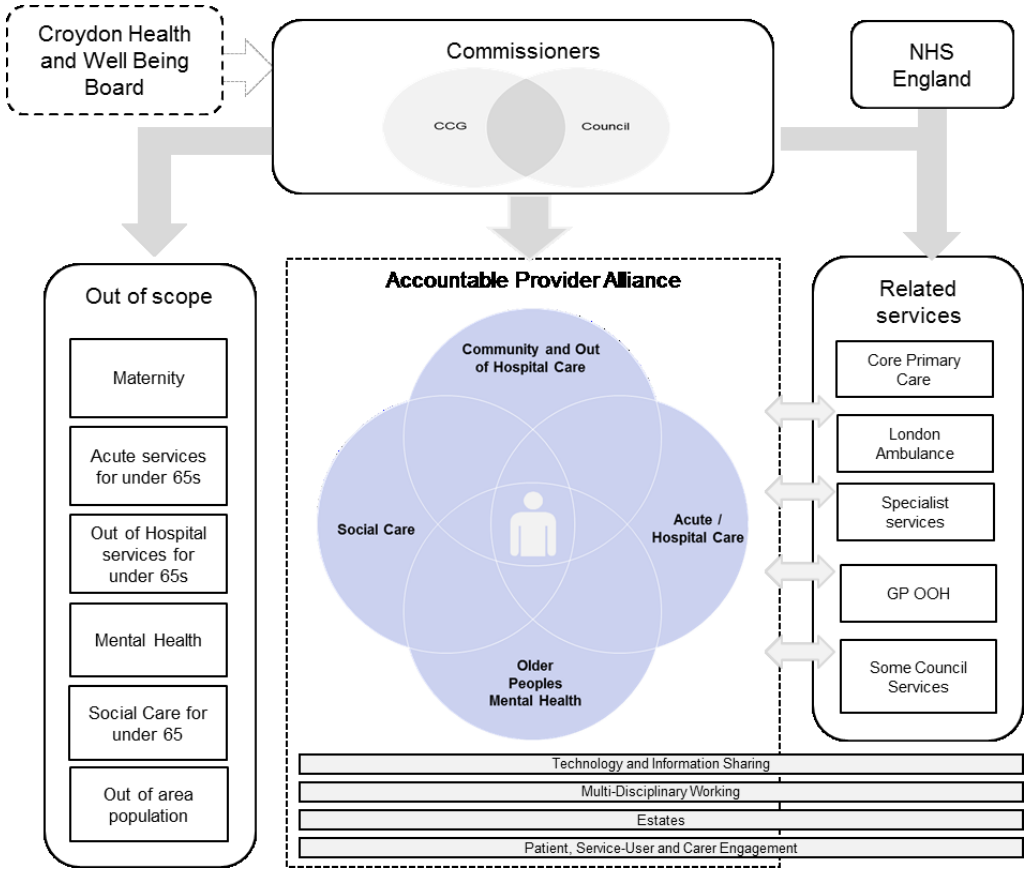
Provider considerations and capability framework



Governance and 'system' model

To commission integrated care on an outcome and capitated basis the CCG and Council will need to consider how they work together to procure and manage a contract on the scale set out in this report. Joint commissioning arrangements will need to be agreed early in phase 3 and further refined and developed in line with the scope and financial envelope.

It is, however, possible to set out how the future system could operate based on the recommendations set out in this report. This is set out in the graphic below along with a description opposite.



Commissioners

- Council and CCG will jointly commission health and social care services for over 65s. An agreed governance structure will need to be established to ensure accountability.
- Outcomes framework developed to hold provider to account.
- Single contract is let to an accountable provider alliance who is responsible for the health and care of over 65s.
- Some services, commissioned or delivered by the Council and CCG will be retained. Similarly services commissioned by NHSE will not initially be included in scope.
- Commissioners will continue to procure services for the remainder of the population which are outside the scope of this contract. Many of these services will be delivered by the same organisations delivering care for older people.

Accountable Provider Alliance

- The accountable provider alliance, made up of a group of providers manages and pays for a range of services that are centred around the patient. These services are designed to achieve the outcomes set by the commissioners.
- There is the potential for parts of the Council to form part of the alliance in order to integrate social care services effectively
- Alliance will manage providers through a range of contractual mechanisms to ensure that they are contributing to the delivery of outcomes.
- Enablers are identified and put in place to support the delivery of joined up care.
- The provider will need to establish protocols and ways of working with services outside of scope that may have an influence on the outcomes set by the commissioner. This may involve the enablers developed to support the delivery of the outcome being shared across the wider health and care economy.

Delivery organisations

- Some organisations will not be part of the accountable provider body
- The accountable provider will manage and reward the delivery of care provided by a number of organisations.
- Providers delivering services to patients in Croydon will continue to be subject to national and regional standards and measurements.
- Many of these organisation will provide services for patients and service users for the wider population.

Summary of recommendations

Section	Summary of recommendations
Population	• Over 65s should remain the focus of outcome based commissioning as the Council and CCG progress into phase 3 of the programme • Note the requirement to establish an appropriate process to measure and report the size of the population
Outcomes that matter	• The outcome framework (set out in appendix 1) is adopted and used as a basis for contract requirements and dialogue with providers in phase 3 of the programme
Scope of the contract	• Croydon Council and CCG should, in partnership, continue to pursue an outcome based commissioning approach for over 65s jointly in order to realise organisational and patient/service user benefits • That the contracts and budgets identified as being in scope of the contract should be incorporated in advance of discussions with providers
Delivery model	• Use the provider alliance delivery model as that preferred by the CCG and Council. Providers will develop and propose their legal and commercial structures in response to the requirements set out by the CCG and Council
Payment Mechanism	• Use a capitated based payment with associated outcome based payments that are appropriately aligned as being that the most appropriate payment mechanism to support the achievement of outcomes
Contract design	• Taking into account the scale of transformation across health and social care and the likely need for investment, seek a contract for an 8 year term with a possible extension of 2 years (8+2). This includes any development period/shadow running in advance of contract commencement
Governance	• The requirement for the Council and CCG to align as commissioners and establish a joint arrangements in phase 3 of the programme
Implementation	• The Council and CCG should adopt the implementation approach set out in this paper • Note that a further report to seek agreement on the final recommendation for contract award will be brought to a future meeting of Cabinet and Governing Body

Overview of key actions in phase 3

This is the report from phase two of the outcome based commissioning (OBC) for over 65s programme. It builds on the case for change agreed by Croydon CCG and Council in 2013, which concluded there was a strong case for moving to an outcome based commissioning model for over 65s in Croydon. This report is designed to inform CCG and Council decisions about whether to proceed to final phase of the process which involves drawing up a detailed contract and entering into negotiations with potential providers ahead of contract award.

As summarised throughout this report there are a number of further steps required as the project enters the implementation phase and moves to contract commencement.

In addition there are a number of ongoing activities that will need to continue. This includes the ongoing improvement in data quality for over 65s in Croydon.

At the beginning of phase 3 the appropriate governance structure will be established to manage the process through to contract award.

Key Phase 3 Workstreams:

The following are the key delivery workstreams for the next phase of the Outcomes Based Contract.

- Develop joint commissioning delivery vehicle
- Preparation of contract documents
- Development of MCP assessment milestones & criteria
- Deliver capability assessments
- Support evaluation of capability assessments milestones
- Shadow running
- Support negotiation of contract
- Project management (Governance, Project Mgt, Comms, Engagement)

The timing of activities to deliver the above outputs is summarised in the following high level delivery plan for the MCP route.

Key actions and outputs for phase 3 include:

To ensure that we build upon the work delivered in phase 2, the following activities needs to delivered at the beginning of phase 3.

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

The timing of activities to deliver the above outputs is summarised in the following high level delivery plan.