Croydon Better Care Fund Plan 2016-17

1 Authorisation and sign off

Signed on behalf of	Croydon Clinical Commissioning Group
By	Mrs Paula Swann
Position	Chief Officer
Date	19th April 2016 (planned date)

Signed on behalf of	Croydon Council
By	Mr Paul Greenhalgh
Position	Executive Director - People
Date	19th April 2016 (planned date)

Signed on behalf of	Croydon Health & Wellbeing Board
By	Cllr Maggie Mansell
Position	Chair of Health and Wellbeing Board
Date	19th April 2016 (planned date)

2 Introduction

2.1 About this document

This document sets out the essentials of Croydon's Better Care Fund (BCF) plan for 2016/17.

This year no plan template was defined by NHSE, but the document headings and content are structured in line with the NHSE assurance key lines of enquiry headings

The content of this plan is focussed on new requirements for 2016/17 and incremental change since Dec 2014. As such, extensive references are made to previous (Dec 2014) BCF plan and other supporting documents, but content from these other documents is not reproduced here.

2.2 Croydon BCF context

Croydon have a very real commitment to integration of health and social care. However, Croydon's BCF plan must be considered in the wider context of integrated service delivery: Croydon's Outcomes Based Commissioning (OBC) programme for over-65s service provision will be an integrated programme covering spend of approximately £212m per annum across health and social care, compared with approximately £24m invested via BCF.

Croydon's very significant and demonstrable commitment to integrated care via OBC supports our aspiration to "graduate" from BCF at the earliest opportunity.

2.3 Key references

Key documents referred to in this plan are:

a) Croydon Better Care Fund Planning Template Part 1 signed 12 Dec 2014
http://www.croydonccg.nhs.uk/get-involved/Documents/Croydon%20BCF%20Template%20(Part%20One)%20NEW%20FINAL VERSION.pdf

b) Outcomes based commissioning for over 65s – Update Report, report to Croydon Health & wellbeing Board 10th Feb 2016
https://secure.croydon.gov.uk/akscroydon/users/public/admin/kabatt.pl?cmte=WEL&meet=18&href=/akscroydon/images/att7014.pdf

3 The local vision for health and social care services

3.1 Our vision

Our vision for health and social care services is set out in the Dec 2014 BCF plan (P7-16) and has not changed.

The CCG and Council vision is to ensure that the services we commission and provide to our population are of the highest quality care, delivered at the right time and in the right place appropriate to their needs.

The CCG, the Council, and health providers have worked together since 2011 on a number of joint initiatives through the Council's Reablement and Discharge Programme, and the CCG's Strategic Transformation Programme, to jointly deliver innovative community-based patient/client-focused services. The BCF has provided the momentum to continue integrated working, on-going joint service innovation, and to facilitate the cultural change that would ensure that integration is sustained and continues to deliver the best outcomes for patients.

The CCG and Council proposed Model of Integrated Care in Croydon for over 65s, describes how Croydon will be moving forwards in implementing this vision with all partners (statutory, voluntary and community) coming together to provide high quality, safe, efficient, coordinated, seamless care to the people of Croydon and users that is proactive, focused on prevention, supports people to stay well and independent and is delivered as far as possible in the community.

Croydon's BCF plan should be considered in the context of its Outcomes Based Commissioning (OBC) programme for over-65s service provision which will be an integrated programme covering spend totalling approximately £206m per annum across health and social care.

OBC and BCF are foundations for integrated care in Croydon's future Sustainability & Transformation Plan, which will further extend the work already done in creating the 5 year strategy and CCG operating plan.

3.2 Outcomes based commissioning (OBC)

Croydon Clinical Commissioning Group (CCG) and Croydon Council have worked collaboratively to develop a transformation programme which will enable improvements to be achieved through a whole systems approach to health and social care.

The vision for Croydon is that people experience well-co-ordinated care and support in the most appropriate setting, which is truly person-centred and helps them to maintain their independence into later life. With an ageing population, the focus of the programme is on services for the over 65s and the outcomes that local residents have said are important to them – those factors that make a genuine difference to their health, well-being and quality of life.

The proposal has been developed to deliver Croydon CCG's vision of "longer, healthier lives for all the people in Croydon" and meets the key national overarching aims – 'Everyone Counts: Planning for Patients 2014/15 to 2018/19. NHS England' and supports the Council's key strategic priorities with regard to promoting and sustaining independence, well-being and good health outcomes for Croydon residents.

Additionally, the programme aligns with the aims of the Better Care Fund which are that health and social care services must work together to meet individual needs, to improve outcomes for the public, provide better value of money and be more sustainable. The programme builds on a long history of joint work in Croydon, including recent developments in delivering whole person integrated care through the Transforming Adult Community Services work.

Age UK Croydon, Croydon Council Adult Social Care, Croydon GP Collaborative Ltd, Croydon Health Services NHS Trust and South London and Maudsley NHS Foundation Trust agreed to form an Accountable Provider Alliance (APA) in June 2015 to be able to meet the decision by NHS Croydon Clinical Commissioning Group (CCG) and Croydon Council to transform the way services for people over 65 are commissioned.

The APA aims to deliver a model of care that is people centred, with an overall vision of 'Working together to help you live the life you want'. The APA has therefore defined a model of care that is focussed on staying healthy and independent to ensure people are at the centre of their care, enabling them to achieve the outcomes that are important to them. This will include in year 1 (2016/17) delivery of 5 key initiatives:

- Development of Multidisciplinary Community Networks;
- Development of 'My Life' plan;
- Establishment of Personal Independence Coordinators
- Single Point of Access and Information
- Integrated Independent Living Service

By joining forces, the APA believe they (a) are best placed to deliver community based healthcare services in people's homes and in the communities where they are comfortable and (b) will be able to provide a more holistic, well-rounded and bespoke health and social care service to our people.

For further detail on OBC, refer to the report "Outcomes based commissioning for over-65s – update report" to Croydon Health and Wellbeing Board 10th February 2016.

4 Evidence base supporting the case for change

4.1 Summary Case for change

The Dec 2014 BCF plan highlights (p 17-44) the case for change which **remains valid today.**

Key health and social care challenges arising from the changing demographic in Croydon have been highlighted as:

1. Increasing elderly population living for longer with one or more long term conditions;
2. Areas of deprivation in the borough with consequential impact on health;
3. Increasing numbers of younger people with disabilities requiring health and social care;
4. Increasing demand on mental health services
5. Increasing demand taking place at a time of financial challenge for health and social care

BCF changes had been planned to deliver benefits through

- 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

4.2 New schemes in 2015/16

The Dec 2014 BCF plan refers (p23) to priority schemes to be delivered via BCF including some new schemes:

- Review of A&E Front of House
- Create a Roving GP Service
- Improving the Clinical Support and Competencies of Care Homes

These schemes have now been implemented. Progress and initial impact is described below.

4.2.1 Review of A&E Front of House

Over 2015/16 the CCG has worked closely with Croydon Health Services (CHS) to implement the proposed changes to support improvements in patient pathways at the Emergency Department (ED) at Croydon University Hospital.

This has included:

- Greater integration between the A&E Liaison and Rapid Response services with the services now operating as one service to support admission avoidance within the community and at the CUH ED. The integrated service (operating 7days/wk 09:00-

17:00 for the ED in-reach, and 24/7 for Rapid Response) enables patients to be assessed within 1hr of referral from the ED, treated if appropriate and to have a jointly developed discharge plan to enable the patient to return to place of residence with or without further intervention and support from appropriate services, including Rapid Response.

- The establishment of a Rapid Access Medical Unit (RAMU) in November 2015 operating 7 days/wk 09:00-21:00 providing a one-stop acute medical day care unit for urgent ambulatory patients who are either referred by their GP, or have attended the CUH ED. The Consultant-led team treat patients that require urgent medical review without the need for a hospital stay, including conditions such as DVT, Cellulitis, Low risk GI bleed, Low risk pneumonia, and Low risk pulmonary embolism.
- Co-location of the RAMU service with the Acute Care of the Elderly service (consultant-led team supporting elderly patients 75 years and over), and the HOT Clinic provided by the Respiratory Team (to provide care for Chronic Obstructive Pulmonary Disease patients who are acutely unwell). This has enabled better integration of care with patients being quickly seen by the most appropriate clinician and a multi-disciplinary team without having to be necessarily admitted to hospital.

4.2.2 Create a Roving GP Service

A Roving GP service has been piloted in Croydon since June 2015, providing a rapid medical response to patients with urgent care needs within 1 hour of referral to avoid unnecessary admissions into hospital. The initial phase of the pilot provided access during Mon-Fri 08:30-17:00, but has subsequently been extended to Mon-Fr 08:30-01:00 and Sat-Sun 13:00-01:00 as part of a wider service delivery model being piloted across the South West London CCGs.

To date (Jun 2015-Jan 2016) the service has seen 249 people and successfully supported 89% of people to be cared for at their place of residence without the need for a hospital attendance or admission. The service is now ramping up to higher volumes of patients per day.

4.2.3 Improving the Clinical Support and Competencies of Care Homes

A number of initiatives have been implemented over 2015/16 to establish the basis for improving the clinical support to nursing care homes, and for improving competencies of care home nursing teams. This has included:

- Additional investment in nursing, and speech and language therapy staffing in the Rapid Response team to work proactively with nursing care homes to support patients, improve care planning in conjunction with the care home nursing staff, and to work collaboratively with the Croydon Council Care Support Team to identify, support and provide appropriate nursing and speech and language therapy training to improve patient care and nursing home standards. This improved capacity began in September 2015 and have been working with the top 5 Nursing Homes with the highest London Ambulance Service conveyances to assess practice and support requirements
- Consultant Geriatrician input into the top 5 care homes with weekly joint ward rounds with the GPs of the care home residents and nursing home staff
- Development of a Purple Guide clinical guidance document for the management of common problems within the care home setting to support all nursing care homes in providing improved care to care home residents
- Undertaking a comprehensive review of services supporting care homes to develop a plan for better co-ordination of care provision, including rationalising GP Practice cover of care homes to improve accessibility and accountability

- A review of non-elective (NEL) emergency admissions for Oct-Dec 2015 vs Oct-Dec 2014 shows a reduction in the number of NEL admissions in 3 of the 5 care homes (15 less). Further work is ongoing with these care homes, and in identifying the next set of homes to support over Q1 2016/17.

4.3 2015/16 scheme review

All Croydon BCF schemes have been briefly reviewed in order to inform planning for 2016/17. Individual scheme performance has been considered, alongside the totality of delivery against BCF objectives.

Key questions considered were:

- Is performance on track?
- Is there evidenced delivery against BCF metrics?
- What is the need for improvement?
- What is the potential to impact on delivery of BCF targets

Each scheme was re-mapped to the relevant 2015-16 BCF national indicators, these being:

1. Non-elective admissions
2. Permanent admissions of older people to residential and nursing care homes
3. Proportion of older people still at home 91 days after discharge from hospital into reablement/rehabilitation services
4. Delayed transfers of care from hospital
5. Discharges over the weekend for Croydon Healthcare Service (Croydon local metric).
6. Social care-related quality of life

In addition, schemes were mapped to:

- OBC – whether the scheme is included (fully or partially) in Croydon's outcomes based commissioning for over-65s services.
- Out of Hospital services – whether the scheme can be considered as an Out of Hospital Service (new BCF national condition).

The review findings indicated that each of the current set of BCF schemes was delivering substantially as planned though, as was expected in a culture of continuous improvement, remedial actions and opportunities for further improvement were identified. Priority actions arising from the review have been incorporated into Croydon's BCF work plan for 2016/17.

Regarding the totality of BCF schemes, the review indicated that all BCF metrics were suitably well-served, and that the new national condition for investment in out of hospital services could be comfortably met by the current set of schemes.

The review also highlighted that approx. 80% of Croydon's BCF spend would become part of Croydon's over-65s OBC programme during 2016/17.

4.4 Emphasis for 2016/17

Our 2016/17 BCF portfolio builds strongly on our 2015/16 delivery as set out in 4.2 and 4.3 above. Based on our review of 2015/16 activity, some adjustment to schemes and funding has taken place to increase investment in:

- GP roving services – extending to weekends and care and nursing homes
- End of life care – sitting service in care homes and at service user's homes
- Enhanced care co-ordination for frail and vulnerable patients – greater support to MDTs and improved sharing of care plans

5 A co-ordinated and integrated plan of action for delivering that change

Much of the plan and governance arrangements set out in the Dec 2014 BCF plan (p 45-56) is still valid. This section sets out only the areas of change.

5.1 Governance structures

The BCF Executive Group will continue to exercise its functions providing overall accountability for the delivery of the Better Care Fund Plan. However, recognising the large (approx 80%) overlap of BCF with Croydon's OBC for over-65s, during 2016/17 there will be a planned transfer of governance functions to the OBC governance group.

5.2 Delivery milestones for 2016/17

The following table gives summary milestones for overall management of the BCF plan. Individual schemes have their own supporting work plans.

Date	Key milestones
Apr/May 2016	Plan signed off by Health & Wellbeing Board New schemes for 2016/17 formally initiated. S75 agreement signed.
Jun/Jul 2016	Q1 DTOC priority actions complete. DTOC plan refreshed. Priority 1 remedial/improvement actions (identified in 2015/16 scheme review) completed.
Aug/Sep 2016	Deep dive review completed on out of hospital activity – new national condition. Health check completed on new governance arrangements via OBC.
Oct/Nov 2016	Full review completed across all BCF schemes. First draft integration plan for 2020 and beyond prepared (subject to DoH making plan requirements available in a timely fashion)
Dec/Jan 2017	Bid prepared for "graduation" from BCF
Feb/Mar 2017	Plan approved for transfer of BCF schemes to new governance arrangements on "graduation" from BCF

5.3 Risk log

Key risks from the BCF risk log are shown in the following table:

Ref	There is a risk that..	How likely is the risk to materialise? (L)	Potential Impact (I)	Overall risk factor (LxI)	Mitigating actions
1	Demand pressures for social care services required to support health outcomes in Better Care plan exceeds projections	2	5	10	The council are implementing a comprehensive programme of transformation and demand management. BCF funding continues in 2016/17 at stable levels. The council and the BCF Executive Group will continue to monitor and take additional action as necessary.
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	Realignment of Croydon social work resource has taken place during 2015/16 to meet additional demand, and this will continue through 2016/17 as part of Croydon's social care transformation plans. The council and the BCF Executive Group will continue to monitor and take additional action as necessary.
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/servic es 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. 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	Funding will continue via BCF in 2016/17 for reablement and early intervention schemes. The Council's social care transformation programme will further re-emphasise early intervention and reablement.

					BCF Executive Group will monitor progress throughout 2016/17 and agree 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 Monies earmarked under BCF as contribution to ongoing delivery of new statutory duties.
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	Managed by Transforming Care Implementation Group with escalation to Croydon Contract Management Group and Transforming Care Board as required. Managed via Outcome Based Commissioning contract arrangements.
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. Further integration of health care data is progressing between primary and secondary care including community. Planning with the APA includes shared care planning between health and social care with potential IT solutions.

5.4 Process for monitoring of scheme delivery and issue resolution

Each BCF scheme has a named delivery lead who is responsible for day to day implementation of the scheme, and for reporting on activity figures and key milestone delivery to the BCF Fund Manager. In the first instance, issues are managed through the usual operational channels for each scheme.

The BCF Fund Manager (CCG) and the Council BCF Lead regularly (currently monthly) review delivery across all schemes, and overall performance against BCF indicators, Where there is apparent under-performance, further enquiries area made, remedial actions initiated and/or issues escalated through the appropriate channels for that scheme.

Additionally in 2015/16 a deep-dive review across all schemes was conducted to review scheme performance and continued alignment with BCF objectives. Remedial and improvement actions arising from this review are allocated to named owners and progress is reviewed regularly with BCF Fund Manager and Council BCF lead. A similar review will be conducted in 2016/17.

The BCF Executive Group will meet quarterly during 2016/17 to provide oversight across the BCF programme. Standing items on the meeting agendas include:

- Performance and spend by scheme
- Performance against BCF indicators
- Key risks and issues

6 Compliance with National Conditions

6.1 Plans to be jointly agreed

NATIONAL CONDITION: *Plans to be jointly agreed.*

This plan has been developed jointly by colleagues across Croydon Council and CCG in close collaboration. The plan was approved firstly by Croydon's BCF Executive Group, with senior officer representation from both organisations including the Chief Officer, Croydon CCG; and Executive Director - People, Croydon Council. Secondly, it was approved by Croydon Health & Wellbeing Board, by means of delegated approval to the Croydon Health & Wellbeing Executive.

The various forums for engagement with providers were comprehensively set out in Croydon's BCF planning template dated 12/12/14 (p 86 onwards). Provider engagement has continued in this way throughout 2015/16.

Croydon's 2016/17 BCF plan shows a high level of stability from 2015/16, and implications for providers are therefore minimal in terms of any changes from those set out in the Dec 2014 BCF plan (p88 onwards). Implications for providers were highlighted to the Health & Wellbeing Board in the paper requesting approval of Croydon's 2016/17 BCF plan.

As the Disabled Facilities Grant is again allocated through the BCF, the local housing authority within Croydon Council have been fully engaged in planning for the use of DFG

monies within the BCF context. Given that, at time of writing, the grant conditions for DFG have not yet been published, DFG plans have not yet been finalised. However, the housing team are putting in place the capacity to ramp up the number of adaptations, and are working closely with commissioners to identify the optimum balance of adaptations and other capital projects to best meet local needs.

Commissioner and providers in Croydon have been working closely together to develop an Outcomes Based Commissioning delivery model, initially (from April 2016) for over-65s' services. OBC forms a core component of Croydon's strategic plans for integrated health and social care delivery. During 2016/17 it is expected, by commissioners and by providers, that the majority of Croydon's BCF delivery will be incorporated into OBC (while maintaining mandated BCF oversight and reporting).

6.2 Maintain provision of social care services

NATIONAL CONDITION: *Maintain provision of social care services.*

Our local definition for "maintain provision of social care services" is unchanged from the Dec 2014 BCF plan: that under BCF, the Council has sufficient resource to help meet current and any future increased demand in social care support in order to continue to manage demands on acute services and enable people to receive care at home.

All BCF social care schemes funded in 2015/16 are planned to continue in 2016/17, with funding uplifted for inflation and for demographic growth. This approach has been chosen to ensure stability in the local social and health care system. Management of the pressure on its budgets resulting from the support it gives in enabling timely and safe hospital discharge remains a key on-going issue for social care and the Council are therefore implementing a programme of demand management to mitigate this impact.

Schemes and figures for both years are given in Croydon's BCF planning return template. As in 2015/16, this approach is consistent with the 2012 Department of Health guidance to NHS England on the funding transfer from NHS to social care in 2013-14.

Croydon's 2016-17 BCF allocation to Care Act duties is £806,000, as per the LGA ready reckoner.

Our assessment of changes to services, and approach to managing interdependencies between Care Act and BCF are set out in our Dec 2014 BCF plan, pages 68-75.

6.2.1 Carer support

A reflection on the effectiveness of services commissioned in 2015-16

In 2015/16 Croydon have commissioned:

- 2 full time assessing & case work officers
- 2 part time assessing & case work officers

They have provided 337 assessments and 158 follow up case work on issues such as housing, benefits, social care, direct payments, employment advice, legal advice

The service offers assessments and follow ups in the carers home in addition to support in the Carers Support Centre on George Street, Croydon. As well as the additional support provided to carers as a result of the assessment, in some instances the carer assessment has identified a need to reassess the cared for person, thus increasing their package of support. This therefore has a positive impact on the carer and the cared for person.

The service is working well and is seeing an increasing number of referrals. The third sector is well placed to provide these assessments and have a long history of providing support to carers in Croydon.

Confirmation of services being commissioned in 2016-17 and how these will impact on the experience of carers.

Service for young adult carers: typically NEETs (not in education, employment or training), this cohort of individuals require peer support, one to one support, support with housing, benefits, CV building, education and employment. Without support this cohort of carers can become reliant on the state and even become patients themselves, due to the impact on their wellbeing (Burstow, 2016). 45% of young adult carers report a negative impact on their mental health (Carers Trust, 2014)

Service for working age adults: typical age of a carer is 45 – 64, this age range is also the age a person reaches their peak earning capacity. When people begin a caring role they are typically in work and continue to work for a number of years, either full or part time. Leaving work can cause financial issues for carers, and negatively impacts the local economy. £5bn nationally is wiped from the economy by carers leaving work to care (Carers Trust, 2012). To help support carers to stay in work for as long as possible, this service would encourage organisations to become 'Carer Friendly', allowing flexible working where suitable, educating management about the valuable role a carer can have in the workforce and provide carers with an early intervention that enables them to get information when they need it, thus reducing the chance of reaching a crisis point (RCGP, 2013).

Evidence-based consideration of how carer support will impact on patient-level outcomes.

Providing support to unpaid carers is the best way to help prevent a care breakdown, which can result in an emergency admission for the cared for person and/or the carer (RCGP, 2013). Moreover, new research indications that for every £1 spend on carers, creates £4 of long-term cost savings for a CCG (RCGP, 2015).

References:

Burstow, Rt Hon P. (2016) *Invisible and in distress: prioritising the mental health of England's young carers.* Carers Trust, London

Carers Trust (2012) *Carers & Employment.* Carers Trust [Online], available from: <https://www.carers.org/help-directory/carers-and-employment> [accessed 11.03.16].

Carers Trust (2014) *Who are young adult carers.* Carers Trust [online], Available from: <https://professionals.carers.org/who-are-young-adult-carers> [accessed 11.03.16].

RCGP (2013) *Supporting Carers in General Practice.* London, Royal College of General Practitioners.

Royal College of General Practitioners (2015) *Cost savings of supporting carers to Clinical Commissioning Groups.* Unpublished Data.

6.3 7 days services

NATIONAL CONDITION: *Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;*

Our Dec 2014 BCF plan sets out the comprehensive range of 7-day services which were already in operation relating to physical and mental health, and social care, and their focus in terms of admission avoidance and smooth patient flow.

To ensure suitable visibility of progress on 7-day working, we have chosen for our locally-proposed BCF metric:

'20% of discharges over the weekend for Croydon Healthcare Service'.

The percentage of discharges over the weekend at Croydon Healthcare Service (from Friday midnight to Sunday midnight) for patients aged 18years plus after an inpatient (excluding day cases, obstetrics and regular day attenders).

During 2015/16 we have implemented the following enhancements to our 7-day services:

- The establishment of a Rapid Access Medical Unit (RAMU) in November 2015 operating 7 days/wk 09:00-21:00 providing a one-stop acute medical day care unit for urgent ambulatory patients who are either referred by their GP, or have attended the CUH ED.
- Started the procurement of an integrated Urgent Care service comprising a co-located Urgent Care Centre at Croydon University Hospital, GP Out of Hours, and 3 GP Hubs offering a 365 days service. The integrated service model will be commissioned to start from 1st April 2017.

6.4 Data sharing

NATIONAL CONDITION: Better data sharing between health and social care, based on the NHS number;

Croydon Council have made excellent progress in the use of NHS number: data matching of service user records has taken place to identify NHS number, NHS number is now available in the social care systems, a process is in place to capture NHS number at an early point of contact, and work is progressing to update standard letters and reports where appropriate to show NHS number.

Further integration of health care data is progressing between primary and secondary care including community. Planning with the APA includes shared care planning between health and social care with potential IT solutions.

Croydon are continuing to pursue open APIs as per the approach set out in the Dec 2014 BCF plan p78-81. Work on the planned data sharing portal has been temporarily paused while the ICT strategy for the OBC Accountable Provider Alliance (APA) is developed.

Lack of N3 connectivity from Croydon Council remains an obstacle to easy data sharing. This is expected to be resolved during 2016/17, enabled by means of a refresh of the Council's ICT estate.

Close collaboration is in place between Council and CCG on all relevant aspects of Information Governance. In relation to Caldicott principles, a dedicated group including the Caldicott Guardians for Council and CCG are working to ensure effective implementation, in particular to support the shared record being developed by the Accountable Provider Alliance for OBC.

We have ensured that local people have clarity about how data about them is used, who may have access and how they can exercise their legal rights through various means for example:
http://www.croydonccg.nhs.uk/about-us/YI/Pages/default.aspx

6.5 Joint approach to assessments and care planning

NATIONAL CONDITION: Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;

The Dec 2014 BCF plan (p 81-84) sets out Croydon's approach to risk stratification, and the proportion of the population who are identified as "high risk"(2.4%) or "very high risk" (0.7%). The risk stratification multi-disciplinary teams are now fully active across all 6 of Croydon's GP networks, with approximately 2865 patients being case-managed through this process. In 2016/17 BCF funding is allocated for continued support to the two key schemes which underpin this approach: MDT delivery and the Practice Development and Delivery Scheme.

Dementia services have been identified as a particularly important priority for better integrated health and social care services. Since October 2015, four dementia advisors and a dementia support manager have been in post. Their remit is to provide 1-2-1 support to people recently diagnosed with dementia, and their carers. This is recognised as vital post diagnosis support where often the medical side steps back, particularly where there is no medication that can be offered. The dementia advisors provide support to dementia sufferers and their carers with: understanding diagnosis, coping strategies, prevent isolation, accessing peer support and community resources, obtaining social resources to live at home as long as possible / appropriate and ensuring people are supported to make choices and plan for the future. BCF funding for the dementia advisors continues via BCF in 2016/17.

6.6 Consequential impact of the changes on the providers

NATIONAL CONDITION: *Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;*

The Dec 2014 BCF plan (p 85-89) sets out the engagement with service users, patients, public and providers that was undertaken in development of Croydon's BCF plan. Similar engagement has continued through 2015/16.

Many of the resultant changes are likely to be felt most intensely by acute providers. Recognising this, the Local Authority and Croydon CCG has had a long record of working with our key acute providers particularly Croydon Healthcare Services (CHS). All key defined Projects that have activity assumptions related to Non-elective Admission Reduction have been shared with the provider including our in-depth Project Initiation Documents. Plans for financial and activity shifts have also been shared.

BCF is aligned with and draws on a range of existing services and work programmes, and receives inputs from consultation and engagement from those services/programmes. Service user and patient participation groups at GP network level and wider public forums, and service user feedback from Friends and Family Test surveys carried out by primary care, community, hospital and mental health services, will help to ensure we continually capture views and suggestions about services and service development. Examples of public engagement during 2015 on OBC which have also informed BCF include:

- Have held a public discussion and feedback event in Fairfield Halls 24th June with 50 people attending
- Attended and gained feedback from the CCG's PPI Reference Group 25th June
- Attended and distributed leaflets at Croydon's Ambition Festival 25th July
- Met with community leaders/ groups including PPG Groups, Cultural Groups, Carer Groups, Lunch Clubs and Community Panels, Day Centres, and the general public
- Public event, held on 19th October at Fairfield Halls
- OBC survey designed and online closed 16th October https://www.surveymonkey.com/r/Croydon_Survey
- Continuing to update web pages to show what engagement has taken place and how it's informed the development of the future model:
- http://www.croydonccg.nhs.uk/get-involved/Pages/Outcomes-based-commissioning.aspx
- https://www.croydon.gov.uk/healthsocial/adult-care/outcome-based-commissioning
- Creation of the OBC Service User Engagement Specialist group that will inform the OBC Programme Board.

To ensure continuing visibility and political buy in, BCF has been reported through the year to a range of groups which are wholly or partly formed of elected members. These groups include:

- Health and Wellbeing board
- Health, Social Care and Housing Scrutiny committee
- Adult social services review panel

In addition, periodic BCF briefings are given to the Chair of Croydon Health & Wellbeing Board, and the Cabinet member for Families, Health and Social Care.

Mental and physical health are considered equal in Croydon's plans. Croydon's Vision for integrated services anticipates that integrated services will make better provision for mental health care to enhance overall wellbeing, independence and 'social capital'. Croydon's BCF includes provisions for mental health alongside physical health through e.g

- mental health professionals as a part of MDTs
- mental health reablement (in additional to physical reablement services)
- recognition of the links between poor physical and mental health through aspects of the IAPT provision targeted at older adults with long term conditions.

BCF is fully aligned with other CCG and Council initiatives and plans, as set out in the Dec 2014 BCF plan (p 60 – 65). Of particular note during 2015/16 has been the development of Croydon's plans for outcomes based commissioning for over-65s' services, with OBC contracts due to be put in place during 2016/17. Planning for BCF in 2016/17 has included close collaboration with the OBC programme team to ensure alignment of objectives and metrics, phased handover of scheme delivery as OBC contracts come on line, agreed reporting between OBC and BCF, and adjustment to Croydon BCF governance as BCF is gradually subsumed by OBC.

6.7 Out-of-hospital services

NATIONAL CONDITION: *Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;*

In 2016/15, Croydon's BCF investment in NHS commissioned out-of-hospital services will total approx. £12.5m, this being well in excess of the mandated minimum of £6.4m. Individual schemes and expenditure plans are listed in the BCF planning template return.

During 2015/16, Croydon has not achieved the planned improvement on non-elective admissions. However, performance has shown an improvement during Q3 which is expected to continue. This is attributed to the impact of new schemes such as Roving GP service, rapid response and ACE RAMU which have now started to become effective. This improved performance is expected to continue as the services bed in. To maintain this upward trajectory of performance, all 2015/16 out-of-hospital schemes will continue to be funded in 2016/17, at similar funding levels to 2015/16 but suitably uplifted for inflation and demographic growth. In 2015/16, the non-elective admissions target was not reached and the pay for performance risk share funding was not payable into the BCF fund. However, Croydon CCG chose to contribute the full equivalent funding to the BCF, on the basis that investment in out-of-hospital services directed at admission avoidance was the best mitigation of future risk on non-elective admissions performance.

In considering the need for a local risk-sharing arrangement, performance trends and attitude to risk mitigation have been reviewed. Bearing in mind:

- The improving trajectory of non-elective admissions performance
- The preference for investment in admission-avoidance activity

it has been decided not to put in place a pay-for-performance fund linked to non-elective admission performance.

Croydon is part of the South West London CCG's Out of Hospital Group who are working on the development of the 5 year SWL plan for Out of Hospital provision. This would provide at a strategic level what SWL CCG's are looking to move out of hospital, and how that is envisaged to happen.

A stock take of current services is currently underway, looking at the range of health and social care services in each of the 6 boroughs to understand: what's in place, the scale of impact, and workforce delivering it, any gaps that could support pan SWL developments or local developments to achieve the activity shift.

6.8 Delayed transfers of care

NATIONAL CONDITION: *Agreement on local action plan to reduce delayed transfers of care.*

Croydon's performance on delayed transfers of care is better than London and England averages, but falls short of our own target. The high volume of delays being seen for 2015-16 in part are attributable to a high number of delays from the mental health commissioned service provider. The first priority actions in our local action plan therefore relate to reducing mental health DTOC. Detailed analysis of patient flow and reasons for delay has been carried out by the provider. The plan for DTOC reduction has been co-produced by Council, CCG and provider. Mitigation actions in place include:

- Weekly meeting in the Trust to review any barriers to discharge.
- Closer scrutiny of recording to ensure DTOCs correctly captured.
- Greater direct liaison between the Trust and Council Housing Needs team to arrange temporary emergency accommodation.
- Transfer of the mental health supporting people facility to more suitable accommodation in Dec 2015, thereby ending a temporary reduction in capacity in the lead up to transfer.
- Planning for greater use of the "look ahead" contract to support service users in their own homes.

This plan is owned by the BCF Executive group.

Across the broader spectrum of discharge planning and patient flow, a range of initiatives are underway:

- Discharge planning sub-group at Croydon University Hospital is assessing barriers to discharge.
- A CQUIN target has been set relating to discharges before 1 p.m.
- Croydon Healthwatch have carried out a survey of patient experience of the discharge process.
- The Continuing Health Care action plan includes training for staff re. referrals so that awaiting CHC arrangements does not increase delay.
- SRG planning for discharge.
- Agreement on how to manage DTOC-reduction targets via OBC performance management process

Given the wide range of work underway, priorities for Q1 2016/17 are:

- Progress with the mental health DTOC-reduction actions noted above.
- Ensure DTOCs are being correctly recorded across all settings.
- Complete the mapping of current discharge/patient flow work-in-progress
- Identify any need for greater co-ordination across the patient flow/discharge activity
- Self-assess against the eight 'high impact interventions' that were agreed by ECIP (informal self-assessment done so far)
- Agree priority actions for Q2 and beyond.

The DTOC target for 2016/17 is given at section 9.4. Croydon have considered use of a risk-share agreement relating to DTOC. Taking a consistent approach to that applied to non-elective admissions (see section 6.7above), we have chosen not to put in place a pay-for-performance fund as part of our risk share agreement, choosing instead to invest in schemes to reduce DTOC.

7 Approach to financial risk-sharing and contingency

The general approach to risk-sharing and contingency is set out in the Dec 2014 BCF plan (p57-59).

In brief: 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.

Specifically, for 2016/17 it has been agreed NOT to use a pay-for-performance risk share agreement for either non-elective admissions or DTOC.

The BCF section 75 agreement specifies details of financial risk-sharing with regard to over-spends and under-spends.

8 Scheme level spending plan

The BCF schemes and the allocated funding to each is given in the following table:

Scheme name	2016/17 allocation	Lead commissioner
St Christophers End of Life - Core Contract	£286,000	CCG
Marie Curie End of Life - Core Contract	£65,000	CCG

St Christopers End of Life - QIPP Scheme	£114,000	CCG
Marie Curie End of Life - QIPP Scheme	£145,000	CCG
End of Life Training - QIPP Scheme	£27,000	CCG
St Christophers Palliative Care	£1,354,000	CCG
Crossroads - Palliative Care	£121,000	CCG
End of Life - social care	£253,000	Local Authority
SLaM - Community Investment (HTT)	£1,591,000	CCG
SLaM - Older Adults Community Investment	£307,000	CCG
MHOA - Dementia - Altzheimers Society	£200,000	CCG
Care UK Amberley Lodge	£260,000	CCG
Mental Health - Reablement	£202,000	Local Authority
Mental Health - Packages of Care	£303,000	Local Authority
IAPT - Long Term Conditions Pilot	£177,000	Local Authority
Transforming Adult Community Services	£2,459,000	CCG
Transforming Adult Community Services - Nursing Homes	£204,000	CCG
TACS - Social Work Input	£455,000	Local Authority
Enhanced Care Management	£317,000	CCG
ACE/RAMU	£1,025,000	CCG
GP Roving Service	£401,000	CCG
COPD	£521,000	CCG
Extended Staying Put	£121,000	Local Authority
Specialist Equipment eg Telehealth / Telecare	£187,000	Local Authority
Disabled Facilities Grant	£2,046,194	Local Authority
Early Intervention & Reablement	£1,023,000	Local Authority
Demographic pressures - package of care	£2,043,000	Local Authority
Social Care Pressures	£1,111,000	Local Authority
Prevent return to acute / care home	£480,000	Local Authority
Falls Service	£220,000	CCG
Age UK - Integrated Falls Service	£30,000	CCG
Falls & Bone Health Communications	£10,000	CCG
Intermediate Care Beds	£480,000	CCG
Integrated Stroke Service	£64,000	CCG
Medicines Optimisation	£100,000	CCG
Diabetes Service	£1,000,000	CCG
Diabetes LES	£96,000	CCG
Basket LES	£414,000	CCG
Practice Delivery & Development Schemes	£2,020,000	CCG
Step Down & Convalescence Beds	£505,000	Local Authority
A&e Triage	£177,000	Local Authority
Hospital Discharge	£177,000	Local Authority
Care Support Team nurses	£126,000	Local Authority
Alcohol Diversion	£61,000	Local Authority
Care Act	£806,000	Local Authority
To be allocated during 2016/17	£415,598	Joint

TOTAL	£24,499,792

The BCF Planning Template return provides further detail.

For each scheme, the BCF section 75 agreement includes a 1-page summary of: funding allocation, scope of what is to be delivered, agreed reporting and activity or other metrics.

In addition, each scheme has a service delivery plan and/or project implementation plan suitable to the scheme size, complexity and maturity. The process for monitoring scheme delivery and management of issues is outlined in section 5.4 above.

These schemes are integral parts of other plans including CCG operating plan, and Sustainability and Transformation Plan (under development).

9 National metrics

The Council target-setting process for 2016/17 is currently (March 2016) underway. Therefore the information provided in this section is **PROVISIONAL** and may be amended for sections 9.2, 9.3, 9.4 and 9.6.

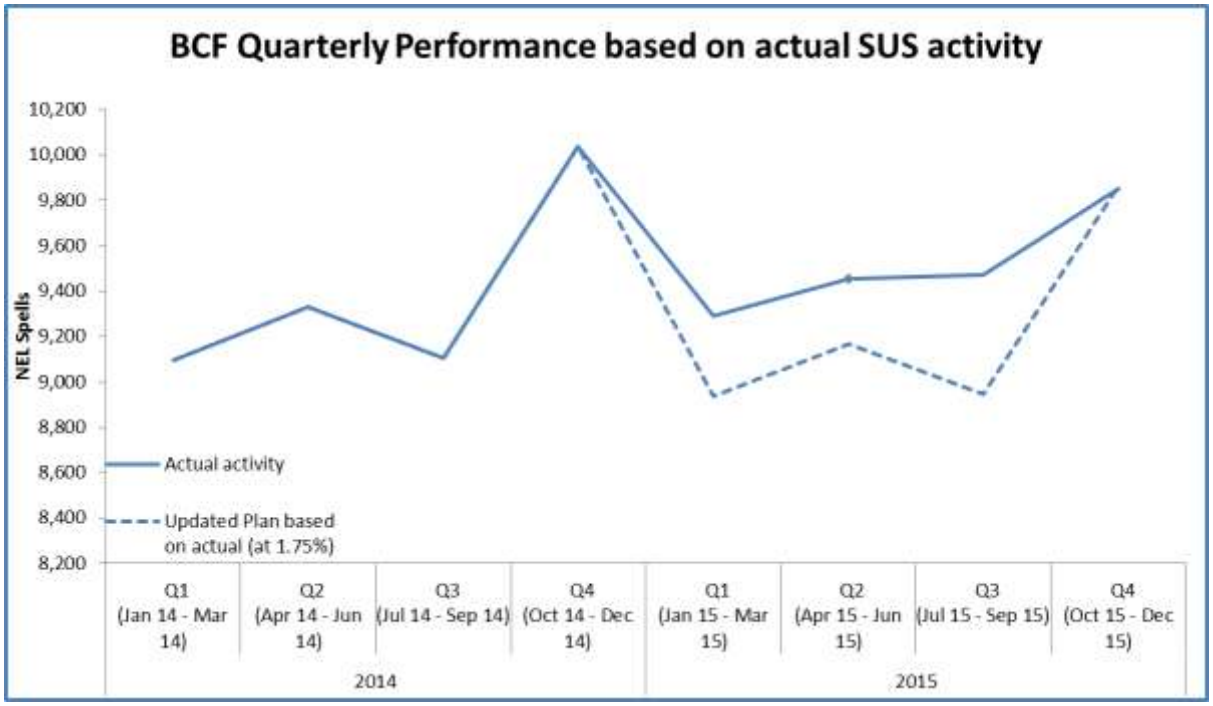
The target-setting process encompasses a robust analysis of current performance and trends in performance over the last few years, alongside consideration of relative performance to England average, London average and other comparators. Expected Impact of planned service changes, whether delivered through BCF or other initiatives, is also taken into account.

9.1 Non-elective admissions

Croydon CCG have continued to work collaboratively with our providers in 2015/16 to assess how further improvements in patient quality can be achieved in 2016/17. This has involved different approaches including use of national guidance and best practice, bench marking against local and London peers to identify areas for investigation, and working together with providers to identify areas where providers have highlighted could be provided in a different way to improve patient care. Discussions in the various clinically-led steering groups (including both CCG and providers) have enabled the CCG to define the QIPP initiatives we have stated in our 2016/17 Operating Plan, using specific HRGs to build and define the cohort of non-elective activity that is expected to be impacted upon as a result of the pathway improvement.

In 2015/16 performance against the year to date target at month 10 was 3% higher than planned (38,067 vs 36,914), however there was improvement over the previous 2 months (see Graphxx: Total Year to Date Non-Elective Admissions as at November 2015 forecasted to Full Year).Mitigating actions were implemented to improve performance across the year including validation of HRGs mapping following introduction of the new ETO tariff in 2015/16 and agreement with NHSE to measure activity based on SUS (HSCIC's Secondary Use Service) to improved accuracy of reporting, and expansion of admission avoidance service provision by the Rapid Response and GP Roving Services.

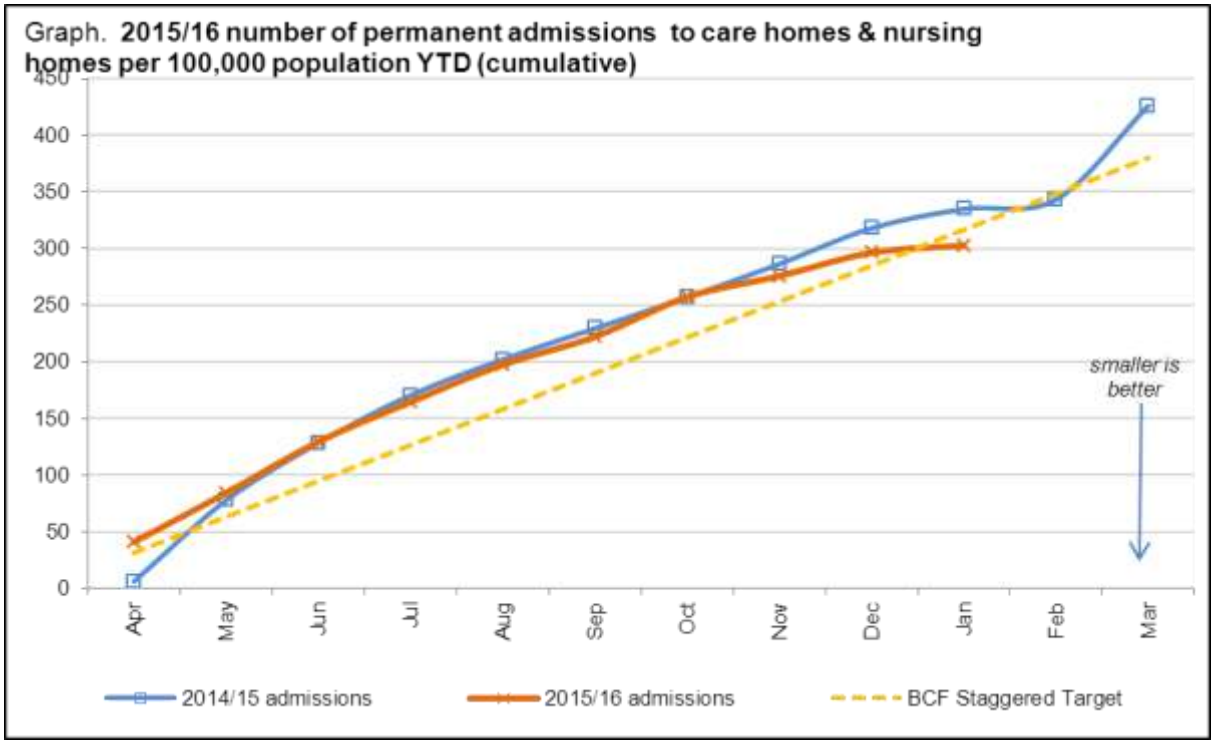
Graph: Total Year to Date Non-Elective Admissions as at December 2015 forecasted to Full Year



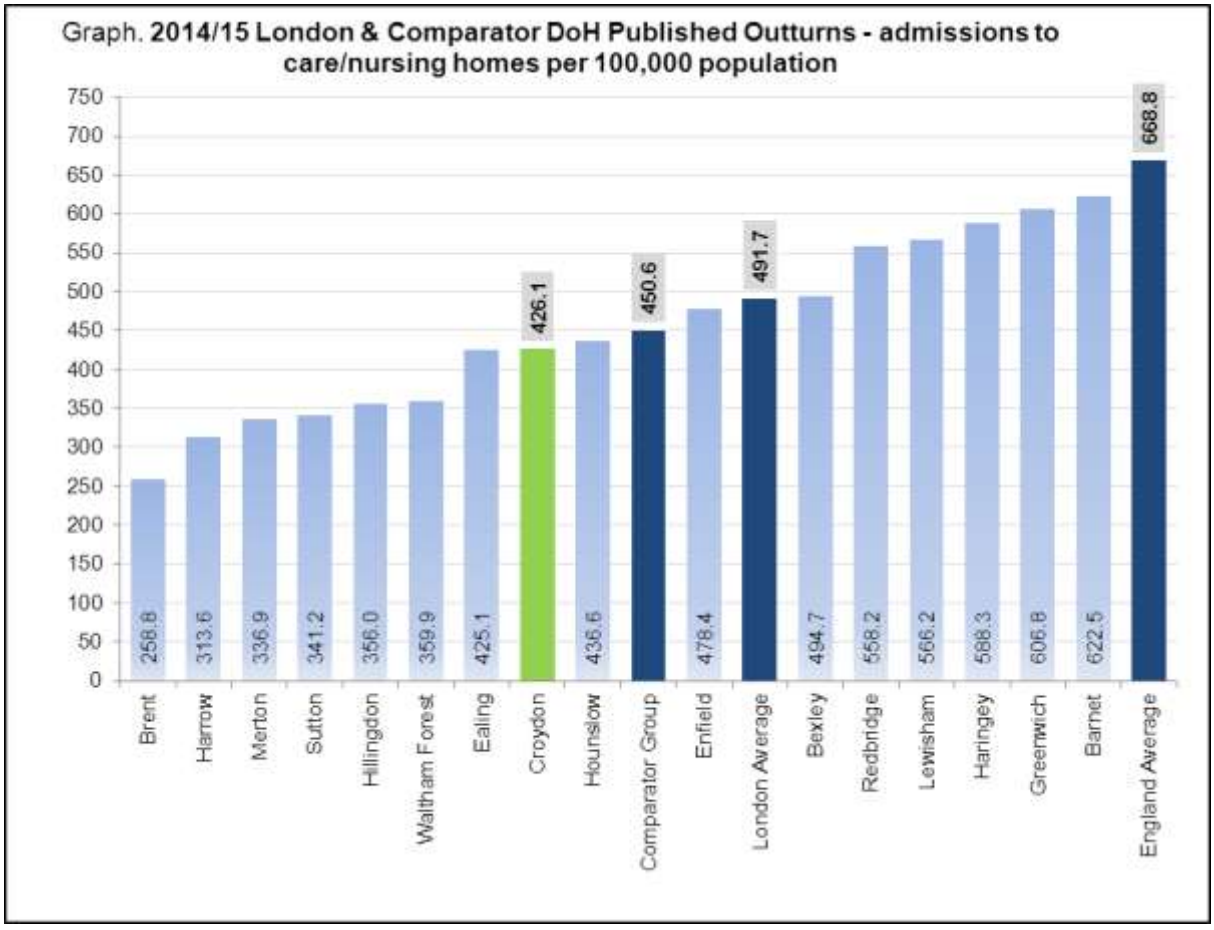
9.2 Admissions to residential and care homes

In 2014/15 Croydon did not meet its own ambitious target for admissions to residential and care homes. In 2015/16, Croydon are on track to just meet target. This has been accomplished at some significant cost pressure on home care packages, which has been partially alleviated through BCF funding, as well as investment in a range of preventative schemes via BCF and elsewhere.

Performance is shown in the following graph.



Croydon's performance on this measure is relatively good – better than the London average and less than 2/3 of the England average, as per the following graph:



BCF investment continues during 2016/17 on schemes to protect social care (including home care), as well as preventative measures. There is an increased investment in home adaptations in 2016/17 via the Disabled Facilities Grant, however that will take some time before impacting on performance. Through OBC, a range of improvements are anticipated which will have a positive outcome on this measure. However, pending completion of the Council's target setting exercise, the 2016/17 target for this measure remains unchanged from 2015/16 at **380 permanent admissions of older people to residential and nursing care homes, per 100,000 population.**

9.3 Effectiveness of reablement

In 2014/15 Croydon did not meet its own ambitious target for effectiveness of reablement, though there was an improvement on the previous year's performance. In 2015/16, Croydon are on track to just meet target. This has been accomplished at some significant cost pressure on reablment packages, which has been partially alleviated through BCF funding.

Performance is shown in the following table.

Table : **Performance Data - Effectiveness of reablement - 2013 - to date**

2015-16	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Target
	>>>>>>>>>>>>> Denominator			>>>>>>>>>>>>> Denominator			>>>>>>>>>>>>> Denominator			>>>>>>>>>>>>> Denominator			
Numerator	Jan-Mar 2015 Numerator		120	Apr-Jun 2015 Numerator		115	Jul-Sep 2015 Numerator		104	Oct-Dec 2015 Numerator			BCF 88%
Denominator	Apr-Jun 2015		138	Jul-Sep 2015		128	Oct-Dec 2015		119	Jan-Mar 2016			
Outturn			**87.0%**			**89.8%**			**87.4%**				

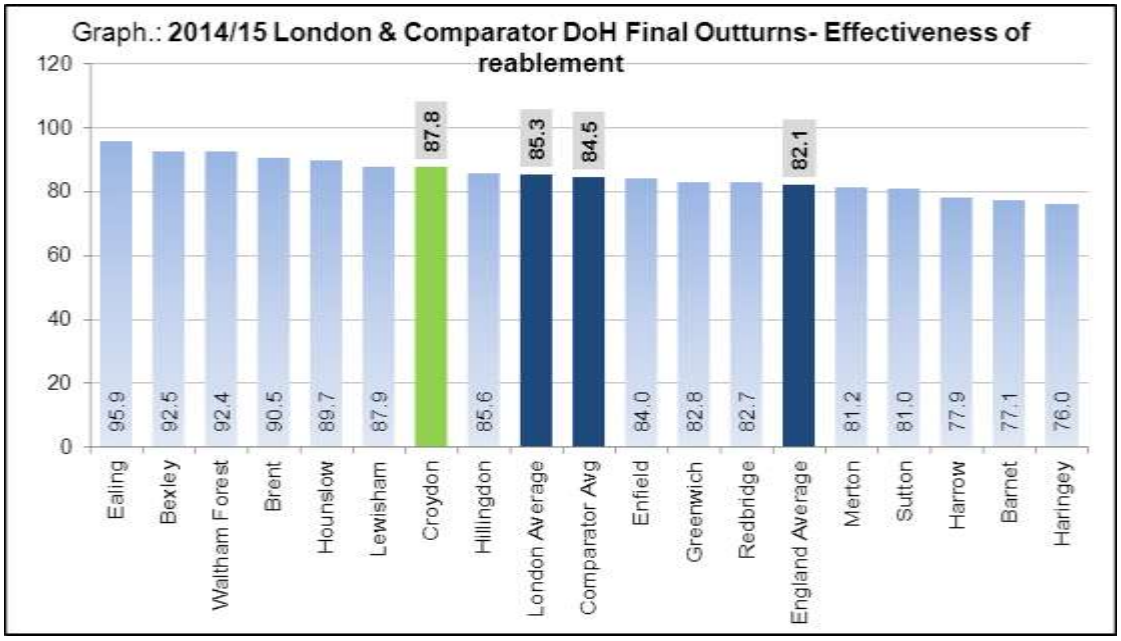
2014-15	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Target
Numerator												122	BCF 88%
Denominator												139	
Outturn												**87.8%**	

Year End 2014/15:
Denominator is calculated Oct-14 to Dec-14
Numerator is calculated Jan-15 to Mar-15

2013-14	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Target
Numerator												138	75%
Denominator												162	
Outturn												**85.2%**	

Year End 2013/14:
Denominator is calculated Oct-13 to Dec-13
Numerator is calculated Jan-14 to Mar-14

Croydon's performance on this measure is relatively good – better than the London and England averages as per the following graph:

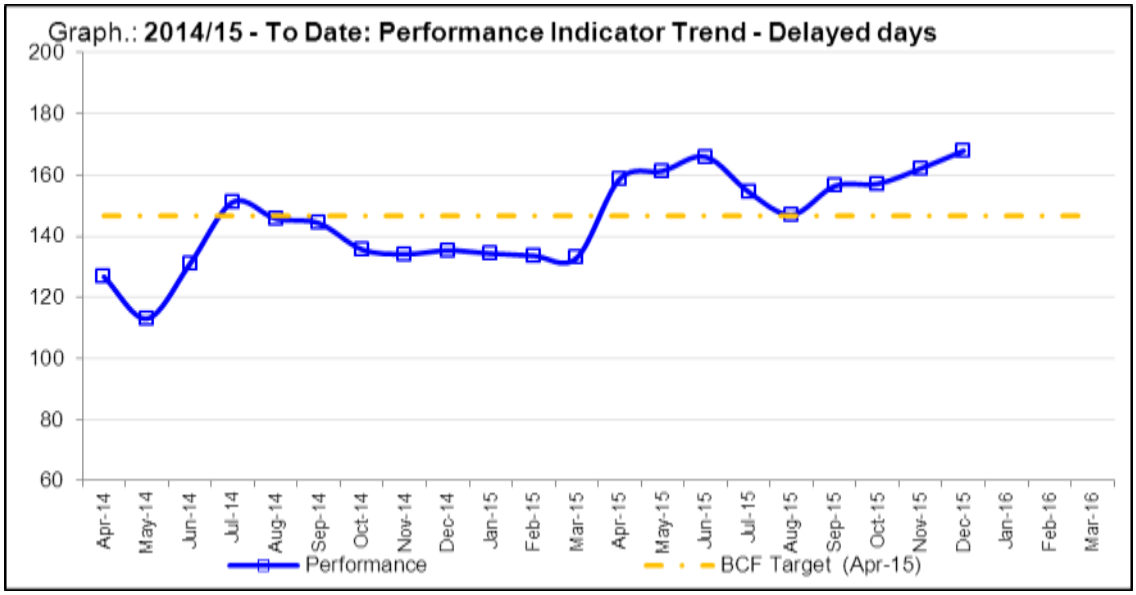


BCF investment continues during 2016/17 on reablement schemes. Through OBC, a range of improvements are anticipated which will have a positive outcome on this measure. However, pending completion of the Council's target setting exercise, the 2016/17 target for this measure remains unchanged from 2015/16 at **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (successful reablement) = 88%.**

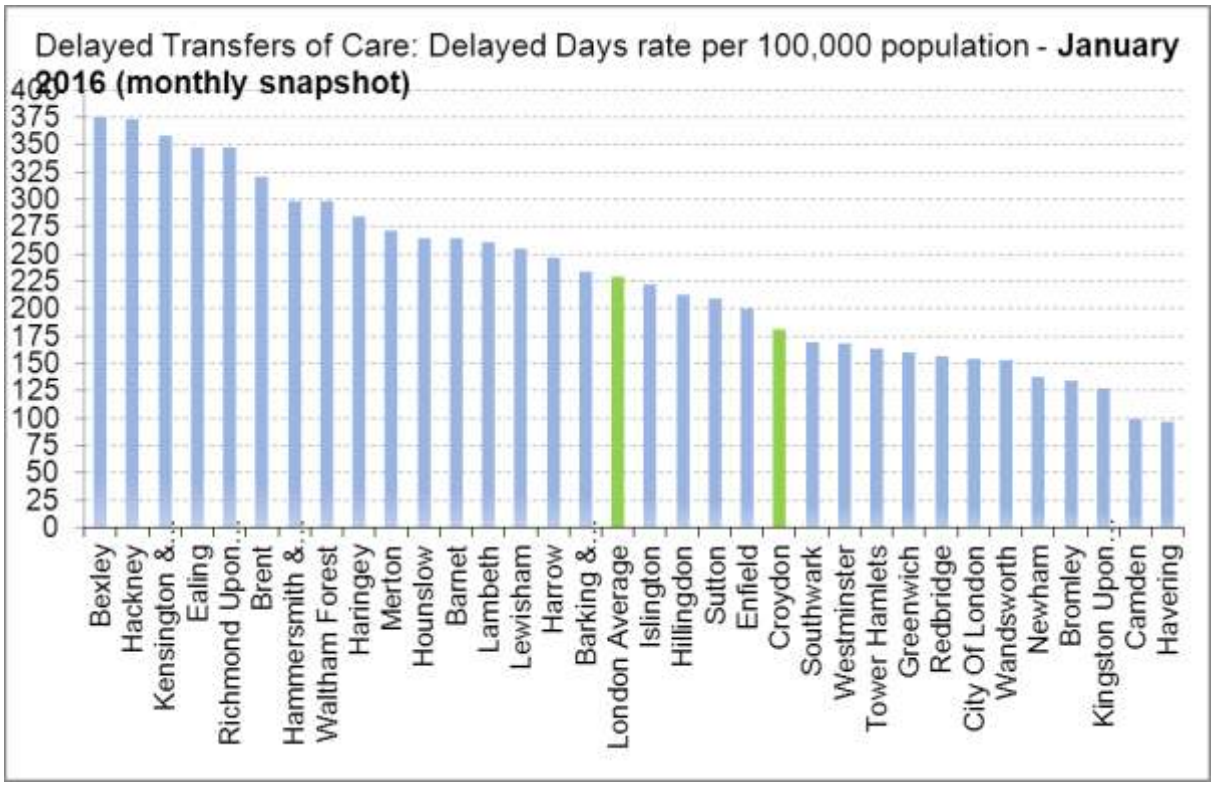
9.4 Delayed Transfers of Care

In 2014/15 Croydon met its own ambitious target for delayed transfers of care (DTOC). In 2015/16, Croydon will not meet the target.

Performance is shown in the following graph.



Performance issues and action plan for DTOC are detailed in section 6.8 above. Despite not meeting our own target for 2015/16, Croydon's performance on this measure is relatively good – better than the London and England averages as per the following graph:



Pending completion of the Council's target setting exercise, the 2016/17 target for this measure remains unchanged from 2015/16 at **Delayed transfers of care (DELAYED DAYS) from hospital per 100,000 population = 146.7**

9.5 Weekend discharges from CUH

In June 2014, the six South West London (SWL) CCGs submitted their 5 year strategy for health services across south west London, with a vision for integrated care services across SWL which included the development of services that:

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

Croydon's System Resilience Group as part of the development of an operational resilience strategy and plan for 2015/16 identified key initiatives that would be required to improve the operational resilience of Croydon University Hospital (CUH) and to support the achievement of the A&E 4-hour waits. These included changes that would improve patient flow through the emergency department and the hospital, including effective discharge planning, developing innovative solution tackle workforce challenges, building intermediate care capacity and flex, facilitating discharges to nursing and care homes at weekends, enhancing therapies to ensure early rehabilitation on wards and follow up on discharge at the weekends, enhanced social care support at weekends and access to emergency services e.g. housing.

A local metric for encouraging improvement in weekend discharges from CUH was therefore established based on assessment of performance over 2013/14 with a stretch target from 18.7% to 20%.

In 2015/16 performance against the year to date target at month 10 was lower than planned at 18.6% with a forecasted year end position of 18.5%. The main reasons for the underperformance were that although non-elective discharges had increased, elective discharges had reduced. Mitigating actions implemented across the year to address the situation included ongoing enforcement of the systems resilience group recovery plan and the 95% recovery plan, and the establishment in February 2016 of a discharge process working group by Croydon Health Services led by the Deputy Chief Operating Officer to develop solutions to address issues impacting on delivery.

The stretch target for 2016/17 remains at 20%.

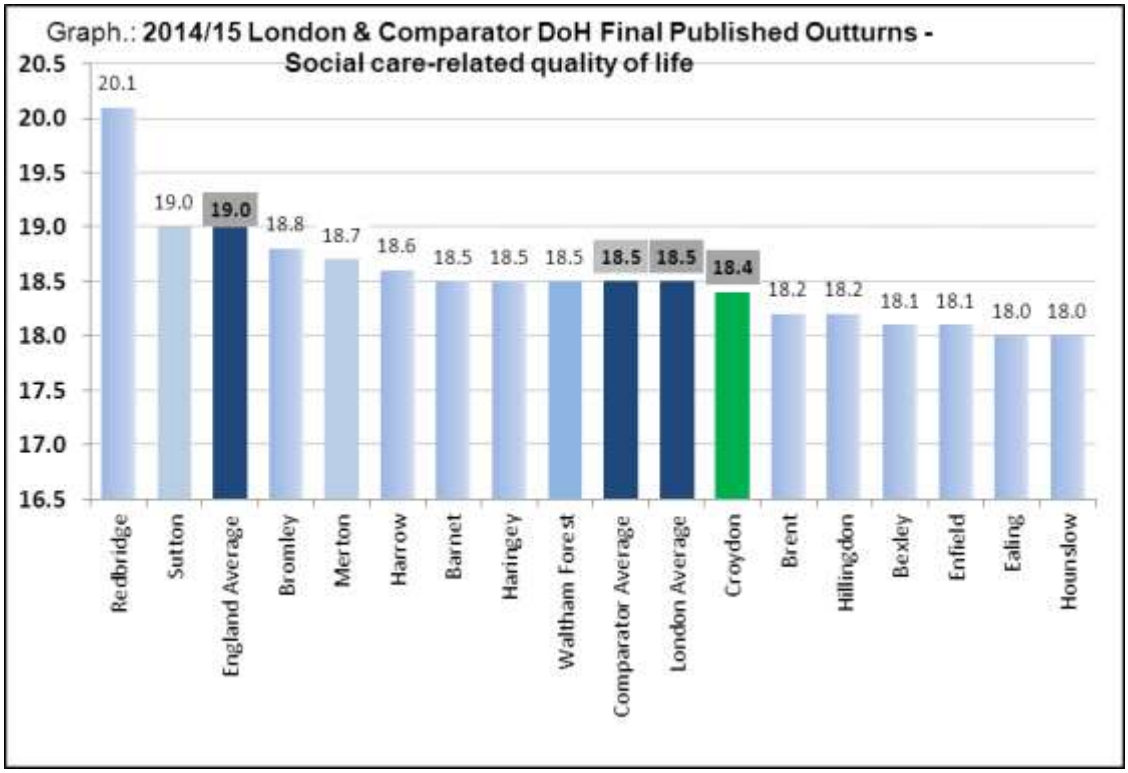
9.6 Social care-related quality of life

In 2014/15 Croydon did not meet its own ambitious target for social care related quality of life.. For 2015/16, data is not yet available, as the base information is collected only once annually. Performance is shown in the following graph.

Table: **Performance Data - 2012/13 - to date – Social care-related quality of life**

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Target
	Annual ASCOF Survey												
Numerator												78980	BCF
Denominator												4300	19.0
Outturn												**18.4**	
	Apr-13	**May-13**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**	**Target**
Numerator												85493.4	n/a
Denominator												4561	
Outturn												↗ **18.7**	
	Apr-12	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**Oct-12**	**Nov-12**	**Dec-12**	**Jan-13**	**Feb-13**	**Mar-13**	**Target**
Numerator												91430	n/a
Denominator												5015	
Outturn												→ **18.2**	

Croydon's performance on this measure is close to the London average but worse than the England average as per the following graph:



Pending completion of the Council's target setting exercise, the 2016/17 target for this measure remains unchanged from 2015/16 at **Social care related quality of life – annual adult social care survey score =19.**