NHS
Croydon Clinical Commissioning Group

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Outcomes Based Commissioning for Croydon's over 65s

Health and Wellbeing Board
9th February 2016

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1. Vision for OBC in Croydon

A Whole System Approach

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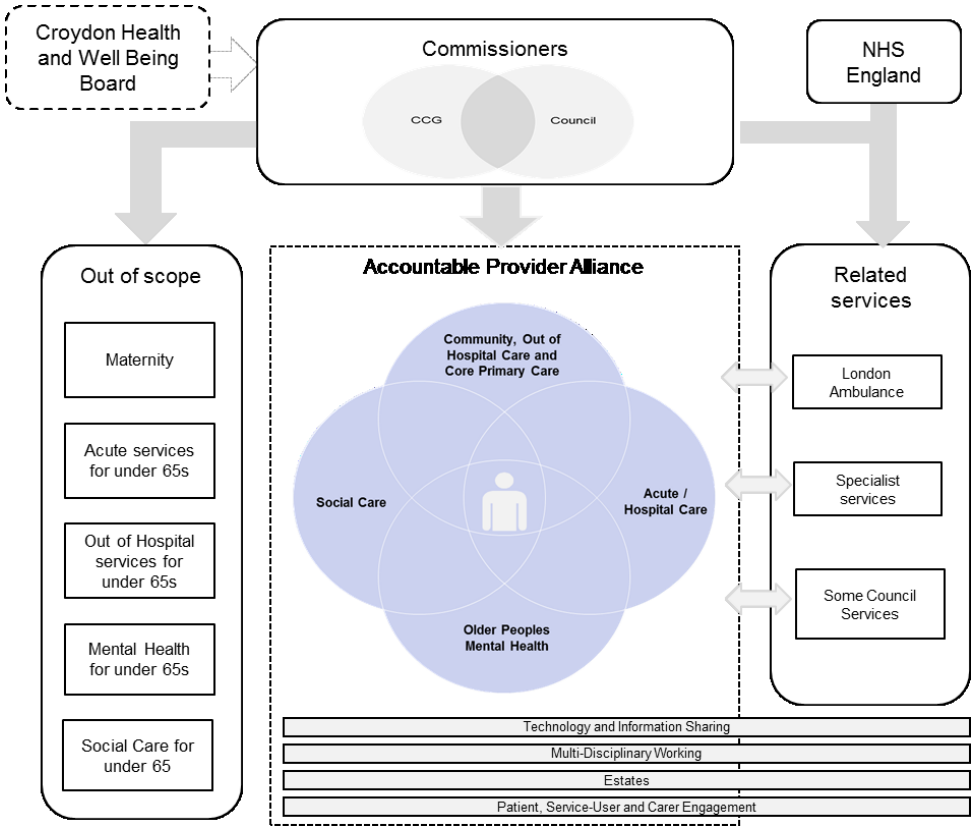
For all partners (statutory, voluntary and community) to come together to provide high quality, safe, seamless care to the older people of Croydon that supports them to stay well and independent. Our users will have a co-ordinated, personalised experience that meets their needs.



Patients/Users age 65 at the date of attendance /discharge and registered with a Croydon GP

An Accountable Provider Alliance (APA) model - responsible for delivering health and social care services over the contract term (10 years). APA is:

- Age UK
- Croydon Council Adult Social Care
- Croydon GPs Group (this is all the GP practices in the borough)
- Croydon Health Services NHS Trust
- South London & Maudsley NHS Foundation Trust

APA to move to an Accountable Care Organisation model through a Joint Venture over time

A capitated budget for over 65 population (£206M in year one) - will incentivise APA to invest proactively in maintaining and managing the health of the population

In-scope services include:

- Acute / Hospital Care
- Community and Out of Hospital Care
- Older Peoples Mental Health
- Adult Social Care

2. The Case for Change

Why is there a need to do OBC for Older People

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The need for change

Croydon has both a growing and ageing population (increase of 23.8%) *

Increasing numbers of patients are living with long-term conditions

There is potential for Croydon to improve its performance in terms of care for patients over 65: this includes addressing **a higher rate of admissions**, **emergency admissions**, and **emergency readmissions** to hospital

People over 65 are higher users of health (£177M) and social care services (£29M) and account for £206M of spend per annum.

Why Croydon?

Croydon is a coterminous local health and social care economy, with one CCG, one local authority and one main acute integrated hospital provider

We have a long history of joint-working between health and social care

Croydon CCG and the Acute Trust face significant financial deficits, £11.9M and £25.5M respectively.

Croydon Council is also under pressure to deliver considerable financial challenges

These are challenges but are an opportunity as well….

*GLA 2014 Capped Household Size Projections

3. Summary of Potential Benefits

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

- that are more joined up and allow people to live more independently, stay at home for longer and are better suited to the needs of the people that use them
- that incentivise proactive health and wellness management across the population, improve outcomes and user/patient experience
- that are not activity driven – as not all activity is necessary or effective
- that put the users/patients at the centre of their care, supported to manage their lives/conditions and actively involved in decisions about their care
- that use health and social care resources more effectively

Opportunities

- **More co-ordinated and integrated care:** by removing the barriers to working in collaboration to provide a coordinated service across organisational boundaries and care settings
- **Opportunities to deliver care in lower cost settings**: Providing services across pathways can enable organisations to change the setting of care and reward preventative activities more effectively. For example, Elective care (increase in day case and outpatient appointments out of hospital), Ambulatory care (increase in day cases) and, Urgent Care (A&E minors to more appropriate settings)
- **Promote patient empowerment and self-care:** Patients are able to manage their own care in the community and their own homes

Example interventions / models of care

- Proactive health and social care management
- Self empowerment and self-management
- Enhanced multi-disciplinary team working
- Admissions avoidance and crisis intervention
- Care co-ordination, planning and management
- Risk stratifications
- 'in reach services'
- Supported discharge

Potential system and population benefits

- Improved patient /service user experience
- Less service fragmentation and improved integration
- Increased independence and self-reliance
- Improved access to care
- Reduced institutionalisation including hospitalisation and residential care
- Reduced Duplication
- Improved ability to manage long-term conditions leading to reduced complications

Potential financial benefits

An estimate of up to 29% saving on current 65+ service expenditure over the 10 years

Improved likelihood of delivering existing transformational plans and initiatives

4. Outcome Framework

Outcome domains and indicators

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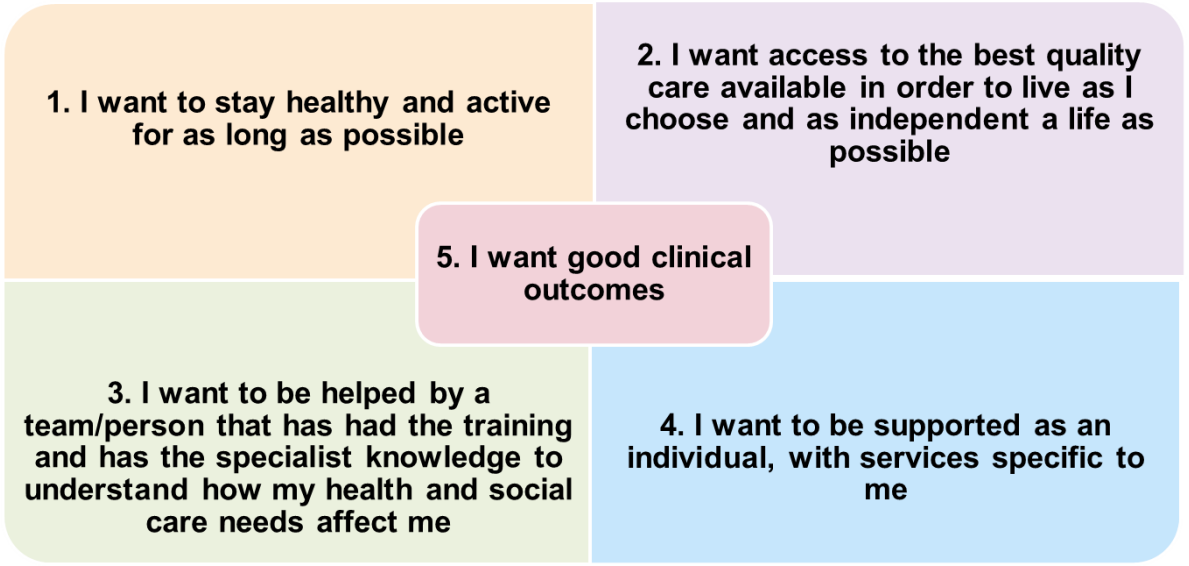
Working with patients and public:
Developed an outcome framework that represents outcomes that matter to the people of Croydon.

Town hall events and working groups were central to the co-design.

Overall **400** individuals provided input and the views and opinions gathered.

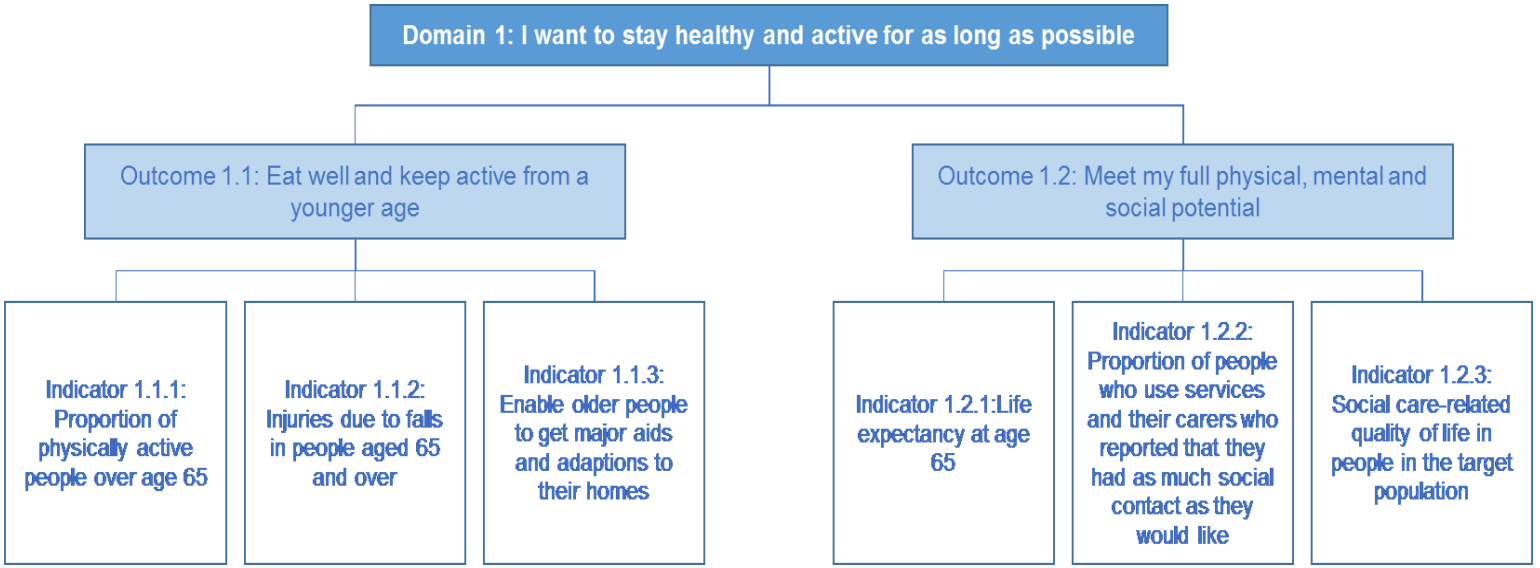


Outcomes Framework:
Indicators are baselined

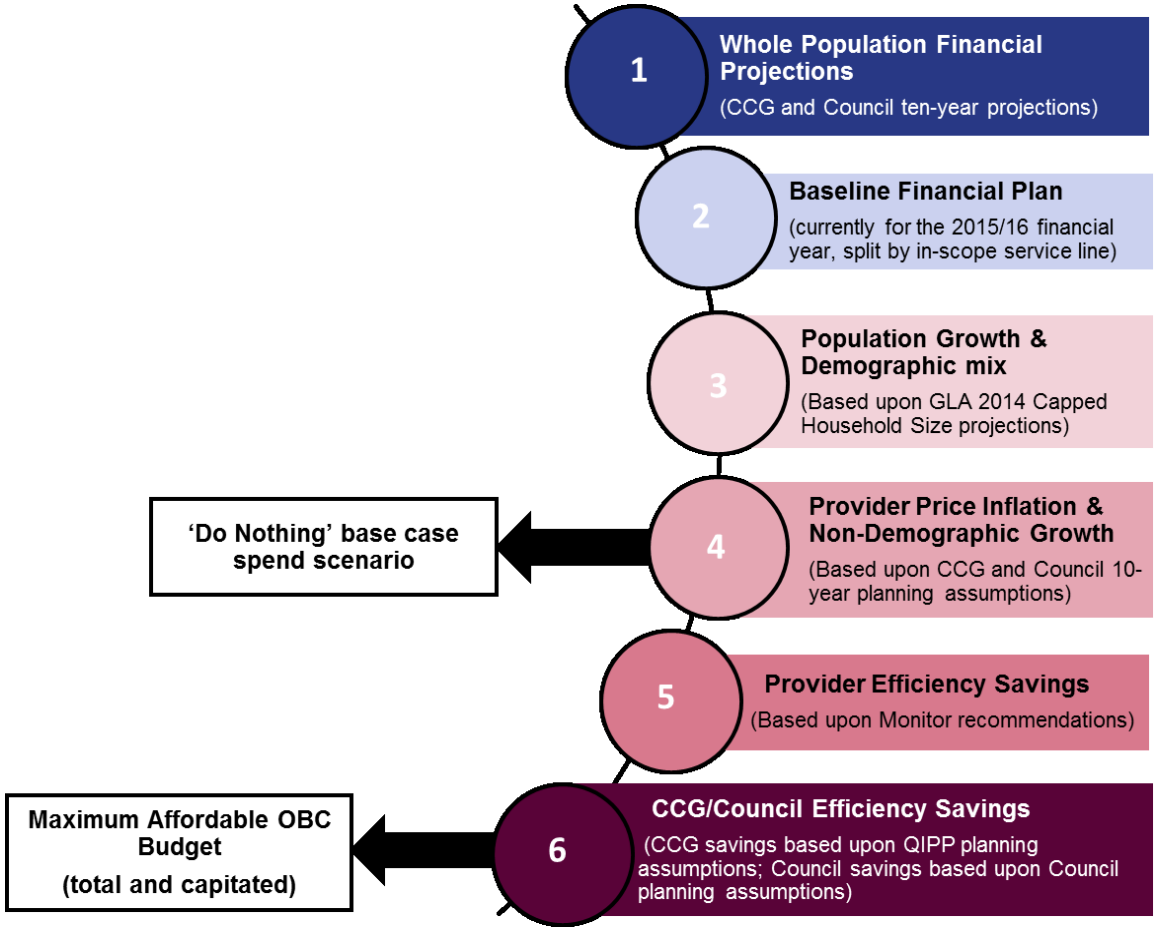
Targets are set for improvement:

- Phase 1 - national / peer average,
- Phase 2 - upper quartile
- Phase 3 - upper decile

Incentive payments linked to key indicators



5. Financial Model Methodology



6. OBC Foundations

Schemes implemented to support OBC

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- Falls prevention
- Strength and balance training
- Smoking/weight/alcohol programmes
- Influenza and pneumococcal vaccination programmes
- Screening – Depression, Dementia LTC-DMT2, IHD, AF
- Home hazards risk assessment

- Risk stratification
- Integrated case management
- LTC self care
- Advanced care planning
- End of life care
- Carer support

- Rapid assessment
- GPs offering enhanced services
- Senior assessment (consultant/GP) of all frail/elderly in A+E and AMU
- Rapid response MDT team
- Outreach to community
- Inreach to A+E, AMU
- Comprehensive geriatric review
- Rapid access clinics
- Ambulatory service
- Step up beds in the community (care homes, community hospitals)
- Easy access to patient transport

- Longer term rehab/ reablement
- Equipment services
- Home adaptations
- 3rd Sector "Low level support" i.e. Social / Psychological /Physical
- Carer support
- Self management

Healthy living and wellbeing → Proactive care → Crisis intervention and admissions avoidance → Bedded care (Acute) → Discharge to assess → Maintaining independence

- Coordinated discharge planning at the point of admission
- Early supported discharge before full recovery
- Geriatric follow-up in the community
- Community support teams
- Coordinated rehab/re-ablement in community setting
- Short term care packages
- Step down community beds (care home, comm hospital)
- Equipment services

- Elderly care specialists leading multidisciplinary teams
- Dementia awareness psychiatric liaison
- Proactive community teams in reach into hospital
- Information sharing with community teams
- Assertive community outreach/treatment

7. APA New Models of Care

Emerging model of care in Croydon

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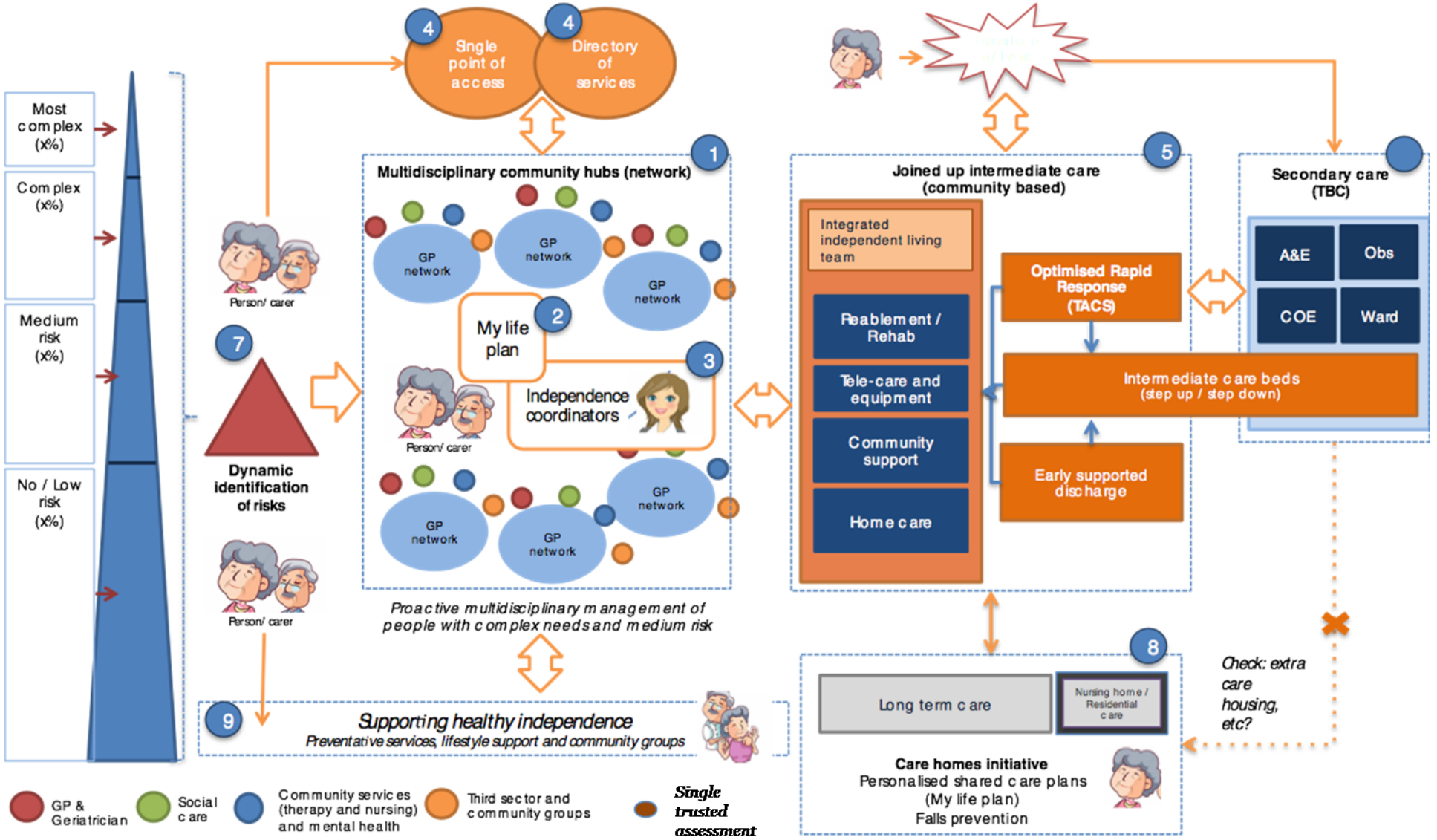

7. APA New Models of Care

Five initiatives in year 1

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1. Create a multidisciplinary community hub - in each of the 6 GP networks
   - *Delivery: Strengthening MDT working with GPs to include links with voluntary groups and third sector organisations so they provide a responsive, flexible and timely service*
   - *Outcomes: Ensures people go straight to the right place*

2. Develop 'My Plan'
   - *Delivery: Helping individuals take positive steps*
   - *Outcomes: Maximises an individual's health and wellbeing*

3. Establishment of Independence co-ordinators
   - *Delivery: Offering a continual supportive presence, ensuring services and support are delivered in a personalised, co-ordinated, relevant and timely way*
   - *Outcomes: Every person has someone to speak to*

4. Single point of access and information to voluntary sector and health and council (link to Gateway)
   - *Delivery: Bringing existing resources together with a single access point for information and advice and a call centre drawing on a shared directory of services*
   - *Outcomes: Ensures people go straight to the right place*

5. Integrated independent living team
   - *Delivery: Providing integrated step-up and step-down reablement and rehabilitation to reduce the need for hospital admissions and care home placements, and help people return home from hospital safely*
   - *Outcomes: Ensures people are supported to regain their independence*

(See more details in Appendix B, Slides 21 & 22)

8. Programme Progress

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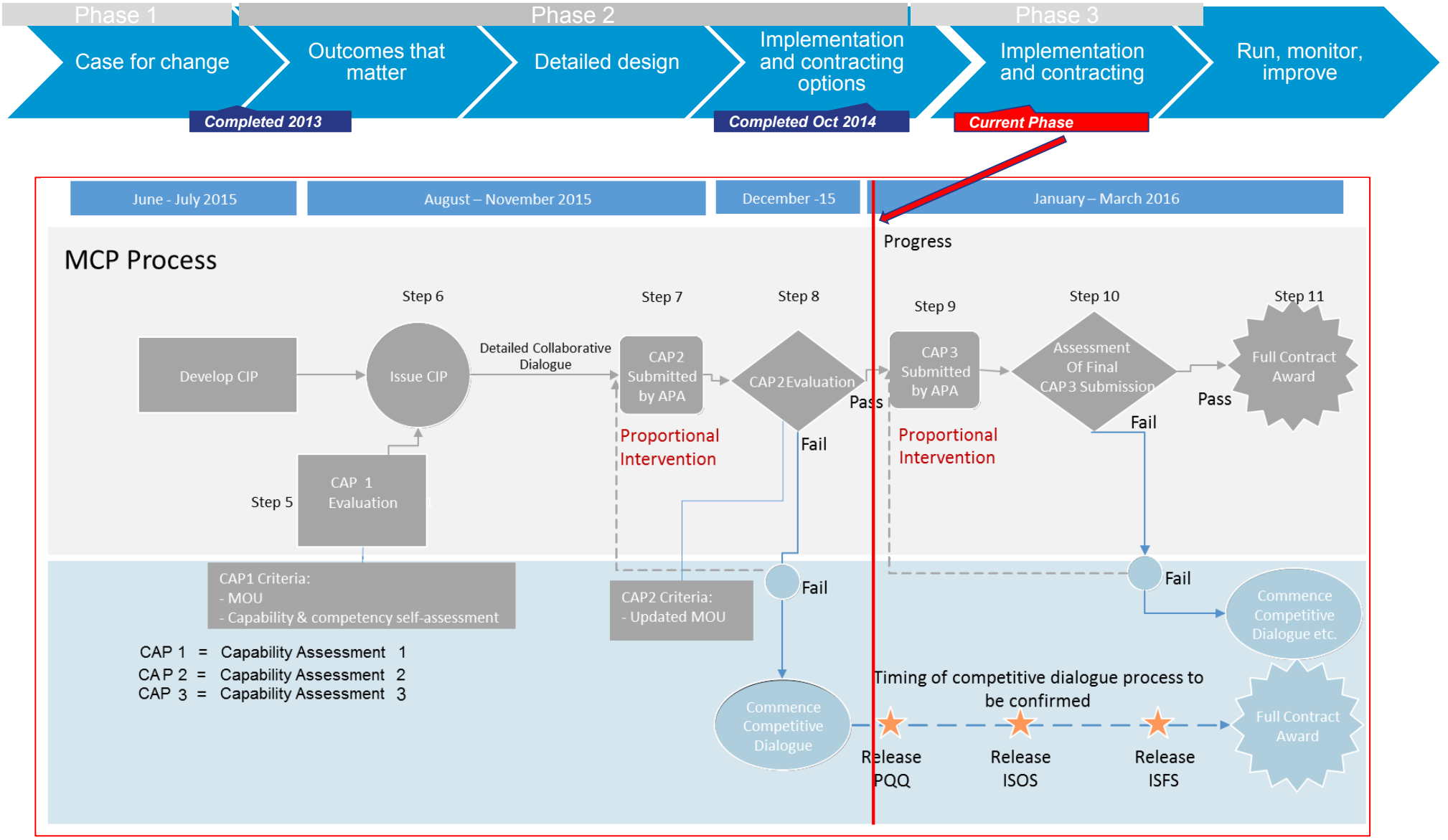

8. Programme Progress

Capability Assessment 3

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On 25 January 2016, the APA are required to submit the following information:

- Assessment Criteria 1: Updated Organisational Capabilities Toolkit;
- Assessment Criteria 2: Care Model proforma;
- Assessment Criteria 3: Finance information;
- Assessment Criteria 4: Transition Plan and Transformation Plan; and
- Confirmation of a signed MoU