REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **08 February 2017**
AGENDA ITEM:	**12**
SUBJECT:	**Progress on outcomes based commissioning for over 65s**
BOARD SPONSOR:	**Paula Swann, Chief Officer, Croydon Clinical Commissioning Group** **Barbara Peacock, Executive Director People, Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

The vision for Croydon OBC Programme 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 Croydon Alliance Agreement and Contract for Outcomes Based Commissioning (OBC) for over 65s 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. The outcomes are aligned to "Ambitious for Croydon" promises:

- creating growth in the economy;
- helping residents be as independent as possible, and;
- creating a pleasant place in which people want to live.

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.

OBC integrates health and social care for the over 65s and has a comprehensive outcomes framework that is focussed on improving outcomes for people. Extensive consultation with local people on what outcomes they wanted took place, and they chose the following:

- Staying healthy and active for as long as possible;
- Having access to the best quality care available in order to live as I choose and as independent a life as possible;
- Being helped by a health and social care team that has had the training and has the specialist knowledge to understand how my health and social care needs affect me;
- Being supported as an individual, with services specific to me;

- Having improved clinical outcomes.

OBC draws on a number of recommendations from existing strategies that have been developed, including The Independence strategy 2015-181 and Croydon-wide End of Life Strategy 20152 and the emerging Out of Hospital Strategy 2016. It aligns with the wider health system changes outlined in the South West London Sustainable Transformation Plan (SWL STP).

The contract for delivery of integrated health and social care will go further than before and takes a pro-active and transformational position. The individual and their family will be at the centre of Croydon's health and care system, ranging from the promotion of good health and well-being, through early intervention and support and, when needed, the delivery of treatment and care services. Croydon's older people and their families should expect to experience seamless, joined- up care and health provision of consistent quality and high standard; services will be arranged around them and their needs, rather than their having to fit in with how health and social care professionals structure or organise services.

FINANCIAL IMPACT:

The ambition for the contractual arrangements for OBC for the over 65s will be to use a capitated (per head) payment mechanism that incentivises the providers to improve outcomes for the population. This means that the providers will be given a fixed amount (the capitated fee) to cover the costs of health and care for the population rather than being paid directly for activity. The aim is to ensure a financially sustainable economy with a transformed health and care system for Croydon residents. The contracting options for year one are being defined and will allow for a transition year to support a secure move to a capitated budget from year two.

There are defined efficiency savings in the early years of the contract which align with the CCG's QIPP targets and the Council's agreed savings programme plus 5% social care efficiency built in for future years. Business cases for the delivery of these savings are in development.

In the transition year risk share arrangements will be developed where each party will share risk proportionally.

1. RECOMMENDATIONS:

1.1 The Health and Wellbeing Board is asked to note the progress of the OBC Programme.

2. EXECUTIVE SUMMARY

2.1 The purpose of this report is to update the Health and Wellbeing Board members on the progress of OBC Programme towards a 10 year contract to develop an Integrated Health and Social Care system for the over 65s population in Croydon.

2.2 OBC brings together a number of recommendations from existing strategies that have been developed, including The Independence strategy 2015-18, Croydon-wide End of Life Strategy 2015 and the Out of Hospital Strategy 2016. The contract for delivery of integrated health and social care will go further than before and takes a pro-active and transformational position. The individual and their family will be at the centre of Croydon's health and care system, ranging from the promotion of good health and well-being, through early intervention and support and, when needed, the delivery of treatment and care services. Croydon's older people and their families should expect to experience seamless, joined- up social care and health provision of consistent quality and high standard; services will be arranged around them and their needs.

3. DETAIL

3.1 **Croydon OBC Alliance -** The Commissioners and Providers have agreed to combine their strengths to form a Commissioner / Provider Alliance from year 1 with the view of Commissioners stepping out of the Alliance in a few years when the capability for managing the whole system as an Accountable Care System has been established.

3.2 An Alliance of Commissioners and Providers in Croydon has been formed to deliver the transformation with the following parties:

- Age UK Croydon
- Croydon Council Adult Social Care
- Croydon GP Collaborative
- Croydon Health Services NHS Trust
- South London and Maudsley Mental Health NHS Foundation Trust
- Croydon Council as Commissioner
- Croydon Clinical Commissioning Group

3.3 The signing of the Alliance Agreement and in scope service contracts in phase one is planned to be completed between the 31 January and 31 March 2017 for a commencement date of April 2017.

3.4 The Alliance Board has been established and an independent Chair is to be recruited. The Chair the Croydon GP Collaborative has been agreed as the Senior Responsible Officer, on behalf of the Alliance Board.

3.5 To enable a contract to be signed to commence from April 2017 it was agreed at the Alliance Board that a 1 year contract with the option to extend by 9 years is the best option. Year 1 will be a transition year to a full capitated Outcomes contract from year 2.

3.6 The Outcomes framework has been agreed and further work to establish the measuring of the Outcomes is underway.

3.7 Progress has been made on the New Model of care initiatives, with Personal Independence Co-ordinators (PICS) now in place for 2 of the 6 GP networks. Lessons learned in this early implementation stage will be implemented in the wider rollout of PICS to the remaining 4 networks.

4. CONSULTATION

4.1 Both Croydon Council and Croydon CCG are committed to ensuring that there is regular communication and engagement with our population, the wider health and social care community and our local stakeholders to maintain public trust and confidence in services for which we are responsible.

4.2 OBC 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.

4.3 The Service User Engagement Specialist Group (SUESG) has been established for over a year and has diverse representation from the over 65 age group. There is an established feedback loop between the SUESG members and the transformation workstream to enable user input into system changes and design.

5. SERVICE INTEGRATION

5.1 The transformation team have created a vision for the New Model of Care in Croydon and is illustrated below.

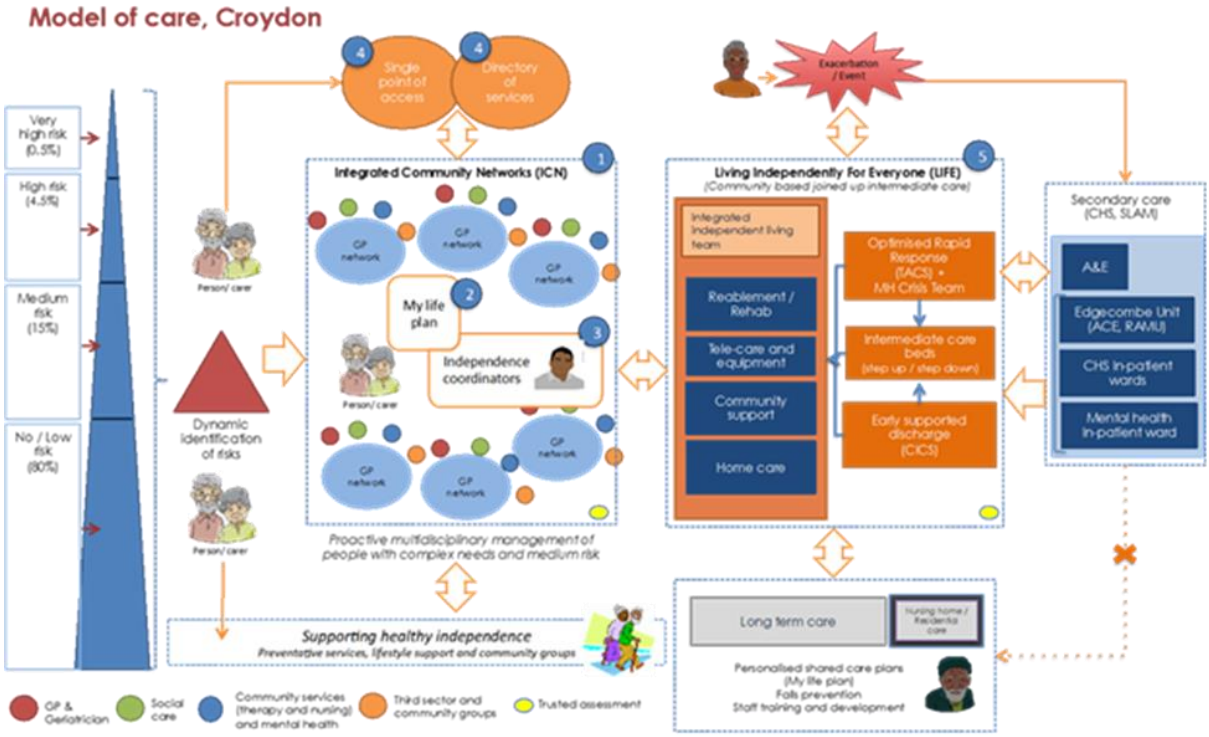

Figure 3: New Model of Care in Croydon

5.2 The two key programmes of transformation, ICNs and LIFE, are described in more detail below.

5.3 **Integrated Community Networks (ICNs) -** a tranche of the OBC Portfolio is the development of Integrated Community Networks (ICN) Programme, which has a remit to deliver the solution through 6 projects, these being:

5.3.1 **The Core ICN Team Multi-Agency Working Project** - The purpose of the Core ICN Team Multi-Agency Working project is to align and integrate staff from the five provider alliance organisations to each of the 6 GP Networks within Croydon. This to ensure medium to high-risk patients are identified quickly and are proactively case managed by one or more members of the multi-disciplinary team.

5.3.2 The key features of core ICN team multi-agency working are:

- One, trusted assessment between the core team
- Risk stratification, including both health and social risk indicators
- Worry score
- Huddles
- One to one support in planning and co-ordinating seamless care

5.3.3 **The Complex Care Hubs Project** - The purpose of the Complex Care Hub (CCH) is to meet as a MDT to discuss people who are deemed or proven to be too complex and challenging for the core ICN team and are deemed to be very high risk. The frequency of these CCH MDT meetings will initially be weekly (for two hours). The plan is to have two hubs; one in the north of the borough and one in the south.

5.3.4 **The My Life Plan (MLP) Project** - A MLP is a dynamic care plan based on input from the person through guided conversations. Every person over 65 in Croydon (and their carer) will have access to a website / app or hard copy that takes them through a systematic process of developing a personalised MLP. Care planning will be undertaken at various levels; initial planning will be undertaken with the person/family/carer by a skilled professional within the ICN.

5.3.5 **The Personal Independence Coordinators Project** – A new role titled Personal Independence Coordinator (PIC) has been created. This person will be a member of the core ICN team, bringing together the local voluntary sector and health and care organisations to support people over the age of 65. The PIC will be independent of social services and the NHS, and not part of the person's family or friends and will work intensively with people with long term conditions, if necessary, on a one to one basis.

5.3.6 **The Points of Access and Information Project** - Points of Access and Information will deliver high quality, easily accessible information and advice services which give people over the age of 65, and their families/carers, real choice and control over their lives – equipping them to identify and access services and products which meet their individual needs; supporting them to stay independent, healthy and safe; and enabling them to play an active role in their local community.

5.3.7 This will be provided via an advertised central telephone advice line, text messaging/ email service and face to face help via home visits and a General Advice Drop In within each of the 'front doors' in the 6 ICNs. The trained advisers will have access to a comprehensive and intuitive directory of service, which will provide information about statutory and voluntary sector services available, including online factsheets.

5.3.8 **The Galvanising Community Networks Project** - the Galvanising Community Networks project aims to strengthen the formal and informal social networks and focuses on the strengths and assets of an ICN, including:

- Recognising the skills and abilities of individuals within the ICN and finding people who are passionate about the community and who are good at making connections;
- Identifying voluntary and community organisations and networks and what they offer (or could offer) to the ICN; and
- Encouraging the voluntary and community organisations who are commissioned to provide preventative services to Croydon residents to work together to find new ways of developing services and/or activities that meet the growing and changing needs of a diverse population within each of the ICNs.

5.4 **LIFE -** The LIFE (Living Independently for Everyone) Programme seeks to establish an integrated reablement and rehabilitation service across the borough, comprising services from across Adult Social Care, Croydon Health Services and Croydon University Hospital. The long term ambition of LIFE is that it will see key services brought into a new LIFE integrated Reablement and Rehabilitation service – a new intermediate care service.

5.4.1 **Community-based Reablement** - As a step towards the long term ambition is the intention to establish a community-based reablement service funded by existing resources within Adult Social Care and additional resources from the Better Care Fund.

5.4.2 This project therefore is to establish the new community-based reablement service. Much work has been carried out prior to now to develop the LIFE model. There exists a Programme Development Group (PDG) and a Focus Group. It is therefore anticipated that these 2 groups will become central to the project and form the Project Team to undertake the work to establish the service.

5.4.3 **Multi-disciplinary Intermediate Care Service** - The Project will review the current reablement/ rehabilitation pathways for people leaving hospital. At the moment the council and Croydon Health Services (CHS) have a fragmented approach, with some people qualifying for a CICs service and other people being referred for a reablement service which is provided from one of the nine home care providers. The new service will be a multi-disciplinary team that includes nurses, occupational therapists, and physiotherapists. The service will work alongside the PACE, Community neuro rehab, Stroke. The following services will be in scope:

- Falls services
- Reablement following hospital discharge
- Rapid Response
- CICS
- A&E Liaison Team
- Step up/ Step down beds

5.4.4 **First Stop services**

5.4.5 The project will review the current S75s for the Occupational Therapy and Equipment and develop a new joint service; the service will also include a new one stop shop for equipment, telecare and telehealth.

5.5 **Transformation Strategy** - Further work is required to develop a comprehensive strategic ambition for the whole system including the impact on the delivery of planned care and the wider implications for the whole health and social care system.

5.6 The development of the ambition will form the cornerstone of the 5 year transformation plan for the OBC programmes. This plan needs to influence and be aligned to the Croydon STP and the strategic plans for all alliance partner organisations. A work plan has been developed to complete this work within the tight timeframe whilst also aligning with the South West London transformation case for change.

5.7 The development of the ambition will include working with an Innovation Think Tank: a group of Clinical and non-Clinical Leaders, along with private sector experts, to be used as a sounding board for developing and testing out ideas and ambitions for service improvement.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 **Revenue and Capital consequences of report recommendations -** The Commissioners wish to move to a capitated payment mechanism incentivised to improve outcomes for the population. With the 1+9 contract term, year 1 budget will be the value of the service contracts with the Providers in the Alliance. It is intended that from year 2 the capitated payment mechanism, as described below, will be in place.

6.2 This means that the Providers will be given a fixed amount per capita to cover the costs of care for the population rather than being paid directly for activity. The outcomes framework supports the capitated payment approach as it will incentivise the Providers to manage the quality and cost of provision – the Providers will be able to decide where to invest in order to deliver these outcomes, incentivising early intervention and prevention and thereby keeping patients well and out of hospital. The incentivisation of outcomes is expected to cascade through the care system to align and focus care teams such that each care pathway/intervention maximises outcomes for the population.

6.3 **Risks -** There are a number of programme risks being managed by the OBC PMO. These are monitored monthly by the OBC Programme Board, with membership from the CCG and Council. This will be monitored by the Alliance Board going forward to assure all parties that effective programme management is in place and that risks are suitably mitigated.

6.4 **Health Efficiency Saving Assumptions -** The health Quality, Innovation, Productivity and Prevention (QIPP) scheme is designed to ensure that each pound spent is used to bring maximum benefit and quality of care to patients.

6.5 There are defined efficiency savings in the early years of the contract which align with the CCG's QIPP target. Business cases for the delivery of these savings are in development.

6.6 **Council Efficiency Saving Assumptions -** The Council also has efficiency savings they expect to make. Savings of 5% in futures years of the contract and a slightly lower efficiency target in the earlier years.

6.7 It is expected that the shift of resources through whole system transformation will be from acute to community and preventative provision; including to social care, the voluntary sector and primary care. Detailed financial modeling being completed in year 1 will show this and will model the requirement for growth and savings per year.

7. LEGAL CONSIDERATIONS

7.1 Gowling WLG LLP, (Formerly Wragge & Co LLP) have been supporting the OBC programme from the outset. Gowling are leading on the production of the commercial documents on behalf of all parties.

7.2 The Council are being supported further by legal advisors from Trowers LLP. Other Providers may engage legal advisors to undertake a final review of the contract prior to agreement and signing.

8. EQUALITIES IMPACT

8.1 The equality analysis (EqIA) has previously been completed in the early phase of OBC, and has now been refreshed.

8.2 Evidence that underpinned the refresh of the EqIA included the draft Joint Strategic Needs Assessment (JSNA) that assesses the 'Health and Social Care Needs of Croydon's Older Adults & Carers. This provides a detailed understanding of the demographic characteristics, social determinants and health and social care needs of Croydon's over 65 population, and carers of people over 65. Following a high level appraisal of current need, the JSNA makes recommendations in areas for improvement.

8.3 Another key evidence base used is the 'Croydon Outcomes Framework for Older People's Care, Technical Specification'. This provides details of the indicators and metrics which will demonstrate delivery of outcomes that matter to local people and ensure health equity.

8.4 The updated EqIA includes actions detailing how potential impacts are being responded to and how future arrangements will continue to identify and address equality monitoring and performance requirements.

8.5 Approved by: Sarah Ireland (Director of Commissioning, Commercialism & Improvement)

CONTACT OFFICER: Martin Ellis, OBC Alliance Programme Director
Martin.ellis@croydonccg.nhs.uk
Phone: 02034585445